RESULTS: Eight years (01/10/96–30/09/00) of Massachusetts hospital discharge data were analyzed. Patients admitted for IS from 01/10/99–30/09/00 (index year) were identified using ICD-9 principal diagnosis codes (433.X1, 434.XX, 436) and unique patient identifiers. Patients with pre-index IS or hemorrhagic (ICH) stroke (ICD-9 codes: 430, 431, 432.X) admissions were excluded. All post-index hospital stays were examined for stroke readmissions. PAC costs (2005 US$), reflecting first six months post-event, were developed using claims data, fee schedules and published information.

METHODS: Typically, economic analyses do not account for potential differences in post-acute care (PAC) costs between first and subsequent ischemic strokes (IS). This analysis was performed to identify differences in discharge location and the impact on PAC costs. METHODS: Eight years (01/10/96–30/09/00) of Massachusetts hospital discharge data were analyzed. Patients admitted for IS from 01/10/99–30/09/00 (index year) were identified using ICD-9 principal diagnosis codes (433.X1, 434.XX, 436) and unique patient identifiers. Patients with pre-index IS or hemorrhagic (ICH) stroke (ICD-9 codes: 430, 431, 432.X) admissions were excluded. All post-index hospital stays were examined for stroke readmissions. PAC costs (2005 US$), reflecting first six months post-event, were developed using claims data, fee schedules and published information.

RESULTS: Of the 7801 patients admitted for IS in 2000, 814 (10.4%) were excluded for previous IS or ICH. Of the remaining 6987 patients, 769 (11%) had at least one readmission (range: 1–3) within four years for IS (91.3%), or ICH (7.3%) or both (1.4%). Of those readmitted for IS (n = 713; mean age: 75 years; female: 56%), 4% died during their second IS hospitalization. Compared to index IS admission, significant (p < 0.001) differences in average hospital length of stay (+2 days), home health care service referrals (+12%), and skilled nursing facility transfers (−14%) were noted at second IS discharge. More patients, albeit not statistically significant (p > 0.05), were admitted to chronic hospitals (+1%) and fewer to rehabilitation hospitals (−1%) after second IS. Average time between first and second IS hospitalization was 8.9 months (±11.2). Average PAC costs were $365 lower per patient following second IS. CONCLUSIONS: Differences in discharge location between first and second IS that affect PAC costs were identified. These differences should be considered when modeling lifetime stroke costs, as it reduces PAC costs following a second IS by roughly $500,000 per 1000 patients.

OBJECTIVE: The purpose of the study was to assess the utility loss and indirect costs at different time points following a stroke in Sweden. METHODS: In collaboration with the National Stroke registry (RIKS-STROKE), a questionnaire consisting of the EuroQol-5D (EQ-5D) and questions regarding the present working status and the status prior to the stroke was mailed to patients <76 years of age at six participating centres. The questionnaire was mailed to 393 patients, divided into groups with 3, 6, 9, or 12 months having passed since the stroke. The EQ-5D scores were converted to utilities using the UK social tariff. Indirect costs were valued according to the average salary + employer contributions (2006 Swedish Kronor). RESULTS: Two hundred questionnaires (70%) were returned. 32 questionnaires were completed by someone other than the patient; these were only used in the calculation of indirect costs. The average age was 64 years, with 40% of the sample being female. Utility scores were similar over time: 0.65, 0.75, 0.63, and 0.67 at 3, 6, 9 and 12 months respectively. The recalled utility prior to the event was 0.84 (similar to the general population 0.81). 56% of the sample below the age of 65 was working prior to the stroke (27% if considering the entire sample). This corresponds to 0.51 full time equivalents per patient. At 3, 6, 9 and 12 months, work performed corresponded to 0.13, 0.20, 0.15, and 0.14 full time equivalents. Using linear interpolation between measurements, this would lead to a 18.5 work weeks lost caused by the stroke, corresponding to an indirect cost of 120,000 SEK (€13,200). CONCLUSION: Stroke causes a significant reduction in utility and causes high indirect costs. There doesn’t seem to be a substantial improvement over time, which is important to consider in economic models.
OBJECTIVES: No method exists for measuring cost-effectiveness of services rendered to patients throughout the continuum of care. Products categorized within the durable medical equipment (DME) benefit add another complicating factor in determining the economic value of therapies. The objective of this study is to determine the cost-effectiveness of V.A.C.® Therapy compared to standard wound treatment for a dehisced chest wound patient treated across the continuum of care. METHODS: Treatment flows were determined through analyses of clinical literature and verified by physicians. An economic model was constructed using data from published literature to determine events and transition probabilities. Publicly available sources were used to determine clinical outcomes, hospital days, nursing time, and costs. A claims database was used for home care information. Meta-analyses served to integrate disparate data sources, (e.g., by calculating weighted averages). RESULTS: The economic model estimated the potential cost savings greater than $8,500 for treating dehisced chest wound patients with V.A.C.® Therapy when compared to wet-to-moist dressings. The return on investment (ROI defined as potential savings divided by material costs for V.A.C.® Therapy), is calculated to be $6.68: $1. This figure suggests that every dollar spent on V.A.C.® Therapy may be associated with more than $6 potential savings. The largest factor contributing to the cost-effective outcomes of V.A.C.® Therapy was the number of hospital days. V.A.C.® Therapy was associated with an estimated 5.2 fewer days compared to wet-to-moist therapy. The difference in closure method (e.g., primary closure instead of flap, secondary closure instead of primary closure) was the second largest contributor to the model results. CONCLUSIONS: This study suggests that V.A.C.® Therapy for a dehisced chest wound may provide a potential cost savings when compared to wet-to-moist treatments. These results highlight the importance of assessing wound therapy based on cost-effectiveness and ROI rather than on daily DME cost.

