OBJECTIVES: Hospital admissions for congestive heart failure (CHF) are a major driver of costs for health systems, and CHF is especially prevalent in patients aged 65 and older. This study assessed whether provision of oral nutritional supplements (ONS) in the hospital can reduce these costs, by estimating the effect of ONS use on 30-day readmission rates, length of stay (LOS), and hospitalization episode costs. METHODS: Using the 2000-2010 Premier Research database, a large claims database, we extracted a sample of 43,273 patients aged 65 and older with a primary diagnosis of CHF. We excluded episodes involving tube feeding and those ending in death (due to censoring). Using propensity score matching, we created a 1:1 matched sample of ONS and non-ONS receiving patients with similar demographics, severity, and comorbidities. Using (IV) regression analysis we investigated the outcomes of ONS use. The key outcomes studied were 30-day readmission rates, LOS, and episode costs (measured in 2010 US$). RESULTS: Propensity score matching produced a matched sample of 38,418 CHF episodes. Naïve OLS analysis, which did not account for selection bias, suggested that ONS increased costs, LOS, and probability of 30-day readmission. However, using IV regression analysis to control for selection bias revealed that ONS use reduced the probability of readmission within 30 days by 10.1% from 0.387 to 0.360 (p < 0.01). LOS was reduced through ONS use by 1.28 days (14.2%), from 9.03 to 7.75 (p < 0.01). Episode costs were significantly lower with ONS use, reducing total medical expenditures from €15,900 to €13,900 (p < 0.01). CONCLUSIONS: In elderly patients hospitalized with CHF, ONS improves 30-day readmission, LOS, and episode cost outcomes. ONS use could provide a low-cost strategy for improving hospitalization outcomes for elderly patients with CHF and reducing burden on health systems from CHF.

PCV174
KNOWLEDGE TRANSFER GAP BETWEEN CARDIOLOGISTS AND PATIENTS UNDERGOING PERCUTANEOUS CORONARY INTERVENTION REGARDING RISKS ASSOCIATED WITH DRUG-ELUTING STENTS: AN ASIAN & EUROPEAN SURVEY
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OBJECTIVES: The choice of stent used in percutaneous coronary intervention (PCI) is often at the discretion of the interventional cardiologist (IC) without informed shared decision making. We aim to assess the impact of ICs’ awareness of the risk of delayed arterial healing associated with drug-eluting stents (DES) on patient knowledge transfer. METHODS: 132 ICs from 11 countries (3 Asian: Malaysia, Hong Kong, Singapore and 8 European: Germany, Italy, UK, The Netherlands, Belgium, Denmark, Russia and Serbia) were invited to complete an online survey using a 4-point scale regarding their (i) familiarity with delayed arterial healing associated with DES, (ii) how concerned they are about delayed arterial healing, (iii) frequency they discuss how concerned they are about delayed arterial healing; (iii) frequency they discuss this risk with their patients and (iv) frequency this risk influence the type of stent they use. Responses from Asian cardiologists were compared with Europeans. RESULTS: 43.2% of ICs were Asians and 56.8% were Europeans. Majority of ICs were extremely/very concerned about delayed arterial healing with DES (59.6% vs. 32.4%, respectively, p < 0.01). Although twice as many Asian compared to European ICs were extremely/very concerned about delayed arterial healing with DES (59.6% vs. 32.4%, respectively, p < 0.01), there were no significant differences in the frequency this risk was discussed with patients (often/always: 24.6% Asia vs. 26.7% European, p=NS) or influence the type of stent used (often/always: 47.4% vs. 35.7%, p=NS). CONCLUSIONS: Many patients are not well informed of the risk associated with DES despite high level of physician awareness and concern of this risk. This knowledge transfer gap exists in both Asia and Europe.

PCV175
ACUTE ISCHEMIC STROKE (AIS) PATIENT MANAGEMENT IN FRENCH UNITS AND UNIT IMPACT ESTIMATE OF THROMBOLYSIS ON CARE PATHWAYS AND ASSOCIATED COSTS
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OBJECTIVES: This study aims to evaluate the current management and associated costs of acute ischemic stroke (AIS) for patients admitted in stroke units in France and over a 1 year follow-up period as well as to assess the impact of implementing a process of increasing the proportion of patients receiving thrombolysis and/or treated within 3hrs from symptom onset on functional recovery and care pathways. METHODS: A decision model was developed with 2 components: the acute hospital management phase of patients with AIS up until hospital discharge and the second corresponding to the post-acute phase. Patient journeys and costs were determined for both phases. Improved thrombolytic management was modeled by increasing the proportion of patients satisfied with the care pathway and estimated level of 16.7 to 25% as well as subsequently increasing the proportion of patients treated within 3 hours of the onset of symptoms post-stroke from 50% to 100%. The impact on care pathways was estimated from clinical data. RESULTS: In 2011, 29,999 stays took place in a stroke unit in France. 60% of discharges were to home, 25% to rehabilitative care then home, 2% to rehabilitative care then a nursing home, 7% to long-term care and 6% of stays ended with a patient death. Of a total cost over 1 year of €610 million (mean cost per patient of €20,326), 70% concern the post-acute phase. By increasing the proportion of patients thrombolysed, costs are reduced primarily by a decrease in rehabilitative care, with savings per additional treated patient of €1,662. By doubling the proportion of patients treated within 3hours to more than doubled (€1,833 per additional patient). CONCLUSIONS: By improving thrombolytic management in stroke units, patient journeys through care pathways can be simplified, with increased discharges home, a change of post-acute resource consumption and net savings.

