18 months follow-up period. For the Markov model, four health states were considered and the transitions probabilities were taken from Yao, 2007. Effectiveness was calculated from the probabilities of moving from one NYHA Class to a better one. Utilities for each NYHA to calculate QALYs were taken from Kirsch, 2000. Colombian general mortality rate and 3.5% discount rate were applied. Specific utilities for HF, were taken from Inglis-2011. Survival analysis was done. RESULTS: With the HFC, 69.1 LY were obtained compared to 53.7 with CMM and 1.54 additional LYGS. When utilities were applied to each LYG, 4.54 QALYs were obtained compared to 3.68 with CMM, with improvement in the mean utility of 1.65 more. CONCLUSIONS: HFC produces more LYG than CMM to a higher quality of life in terms of QALYs. HFC should be implemented in those specialized institutions for HF.

CARDIOVASCULAR DISORDERS – Health Care Use & Policy Studies

PCV22
MODELLING THE BURDEN OF CARDIOVASCULAR DISEASE IN COLOMBIA AND THE IMPACT OF REDUCING MODIFIABLE RISK FACTORS
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OBJECTIVES: This study aims to estimate the current and future burden of cardiovascular diseases (CVD) in Colombia, and quantify the impact of reducing modifiable risk factors. METHODS: A burden of disease model was used to forecast the burden of CVD in Colombia, and estimate the impact of reducing modifiable risk factors (tobacco use, hypertension, type 2 diabetes, obesity and physical inactivity) in the general Colombian population, in accordance with World Health Organization (WHO) targets. Another model estimated the impact of reducing LDL-cholesterol through increased access to effective treatment for two high risk populations: hypertensive patients, and patients with coronary artery disease who are undergoing PCI. These models were then merged to find a focus on patients with LDL-cholesterol >100 mg/dL. Inputs for the models included disease and risk factor prevalence, population forecast, CVD event rates, and treatment effectiveness, primarily derived from the published literature. Direct costs to the public health care system and indirect costs from lost production due to premature mortality, hospitalizations, and absenteeism were included, although the cost programs and pharmacological interventions to reduce risk factors was not considered. RESULTS: The prevalence of CVD is projected to increase to 1.6 million by 2035, while the economic burden, including both direct and indirect costs, would increase to US$14 billion. The value of reducing modifiable risk factors (except for LDL-cholesterol) is estimated at US$0.5 billion over the forecast period. Similarly, the value of reducing LDL-cholesterol through increased access to effective treatment for all high-risk patients would be US$17.5 billion for HF patients and up to US$9.2 billion for SP patients over the forecast period. CONCLUSIONS: The burden of CVD is significant and growing. Efforts to achieve WHO risk factor targets and further lower LDL-cholesterol through increased access to effective treatment for high-risk patients are projected to greatly reduce the clinical, economic, and humanistic burden of cardiovascular disease in Colombia.

PCV23
POTENTIAL MORTALITY REDUCTION WITH OPTIMAL USAGE OF SACUBITRIL/valsartan FOR THE TREATMENT OF HEART FAILURE IN ARGENTINA
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OBJECTIVES: To understand the disease and treatment patterns of Chronic Heart Failure (CHF) in Argentina. METHODS: Data from the Pan American Health Organization was used to quantify the target population and a literature review was conducted to determine the prevalence of HF in Argentina, the proportion of those in NYHA Class II-IV and finally, the proportion of patients with HF/EHF. The number needed to treat (NNT) to avoid one death, standardized to 12 months, was derived from the PARADIGM-HF trial. The potential number of deaths prevented or postponed as a result of treatment with sacubitril/valsartan was estimated, ECF was used to consider all cause mortality. RESULTS: The prevalence of HF in Argentina was estimated at 1.56% and was applied to determine the number of HF patients. Of these, 75% were considered to be NYHA Class II-IV, of which, 75% had reduced ejection fraction. This was equated to 189,149 HF/EF patients, with NYHA classification II-IV. The percentage of patients eligible for RAS inhibition (ACEI/ARB) was 91%, yielding 172,126 patients. Finally, the absolute reduction in mortality in PARADIGM-HF was 2.8% over an average follow-up time of 274 days. This was then multiplied by 50 years of age or over. The number of deaths equated to 2,144 deaths each year. CONCLUSIONS: The findings from this analysis suggest that, with the relatively low mortality risk currently being potentially be provided by the optimal implementation of sacubitril/valsartan therapy. Thus, implementation of sacubitril/valsartan into routine clinical practice is important, and may improve clinical outcomes among HF/EF patients in Argentina.

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OBJECTIVES: To understand the disease and treatment patterns of Chronic Heart Failure (CHF) in Mexico. METHODS: A Disease Specific Program was conducted

PCV25
PHARMACO TOOL: AN ECONOMIC AND EPIDEMIOLOGICAL CALCULATION TOOL TO AIM PLANNING FOR REDUCING CARDIOVASCULAR MORBIDITY IN BRAZIL
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OBJECTIVES: To elaborate a pharmacoeconomic tool from epidemiological and pharmacoeconomic analysis to assist health managers in the planning and implementation of Pharmaceutical Care (PC) for reducing cardiovascular morbidity in Brazil. METHODS: A disease specific economic model tool was developed according to budget impact analysis grounded in a cost-benefit analysis nested in a clinical trial. Direct medical and non-medical costs and indirect costs were considered. RESULTS: The perspectives considered were the Brazilian public payer and the Brazilian government. The model was in five steps: direct cost analysis, cost and outcomes projection, cost-benefit analysis, Monte Carlo sensitivity analysis, and epidemiological impact measurement. The externalization of the epidemiological and economic impact analyses structured the pharmacoeconomic tool. RESULTS: For a disbursment of US$ 93,700/year for the implementation of PC at a municipal level, the pharmacoeconomic tool has estimated that three pharmacists would need to be hired and there would be a surplus of US$ 2,953.74. In the future year there would be 312 patients assisted, and there would be a saving of US$ 47,181.45 in health resources. In the overall summary for 10 years, 3,120 patients would be patients could be hired and there would be a surplus of US$ 2,953.74. In the future year there would be 312 patients assisted, and there would be a saving of US$ 47,181.45 in health resources. In the overall summary for 10 years, 3,120 patients would be benefited, and also 2,640 of the 3,120 patients would have their blood pressure at satisfactory levels. As a result of the saving generated at present value, the tool showed with 95% certainty that net present value would be US$2,632,414.91 over ten years. CONCLUSIONS: The pharmacoeconomic tool, currently in the patent process, has shown to be able and sensitive to assist health managers in the implementation of PC for reducing cardiovascular morbidity and saving health resources.

PCV26
TREATMENT PATTERNS OF CHRONIC HEART FAILURE (CHF) IN ARGENTINA
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OBJECTIVES: To understand the disease and treatment patterns of Chronic Heart Failure Patients in Argentina. METHODS: A Disease Specific Program was conducted

PCV27
TREATMENT PATTERNS OF CHRONIC HEART FAILURE (CHF) IN MEXICO
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OBJECTIVES: To understand the disease and treatment patterns of Chronic Heart Failure (CHF) in Mexico. METHODS: A Disease Specific Program was conducted