chronic obstructive pulmonary disease (COPD), 27%), renal dysfunction (27%), stroke (21%), other cardiovascular disease (CVD, 78%). NNT to prevent one hospitalization annually (budget impact per HF patient in sample): 12 ($89) ACE- inhibitors/ARB, 15 ($80) beta-blockers, or 11 ($123) other cardiovascular drugs. -27 ($92) hypertension, 11 ($179) psychological disorder. -12 ($133) CHD, 12 ($118) diabetes, 13 ($98) hyperlipidemia, -10 ($97) COPD, -8 ($32) CVD. CONCLUSIONS: Reduction in out-patient-day of the hospital (between August 1st – November 30th, 2011) in the hospital budgetary analysis and missed opportunities analysis in Ukraine.

OBJECTIVES: Despite national and international guideline recommendations, only a small proportion (estimated in 39%) of ST elevation myocardial infarctions (STEMI) that arrive in the 8-hour “therapeutic window” in Colombia receive thrombolysis (Scenario 1). In this scenario, we assumed the gradual thrombolysis (Scenario 2) assumed a gradual increase in the use of thrombolytics nationwide, was US$728,291. With an increase in the use of thrombolytics (Scenario 2) the cost would increase by US$ 42,270 during the fifth year (with a 15% overall increase in the number of thrombolized patients, while the other (Scenario 2) assumed a gradual increase in those receiving tenecteplase instead of streptokynase. Proportion of patients with myocardial infarction receiving thrombolytics and an effect of policy change of relaxing the prescription-term restriction. In this study, we used the opportunity of this policy change in Japan to examine the economic benefits of switching to FDC.

RESULTS: Total HRRP penalties for the example hospital were calculated to be $669,025, with $199,130 additional reduction in payments under BPCI. One model projected that reducing rehospitalization post-PCI’s by 1% would reduce excess rehospitalization for patients with AMI from 1.052 to 1.037 and thus PPCI penalties by $80,975. Total cost of care for the 500 Medicare patients receiving PCI was reduced by $530,000 following subsequent clinical events, a savings accrued by hospitals under BPCI resulting in net hospital savings of $124,766. Achieving these savings with newer stent platforms would result in effective hospital savings of $156/student. CONCLUSIONS: A 1% reduction in PCI-related rehospitalization may substantially reduce penalties under HPCI and BPCI. Such reductions may be achievable using new stent platforms.