costs were also modeled using linear regression. In this model the “Grier-effect” was estimated by using a dummy variable. RESULTS: For all months (November 2000–July 2001) projected PMPM cost of antibiotic therapy was lower than actual PMPM cost of antibiotic therapy. The r-squared for the model was 0.96. The 9-month average for projected PMPM antibiotic costs was $2.52 and actual PMPM antibiotic costs were $3.51, for an average differential of nearly $1.00. The extrapolated cost differential over the forecasted 9-month period was $12.5 million. This translates into $16.7 million in additional annual costs for antibiotic therapy due to the “Grier-effect”. Regression analysis of the effects of Grier indicated the GCD increased expenditures for antibiotics by 30% (p < 0.0001). According to regression modeling, a 30% increase in expenditures due to Grier increased costs of antibiotic therapy by $18.3 million. CONCLUSIONS: The GDC significantly increased antibiotic costs of antibiotic therapy by $18.3 million.

OBJECTIVE: Community Acquired Pneumonia (CAP) is a major cause of mortality and healthcare resource use worldwide. Proper management of less severe outpatient CAP has demonstrated resource savings without adverse patient outcomes. Although treatment guidelines recommend the use of certain pharmacological agents such as macrolides, fluoroquinolones or doxycycline for outpatient CAP, limited data are available on actual usage. We aim to describe current antibiotic prescribing patterns using a large prescription database. METHODS: The study population comprised IMS MediPlus-UK. Adult CAP outpatients (ICD-10: J13–J15) diagnosed during January 1, 1997 through December 31, 2001 and treated with antibiotics were included. Patients were followed through the initial duration of therapy and an additional 4-week period to capture the original therapy and added antibiotic use. Those with HIV/AIDS were excluded. Antibiotics were categorized as “penicillins”, “cephalosporins”, “macrolides”, “tetracyclines”, “quinolones”, and “other” (including multisubstance and trimethoprim). RESULTS: Among 739 episodes identified, most were initially treated by penicillin group (including amoxicillin, ampicillin, penicillin, 41%), and macrolides (erythromycin, azithromycin, clarithromycin, 28%). Cephalosporins, tetracyclines, and quinolones were used less often, 10%, 4% and 5%, respectively. The median prescribed length of therapy was 7 days, except tetracyclines (6). The means (days) (standard deviation) were: 6.9(2.8) for penicillins, 7.4(1.9) for cephalosporins, 9.5(17.2) for macrolides, 6.3(2.5) for tetracyclines, 6.4(1.5) for quinolones, and 6.7(1.5) for other. The percentage of patients received a second antibiotic during study period ranged from 15% to 23%, with the second round mostly in the same category as the initial antibiotic. CONCLUSIONS: Duration of therapy for CAP outpatients remains relatively long in this UK population. A substantial proportion of patients received additional therapy during the episode of care. Long therapy duration has been associated with patient nonadherence, and/or treatment failure. Effective therapy options with shorter length of therapy are needed to improve CAP outpatient management and patient outcomes.
the use of other antibiotics. We conducted a subsequent study to determine the impact of the policy on resistance rates.

THE ALLOCATION OF HIV PREVENTION FUNDS
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OBJECTIVE: It has been asserted that “decisions regarding the allocation of public HIV prevention funds represent the single most important set of HIV prevention decisions made,” (Ruiz et al., 2000; p.19). As a result, several approaches to allocating these funds have been proposed. However, the application of these models is limited because the measurements of performance are usually not quantifiable in real practice. This research outlines a resource allocation model that can be used to assist decision-makers in allocating HIV prevention funds. METHODS: The current process of allocating HIV prevention funds within various states was reviewed in detail. Specifically, population subgroup, intervention, and geographical issues were considered. In addition, measures of successful intervention implementation were identified. After this thorough review, parameters (i.e., prevalence, infectivity, input from local planning groups) deemed to be important in determining the proper allocation of funds were identified. These parameter choices were guided by the need to be able to estimate parameter values from available data systems. Using linear programming techniques, a model based on our parameter choices was developed for use by decision-makers that incorporates a quantifiable measure of success. This model also includes funding and equity constraints. RESULTS: An allocation of funds can be made such that several system constraints can be considered and the model can be validated through prospective data collection. The model was programmed in Microsoft Excel® with a user-friendly interface and was prototyped within a state health department’s allocation system.

DYSLIPIDEMIA MANAGEMENT AMONG HIV-INFECTED PATIENTS TREATED WITH PROTEASE INHIBITORS (PI)
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OBJECTIVES: Current guidelines recommend pravastatin or atorvastatin, and not lovastatin or simvastatin, to avoid drug interactions in PI-treated HIV+ patients requiring dyslipidemia treatment. Because limited data are currently available on the historical management of dyslipidemia within the PI-treated HIV+ population, we examined the annual utilization trend of non-recommended HMG-CoA reductase inhibitors (statins) within this population. METHODS: This was a retrospective, cross-sectional analysis using pharmacy claims from 1998–2001 from a managed care organization (MCO) of about 3.5 million lives. Patients with at least 2 claims for antiretroviral therapy with a cumulative days’ supply >30 and concurrent statin-PI utilization during the same calendar year were included. Logistic regression was used to evaluate whether age, gender, or physician specialty were associated with non-recommended statin use. RESULTS: There were 4 non-mutually exclusive yearly cohorts with 492 unique HIV+ patients with concurrent statin-PI therapy (1998:n = 141; 1999:n = 224; 2000:n = 231; 2001:n = 250). Mean ages ranged from 45.7–47.3 years and >95% were male. There were 58 occurrences (6.9%) of concurrent simvastatin-PI utilization between 1998–2001. No concurrent lovastatin-PI was identified. Most patients (72.5%) received their statins and PI from the same physician. Patients receiving these medications from different physicians were significantly more likely to have concurrent simvastatin-PI utilization (OR: 2.01, 95% CI: 1.13–3.58). Although no overall trend in simvastatin-PI utilization was observed, a significant decreasing trend was seen among infectious disease (ID) physicians (p = 0.04). CONCLUSIONS: As this patient population and its longevity grow, the quality of their management becomes increasingly important. Since simvastatin and lovastatin were not on this MCO’s formulary, the prevalence of non-recommended statin use was low. Nevertheless, we found a proportion of patients who received concurrent simvastatin-PI and a decreasing utilization trend among ID physicians as guidelines became better established. Awareness, however, among non-ID physicians may still need to be improved and greater coordination established between different physician prescribers of statin and PI therapy.

IMPLICATIONS OF APPLYING DIFFERENT NATIONAL GUIDELINES ADDRESSING SURGICAL ANTIBiotic PROPHYLAXIS:
A CROSS SECTIONAL STUDY OF 386 PATIENTS UNDERGOING TOTAL HIP REPLACEMENT SURGERY
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OBJECTIVES: To assess potential implications of applying four competing national guidelines addressing antibiotic prophylaxis of Total Hip Replacement (THR) surgery. METHODS: Four guidelines were applied to a random sample of 386 medical records of patients who underwent THR surgery from January 1999 to December 2000. Setting: Orthopaedic surgery wards in a 2200-bed French teaching hospital. Main outcome measure: Compliance of physician practice with the French guideline (French National Agency of Accreditation and Health

Abstracts