simulated...
OBJECTIVES: To estimate acute, short-term and long-term healthcare costs among high-risk patients following an acute ischemic stroke. METHODS: A retrospective cohort study examined hypertensive patients (≥1 medical claim and/or ≥1 prescription for lipid-lowering therapy) using longitudinal administrative claims data from a large commercial US insurer. Those with a CVE and those without a CVE were propensity-matched to control patients. The co-primary outcomes of interest were hospitalizations, comorbidities, and coronary heart disease risk. Qualifying CVEs were MI, ischemic stroke, PCI, CABG, unstable angina, TIA or heart failure. Patients were followed from index date (first CVE to a randomly selected date for those with a CVE) until the earlier of disenrollment, 8/31/12, or 36 months after the index. Analyses reported here are limited to commercially enrolled CVE patients and their matched non-CVE pair. The payer perspective was taken for all analyses with cost representing the total healthcare plan, patient, and drug costs. 

RESULTS: The study included 156,576 patients. Acute costs among those with no CVE were significantly lower at $799±4,037 (p<0.001). Costs in the short-term were $18,532±48,721 ($6,484±15,948 for no CVE, p<0.001; 2nd year costs were $15,355±43,438 ($3,964±83,152 for no CVE, p<0.001) and 3rd year costs were $14,988±99,075 ($3,744±149,286 for no CVE, p<0.001). CONCLUSIONS: Acute costs are highest in hypertensive patients with a CVE compared to those without the main driver of costs following a CVE was inpatient hospitalizations. Although costs decline in the short- and long-term, costs of patients with CVEs remain high for several years compared to hypertensive patients without CVEs. 

PCV54 TREATMENT EFFECTS ON THE COST BURDEN OF HOSPITALIZATIONS IN PATIENTS WITH CHRONIC SYSTOLIC HEART FAILURE
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OBJECTIVES: To quantify the cost savings potential due to a reduction in hospitalizations (all-cause and for worsening HF) for patients with chronic systolic HF. METHODS: An economic model was developed to quantify the rates and costs of hospitalizations from both the US commercial (≥65 years of age) payer and Medicare perspectives. Medications with data on hospitalization rates and costs by hospitalization type were taken from US commercial and Medicare claims data. The SHIFT trial was used to obtain rate ratios for type by hospitalization of patients receiving ivabradine versus placebo on a background of guideline-suggested drug therapy. A generalized linear model with Poisson distribution and log-link function was used to estimate admission rate ratios adjusted for baseline beta-blocker use. RESULTS: In the commercial HF population, an annual rate of all-cause hospitalizations per patient was reduced by 15% if 1.5% of patients were treated with ivabradine versus placebo. The incremental cost per additional patient treated with ivabradine was $46,215/PY; 75% of that cost is from HF-related hospitalizations. The rate ratios and 95% confidence intervals with ivabradine over the entire trial follow-up were 0.74 (0.68-0.80) and 0.89 (0.82-0.96) for HF-related and all-cause hospitalizations, respectively. With ivabradine, a reduction of $9,980/PY in all-cause hospitalization costs was estimated in the commercially insured HF population, $8,904 of which was due to reductions in HF-related hospitalizations. A higher rate of hospitalization in the Medicare population was observed (2.19/PY), but was associated with a lower cost of $18,630/ PY; 89% of that cost is from HF-related hospitalizations. CONCLUSIONS: The primary objective of this study was to systematically identify and quantify the non-health sector costs for adults with HF and in caregivers to patients with HF. METHODOLOGY: This review assessed the cost-effectiveness of GCA in France and to identify driver costs of GCA in the North-American context. The aim of this study is to assess the net costs due to GCA in France and to identify driver costs of this disease. 

RESULTS: Two studies are included in this review. One study is to assess the net costs due to GCA in France and to identify driver costs of GCA in the North-American context.

OBJECTIVES: To study the cost effectiveness of cardiovascular events (CVEs) for 3 years post-CVE among high-risk patients diagnosed with hypertension. METHODS: A retrospective cohort study was conducted among high-risk hypertensive patients with and without a new CVE, using IMS LifeLink PharMetrics Plus data 01/01/2006-06/30/2012. CVEs included primary inpatient claims for myocardial infarction, unstable angina, ischemic stroke, transient ischemic attack, revascularization and heart failure events. Only scarce information pertaining to direct non-health care sector costs (caregiver time and patient out-of-pocket expenses), and indirect effects (e.g. informal care, lost wages, patient working days lost) were reported. CONCLUSIONS: In summary, this review highlights the paucity of available societal cost evidence for patients with chronic heart failure. Further studies are needed to address this knowledge gap.

PCV56 DIRECT MEDICAL BURDEN AND READMISSION RATES AMONG NON-ELDERLY PATIENTS WITH ACUTE ISCHEMIC STROKE IN THE UNITED STATES
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OBJECTIVES: To describe the healthcare resource utilization and costs in the year following hospitalization for acute ischemic stroke (AIS). The mean lifetime cost of AIS is approximately $140,000. With cost estimates projected to increase three-fold by 2020, it is important to gain a better understanding of the direct economic impact of AIS. The incidence of GCA in France is 10 to 20 per 100,000 people older than 50 years. The aim of this study is to assess the net costs due to GCA in France and to identify driver costs of this disease. 

RESULTS: Two studies are included in this review. One study is to assess the net costs due to GCA in France and to identify driver costs of GCA in the North-American context.

OBJECTIVES: To study the cost effectiveness of cardiovascular events (CVEs) for 3 years post-CVE among high-risk patients diagnosed with hypertension. METHODS: A retrospective cohort study was conducted among high-risk hypertensive patients with and without a new CVE, using IMS LifeLink PharMetrics Plus data 01/01/2006-06/30/2012. CVEs included primary inpatient claims for myocardial infarction, unstable angina, ischemic stroke, transient ischemic attack, revascularization and heart failure events. Only scarce information pertaining to direct non-health care sector costs (caregiver time and patient out-of-pocket expenses), and indirect effects (e.g. informal care, lost wages, patient working days lost) were reported. CONCLUSIONS: In summary, this review highlights the paucity of available societal cost evidence for patients with chronic heart failure. Further studies are needed to address this knowledge gap.

PCV58 LONG-TERM ECONOMIC BURDEN ASSOCIATED WITH CARDIOVASCULAR EVENTS AMONG HIGH-RISK PATIENTS WITH HYPERLIPIDEMIA
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OBJECTIVES: This study evaluated the economic burden associated with new cardiovascualr events (CVEs) for 3 years post-CVE among high-risk patients diagnosed with hyperlipidemia. METHODS: A retrospective cohort study was conducted among high-risk hyperlipidemic patients with and without a new CVE, using IMS LifeLinkPharMetrics Plus data 01/01/2006-06/30/2012. CVEs included primary inpatient claims for myocardial infarction, unstable angina, ischemic stroke, transient ischemic attack, revascularization and heart failure events. Only scarce information pertaining to direct non-health care sector costs (caregiver time and patient out-of-pocket expenses), and indirect effects (e.g. informal care, lost wages, patient working days lost) were reported. CONCLUSIONS: In summary, this review highlights the paucity of available societal cost evidence for patients with chronic heart failure. Further studies are needed to address this knowledge gap.