clinicians. **Methods:** The American Health Information Community (AHIC) is a federal advisory body organized to make recommendations to the Secretary of the US Department of Health and Human Services on how to accelerate the adoption of HIT. In July 2007, AHIC advanced recommendations to improve electronic health information exchange via the implementation of standards for FH information. The first step to developing interoperable HIT systems for the collection, interpretation, and exchange of FH information is the development of a widely accepted core minimum dataset for FH. To this end, the Personalized Healthcare Workgroup of the AHIC assembled the FH Multi-Stakeholder Workgroup to develop a minimum core dataset. The workgroup is comprised of over 40 members representing approximately 18 different public and private organizations with expertise in the area of FH, HIT, and healthcare delivery. **Results:** The FH core dataset for primary care was developed using an interactive, iterative process that used the proposed standards for FH information contained in the Continuity of Care Record (CCR) as a foundational document. Some key features of the core dataset are, FH information should be collected in a structured manner that permits the generation of a pedigree, age of disease onset should be collected, and self-identified race and ethnicity data should be included as FH information. The document outlining the requirements will be made available for public comment in early 2008. **Conclusions:** The document should serve as a solid foundation for public and private efforts to create HIT systems and demonstration projects examining the utility of interoperable FH information in clinical and research settings.

Abstract C-D2-05

Creation of State Legislation to Protect and Facilitate Use and Exchange of Electronic Health Information

Margaret J. Gunter, PhD, *Lovelace Clinic Foundation*; Shelley Carter, RN, MPH, MCRP, *Lovelace Clinic Foundation*; Bob Mayer, *New Mexico Department of Health*; Randall McDonald, JD, *Miller Stratvert P.A.*

Background: In examining potential barriers to implementing a statewide health information exchange in NM, we identified as a key barrier NM's laws regarding the protection of health information. The laws are fragmented and dated, adopted prior to HIPAA, and address only health data in paper-based formats. Enactment of specific state legislation authorizing transmission, use, and exchange of electronic health information would eliminate the detrimental effects of the existing state laws. **Aim:** To develop and pass comprehensive state privacy legislation in New Mexico governing the use, storage, and exchange of electronic health information. **Methods:** Review of health privacy legislation nationally, interviews with privacy experts, development of a draft of the legislation, and solicitation of input from a variety of stakeholder groups to identify controversial areas of the legislation and to garner legislative support were performed. Key privacy experts (e.g., legislators, healthcare providers, and attorneys) discussed their concerns and opinions about electronic transmission of health information. Attorneys researched privacy legislation in other states and drafted NM's Electronic Health Information Act. This draft was examined and discussed with numerous stakeholder groups to determine needed revisions. **Results:** Interviews with key privacy experts and stakeholders revealed conflicting points of view concerning the legislation, especially regarding issues of patient consent. Patient privacy advocates strongly favored patient control of access to their health data and more restrictive rules for patient consent than required by HIPAA. In contrast, providers, payers, and advocates for health information exchange networks typically favored less restrictive patient consent (consistent with current HIPAA regulations) to avoid additional time, burden, expense, and delays in implementing health information exchange. Review of legislation in other states revealed only Minnesota and Nevada have enacted laws specifically addressing electronic health information exchange. **Conclusions:** Current NM legislation (and legislation in most other states) does not adequately address the use and exchange of electronic health information. Current efforts to develop health information exchange networks in NM and elsewhere require resolution of key patient privacy issues and the passage of appropriate legislation. Funded by the Agency for Healthcare Research and Quality.