PCV176
LAUNCHING NOVEL CLASS III IMPLANTABLE CARDIAC DEVICES FOR CARDIOLOGY IN EUROPE FIRST, IS THIS COMMON COMMERCIAL PRACTICE?
Impeving HEALTH CARE QUALITY FOR EUROPEANS
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OBJECTIVES: Regulatory hurdles for novel medical devices are lower in Europe than in the US. The costs and evidence requirements to achieve CE marking for medical devices are less stringent than FDA approval and they may be easier to achieve FDA approval via a 510k submission. As such, many companies have chosen to enter European markets with innovative cardiac devices before entering the US market. This study sought to understand the frequency with which has occurred in the last 10 years, and the correlation between market access timing and cardiac outcomes. METHODS: A review of CE mark and FDA approvals for class III implantable cardiac devices was conducted for the period of 2003-2013. Devices were identified and cross referenced to determine whether both CE mark and FDA approval were achieved. Those both achieved were then compared by the date of approval to determine market access variance in the US versus Germany. Publically available coverage and reimbursement policies were reviewed where market in combination with relevant disease prevalence rates over the study period. RESULTS: Implantable cardiac devices were routinely available in Germany before the US during the study period. Early use across europe, in many cases, has resulted in additional evidence generation prior to the FDA approval and follow-on reimbursement assessment processes in the US. While HTAs for devices was relatively rare in Germany, similar rates of reimbursement and access were achieved in both markets. Rates of cardiovascular associated mortality have dropped drastically, across both markets in the last decade. CONCLUSIONS: German approval was earlier than FDA for many innovative implantable cardiac devices during the period of 2003 to 2013, as compared to their American counterparts. The link between early access, clinical outcomes, and cost needs to be further analyzed in future studies.

PCV177
RECRUITING CARDIOLOGISTS AND CHRONIC HEART PATIENTS FROM A MANAGED PHYSICIAN PANEL TO SUPPORT CLINICAL STUDIES PHASE III/IV OR HEALTH OUTCOME STUDIES
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OBJECTIVES: To identify cardiologists willing to participate in Health outcome or Clinical Studies Phase III/IV in internal medicine and to include patients for outcome assessments. Real life patients are a time- and cost-effective option for recruiting sites and patients for observational post-approval studies. METHODS: In 2015, a representative survey among 4779 French cardiologists and patients and 9181 chronic heart disease patients (minimum 20; maximum more than 500). 93,5% of the cardiologists are willing to ask their patients to participate in clinical studies. 92,7% of this group was ready to be named as principal investigator to an ethical committee for recruiting patients. Maximum more than 500). 93,5% of the cardiologists are willing to ask their patients to participate in clinical studies. CONCLUSIONS: Germaniæn benefits from earlier access to many innovative implantable cardiac devices during the period of 2003 to 2013, as compared to their American counterparts.

PCV178
HEALTH CARE STAKEHOLDERS’ EVALUATION OF A USER-FRIENDLY TOOL WHICH ESTIMATES LONG-TERM HEALTH GAINS FOLLOWING THE REDUCTION OF LDL LEVELS
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OBJECTIVES: Demonstration of long-term reduction of preventive care in terms of health gains for patients with uncontrolled hypercholesterolemia and the associated costs with disease progression may be of great value to those who need to prioritize health policies. This analysis aimed to evaluate physicians’ and primary care patients’ opinions about a user-friendly tool which estimates long-term health gains following LDL-C reduction. METHODS: A user-friendly tool is internally published in a Markov model employed to evaluate health outcomes, including cardiovascular (CV) events and due costs. The model incorporated Framingham risk equations, Portuguese population characteristics, national mortality rates and local costs. Software version 10.0 and the tool may simulate for 3, 5 and 10 years the expected CV events drop following a given LDL-C
reduction. A predefined questionnaire was delivered to physicians’ and primary care providers’ (namely members of the regional health authorities) to survey their opinions about the value of this tool. RESULTS: Overall opinion from 30 physicians and 11 primary care doctors (geographically distributed) was positive, averaging 3.9 in a likert scale from 1 (strongly disagree) to 5 (strongly agree). Physicians averaged 3.5 in their opinion about the value of the tool. CONCLUSIONS: Since the mean of 3.9 ± 0.6 is above the 3.5 threshold of the overall assessment of the tool. Regarding more specific topics using the same likert scale, global, physicians’ and primary care doctors’ responses averaged as follows: usefulness of the tool: 3.6 ± 0.6; relevance of the tool: 3.9 ± 0.7; Value of the tool to understand LDL-C treatment targets: 4.0, 4.2 and 3.6. CONCLUSIONS: This approach is useful to understand user’s opinions about a tool which aims primarily to raise awareness on the importance of the LDL-C reduction and feasible evidence demonstrates that health care professionals still need to understand the public health potential of LDL reduction. This tool might be of great value to address this need.

