Enrolled patients completed a series of questionnaires assessing individual anticoagulation knowledge and beliefs, literacy and numeracy skills. Only patients in the intervention arm had the information incorporated into the clinical chart used by the pharmacist to manage warfarin therapy. RESULTS: A total of 160 patients consented and were randomized into the study, representing a 69.2% enrollment rate. Variation in INR readings did not improve as a result of the inclusion of patient information sheets in the charts of the intervention group as compared to patients receiving standard of care (difference = 0.037; p = 0.58). Patient knowledge of anticoagulation therapy significantly improved in the intervention group as compared to patients receiving standard of care (difference = 0.8 points (measured on a 20-point scale); p = 0.04).

CONCLUSION: Systematic inclusion of information regarding patient knowledge and beliefs of oral anticoagulation therapy, literacy and numeracy skills did not improve INR control but improved patient knowledge of anticoagulation therapy. While patient knowledge can be improved by providing opportunities to individualize educational interventions, further studies are needed to identify effective interventions to improve INR control and patient outcomes.

EVALUATION OF THE EFFECT OF ACUTE DECOMPENSATED HEART FAILURE GUIDELINES IN COMMUNITY HOSPITALS

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OBJECTIVE: Myocardial perfusion imaging (MPI) is recommended by the American Heart Association/American College of Cardiology for the evaluation/diagnosis of patients with coronary artery disease. Disparities have been found in the use of exercise stress testing based on gender and other sociodemographic factors. Our goal was to specifically assess these disparities in MPI. We hypothesized that women are less likely to receive MPI procedures than men after controlling for other sociodemographic factors.

METHODS: Patients undergoing MPI were identified using data from the 2004 National Ambulatory Medical Care Survey (NAMCS) and National Hospital Ambulatory Medical Care Survey (NHAMCS) using the International Classification of Diseases, 9th Revision procedure code 79.44. Utilization rates (tests/100,000) by gender were calculated at a national level. Multiple logistic regression analyses (with sample weights applied) were conducted controlling for age, race, ethnicity, and payment type.

RESULTS: In the United States in 2004, 2.9 million and 228,000 MPI procedures were ordered by office-based physicians and hospital outpatient departments, respectively. The utilization rates differed by gender (NAMCS: men 420, women 250; NHAMCS: men 415, women 175). Logistic regression analyses revealed that for office visits and hospital outpatient visits, women were less likely than men to have MPI orders (NAMCS: OR 0.63, 95%CI 0.41–0.97; NHAMCS: OR 0.54, 95%CI 0.32–0.91) after controlling for other sociodemographic factors. For office visits, age and race were also associated with the MPI orders (both p < 0.05). Subgroup analyses among women showed that for office visits, age had significant impact (p < 0.001) on the use of MPI in women; while for hospital outpatient visits none of the sociodemographic factors studied were significantly associated with the use of MPI in women.

CONCLUSION: MPI was ordered less frequently for women regardless of age, race, ethnicity, and payment type. Understanding why the gender disparities exist requires further research into clinical and social factors.

HEALTH CARE UTILIZATION ASSOCIATED WITH DEPRESSION FOLLOWING THROMBOTIC CARDIOVASCULAR EVENTS IN ELDERLY MEDICARE BENEFICIARIES

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OBJECTIVE: To measure the impact of depression following a thrombotic cardiovascular event (TCE) on health care services utilization in elderly Medicare beneficiaries and to determine whether antidepressant use affects this relationship.

METHODS: A cohort of 7051 community-dwelling non-HMO elderly beneficiaries who experienced a TCE were pooled from the 1997 to 2002 Medicare Current Beneficiary Survey. Baseline characteristics and antidepressant utilization were ascertained through the self-reported survey. TCEs (410, 411, 413, 414, 415, 433–438, 452, or 453) and depression (296.2, 296.3, 296.5, 296.6, 298.0, 300.4, 300.8, 309.0, 309.1, 309.4, or 311) were identified by ICD-9 codes on Medicare claims. Depression was identified by a depression claim within six months after the TCE. Antidepressant utilization by class was measured through at least one drug mention. Time to first emergency department visit, inpatient