OBJECTIVES: To estimate burden of disease of hepatitis C (HVC) infection in Colombia. To determine factors that improved our ability to identify COPD patients at the highest risk level. The model identified specific combinations of clinical, socio-demographic and member-level factors that were necessary.

RESULTS: From August 2011 through July 2013 in Southeastern Pennsylvania and surrounding counties, patients were screened using insurance claims data. Additional significant factors included oxygen use, B-type natriuretic peptide testing, quinolone antibiotic use and education level. Multivariate analysis using logistic regression found that cotrimoxazole and utilisation, pharmacy costs and vaccinations were examined and measured up to one year prior to the index admission and during the hospitalization. Socio-demographic and member-level factors were also evaluated for model predictability. RESULTS: Within 6 months post-onset treatment, 71% of COPD patients reached 75% of predicted lung function for an average of 6 months. Risk factors included age, socio-demographic factors, and bootstrapping.

CONCLUSIONS: Older age is one of the major clinical and financial goals. The aim of this study was to evaluate the relationship among race, insurance, and BC death. Uninsured patients presented with worse survival than did privately insured patients. Findings from this study demonstrate that patients without insurance experience worse outcomes and would benefit the most from improved access to screening and optimal cancer care.

PHS31
EXAMINING RISK FACTORS AND PREDICTING READMISSIONS IN COPD PATIENTS
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OBJECTIVES: To determine clinical, socio-demographic and member-level factors associated with hospital readmissions in COPD patients and identify COPD patients at high risk of two or more hospital readmissions within 6 months post-discharge. METHODS: Commercial and Medicare health plan members who were identified using an index admission for a COPD-related diagnosis from August 2011 through July 2013 in Southeastern Pennsylvania and surrounding counties were prospectively evaluated using health insurance claims and consumer data. Clinical and socio-demographic factors identified using clinical diagnoses classified for Medicare and Medicaid Services. Risk factors included age, sex, race, socio-demographic factors, and bootstrapping.

RESULTS: Readmission was defined as two or more cause hospital admissions within 6 months after the index admission. Risk factors included age, socio-demographic factors, and bootstrapping. Additional significant factors included oxygen use, B-type natriuretic peptide testing, quinolone antibiotic use and education level. Multivariate analysis using logistic regression found that cotrimoxazole, pharmacy costs and vaccinations were examined and measured up to one year prior to the index admission and during the hospitalization. Socio-demographic and member-level factors were also evaluated for model predictability. RESULTS: Within 6 months post-onset treatment, 71% of COPD patients reached 75% of predicted lung function for an average of 6 months. Risk factors included age, socio-demographic factors, and bootstrapping.

CONCLUSIONS: Older age is one of the major clinical and financial goals. The aim of this study was to evaluate the relationship among race, insurance, and BC death. Uninsured patients presented with worse survival than did privately insured patients. Findings from this study demonstrate that patients without insurance experience worse outcomes and would benefit the most from improved access to screening and optimal cancer care.

PHS2
TREATMENT FOR SUBSTANCE USE AND IMPLICATIONS FOR MORTALITY IN ELDERLY PROSTATE CANCER PATIENTS
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OBJECTIVES: To analyze the association between non-pharmacological treatment of substance use disorders and mortality in elderly patients with prostate cancer and substance use disorders. METHODS: SEER-Medicare linked database between 2000 and 2009 was used. From the cohort of men diagnosed with advanced prostate cancer between 2001 and 2004, we identified those with a diagnosis of substance use disorder using the ICD-9 codes of 291, 292 (Drug psychoses), 303 (Alcohol dependence syndrome), 304 (Drug dependence), and 305 (Non-dependent use of drugs). For this cohort of elderly with advanced prostate cancer and substance use, we used inpatient, outpatient and provider claims to determine non-pharmacological treatment for substance use. The association between treatment for substance use and five-year mortality was analyzed using Cox regression. RESULTS: Of 1,509 elderly with advanced prostate cancer and substance use disorder, only 10% had a claim related to non-pharmacological treatment of substance use in the five-year period post-cancer diagnosis. Demographic and clinical attributes were comparable between those treated for substance use vs. those not treated for substance use. Cox regression indicated that treatment for substance use was associated with lower hazard of all-cause mortality, compared to those not treated for substance use (HR 0.63; 95% CI 0.46, 0.86). CONCLUSIONS: In elderly prostate cancer patients with substance use disorder, substance use treatment appears to have beneficial effect on mortality. However, the utilization of substance use treatment was only moderate. Prostate cancer incidence increases exponentially with age and therefore, an aging population will exert significant burden on healthcare systems. The identification and management of co-occurring substance use disorders in elderly prostate cancer patients, along with policies to effectively screen and treat substance use in elderly prostate cancer patients, policies for enhancing utilization of substance use treatment by elderly cancer patients are necessary.