PCV179
TREATMENT PATTERNS AMONG HEART FAILURE PATIENTS WITHIN 30 DAYS POST DIAGNOSIS: RESULTS FROM A US CLAIMS DATABASE ANALYSIS
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OBJECTIVES: Clinical guidelines recommend ACEIs (angiotensin converting enzyme inhibitors), ARBs (angiotensin receptor II blockers) for patients intolerant to ACEI, beta blockers (BBs), aldosterone antagonists (AAs) and diuretics as the pharmacological treatment for heart failure (HF). This study assesses the treatments prescribed within 30 days post diagnosis among HF patients in a real-world setting based on an administrative claims database in the US. METHODS: This was a retrospective cohort study conducted using MarketScan database. Adult patients having ≥2-HF-related medical claims in hospitalization with primary HF diagnosis between April 2009 and March 2012, and with a minimum of 12 months pre- and post-index continuous medical and pharmacy eligibility were included. Index date was defined as the first HF-related medical claim between April 2009 and March 2010. BIs were prescribed to 51.0% of patients in 12 months pre-index period were excluded. Demographics, clinical characteristics and index treatment (defined as a 30 days window period after HF diagnosis) were analyzed. RESULTS: Among 121,904 patients included in the analysis, 48.3% were >75 years of age, 53.6% were male, and 38.3% were ≥65 years of age. 76.0% (95% CI: 74.2-77.8%) of patients had one or more Charlson comorbidities, 26% and 16% of patients were classified as mild and moderate treatment intensity, respectively. The most commonly prescribed medications were diuretics in 79.9% of patients, ACEIs in 50.8% of patients and ARBs in 24.6% of patients. β-blockers were prescribed to 51.0% of patients in 12 months pre-index period were excluded. CONCLUSIONS: Overall opinion from 30 physicians and 11 primary care doctors (geographically distributed) was positive, averaging 3.9 in a likert scale from 1 (strongly disagree) to 5 (strongly agree). Physicians averaged 3.5 in their opinion about the value of the tool. CONCLUSIONS: Since the mean of 3.9 ± 0.6 is above the 3.5 threshold of the overall assessment of the tool. Regarding more specific topics using the same likert scale, global, physicians’ and primary care doctors’ responses averaged as follows: usefulness of the tool: 3.6 ± 0.6; relevance of the tool: 3.9 ± 0.7; Value of the tool to understand LDL-C treatment targets: 4.0, 4.2 and 3.6. CONCLUSIONS: This approach is useful to understand user’s opinions about a tool which aims primarily to raise awareness on the importance of the LDL-C reduction and feasible evidence demonstrates that health care professionals still need to understand the public health potential of LDL reduction. This tool might be of great value to address this need.

PCV180
PATTERNS OF BENZODIAZEPINES UTILIZATION IN OUTPATIENTS WITH HYPERTENSION IN SERBIA
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OBJECTIVES: Benzodiazepines (BZD) are often administered to patients with arterial hypertension in addition to antihypertensive agents. The aim of this study was to analyze patterns of BSD usage among hypertensive outpatients in Serbia according to sex, age and LDL-C levels of the sample decreased from 150.2 ± 32.9 mg/dL at baseline to 61.1 ± 45.8 mg/dL 100 mg/dL, as defined in the AHA, after 12 weeks at baseline. The current model aims to assess the ability of evolocumab treatment in patients with familial hypercholesterolemia to reduce the proportion of patients requiring apheresis in Germany. METHODS: Data on secondary prevention patients eligible for apheresis, excluding homoyzgs familial hypercholesterolemia patients, were extracted from the German IMS Disease Analyzer 2011-2013 database (n=8,262) and included in the analysis. The calculated mean LDL-C reductions observed in the DESCARTES and LAPLACE-2 evolocumab trials, ranging from 59.3% (95% CI [54.9, 63.8%]) to 72.3% (95% CI [69.1, 75.4%]), were applied to baseline LDL-C levels of the identified patient-profiles, following a probabilistic sampling method. The goal of the German study patients was LDL-C 100 mg/dL, as defined in the German lipid association (DGfP) guideline. RESULTS: The mean ± standard deviation LDL-C levels of the sample decreased from 150.2 ± 32.9 mg/dL at baseline to 61.1 ± 13.8 mg/dL at endpoint (P<0.001). In DESCARTES and LALPAC-2 evolocumab treatment, from an initial proportion of 100% of patients eligible for apheresis at baseline, apheresis treatment led to a proportion of 1% (DESCARTES) and 0% (LAPLACE-2) of patients requiring apheresis. Thus, in the analyzed population, apheresis-related costs were largely reduced. CONCLUSIONS: The use of evolocumab in the treatment algorithm of high-risk patients not at LDL-C goal could allow reducing the invasive, time-consuming, burdensome and costly weekly apheresis treatments. As a result, significant savings of apheresis-related costs could be achieved by the German Health Care System.