population (N = 25,288), 44.51% were users. The prevalence of use has increased over time from 2006 to 2010. Of its strongest predictors, users were older (45.03 years vs. 41.36), had higher Charlson Comorbidity Indices (0.63 vs. 0.29), filled more prescriptions per person (33.62 vs. 14.53), and used more unique medications (7.33 vs. 3.80). The majority of users were female (59.79%), employed (56.45%), and white (86.59%). Prescription drug coverage (69.26%) and fell into the two highest income categories (28.38%). Increasing age was a significant predictor of LCGP use as individuals 35-54 (AOR = 1.14, 95% CI 1.07 – 1.20), and 55-64 (AOR = 1.05 – 1.16 – 1.39) were more likely to be users compared to those aged 18-34. The odds of LCGP use increased nearly 20% (OR = 1.19, 95% CI 1.18 – 1.20) for each additional unique medication used during an individual’s two-year study period.

CONCLUSIONS: The prevalence of LCGP use in this privately insured adult population suggests a high potential for exposure misclassification in administrative claims datasets.

PHS108
SOCIOECONOMIC DIFFERENTIAL IN ONE-YEAR SURVIVAL AFTER HOSPITALIZATION FOR ISCHEMIC STROKE: THE EFFECT OF ACUTE AND POST-ACUTE CARE PATHWAYS

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OBJECTIVES: To explore the role of ischemic stroke care-pathway on the association between education level and one-year survival after admission. METHODS: From the Lazio health database (the incident hospitalizations for ischemic stroke in adults during 2011/2012 were selected. For each subject the clinical history was defined by reviewing previous hospitalizations and medications. The survival time between education level and mortality after stroke was studied for acute (2-30 days from admission) and post-acute phase (31-365 days from discharge) using multivariate and cause-specific methods respectively. Four different stroke care-pathway we considered hospital performance (in terms of 30-days mortality), acute phase, access to rehabilitation and drug treatment post-discharge (number of drug prescription, frequency of the top-10 medical procedures). RESULTS: We found similar patterns of LCGP use among ischemic stroke patients (mean age=76±50, male=53.3%) with elementary education level and 3.2% with university. The mortality was 14.9% in acute phase and 15.7 per 100 person-years in post-acute phase among survivors. The adjusted mortality rates in acute and post-acute phase decreased with the increased of educational level (OR=0.90 p-trend<0.001; HR=0.85 p-trend<0.001). For the best care-pathway (hospital with high performance, access to rehabilitation, drug treatment post-discharge, use of all three drug) the one-year probability ratio university versus elementary was 1.05 (BC95%:1.03-1.08), while was 1.22 (BC95%:1.12-1.32) for the worst care-pathway. CONCLUSIONS: The education level was negatively associated with mortality in acute and post-acute phases. The care-pathway reduces but not eliminates one-year survival inequality.

PHS109
GENDER DISTRIBUTION OF OUTPATIENT CARE PHYSIOTHERAPY SERVICES FOR LOW BACK PAIN IN HUNGARY

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OBJECTIVES: The aim of our study is to assess the utilization of out-patient care-physiotherapy services related to the Low Back Pain according to gender. METHODS: Data were derived from the nationwide database of Hungarian National Health Insurance Fund Administration (NHIFA), based on official reports from participating institutions. The hospitalizations for ischemic stroke in adults during 2012 were selected. For each subject the clinical history was defined by reviewing previous hospitalizations and medications. The survival time between education level and mortality after stroke was studied for acute (2-30 days from admission) and post-acute phase (31-365 days from discharge) using multivariate and cause-specific methods respectively. Four different stroke care-pathway we considered hospital performance (in terms of 30-days mortality), acute phase, access to rehabilitation and drug treatment post-discharge (number of drug prescription, frequency of the top-10 medical procedures). RESULTS: We found similar patterns of LCGP use among ischemic stroke patients (mean age=76±50, male=53.3%) with elementary education level and 3.2% with university. The mortality was 14.9% in acute phase and 15.7 per 100 person-years in post-acute phase among survivors. The adjusted mortality rates in acute and post-acute phase decreased with the increased of educational level (OR=0.90 p-trend<0.001; HR=0.85 p-trend<0.001). For the best care-pathway (hospital with high performance, access to rehabilitation, drug treatment post-discharge, use of all three drug) the one-year probability ratio university versus elementary was 1.05 (BC95%:1.03-1.08), while was 1.22 (BC95%:1.12-1.32) for the worst care-pathway. CONCLUSIONS: The education level was negatively associated with mortality in acute and post-acute phases. The care-pathway reduces but not eliminates one-year survival inequality.

