was significantly higher: $8877 versus $7597; P = 0.001. In patients who had a VTE event, mean cost of care was almost 26% ($3906) and 17% ($1935) higher for stays in short—and long-term facilities, respectively; P = 0.001. On average, Medicare paid 26% ($4057), 17% ($2102), and 17% ($1149) more due to VTE events for patients discharged to short or long-term facility or an SNF, respectively. CONCLUSIONS: Regardless of discharge status, VTE events during initial hospitalization for THR/TKR significantly increase total costs of a 1-year stay.

PCV53
ALISKIREN COMBINED WITH ANGIOTENSIN II-RECEPTOR BLOCKERS (ARB) RESULTED IN BETTER OUTCOMES COMPARED TO ARB COMBINED WITH ANGIOTENSIN-CONVERTING ENZYME INHIBITORS (ACEI): RESULTS FROM A CLAIMS DATABASE ANALYSIS
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OBJECTIVES: To compare compliance/persistence, health care utilization, and costs associated with aliskiren + ARB vs. ARB + ACEI combination therapies among adult patients with hypertension. METHODS: Patients with hypertension (age≥18) initiated on combination therapy (215 days of overlap) with aliskiren + ARB or ARB + ACEI during July 2007-June 2008 were identified in the MarketScan Database. Study outcomes were measured during the 6-month study period, including medication possession ratio (MPR), treatment discontinuation rates, resource utilization, and changes in health care costs (from 6-month baseline to study period). Risk-adjusted differences in outcomes between aliskiren + ARB vs. ARB + ACEI patients and their 95% confidence intervals (CIs) were estimated using multivariate regression models, controlling for demographics, comorbidities, prescription drug use, and health care resource utilization during the baseline period. RESULTS: Comorbidity profiles were similar between patients on aliskiren + ARB (N = 1,395) vs. ARB + ACEI (N = 16,507), though baseline resource utilization and costs were different between the cohorts. Adjusting for baseline characteristics, aliskiren + ARB patients demonstrated significantly higher MPR (difference = 15.2% [95% CI: 13.0%, 17.4%] and lower discontinuation rates (odds ratio = 0.43 [95% CI: 0.37, 0.51]) than ARB + ACEI patients. Aliskiren + ARB patients had fewer all-cause hospitalizations (adjusted incidence rate ratio [IRR] = 0.73 [95% CI: 0.61, 0.86]) and fewer all-cause emergency room (ER) visits (adjusted IRR = 0.72 [95% CI: 0.61, 0.85]) than ARB + ACEI patients; results for cardiovascular-related hospitalizations and ER visits were similar. Compared to ARB + ACEI patients, aliskiren + ARB patients had larger increases in prescription costs by $2464 during the 6 months following therapy initiation (95% CI: $151, $375), but showed a trend in reducing total health care costs by $838 (95% CI: −$2,409, $1,242) during the same 6-month period. CONCLUSIONS: Patients with hypertension initiated on aliskiren + ARB had significantly better compliance/persistence and lower frequencies of hospitalizations and ER visits than those initiated on ARB + ACEI. Trends indicated greater reductions in total health care costs with aliskiren + ARB, despite increased prescription costs.

PCV54
THE INCIDENCE AND COST OF SURGICAL SITE INFECTION (SSI) FOR COMMON CARDIOTHORACIC SURGICAL PROCEDURES IN THE USA: A STUDY USING THE PREMIER PERSPECTIVE™ DATABASE (PPD)
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OBJECTIVES: To estimate the incidence and costs for several common cardi thoracic surgical procedures to better characterize the burden of SSI to hospitals and the health care system.

METHODS: The Premier Perspective™ Database (PPD) was used to estimate the incidence and costs for SSI in several common cardiothoracic surgical procedures using ICD-9 codes discharged between Q2 2006 and Q1 2009 from the over 600 US hospitals included in the PPD. PPD is the largest hospital-based, service-level comparative database in the USA providing detailed resource utilization and cost data categorized under a patients’ principal and secondary diagnosis procedure codes. Our study focused on high volume cardiothoracic surgical procedures including sternum closure (3 codes), CABG (3 codes), and valve replacement (4 codes) to better estimate the incidence and costs of SSIs and the added costs to the health care system.

RESULTS: The incidence of coded SSIs ranged between 1.9% to 6.3%, while the incremental additional costs for each SSI ranged between $30,395 and $67,722. The magnitude, therefore, of increased costs for each SSI was 2- to 6-fold higher compared with not having an SSI, depending on the cardiothoracic surgical procedure. CONCLUSIONS: The incidence of SSIs in several common cardiothoracic surgical procedures were relatively small (1.9%-6.3%), however, the increased costs ranged from 2- to 6-fold higher per SSI representing a substantial economic burden to hospitals and the US health care system. New health care interventions targeting towards reducing the incidence of SSIs for common cardiothoracic procedures along the patient-care continuum are likely to reduce costs in both the short and long-term for hospitals in the US health care system.

PCV55
DIFFERENCE IN OUTCOMES MEASURES OF PATIENTS WITH VALVULAR AND NON-VALVULAR ATRIAL FIBRILLATION
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OBJECTIVES: Real world outcomes differences between valvular and non-valvular atrial fibrillation is unknown. We identified these patients from U.S. claims data and compared the main outcomes differences to determine clinical outcomes and clinical burden of the disease. METHODS: We used U.S. medical and pharmacy claims data from 2003-2007 for the analysis. Patients aged 65 years and older who had 2 or more primary diagnoses for atrial fibrillation occurring within 30 days of one