ECONOMIC EVALUATION COMPAREING FROM HOME TO OPERATION AND CONVENTIONAL PROCESS OF LAPAROSCOPIC CHOLOCYSTECTOMY: PROSPECTIVE RANDOMIZED CONTROLLED TRIAL

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OBJECTIVES: To conduct the first randomized controlled trial comparing the cost-effectiveness of From Home To Operation (FHTO) and conventional process in laparoscopic cholecystectomy (LC). METHODS: In Finnish communal hospitals, the patient is typically admitted to hospital on the preoperative day if he/she is not suitable for day-case. Between 12/2004–7/2005, 47 patients with symptomatic gallstones who were scheduled for LC were randomized to be operated either as FHTO (28 patients) or in the conventional way (19 patients) in Hyvinkää hospital. The quality of life (QoL) was measured with the 15D. Adjustments regarding baseline QoL, age, gender, BMI, ASA group, and smoking were conducted with robust iterative regression (Huber/Tukey) for quality adjusted life years (QALY) gained and with a robust generalized linear model (GLM, gamma distribution; log-link) for costs. A stochastic approach with one month interval for costs, length of postoperative stay, infection rate, and QALYs was employed. RESULTS: Baseline group characteristics were similar. The mean health care costs in the FHTO (1695 EUR) were significantly lower (p < 0.001) than in the conventional arm (2234 EUR). The number of patients discharged on the first postoperative day was 27 (96.4%) and 15 (78.9%) with the number of infections being 2 (7.1%) in the FHTO group and 4 (21.1%) in the conventional group. A significant difference in QALYs gained (0.01742, p = 0.030) favouring the FHTO was observed between the two arms. Assuming a willingness-to-pay of 5000 EUR per QALY, the probability of FHTO falling below this threshold value was 99%. This result was robust to sensitivity analyses. CONCLUSIONS: The FHTO dominated the conventional process in LC. After the initial investments, a Finnish hospital performing 500 standard LCs per year may produce 8 more QALYs, introduce 69 fewer infections and experience potential cost savings of 280000 EUR or require 667 fewer hospital days with the FHTO.

DEMOGRAPHIC PREDICTORS OF RESOURCE UTILIZATION AND COSTS OF SOLID ORGAN TRANSPLANTATION IN BRITISH COLUMBIA, CANADA

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OBJECTIVE: Increasing funding constraints have resulted in considerable pressure to improve the cost-effectiveness of solid organ transplant programs. Such efforts require an understanding of factors driving costs. To date, however, few investigators have examined the impact of patient characteristics on the resources utilized for transplantation. The aim was to determine the impact of demographic characteristics of patients on the mean direct medical costs of care during each of the two years post-transplant. METHODS: Using the Ministry of Health perspective, direct medical costs of all persons undergoing a transplantation of kidney, lung, heart or liver, were determined using data from British Columbia between 1995 and 2003. Health resources categories included inpatient hospital stays, outpatient visits, physician fees, laboratory and diagnostic tests and immunosuppressant medications. Multivariate analysis was used to model the impact of age, sex, and an indirect measure of median household income, on the costs of caring for patients during each of the two years post-transplant, after adjusting for calendar period. RESULTS: The percentage of women undergoing each procedure was 41% for kidney (n = 876 procedures), 40% liver (n = 257), 39% for lung (n = 67) and 23% for heart transplants (n = 133). After adjusting for calendar period, there was no impact of age or median household income on treatment costs during either the first or second years of follow-up after transplant. For persons undergoing lung transplantation, the mean costs of follow-up were significantly increased among men, with no differences in costs observed between women and men undergoing kidney, heart, or liver transplant. CONCLUSION: We observed that, among persons undergoing solid organ transplantation in BC, demographic characteristics did not have a systematic influence on the direct medical costs of post transplant care. Patient-specific clinical factors likely play a greater role in determining costs.