Health Economics

Abstract C-C4-01

Prevalence-Based Costs of HIV-Positive Patients With Multiple HAART Switches

Richard T. Meenan, PhD, MPH, MBA, *Kaiser Permanente Center for Health Research*; Michael A. Horberg, MD, MAS, FACP, *Division of Research, Kaiser Permanente Northern California*; Maureen C. O'Keeffe-Rosetti, MS, *Kaiser Permanente Center for Health Research*; Terry Kimes, MS, *Kaiser Permanente Center for Health Research*; Wendy Leyden, MS, *Division of Research, Kaiser Permanente Northern California*; Diana Antoniskis, MD, *Immune Deficiency Clinic, Kaiser Permanente Northwest*

Background/Aims: Highly active antiretroviral therapy (HAART) successfully treats patients with HIV. However, many patients do not achieve complete suppression. Perhaps the most important reason for treatment failure is infection with antiretroviral drug-resistant variants, which threatens to increase treatment cost as well as limit HAART's clinical effectiveness. This study examines the resource utilization and cost implications of multi-drug resistance using the HIV+ population of Kaiser Permanente Northern California (KPNC). **Methods:** Retrospective cohort analysis of all HIV+ patients in KPNC between January 2000 and June 2005 (total study period). Continuous active membership of 12 months and minimum 12 months of continuous HAART. Cases defined as HIV+ patients on third or later HAART regimen; controls defined as HIV+ patients on first or second HAART regimen. Regimen switch defined as combination change of two or more additions or subtractions of antiretroviral therapy (ART) drugs to or from an existing HAART regimen. Costs include outpatient, inpatient, and pharmacy categories. **Results:** All results are for 2004 only (291 cases, 1,676 controls); costs reported in person-years. Mean total pharmacy costs were \$17,668 for cases vs \$12,417 for controls ($P<0.04$). Of mean pharmacy costs for cases, 85% were ART-based (controls=90%). Mean number of 2004 fills for both ART and non-ART drugs were higher for cases (20 vs 15 for ART; 21 vs 15 for non-ART). Mean total outpatient costs were \$3,275 for cases vs \$2,238 for controls ($P<0.06$). Mean ER visits and mean primary care visits, but not specialty care visits, were both higher for cases than for controls ($P<0.03$). Mean inpatient costs were \$3,803 for cases vs \$1,738 for controls. Mean number of stays was higher for cases than for controls (0.29 vs 0.16; $P<0.05$), but length of stay did not differ between groups. **Conclusions:** In 2004, patients with HIV on at least their third HAART regimen incurred mean pharmacy costs 40% higher than similar patients on first or second regimen. Outpatient and inpatient costs also appear higher among cases, but not strikingly so. Overall cost differentials between cases and controls may be underestimates, as laboratory, radiology, and home health have not yet been added. These cost categories may well widen the cost differences between HIV+ patients who have been forced to switch HAART regimens more than once relative to those who have not.

Abstract C-C4-04

Entering and Exiting the Coverage Gap by Medicare Part D Beneficiaries With Diabetes: a TRIAD Study

Julie A. Schmittiel, PhD, *Kaiser Permanente Northern California Division of Research*; Susan L. Ettner, PhD, *University of California Los Angeles*; Vicki Fung, PhD, *Kaiser Permanente Northern California Division of Research*; Jie Huang, PhD, *Kaiser Permanente Northern California Division of Research*; Norman Turk, MS, *University of California Los Angeles*; Elaine Quiter, MS, *University of California Los Angeles*; Bix Swain, MS, *Kaiser Permanente Northern California Division of Research*; John Hsu, MD, MBA, MSCE, *Kaiser Permanente Northern California Division of Research*; Carol M. Mangione, MD MPH, *University of California Los Angeles*

Background/Aims: Many Medicare Part D enrollees face gaps in their prescription drug cost coverage after \$2,250 in annual drug expenditures. Beneficiaries with chronic illnesses may be particularly vulnerable to coverage gaps, with estimates ranging as high as 64% of diabetic beneficiaries entering the gap. We examined total drug costs and out-of-pocket drug costs, and rates of entry and exit into the Part D coverage gap for beneficiaries with diabetes in two large California Medicare Advantage plans. **Methods:** Beneficiaries from two large health plans in the TRIAD (Translating Research Into Action for Diabetes) Study offering Medicare Advantage Part