The study involves cross-sectional analyses of 44,957 veterans and non-veterans enrolled in Medicare. Merged Medicare claims for fee-for-service enrollees and survey data from multiple years of the Medicare Current Beneficiary Survey from 2001 through 2005. ACHS for thirteen conditions were identified using inpatient Medicare claims developed by the Agency for Healthcare Quality, which uses International Classification of Diseases, 9th edition codes. Dual use was defined as having inpatient or outpatient visits to the VHA and consistent of predominant-VHA use and some VHA use. Unadjusted group differences in any ACHS were examined using t-tests. Logistic regression analyses were used to explore the association between dual VHA use and ACHS after controlling for demographic, socio-economic, health status, mental illness, smoking and obesity. All analyses accounted for the complex design of the survey. RESULTS: The three most common ACHS were congestive heart failure, bacterial pneumonia, and chronic obstructive pulmonary disease. Among inpatient users, 10.1% had ACHS for acute conditions and 15.8% for chronic conditions. Among all survey respondents, 5% had any ACHS; the rates were 4.9% for VHA users and 3.7% for veterans with some VHA use. In bivariate and multivariate analyses dual use was significantly associated with any ACHS. CONCLUSIONS: In a representative sample of Medicare beneficiaries, ACHS were prevalent. Despite poor health status, dual VHA/Medicare use was not associated with increased ACHS rates perhaps due to the provision of good primary care in the VHA system.

EPIDEMIOLOGY OF ADOLESCENT AND YOUNG ADULT HOSPITAL UTILIZATION FOR ALCOHOL AND DRUG USE, SUICIDE, AND POISONING IN THE UNITED STATES

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OBJECTIVES: Adolescence and young adulthood are an important transitional period during which morbidity and mortality often arise from individual's behaviors such as alcohol and drug use, suicide, and poisonings. Self-report survey data regarding health behaviors are readily available, however little data from objective sources has been reported. This study aimed to estimate hospital utilization, particularly hospitalization, related to these behaviors has been conducted. This study examines the patterns and characteristics of individuals admitted to the hospital for these conditions. METHODS: The data for this investigation came from the 2007 National Hospital Discharge Survey (NHDS). Records for all individuals who had an age in the range of 10-24 years and were discharged from the hospital with any recorded diagnosis of alcohol or drug abuse or dependence, suicide, or poisonings were abstracted. National estimates were calculated utilizing the weighted number of discharges and the U.S. Census Bureau population data for this age group. Rao-Scott Chi square tests were performed to evaluate differences between groups and all significance tests were two-sided using p<0.05 as the level of statistical significance. RESULTS: National estimates for hospital discharges per 1,000 10-24 year olds are 54.2 for alcohol/drug use, 3.3 for suicide, and 9.8 for poisoning. Seasonal trends in alcohol/drug and suicide discharges were observed, as were regional differences with more than twice as many alcohol/drug-related discharges in the South. Over 42% of all care related to these diagnoses is expected to be paid for by public health insurance programs. Self-pay is also high for these conditions and all significance tests were two-sided using p<0.05 as the level of statistical significance. All variables were analyzed descriptively. Multivariate analyses were conducted to evaluate the factors associated with follow-up HMB-related costs. RESULTS: Mean [SD] age of the study population (N=21,239) was 39.5 [6.8]; mean [SD] comorbidity score was 0.14 [0.42]. Of the 21,239 women, 57.6% had 1 treatment episode, 15.7% had 2 or more, and 26.6% had no treatment during the post-index. 15,582 patients received treatment, the distribution of initial treatment was 36.4% received medication (oral contraceptive [OC], non-OC, or oral medroxyprogesterone acetate [MPA]), 50.8% had endometrial ablation [EA], and 12.6% underwent hysterectomy. Mean [SD] HMB-related costs of single episode paths were: hysterectomized $4,579.06 [4,539.34], non hysterectomized $4,579.06 [4,539.34]. On average follow-up HMB-related costs are expected to be 9.67 times greater for women with multiple episodes and 6.33 times greater for single episode (ref. group: no treatment). Age, Charlson comorbidity score, geographical region were all total associated with higher follow-up HMB-related costs whereas base-line OC use and pregnancy during the follow-up lowered costs. CONCLUSIONS: HMB has significant clinical and economic impact. Over 1/4 of patients did not receive treatment. Prevalence of surgical procedures was high among those treated, often constituting first-line treatment. Surgical procedures and multiple treatment episodes were associated with higher HMB-related costs.

SUCCESSFUL SEXUAL INTERCOURSE: TIME-TO-EVENT MODELING IN A PHASE 3 TRIAL

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OBJECTIVES: Sildenafil treatment in men with erectile dysfunction. SSI for each episode of sexual intercourse (SSI) with sildenafil and placebo. RESULTS: Median time from the start of the study to achieve initial SSI was 3 days for each group of sildenafil-treated patients (50 mg and 100 mg), received sildenafil 50 mg. Median time from the start of the study to achieve stable (sustained) SSI was 3 days for each group of sildenafil-treated patients (50 mg and 100 mg), achieved stable SSI was 5 days (50 mg) and 3 days (100 mg) for sildenafil-treated patients versus 55 days for placebo-treated patients (P<0.001). (Note that not every attempted sexual intercourse on the first day of treatment.) Median time to achieve stable (sustained) SSI was 5 days (50 mg) and 3 days (100 mg) for sildenafil-treated patients versus 55 days for placebo-treated patients (P<0.001).

CONCLUSIONS: This novel application of time-to-event analysis allows useful insights into how patients progress to sex with initial and then stable improvements with sildenafil treatment. Median times to initial SSI and sustained SSI were significantly shorter for sildenafil-treated vs placebo-treated men.

A NET BENEFIT FRAMEWORK (NBF) ANALYSIS OF CHART DATA FOR HAEMOPHILIA INHIBITOR PATIENTS

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OBJECTIVES: Effective treatment of bleedings in hemophiliac patients is important for limiting costs associated with bleedings and for improving health outcomes. Two health outcomes of interest is the time from treatment initiation to bleeding resolution and the probability of developing re-bleedings. The objective of this study was to use a multi-state transition model with NBF instead of the ICBR for estimating the health economic benefits of a novel treatment with certain characteristics compared to rFVIIa and to identify the major determinants of the net monetary benefit of the novel treatment. METHODS: Data from a medical chart review on hemophilia inhibitor patients in Turkey were used to identify predictors of the
OBJECTIVES: Efficiency in health systems is often a matter of concern and differences on the expected productivity of a given procedure might lead to inefficient variations in the performance of such interventions. Health economics literature has extensively revisited the topic of variations in health care using multivariate models. The analysis of variations has been among geographic regions. The clustering effect of facilities (as a functional unit), however, has not been described before. This analysis examines the extent to which facilities explain geographic variation in health care.

METHODS: A set of individual data on all births from a Contributory-Regimen insurer in Colombia was assessed. We performed a multilevel logistic regression model, taking hospitals as the clustering variable. In addition, we included an alternative variance decomposition specification to estimate the attributable effect of geographic region on the variability across hospitals. We used a set of variables including maternal education and income, physician fees, and complications during pregnancy to control for in this analysis.

RESULTS: Our results reveal that hospitals account for 20% of variation on the probability of performing cesarean sections. Geographic area only explains one-third of the variance attributable to the hospital. CESAREAN DELIVERY

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