PHS111
FREQUENT EMERGENCY DEPARTMENT USE AMONG NON-ELDERLY ADULTS: AN ANALYSIS OF MULTI-STATE CLAIMS DATASETS

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OBJECTIVES: Frequent Emergency Department (ED) visits are associated with high healthcare expenditures and reduced quality of care. Socio-economically disadvantaged, and individuals with high medical needs, use ED frequently. While frequent ED use is often uninsured, in fact, frequent ED users are more likely to have Medicaid or other insurance. The objective of this study is to examine the characteristics of the frequent ED users among Medicaid beneficiaries residing in West Virginia, Ohio, and Maryland. METHODS: A Cross-sectional study design was used. Patient-level data such as demographic factors, Medicaid eligibility, visits to primary care providers (PCP), dental visits and selected chronic conditions were obtained from the state Medicaid claims data for the year 2009. County-level data such as county location in metro area were obtained from the Area Health Resource File. The study population included adults aged 18-64 years, who had at least one visit to the ED, continuously enrolled in fee-service, not enrolled in Medicare and alive in 2009 (n=15,779). Adults with 6 or more ED visits were defined as frequent ED users. Chi-square tests and logistic regressions were used to determine the unadjusted and adjusted associations between patient- and county-level factors and frequent ED use. RESULTS: In our study population, 8.4% were frequent ED users. A higher number of PCP visits was associated with reduction in ED use. In both unadjusted and adjusted models, significant differences in frequent ED use were observed for gender, ethnicity, chronic conditions, and PCP visits. For example, in adjusted analyses racial racial minorities were more likely to have frequent ED use (AOR=1.48, 95%CI=1.16, 1.90) compared to whites. Women were more likely to have frequent ED use compared to men (AOR=1.19, 95%CI=1.01, 1.41). CONCLUSIONS: Interventions to promote visits to primary care providers may reduce the risk of frequent ED use.

PHS112
HUMAN PAPILLOMAVIRUS (HPV) VACCINATION DURING WELL-CHILD VISITS IN PRIVATELY INSURED MALES 9-21 YEARS OF AGE IN THE UNITED STATES IN 2012

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OBJECTIVES: Since October 2011, ACIP has recommended routine HPV vaccination for males 9-11 years of age with catch-up vaccination for males ages 13-21. Well-child visits are a key setting in which to provide HPV vaccination for this population. The objectives of this study were to estimate HPV vaccination rates among males age 9-21years of age during well-child visits and compare HPV vaccination rates during well-child visits in 11-12 year-old males with other vaccines recommended for the same age group (Tdap and Meningoocccal conjunctivae vaccine (MCV4)). METHODS: A large commercial database (MarketScan®) was used for this retrospective cohort study. The study population was males 9-21 years of age in 2012 who had well-child visits for assessment of vaccination rates of HPV, Td, MCV4 and other vaccines recommended for the same age group (Tdap and Meningoocccal conjunctivae vaccine (MCV4)). RESULTS: In our study population, 8.4% were frequent ED users. A higher number of PCP visits was associated with reduction in ED use. In both unadjusted and adjusted models, significant differences in frequent ED use were observed for gender, ethnicity, chronic conditions, and PCP visits. For example, in adjusted analyses racial minorities were more likely to have frequent ED use (AOR=1.48, 95%CI=1.16, 1.90) compared to whites. Women were more likely to have frequent ED use compared to men (AOR=1.19, 95%CI=1.01, 1.41). CONCLUSIONS: Interventions to promote visits to primary care providers may reduce the risk of frequent ED use.