small organizations (84.0%, n = 3,243,961). Regression analyses indicated that increased expenditures were associated with large organizations (exp(b) = 2.00, p < 0.025) and prostate cancer (exp(b) = 1.88, p < 0.039). Increased disability days were associated with melanoma (exp(b) = 3.57, p < 0.039) and cancer of the uterus (exp(b) = 3.85, p < 0.039). Other resource utilization was associated with breast cancer (exp(b) = 1.76, p < 0.011) and cancer of the uterus (exp(b) = 1.85, p < 0.025).

CONCLUSIONS: Cancer is associated with a substantial burden in the workplace, as 3.86 million persons were diagnosed with new cases or had continued treatment over time, ALL likely continues to impose a significant economic burden on society.

OBJECTIVES: The major aims of the current research are to learn the average cost (CT) and initiated on anti-emetic prophylaxis with palonosetron versus other 5-HT3 receptor antagonists for prevention of chemotherapy induced nausea and vomiting (CINV) among patients with cancer.

METHODS: To assess the average total daily CINV-related hospital outpatient visit cost (CINV-OC) among patients with cancer treated with any chemotherapy regimen, patients with a primary diagnosis of ALL (ICD-9-CM codes 204.0x) from the 1997, 2000, 2003, and 2006 were identified from the Premier Perspective database. Weighted estimates of the number of hospitalizations for ALL and associated resource-based outcomes (i.e., total charges, length of stay [LOS], and stem cell transplant procedures) were derived. RESULTS: Between 1997 and 2006, the rate of pediatric ALL-related hospitalizations per 100,000 US pediatric patients increased each year. The mean LOS decreased from 6.10/100,000 in 1997 to 6.62/100,000 in 2000 and 6.60/100,000 in 2003, and 6.62/100,000 in 2006. Mean LOS remained consistent until an increase in 2006 (12.1 days in 1997, 12.4 days in 2000 and 2003, to 13.6 days in 2006). Similarly, the proportion of ALL hospitalizations with evidence of stem cell transplant remained roughly unchanged at ~60% until a sharp increase in 2006 to 64.9%. Finally, mean costs (2010 USD) for ALL-related stays have increased nearly 31%, from $43,247 (1997) to $56,517 (2006). CONCLUSIONS: We examined rates of pediatric ALL-related hospitalizations and documented aspects of inpatient ALL care, and observed a slight increase in the rate of hospitalizations over time. An increase in LOS was seen in 2006, with a commensurate increase in total costs, possibly owing to a marked increase in the rate of stem cell transplant. These findings may be used to support access strategies (e.g., economic modeling efforts) for current ALL therapeutics, as well as for those in the developmental stage.

IMPACT ON HOSPITAL OUTPATIENT VISIT COSTS BY INITIATING PALONOSETRON VERSUS OTHER 5-HYDROXYTRYPTAMINES, RECEPTOR ANTAGONISTS FOR PREVENTION OF CHEMOTHERAPY INDUCED NAUSEA AND VOMITING (CINV) AMONG PATIENTS WITH CANCER

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OBJECTIVES: To assess the average total daily CINV-related hospital outpatient visit cost (CINV-OC) among patients with cancer treated with any chemotherapy regimen, patients with a primary diagnosis of ALL (ICD-9-CM codes 204.0x) from the 1997, 2000, 2003, and 2006 were identified from the Premier Perspective database. Weighted estimates of the number of hospitalizations for ALL and associated resource-based outcomes (i.e., total charges, length of stay [LOS], and stem cell transplant procedures) were derived. RESULTS: Between 1997 and 2006, the rate of pediatric ALL-related hospitalizations per 100,000 US pediatric patients increased each year. The mean LOS decreased from 6.10/100,000 in 1997 to 6.62/100,000 in 2000 and 6.60/100,000 in 2003, and 6.62/100,000 in 2006. Mean LOS remained consistent until an increase in 2006 (12.1 days in 1997, 12.4 days in 2000 and 2003, to 13.6 days in 2006). Similarly, the proportion of ALL hospitalizations with evidence of stem cell transplant remained roughly unchanged at ~60% until a sharp increase in 2006 to 64.9%. Finally, mean costs (2010 USD) for ALL-related stays have increased nearly 31%, from $43,247 (1997) to $56,517 (2006). CONCLUSIONS: We examined rates of pediatric ALL-related hospitalizations and documented aspects of inpatient ALL care, and observed a slight increase in the rate of hospitalizations over time. An increase in LOS was seen in 2006, with a commensurate increase in total costs, possibly owing to a marked increase in the rate of stem cell transplant. These findings may be used to support access strategies (e.g., economic modeling efforts) for current ALL therapeutics, as well as for those in the developmental stage.

For Decision Support for Rural Cancer Patients

Willingsness to Pay and Cost Benefit Analysis of Delivery Methods for Decision Support for Rural Cancer Patients

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OBJECTIVES: Consultation planning (CP), a decision support service for patients provided by trained lay people, increases cancer patients’ decision-self efficacy (DSE) when conducted in-person. It may be more cost-beneficial to conduct CP by telephone. Compare DSE, costs, willingness-to-pay (WTP) and cost-benefit (CB) of two CP delivery methods in rural breast cancer patients. METHODS: Randomly assigned clients from cancer resource centers were enrolled (n = 67). Interventions were CP in-person (n = 32) or by telephone (n = 35) between patients and trained resource center staff to discuss knowledge for informed care decisions at their next physician visit. Outcomes were DSE and WTP for services. 2009 costs of training, CP, telephone, travel, telephone, and per telephone call were obtained. We compared costs and WTP using t-tests, ranked-sum or Kolmogorov-Smirnov tests depending on Shapiro-Wilk tests for normality. CBA compared net benefit and CB ratios for delivery methods. RESULTS: As hypothesized, DSE did not differ between delivery methods (mean = 3.44 in-person, 3.54 telephone) but each improved significantly (p < 0.001). Patients’ WTP did not differ by method, telephone ($154), in-person ($144) (p = 0.78). Intervention costs were significantly lower for telephone than in-person ($139 vs $181, p < 0.001) due to higher patient travel for in-person ($26 vs $2, p < 0.001). Training costs were $57,847/person depending on amortization time frame. Net benefit for telephone over in-person was $75 more value. CB ratios when training ($6.00-$147/person) and overhead ($25/person) are added to program costs are 0.41-0.68 for in-person and 0.49-0.90 for telephone depending on number delivered, so patients are WTP up to 68% of in-person ($25) and 62% more return on telephone CP. CONCLUSIONS: Telephone delivery is more cost-beneficial than in-person CP. The value of CP is the same for either method and there are significant cost savings with telephone delivery. Adoption of CP by telephone could result in additional access for rural patients.