patients who recover to their pre-hospitalization EPO dose, post-hospitalization EDA dose increases frequently persist for several months, possibly due to missed ESA doses. lower Hb from hospital-related stress and immunosuppressive inflammatory states post-hospitalization. Strategies to address the causes of this should be evaluated.

PUK31

HOW COMMON IS CO-OCcurring ED AND BPH IN A HEALTH CARE CLAIMS DATABASE?

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OBJECTIVES: in the medical literature of co-occurrence of erectile dysfunction (ED) and benign prostatic hyperplasia (BPH) in men range from 20 to 80% depending on age, study design and severity of symptoms, and other patient characteristics studied. This study identifies the co-occurrence of these conditions, using healthcare insurance claims data. METHODS: Patients with ED and/or BPH were identified by diagnostic codes in the Thomson Reuters MarketScan® Database from January 1, 2007 to June 30, 2010. Patients in the sample were categorized as having BPH, ED, or co-occurring BPH and ED (defined as chronic kidney disease (CKD) in claims data. RESULTS: The model predicts that switching patients to monthly ESA could result in a 7.95% (95% CI: 7.10%–8.73%) reduction in per-patient/month ESA utilization. This translates into savings of $5,322 (95% CI: 4,748–5,839 U) ESA units/month/patient and $52.37 (95% CI: 46.72–57.46) per-patient/month for an average facility (96 patients), we estimated ESA savings of $510,934 U/month and cost savings of $5,028/month. CONCLUSIONS: The model predicts that increasing the interval between ESA dose adjustments, based upon the FDA approval and administration of a once monthly ESA, could decrease ESA utilization.

PUK32

LOWER CASE MIX ADJUSTERS ARE ASSOCIATED WITH LOWER ERTHROPOIESIS-STIMULATING AGENT (ESA) AND OTHER BUNDLED COSTS

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OBJECTIVES: the CMS dialysis prospective payment system (PPS) uses patient characteristics and co-morbidities to calculate payments. The final list of multipliers is determined by the dialysis facility characteristics and comorbidities to calculate payments. OBJECTIVES: The CMS dialysis prospective payment system (PPS) uses patient characteristics and comorbidities to calculate payments. The final list of multipliers is determined by the dialysis facility characteristics and comorbidities to calculate payments. METHODS: A cost-offset model estimated total ESA utilization and cost for monthly vs. 3x/wk ESA utilization. Input values were derived from a retrospective study of prevalent (<= 120 days), adult (>18 years old) hemodialysis patients (n=78,730), analyzing a large dialysis organization between 01/01/09-12/31/10. Patients dosed 3x/wk experience 1.1 dose titrations and 2.9 Hb measurements on average per patient-month. Each additional monthly dose titration is associated with a 24.1% (95% CI: 21.5%–26.4%) increase in total ESA dose. Based on monthly ESA vs. 3x/wk ESA data (Provenzano et al., ASN 2011), we projected patients on a once-monthly ESA would experience 0.8 titrations and 1 Hb measurement per month, and projected savings-based reductions of mean titrations and tests. Price (derived from published sources), dose and clinical equivalence were assumed across ESAs. Model outcomes include incremental savings/increases, cost-effectiveness and clinical effectiveness. RESULTS: The model predicts that switching patients to monthly ESA could result in a 7.95% (95% CI: 7.10%–8.73%) reduction in per-patient/month ESA utilization. This translates into savings of $5,322 (95% CI: 4,748–5,839 U) ESA units/month/patient and $52.37 (95% CI: 46.72–57.46) per-patient/month for an average facility (96 patients), we estimated ESA savings of $510,934 U/month and cost savings of $5,028/month. CONCLUSIONS: The model predicts that increasing the interval between ESA dose adjustments, based upon the FDA approval and administration of a once monthly ESA, could decrease ESA utilization. Higher CMA categories are associated with ESA utilization. We developed an economic model to quantify the potential impact of switching from a 3x/wk ESA to one dosed monthly. ESA dosing and frequency of ESA titrations are associated with other efficiencies (e.g., reduced administrations). METHODS: A cost-offset model estimated total ESA utilization and cost for monthly vs. 3x/wk ESA utilization. Input values were derived from a retrospective study of prevalent (<= 120 days), adult (>18 years old) hemodialysis patients (n=78,730), analyzing a large dialysis organization between 01/01/09-12/31/10. Patients dosed 3x/wk experience 1.1 dose titrations and 2.9 Hb measurements on average per patient-month. Each additional monthly dose titration is associated with a 24.1% (95% CI: 21.5%–26.4%) increase in total ESA dose. Based on monthly ESA vs. 3x/wk ESA data (Provenzano et al., ASN 2011), we projected patients on a once-monthly ESA would experience 0.8 titrations and 1 Hb measurement per month, and projected savings-based reductions of mean titrations and tests. Price (derived from published sources), dose and clinical equivalence were assumed across ESAs. Model outcomes include incremental savings/increases, cost-effectiveness and clinical effectiveness. RESULTS: The model predicts that switching patients to monthly ESA could result in a 7.95% (95% CI: 7.10%–8.73%) reduction in per-patient/month ESA utilization. This translates into savings of $5,322 (95% CI: 4,748–5,839 U) ESA units/month/patient and $52.37 (95% CI: 46.72–57.46) per-patient/month for an average facility (96 patients), we estimated ESA savings of $510,934 U/month and cost savings of $5,028/month. CONCLUSIONS: The model predicts that increasing the interval between ESA dose adjustments, based upon the FDA approval and administration of a once monthly ESA, could decrease ESA utilization.