observed claim were excluded. Cumulative rates were estimated for all HF-related hospitalizations, cardiovascular (CV) hospitalizations and all-cause hospitalizations within the study period. Results were further categorized by types ofinsurance, specifically, commercial and Medicare advantage. RESULTS: A total of 85,938 patients met the study criteria of which 68.3% (n=58,712) had Medicare advantage coverage and 31.7% (n=27,226) had commercial insurance. The mean age was 63 years for patients with commercial insurance and 77 for those with Medicare advantage. For the total population (commercial + Medicare advantage), the cumulative hospitalization rate, inclusive of the first hospitalization, was 1.07 per patient-year for HF-related hospitalizations, 1.16 for CV-related hospitalizations (inclusive of HF) and 1.76 for all-cause hospitalizations. Cumulative hospitalization rates for patients with commercial insurance were 0.93, 1.00 and 1.52 for HF-related, CV, and all-cause hospitalizations, respectively. For patients with Medicare advantage coverage, the cumulative hospitalization rates were 1.14, 1.24 and 1.88 for HF-related, CV, and all-cause hospitalizations, respectively. CONCLUSIONS: Patients with heart failure who have Medicare Advantage have frequent subsequent hospitalizations. On average, these individuals were hospitalized at least once a year for worsening heart failure, irrespective of their coverage.

PCV113 ASSESSING THE HEALTH CARE RESOURCE UTILIZATION AND ECONOMIC BURDEN AMONG U.S. CARDIOVASCULAR DISEASE PATIENTS IN THE VETERANS HEALTH ADMINISTRATION POPULATION
Mao X1, Shrestha S2, Baser O1, Wang L1
1University of Texas at Dallas and STATinMED Research, Plano, TX, USA, 2STATinMED Research, Plano, TX, USA
OBJECTIVES: To assess health care resource utilization and costs among U.S. patients diagnosed with cardiovascular disease (CVD) using the Veterans Health Administration database. METHODS: Patients diagnosed with CVD or who underwent CVD-related procedures were identified (International Classification of Disease, 9th Revision, Clinical Modification [ICD-9-CM] diagnosis codes 410, 411, 412, 423, 424, 425, 433, 434, 435, 436 and current procedural terminology [CPT] codes 0606, 0636 and 0998) using the VHA dataset from 010072006 through 30052010. The initial diagnosis date was designated as the index date. Patients without a CVD diagnosis, who were of the same age, race and gender as study CVD patients, were identified for comparison. An index date was selected at random to minimize bias. Patients in both groups were required to be ≥ 18 years with continuous medical and pharmacy benefits for 1 year prior to and post index date. One-to-one propensity score matching (PSM) was used to compare health care resource utilization and costs between the CVD and comparison groups during the follow-up period, adjusting for baseline demographic and clinical characteristics. RESULTS: After risk-adjusted analysis using PSM, 36,121 patients in each group were matched. More CVD patients had inpatient admissions (14.40% vs. 1.43%, p<0.0001) and emergency room (14.89% vs. 3.66%, p<0.0001), outpatient office (60.90% vs. 47.19%, p<0.0001), outpatient (61.55% vs. 47.99%, p<0.0001) and pharmacy visits (64.43% vs. 54.89%, p<0.0001) compared to those without CVD. CVD patients also incurred higher costs. Costs were significantly higher for CVD patients than for those without CVD ($8,248 vs. $1,638, p<0.0001). CONCLUSIONS: CVD patients in the VHA population more frequently utilized health care resources and incurred higher costs than those without CVD.