PCV76

STANDARD COSTS AND RESOURCES ALLOCATION IN ATTAINMENT OF TARGET LIPID LEVELS AMONG EXPERIENCED STATIN USERS: RESULTS FROM THE STAR STUDY (STATINS TARGET ASSESSMENT IN REAL PRACTICE)

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OBJECTIVES: The absolute Cardiovascular Disease (CVD) risk is a leading cause of death. Guidelines recommend treatment with lipid-modifying drugs for patients with an elevated CVD risk, since cholesterol target attainment allows a reduction of events. Our aim was to analyze the economic impact (drugs and hospitalization) of LDL target attainment.

METHODS: A multicenter, retrospective observational study using administrative and laboratory databases (1.1 million health-assisted individuals) was conducted. The enrolment date for a given patient was the last date before the patient reached its LDL therapeutic target, according to its CVD profile. Patients without statins prescriptions within the 18 months preceding the enrolment date were excluded.

RESULTS: A total of 17,243 patients were enrolled (54.6% males, age 69.3±10.0). The annual standard cost for statins and cardiovascular hospitalizations to achieve the therapeutic target, obtained from a multivariable regression model, was €698. The standard annual requirements for welfare benefits, calculated on the basis of this approach, had a value of 14% lower (€2,914,807) than the current value of expenditure. This resource saving was attributable to a reduced spending in hospital admissions, likely due to a correct prevention. The standard requirements, however, showed a different items composition of expenditure; particularly, we observed an increase of the pharmaceutical expenditure by 13% (€1,022,825) compared to the current value. 42% of patients did not reach target (33% adherents, 29% non-adherents), 33% reached target (although non-adherent), consuming 28% of the total expenditure, suggesting an over-consumption of resources (27% used high dosages statins); this expenditure could be reallocated within the non-target groups, increasing the adherence and switching to other statins and/or dosages.

CONCLUSIONS: The applicability of this approach and the cost-saving potential support the adoption of a reimbursement system that rewards the care pathway not only in its individual parts (ie, drug treatments).

PCV77

ANALYSIS OF HOSPITAL-SPECIFIC DRG PAYMENTS FOR STROKE AFFECTED PATIENTS IN THE UNITED STATES MEDICARE PERSPECTIVE

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OBJECTIVES: To calculate US hospital-specific DRG payments for in-patient stays with a primary diagnosis of stroke and assess its variability according to Medicare inpatient payments were implemented for each Medicare provider listed in the Federal Register, based on their information found in the 2012 PFS impact files. Weighted average tariffs across DRG, based on discharges reported in the Health Care Cost and Utilization Project (HCUP) statistics were generated and the variability of DRG payments was assessed through descriptive statistics. RESULTS: DRGs are assigned during inpatient stay for stroke and their average payments to Medicare providers ranging from $4,288 to $18,296. Overall weighted mean (median) payments for stroke were $7,193 ($6,728) across all DRGs and Medicare providers. DRG tariffs distributions by region as well as other hospital characteristics (size, urban versus rural location, teaching status) highlighted the disparities related to each of these factors and their relative impact. These findings were compared with HCUP aggregated statistics related to costs and hospital charges.

CONCLUSIONS: Calculating hospital specific DRGs according to the US-Medicare prospective payment system enable to get reliable cost inputs for health-economic models and relevant for adaptation to US-local settings (regional or even hospital based).

CARDIOVASCULAR DISORDERS - Patient-Reported Outcomes & Patient Preference Studies

PCV79

COMPLIANCE WITH WARFARIN THERAPY BY AUSTRALIAN PATIENTS WITH ATRIAL FIBRILLATION

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OBJECTIVES: To study warfarin compliance by Australian patients with Atrial Fibrillation (AF) using a longitudinal, patient-reported, self-assessment of Pharmaceutical Benefits Scheme (PBS) claim records provided by Medicare Australia. We analysed a 10% random sample of all Australian long-term health concession card holders who had taken an anti-arrhythmic medication for AF prior to a new initiation of warfarin (January 2006 to September 2007). We assessed their compliance and for whom warfarin had been dispensed in the 12 months prior to the initiation. Regimen complexity was assessed using the number of strengths of warfarin taken in a 90-day period. Treatment compliance was assessed using the proportion failing to fill a second prescription, median persistence time with medication. Treatment persistence was defined as 6 months without a warfarin prescription.

