of care for different categories of patients including cost of health care provider time per visit, medications, and non-ARVs.

Methods:

For an HIV positive patient with a CD4 count > 350 cells/μl who has not started ART was $51/year. The cost of treating a patient on first line therapy in the first year of ART was $218, and thereafter $284/yr. The cost of a patient on second line ART was $709/yr. The cost of treating and palliating all study patients with M. tuberculosis was $229/year and $413/year respectively. The costs are driven predominantly by ARV costs.

Conclusions: This analysis shows the actual costs of ART in a large urban HIV clinic in SSA. The increasing number of patients on second line ARVs is likely to dramatically increase the financial burden on health services in SSA in the future.

P4S45 PREDICTING HIGH COST ACCUMULATION: APPLICATION OF A GROUPING ALGORITHM FOR SURVIVAL DATA

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Objectives: Approaches for predicting cost accumulation for heterogeneous samples are limited. We employ the Grouping Algorithm for Cancer Cost Data (GACCD) to investigate cost accumulation over time and identify ‘high cost’ patients. Methods: Two-fold cross validation was used to evaluate survival and cost accumulation using linked prostate cancer (PCa) registry and Medicare claims data from 1999-2009. Patients were grouped according to a refined similarity metric using five patient characteristics (cancer stage, age, Charlson Comorbidity Index (CCI), performance status and race). Cost accumulation was evaluated in the test dataset for the GACCD groups identified in the training data. Curves using the test data plotted inverse probability weighted cumulative average total monthly costs (CATMC) for the post-diagnosis period and the proportion of people who were deemed ‘at high cost’. Results: Application of the inclusion criteria resulted in 110,824 patients. Median (mean) follow up was 48 (51) months and the mortality rate was 27.3%. The five GACCD groups had distinguishing characteristics e.g., group 2 patients were younger, with CCI between 0 and 1, whereas patients from later stage or unstaged PCa, group 3 patients were typically younger, with CCI=0 and diagnosed with early stage PCa. Cost accumulation within the first three years varied across the groups, with the lowest (highest) rate in group 3 (group 2) in the training data. Median (mean) lifetime cost at a threshold of $10,000 in regrouping the patients that was high cost within three years following diagnosis ranged from 82% to 93% in group 2 to 90% in group 2, proportions ranged from 45% in group 3 to over 60% in group 2 at a threshold of $25,000; proportions ranged from 15% in group 3 to over 30% in group 2 at a threshold of $50,000. Conclusions: A grouping algorithm with a refined similarity metric can identify patient subgroups that will accumulate higher costs over time.

P4S46 MONTHLY COST OF THERAPY FOR PATTILATIVE TYPE II DIABETES IN MUMBAI: A SURVEY

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Objectives: (1) Survey to estimate the monthly expenditure of a Type II Diabetes patient in Mumbai. (2) To project the fact that even in absence of health insurance policies by government for its citizens, patients receive free or cost subsidized treatment from superior and secondary hospitals. (3) Expand the knowledge in regulating the price of the Diabetes drugs. Methods: Three sets of structured questionnairenaires were designed which captured the patient demographics, prescription trends of type II Diabetes patients in Mumbai, India. The survey through questionnaires targeted the patients of primary and secondary hospitals. Results: Amongst them the population of males affects RX of patient than females in 51% males vs 46% females. (3) The trend of drugs as prescribed by the General Practitioners is same as that of drug prescriptions received by drug stores. The Metformin containing generic brands which fall under The Drug Price Control Order(DPCO) 2013 (cap price removed) majorly prescribed followed by glibpyride , acesbro and pioglitazone containing generic brands. Conclusions: (1) The monthly expenditure of a Type II Diabetes patient in Mumbai is Rs 300 (USD 4.8) when the patient is treated by GP and purchases the drug from the drug stores. (2) The patients are either treated free or in subsidized rates in government hospitals i.e. in 2 4USD per month. (3) The metformin category drugs coming under DPCO 2013 are the majorly prescribed drugs. Thus it is very easy and convenient for type 2 Diabetes patients in Mumbai to suffice their medical needs in the most reasonable and affordable price and also get free treatment from tertiary government hospitals. Although a federal/government health insurance policy does not exist in India the government through its subsidies or free treatments rightly initiates the most reasonable and affordable price and also get free treatment from tertiary hospitals for patients coming under DPCO 2013 are the majorly prescribed drugs. Thus it is very easy and convenient for patients with cancer or diabetes and with obesity or heart disease to suffice their medical needs in the most reasonable and affordable price and also get free treatment from tertiary government hospitals. Although a federal government health insurance policy does not exist in India the government through its subsidies or free treatments rightly initiates the most reasonable and affordable price and also get free treatment from tertiary hospitals for patients coming under DPCO 2013 are the majorly prescribed drugs. Thus it is very easy and convenient for patients with cancer or diabetes and with obesity or heart disease to suffice their medical needs in the most reasonable and affordable price and also get free treatment from tertiary government hospitals. Although a federal government health insurance policy does not exist in India the government through its subsidies or free treatments rightly initiates the most reasonable and affordable price and also get free treatment from tertiary hospitals. Therefore it is very easy and convenient for patients with cancer or diabetes and with obesity or heart disease to suffice their medical needs in the most reasonable and affordable price and also get free treatment.

P4S47 UTILIZATION, COSTS AND REIMBURSEMENT OF INPATIENT AND AMBULATORY TREATMENT OF ACUTE BACTERIAL SKIN AND SKIN STRUCTURE INFECTIONS AMONG THE MEDICARE FEE-FOR-SERVICE POPULATION

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Objectives: Recent clinical trials of antibiotics targeted to ABSSSI have included large proportions of patients treated in the ambulatory setting. An objective of this study was to analyze the relationship between Medicare patients treated in the inpatient versus the ambulatory setting. Methods: Analysis used Medicare 5% Limited Data Set (LDS) files containing claims for 2007-2010 patients age 18+ with a principal diagnosis of ABSSSI between Q4, 2007 – Q3, 2010 from a 5% sample of Medicare beneficiaries, including patients hospitalized for > 2 days (hospitalized patients, HPs), or using emergency room (ER) treatment for 1 day (emergency room patients; ERPs). Reimbursements were based on claims and inflated to 2010 USD, costs were derived from 2010 Premier data. Net reimbursement was analyzed by MS-DRG and length of stay (LOS). The risk of all-cause hospitalization and factors correlated with LOS were determined using logistic regression and comparing cross all study years, the median age was 71 for HPs, 65 for ERPs. Median Charlson Comorbidity Index (CCI) was 4 for HPs and 2 for ERPs. HPs had more cellulitis on the leg or surgical infection, ERPs had more cellulitis on the face, trunk or arm. Median HP LOS was 4 days; 33% of patients had LOS >6 days. Age, race, and history of bacterial infection were correlated with LOS. Median all-cause, ABSSSI-related and index event costs during the index quarter for patients with a principle ABSSSI diagnosis were $9990, $6123 and $604 for HPs, respectively. On average, $1080 and $100 for HPs respectively, apiexaban $598, $512, $490 and $530, respectively. APIBAN was associated with more cellulitis on the leg and post-operative infections. Further research and analysis may help determine whether treating some hospitalized patients with less complicated infections in the ambulatory setting might result in lower costs per patient after controlling for these factors.