OBJECTIVES: Diagnosis and monitoring of lymphoma includes lymph node assessment and evaluation of multiple sites. This study examines the health care resource use among lymphoma patients. METHODS: Patients with ≥2 claims for Hodgkin lymphoma (HL) or non-Hodgkin’s (NHL) lymphoma from 1/01-12/31/12 were identified from a large US claims database, the index date was the first date of diagnosis and patients were retained on the health plan for ≥12 months before and after the index date, were not diagnosed with lymphoma during the pre-index period or diagnosed with cancer other than lymphoma 36 months before the index date. Indication of receipt of biopsy included ≥1 claim for a lymph node biopsy core, needle, fine needle, surgical, other, pathology, or tumor excision (bone marrow biopsy not included). Health care cost and utilization was examined among patients with ≥2 lymphoma claims indicating biopsy was identified for each biopsy type. RESULTS: 20,813 newly diagnosed lymphoma patients met all inclusion criteria. 16,557 (80%) had ≥1 claim indicating biopsy, 12,920 (62%) had ≥2 and 8,783 (42%) ≥3 biopsies. The percentage with an inpatient stay and inpatient health care cost was greatest among patients with ≥3 biopsies (53%, 53%) compared to patients with 2 (33%, 41%), 1 (25%, 34%), or 0 biopsies (24%, 42%). Total health care cost was greatest among patients with ≥3 biopsies ($102,465) compared to ≥2 ($85,565), 1 ($25,614), or 0 biopsies ($8,351). Health care costs associated with ≥3 biopsies ($23,296 for a complex surgical biopsy and $12,353 for other biopsies. Biopsies involving the mediastinum cost $10,554 on average. CONCLUSIONS: Lymphoma patients incur significant health care cost and utilization. Increasing the efficiency of lymph node diagnosis could avoid the need for repeat biopsies and reduce health care costs.

PHS73 COSTS OF PILOT PROGRAMS IN CHICAGO-BASED CENTERS FOR POPULATION HEALTH AND HEALTH DISPARITIES: A CASE FOR TEAM-CARE

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OBJECTIVES: To measure the costs of two team-care based pilot interventions. These interventions were part of a National Institutes of Health Clinical Centers for Population Health and Health Disparities (CPHPD) designed to improve health outcomes in medically underserved communities. METHODS: The data come from two Chicago-based CPHPD randomized controlled trials. Use of a virtual medical record allowed tracking of all patient encounters and claims (BRIGHTEN Heart) and cardio-metabolic syndrome and use of a patient navigator to improve diagnostic follow-up of mammography screening for breast cancer. The programs collected detailed data regarding service delivery and resource use. Costs were measured from a provider perspective. Actual time spent with patients was estimated in the navigator program using details on activities performed and previous time study data for those activities in similar programs. Time was converted to cost based on average billing rates by the BLS by occupational title. BRIGHTEN Heart involved multiple services along with time and travel cost estimates for each encounter and service. RESULTS: There were 483 patients that received patient navigator services and 16 patients in the virtual team-based BRIGHTEN Heart intervention. The patients were almost all minorities and were below average in terms of income and education. The operating cost of the Navigator program was $14,29 following diagnostic screening. The operating cost for the year of virtual team care in BRIGHTEN Heart was $753.18. CONCLUSIONS: Costs are an important consideration for evaluating team-care based interventions to improve patient health in the underserved. The two programs evaluated here offered a glimpse into the cost effectiveness of team-based care strategies employing allied health workers. Given the low cost of care, the programs offer promise of being cost effective. Future work will examine these costs in comparison to the effectiveness of the program.