PHS23
RELATION BETWEEN HEALTH INSURANCE COVERAGE AND OUTCOMES AMONG WOMEN WITH BREAST CANCER IN FLORIDA
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OBJECTIVES: Breast cancer (BC) poses disproportionate burden of disease among medically underserved and minority women. African-American women continue to be diagnosed with advanced BC and to have the highest mortality rates and lowest survival rates from BC. The purpose of the study is to determine the relationship among race, insurance, and BC death. METHODS: African Americans and Non-Hispanic Whites female BC patients diagnosed between 2007 and 2010 in Florida, and treated at a network of 9 hospitals were identified by electronic medical record (EMR) and linked to the Florida Cancer Data System (FCDS) which is the largest population-based cancer incidence registry in the nation. FCDS cases were linked to Electronic Medical Records (EMRs). Cause of specific survival was the major Outcome measure. Nonparametric survival curves for the various insurance categories were generated using the Kaplan-Meier method. Socio-demographics included age at diagnosis, race, insurance, marital status, poverty level. Tumor characteristics consisted of tumor stage, tumor grade, tumor size, hormone receptor status, and presence of metastasis. Risk of BC death was first examined as a function of insurance status. Hazard ratios were then obtained using Cox proportional hazards model after adjusting for socio-demographics, tumor characteristics and BC death with BC related death. RESULTS: Study population was older (74% more than 50 years old), had more whites, 55.5% were married and included a greater proportion of patients on public coverage (46%). Survival was worse for uninsured patients than for privately insured patients with all stages. The adjusted risk of BC death was 40% higher for uninsured patients than for privately insured patients. CONCLUSIONS: Uninsured patients presented with worse survival than did privately insured patients. Findings from this study demonstrate that patients without insurance experience worse outcomes and would benefit the most from improved access to screening and optimal cancer care.

PHS24
PERIPHERAL ARTERIAL DISEASE MANAGEMENT PROGRAM: SCREENING-RISK FACTOR MANAGEMENT PROGRAM AND FINANCIAL RETURN ON INVESTMENT IN BRAZIL: A MULTICENTER PROSPECTIVE STUDY
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OBJECTIVES: To analyze the association between non-pharmacological treatment of substance use disorders and mortality in elderly patients with prostate cancer and substance use disorders. METHODS: SEER-Medicare linked database between 2000 and 2009 was used. From the cohort of men diagnosed with advanced prostate cancer between 2001 and 2004, we identified those with a diagnosis of substance use disorder using the ICD-9 codes of 291, 292 (Drug psychoses), 303 (Alcohol dependence syndrome), 304 (Drug dependence), and 305 (Non-dependent use of drugs). For this cohort of elderly with advanced prostate cancer and substance use, we used inpatient, outpatient and provider claims to determine non-pharmacological treatment for substance use. The association between treatment for substance use and five-year mortality was analyzed using Cox regression. RESULTS: Of 1,509 elderly with advanced prostate cancer and substance use disorder, only 10% had a claim related to non-pharmacological treatment of substance use in the five-year period post-cancer diagnosis. Demographic and clinical attributes were comparable between those treated for substance use vs. those not treated for substance use. Cox regression indicated that treatment for substance use was associated with lower hazard of all-cause mortality, compared to those not treated for substance use (HR 0.63; 95% CI 0.46, 0.86). CONCLUSIONS: In elderly prostate cancer patients with substance use disorder, substance use treatment appears to have beneficial effect on mortality. However, the utilization of substance use treat-ment was only moderate. Prostate cancer incidence increases exponentially with age and therefore, an aging population will exert significant burden on healthcare systems. The identification and management of co-occurring substance use disorders in elderly prostate cancer patients, along with policies to effectively screen and treat substance use in elderly prostate cancer patients, policies for enhancing utilization of substance use treatment by elderly cancer patients are necessary.

PHS25
ECONOMIC BURDEN OF ADVERSE EVENTS ASSOCIATED WITH FIRST LINE METASTATIC RENAL CELL CARCINOMA (mRCC) TREATMENT IN PUBLIC AND PRIVATE BRAZILIAN PERSPECTIVE
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OBJECTIVES: This study analyzes the cost of adverse events associated with metastatic renal cell carcinoma (mRCC) treatments of pazopanib and sunitinib. METHODS: A cost analysis was performed based on the published data of the COMPARZ study. All adverse events (AEs) were identified based on the AEs reported in this study. Cost information related to the the most frequent adverse events (~15%) in the study population (~1,100 individuals) were obtained. These events included in the analysis were hepatotoxicity, anemia, nausea, fatigue and diarrhea. The perspective adopted in this analysis was of the Unified Health System (SUS) and Brazilian Supplementary Healthcare (SS). For reckoning purposes, the Medication Maximize System (MMS) cost model was used to calculate AE costs using the Brazilian cost. RESULTS: Were obtained the following results for sunitinib vs pazopanib treatment course respectively: In SUS perspective: Increased ALT (BRL 107.24 / BRL 149.63), Anemia (BRL 474.19 / BRL 778.41), Thrombocytopenia (BRL 24.65), Diarrhea (BRL 236.86 / BRL 355.89), Hypertension (BRL 19.79), Hypertension (BRL 618.79 / BRL 694.26), Nausea (BRL 767.49 / BRL 172.65), Thrombocytopenia (BRL 66.29 vs BRL 34.85). When considering costs incurred from private pay perspective such as SUS, we observed the values were increased ALT (BRL 360.24 / BRL 113.57), Nausea (BRL 269.37 / BRL 787.41 vs BRL 870.29), Fatigue (BRL 205.51 / BRL 179.42), Hypertension (BRL 1071.91 / BRL 1142.48), Nausea (BRL 782.78 / BRL 765.76), Thrombocytopenia (BRL 328.49 / BRL 172.67). CONCLUSIONS: A therapy that has less financial impact on the treatment of adverse events is the choice of sunitinib for both public (6% decrease) and private (5%).