under-represented in large scale studies or clinical trials. Future research should identify clinical and hospitalization issues associated with prevalent disease in this population.

**PCV12**

**DISEASE MODIFYING THERAPY AND THE RISK OF HOSPITALIZATION IN PATIENTS WITH HEART FAILURE: A CONTEMPORARY MEDICAID COHORT ANALYSIS**

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**OBJECTIVES:** Increasing prevalence of heart failure (HF), increasing enrollment in state programs, sparse literatures on population-based heart failure studies, and the burden of hospitalization among Medicaid patients necessitate an analysis of risk factors for heart failure hospitalization in a contemporary Medicaid population.

**METHODS:** Claims from Maryland State Medicaid, for 14,149 non-dually enrolled, 18-64 year olds with a diagnosis for HF between 7/1/05-12/31/09, followed for at least six months. We examine the factors contributory to heart failure hospitalization rates in this population.

**CONCLUSIONS:** Multivariate Cox Regressions were used to identify independent non-proportionality of risk of hospitalization over the follow-up period. We report numbers needed to treat with first-line therapy to prevent one hospitalization annually. RESULTS: Most patients were <45 years (71%), female (56%), and black (60%). Use prevalence was: beta-blockers (26%), ACE-inhibitors/ARB (29%), aldosterone antagonists (5%), and others including nitrates/hydraulazine (3%). Nearly all (98%) were diagnosed with one or more comorbidities. Relative risk (95% CI) for any hospitalization was 1.43 (1.36-1.51) renal dysfunction, 1.40 (1.31-1.50) other cardiovascular, 1.33 (1.26-1.40) COPD, 1.28 (1.22-1.35) hypertension, 1.20 (1.12-1.30) heart failure, 1.11 (1.05-1.17) hyperlipidemia, 0.81 (0.77-0.85) psychological disorder, 0.77 (0.73-0.81) ACE inhibitor/ARB, 0.83 (0.79-0.87) beta-blocker, 0.76 (0.72-0.80) other cardiovascular drugs. AA and/or nitrates-hydraulazine combination therapy did not impact the risk of hospitalization.

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**PCV13**

**RECURRENT AND RISK FACTORS IN HOSPITALIZED PATIENTS WITH ACUTE VENOUS THROMBOEMBOLISM: A CLAIMS DATABASE ANALYSIS**

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**OBJECTIVES:** Venous thromboembolism (VTE) includes deep-vein thrombosis (DVT) and pulmonary embolism (PE), with a considerable risk of recurrence and mortality. This study examined the recurrence rate and associated risk factors in hospitalized patients with acute VTE in the US clinical practice setting.

**METHODS:** Adult patients with VTE were selected from the linked MarketScan and Medicaid/Chronic Illness database for the period 07/01/2006-12/31/2011. The first hospitalization with a diagnosis of VTE (ICD-9-CM: 451-453, 671.3, 671.4, 671.9, 415.1, 673.2, or 673.8) was designated as index hospitalization. Patients were required to have at least 6 months continuous enrollment and have no VTE diagnosis in the 6 months prior to index hospitalization. Patients were followed until the earliest of VTE recurrence, death, disenrollment, or the end of the study period. Up to three re-hospitalizations within the first 1 year were included up to a maximum of 11 re-hospitalizations. Cox regression models were used to determine the median time to recurrence.

**RESULTS:** Among 43,190 patients, 150 with both DVT and PE (15.7%). Mean age was 62.8 years (SD=15.2), and 432 were female (43%). The most prevalent comorbidity was hypertension (75%), followed by diabetes (56%), and hyperlipidemia (50%). Cox regression analysis revealed that age ≥45 years, presence of CHF at discharge, and duration of index hospitalization were associated with recurrence. The Cox model showed a hazard ratio of 1.55 (95% CI: 1.40-1.72) for patients > age 45 years, 2.55 (95% CI: 2.28-2.84) for patients with CHF, and 1.32 (95% CI: 1.19-1.47) for patients with longer hospitalization.

**CONCLUSIONS:** Recurrence of DVT and PE is associated with advancing age, the presence of CHF at discharge, and length of hospitalization. Long-term anticoagulation should be considered for these high-risk subgroups.