Collaboration between stakeholders underpinned by dynamic information exchange is the prerequisite of a systems-based market. If other industry sectors such as consumer goods, finance and telecommunications serve as a model for systems-thinking, we will expect novel linkages between health care stakeholders to become more prevalent as population health goals unifies incentives. While many acknowledge the potential of building a more integrated systems-thinking approach, one that maps influence patterns, amplifies interdependencies, and drives collective outcomes, they struggle with actual implementation. A recent survey of close to 300 biopharma executives, EU and US Payors, and US providers reveals insights into their needs, their disparate perceptions, and their levels of confidence in the ability to shift to a systems-thinking collaborative culture. Approximately 25% of respondents stated they were not aligned with other stakeholders, though agree they need better alignment and foresee closer collaboration in the future. More than 70% of stakeholders believe data transparency and information-sharing is critically important to a successful and interoperable health care system, yet very few believe that transparency alone will be sufficient. Willing to demonstrate this shift, several health care industry stakeholders are well prepared for the necessary trust-building activities required by this anticipated transition. A viable and sustainable information network provides the structure, aligned incentives and competitive collaboration the breakthrough of a systems-thinking culture is required to achieve. Without the culture of transparency, they won’t achieve the cost and innovation benefits inherent in these cross-industry partnerships. Further detail will be given on insights and challenges gleaned from interviewing large and small stakeholders as well as practical strategies, such as experimentation with data integration projects, to guide the transformation to a systems-thinking industry.

**DISEASE-SPECIFIC STUDIES**

**GASTROINTESTINAL DISORDERS – Clinical Outcomes Studies**

**PG1**

**COMPARATIVE EFFICACY AND SAFETY OF GOLIMUMAB, INFlixIMAB AND ADALIMUMAB FOR THE TREATMENT OF MODERATE TO SEVERE ULCERATIVE COLITIS: A BAYESIAN INDIRECT TREATMENT COMPARISON META-ANALYSIS**

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**OBJECTIVES:** To compare the relative efficacy and safety of golimumab, infliximab and adalimumab for the treatment of moderate to severe ulcerative colitis using indirect treatment comparison (ITC) meta-analysis.

**METHODS:** A systematic literature search identified five randomized controlled trials. Outcomes of interest included clinical remission, clinical response, mucosal healing, sustained response, loss of clinical response, adverse events (SAEs), and discontinuations due to adverse events (DAEs). Data was synthesized using Bayesian indirect treatment comparison (ITC) meta-analysis.

**RESULTS:** After the induction phase, each treatment had significantly greater efficacy than placebo at all endpoints, with the exception of adalimumab for mucosal healing. No statistical differences were observed between golimumab and infliximab. Adalimumab had significantly lower efficacy measures compared to infliximab for clinical remission (odds ratio [OR] 0.42, 95% credible interval [CrI] 0.17–0.97), clinical response (OR 0.45, 95% CrI 0.23–0.89), and mucosal healing (OR 0.64, 95% CrI 0.42–0.98) compared to infliximab. At the maintenance phase, each biologic agent exhibited significantly greater efficacy compared to placebo for clinical remission, clinical response, and mucosal healing. Golimumab 100mg was associated with a low risk of adverse events and a lack of opportunistic infections (OR 1.80; 95% CrI 1.01–3.23) and mucosal healing at 54 weeks (OR 1.88; 95% CrI 1.01–3.49). No statistical differences were observed between adalimumab and infliximab. Both golimumab 100mg and infliximab were significantly better than adalimumab in terms of sustained clinical response (OR 2.89; 95% CrI 1.03–7.47). CONCLUSIONS: In the context of ITC meta-analysis, both golimumab and infliximab appear to demonstrate superior efficacy-safety profiles compared with adalimumab.

**PG2**

**SURGICAL SITE INFECTION AFTER CHOLECYSTECTOMY: RATES AND OPERATIVE RISK FACTORS**

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**OBJECTIVES:** Over 500,000 cholecystectomies are performed in the U.S. annually. The incidence of surgical site infection (SSI) is higher after open compared to laparoscopic cholecystectomy, but other procedural risk factors for SSI have not been well established. We investigated operative risk factors for SSI after cholecystectomy in a large cohort of privately insured patients.