RESULTS: The PBS Claims database yielded information on 1,108 consecutive AF patients newly initiated on warfarin. These AF patients were initiated on 2 different strength of warfarin in the first 3 months and the regimen complexity was 2.0 strengths 12 months later. Australian PBS claims data indicated that 13% stopped warfarin after the first script. Median persistence to warfarin was 22 months, while long term persistence (30 months) was around 42%. Decreasing the cessation criteria from 6 to 3 months revealed large treatment gaps in 16% of warfarin patients at 2 years. CONCLUSIONS: There are patients with complex concomitant regimens and poor persistence in AF patients taking warfarin. Warfarin regimens tend to be complex with AF patients averaging 2 or more strengths of warfarin. Not only do the majority of AF patients stop warfarin within 1 year, but a further one in six had large treatment gaps. If AF patients fail to adopt their anti-coagulation therapy regularly, then this will substantially increase the risk of adverse outcomes including stroke.

PCV80

A RETROSPECTIVE STUDY OF COMPARING COMPLIANCE AND PERSISTENCE OF FREE COMBINATION ANTHYPERTENSIVE THERAPY VERSUS SINGLE-PILL COMBINATION: KOREAN CASUALTY STUDY

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OBJECTIVES: Antihypertensive single-pill combination (SPC) therapy is known to be associated with better compliance and persistence compared to free-drug combinations (FC). However, due to differences in blood pressure, occurrence of hypertension-related diseases, diet, and lifestyle, applying the existing results from a Western population to a Korean population may not be acceptable. In this study, we compared the compliance and persistence of SPC versus FC using the 2009 data of the Health Insurance Review Agency National Patient Sample. METHODS: A total of 65,477,122 prescription claims, patients aged at least one SPC or FC in 2009, were more than 40 years old and had no history of hospitalization, surgery, or cancer numbered 9,822 and 7,494, respectively. Compliance was measured using the proportion of days covered (PDC) and calculated as the proportion of days of days a patient filled the index drug within the 12-month follow-up period in 2009. Persistence with therapy was measured as the number of days from the index date to the therapy discontinuation date, which was defined as a gap in therapy of 30 or more days. RESULTS: The overall average PDC was 0.58 for SPC and 0.59 for FC, which was not significantly different. However, compliance varied by comorbidity status: patients who prescribed SPC showed greater FC than those who were prescribed FC. Notably, among patients with dyslipidemia, diabetes, and chronic heart disease, compliance was significantly higher for SPC than for FC: 0.64 vs. 0.61 for dyslipidemia (p=0.0159), 0.63 vs. 0.60 for diabetes (p=0.0062), and 0.69 vs. 0.66 for chronic heart disease (p=0.0441). However, persistence was not significantly different in either the overall cohort or the cohort stratified by comorbidity.

CONCLUSIONS: Our study suggests that use of SPC in hypertensive patients with comorbidities may provide clinical benefits by improving better compliance compared with patients taking FC.

PCV81

AWARENESS OF SERIOUS CONSEQUENCES OF NON-COMPLIANCE AND SELF-REPORTED ADEQUACY TO ANTIPATELLET THERAPY AFTER PERCUTANEOUS CORONARY INTERVENTION

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OBJECTIVE: Premature discontinuation of antplatelet therapy after percutaneous coronary intervention (PCI) based on a new predictor of silent patient thrombosis which can lead to serious consequences such as death and acute myocardial infarction. We aim to assess the impact of patients’ awareness of consequences of non-compliance on self-reported adherence with antplatelet therapy after PCI. METHODS: We retrospectively analysed 393 patients who underwent PCI with stent implantation from the Care For Your Heart database in Hong Kong. Patients were asked about their awareness of the risk of adverse cardiac events or death from non-compliance with anti-platelet therapy after PCI. RESULTS: Patients who were non-compliant (defined as self-reported missing more than 1 tablet per month) were compared to those who were compliant. RESULTS: Of the 393 patients, 35.6% (n=140) were unaware that non-compliance with anti-platelet therapy was associated with any risk, 50.9% (n=235) were aware of risk of adverse cardiac events or death, and 5.9% (n=23) were considered non-compliant with prescribed antiplatelet therapy after PCI. Non-compliant patients were predominantly male (91.3%) with an average age of 67±0.9 years, of whom 43.5% were not aware that non-compliance was associated with any risk compared to 35.9% (p=0.03) of compliant patients. Patients who were aware of the cardiac risks of non-compliance were more likely to adhere to their antiplatelet regimen (48.2% vs. 26.1%, p=0.03). More patients received their prescription on cardiovascular health from health talks (60.3%) and printed media (28.1%)这件事之后，患者对心脏病的关注度明显提高。