**METHODS:** We performed a retrospective cohort study of persons aged 18-64 years with ICD-9-CM diagnosis codes from 1/1/2004 through 4/30/2010 identifying SSI or septicemia was coded using commercial insurer claims data. Complex procedures and patients (e.g., cancer, end-stage renal disease) were excluded. SSIs occurring within 90 days after cholecystectomy were identified by ICD-9-CM diagnosis codes. Procedures in which SSI or septicemia was coded <30 days before surgery were also excluded.

Multivariable logistic regression was used to determine independent risk factors for SSI, controlling for age.

**RESULTS:** A total of 113,138 cholecystectomy procedures were identified, 76% were performed in females and the median age was 43 years (range 18-64). A total of 833 (0.74%) SSIs occurred; the SSI incidence was higher for open procedures [90 (4.85%) open versus 743 (0.67%) laparoscopic; p<0.001]. Improper repositioning for SSI included acute cholecystitis odds ratio [OR] 1.53, 95% confidence interval [CI] 1.32–1.77, choledocholithiasis (OR 1.44, 95% CI, 1.10–1.88), open approach (OR 5.51, 95% CI, 4.00–7.61) laparoscopic converted to open approach (OR 5.48, 95% CI, 3.99–7.54), and concurrent bile duct repair (OR 4.76, 95% CI, 1.93–1.70). Patients with diabetes significantly decreased risk of SSI (OR 0.75, 95% CI, 0.65–0.88).

**CONCLUSIONS:** Acute cholecystitis, choledocholithiasis, and concurrent bile duct repair were associated with increased risk of SSI (p<0.001). After cholecystectomy, controlling for open surgery, age, and gender. Our findings suggest that stratification of SSI rates by these operative factors is important when comparing rates between facilities.

**PG3**

**WORKING TITLE: CONTRAINDICATIONS FOR HCV THERAPY IN UNITED STATES PATIENTS WITH UNRELATED CHRONIC HEPATITIS C (CHC) INFECTION**

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**OBJECTIVES:** Describe the prevalence of contraindications to chronic hepatitis C (CHC) treatment among CHC patients not receiving CHC treatment (direct-acting antiviral [DAA] protease inhibitors, peg-interferon alpha, or ribavirin).

**METHODS:** Adult patients with ≥2 CHC diagnoses (ICD-9-CM codes 070.44, 070.54, 070.70, 070.71) and no DAA files at any time in their claims history were selected from a de-identified US-based claims database (2010-2012); the first CHC diagnosis after 5/1/2011 was defined as the index date. Patients with CHC treatment 6 months before or 12 months after the index date were excluded. All patients were required to have continuous eligibility and no claims for hepatitis B during the 6-months before (baseline) and 12-months after their index dates. Contraindications (based on the US Food and Drug Administration (FDA) guidance) were identified based on ICD-9 codes and described for the overall cohort as well as stratified by age (18-39; 40-49; 50-59; 60-69; 70-79; 80+). RESULTS: There were 12,726 unique patients identified, of which 7,644 (60.1%) had no contraindication to peg-interferon or ribavirin. Untreated patients were 56 years old on average and more often male (61%). Approximately 86.8% of the untreated cohort had no claim for any CHC treatment any time in their claims history. The most common contraindications included arterial hypertension (32.1%), hepatic decompensation (22.3%), major system impairment (19.2%), and psychiatric depression (11.0%). Age-stratified results showed increasing prevalence of contraindications with age; rates of contraindications increased from 46.2% among patients 18-39 to 76.6% among patients 80 years old and older. CONCLUSIONS: A high proportion of untreated CHC patients had diagnoses for contraindicated conditions, and the prevalence of these contraindications increased with age.

**PG4**

**INFLUENCE OF LORNDOXICAM INTRAVENTRICULAR INJECTIONS ON MORTALITY IN PATIENTS WITH ACUTE PANCREATITIS: A PROPENSITY SCORE-MATCHED ANALYSIS**

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**OBJECTIVES:** Acute pancreatitis (AP) is associated with significant morbidity and mortality, representing a severe economic burden for health care systems. Numerous attempts were made to find medications able to inhibit secretion of pancreatic enzymes, for example, or inflammation in patients with AP. Several studies showed that lornoxicam may inhibit secretion of inflammatory cytokines. The objective of the current study was to find medications able to inhibit secretion of pancreatic enzymes in AP.

**RESULTS:** We attempted to find medications able to inhibit secretion of inflammatory cytokines. The objective of the current study was to find medications able to inhibit secretion of pancreatic enzymes in AP.

**CONCLUSIONS:** Acute pancreatitis is a significant problem in patients with AP.

**PG5**

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