OBJECTIVES: Ontario (ON) and Québec (QC), the two largest provinces in Canada, have implemented mandatory immunization against influenza. We aimed at reviewing and presenting differences and similarities between the two provinces, and identifying resources allocated to respective programmes. METHODS: Government and health professions information sites (medicine, nursing, pharmacy) were searched, as well as related websites, government documentation, supplemented by communication with health care professionals. Resources (professional services and materials) were identified and listed, considering both Ministry of Health and patient perspectives. RESULTS: Major differences were identified between both provinces in the form of influenza vaccines and matching programs. ON has a universal programme covering the entire population except infants (under 6 months of age) and persons in whom the vaccine is contraindicated. In QC, FS are administered mainly by public health nurses and physicians, while in ON, FS can also be injected by pharmacists. General practitioners in QC were not required for prescription of flu shots (FS). QC limits the FS to the elderly (60 years or older), infants (6–23 months) and persons at “risk” (persons with chronic conditions, living in isolated communities, health care workers, caregivers and those travelling to endemic areas). ON has a universal program covering the entire population except infants (under 6 months of age) and persons in whom the vaccine is contraindicated. In QC, FS are administered directly by the Ministry of Health for an honorarium for each injection. There are also differences between rural and urban areas with regard to eligibility in the case of QC and possibly access to FS in rural areas. CONCLUSIONS: The differences between the two provinces are larger than the QC programme, both by expanded population eligibility and through increased availability of resources by making FS available at certified pharmacies. This work will prepare the ground for a future comparative economic analysis.

PHS164
TRENDS IN MEDICARE PART D MEDICATION THERAPY MANAGEMENT ELIGIBILITY CRITERIA
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OBJECTIVES: To describe trends in eligibility thresholds of Medicare medication therapy management (MTM) services to identify patterns that may hinder eligibility. METHODS: Data were extracted from the Medicare Part D MTM Programs Fact Sheets published on the cms.gov website. Fact Sheets for 2008-2013 were used to search for changes and trends over time that may potentially affect the enrollment rate for Medicare beneficiaries. These years were the only ones available from the cms.gov website. RESULTS: of 2010, 48.7% plans opened MTM enrollment to patients with 2 chronic disease states, with the remaining 80% restricting eligibility to patients with 3 or more chronic disease states. The trends for both Medicare Advantage plans and independent Part D plans were similar. CMS policy change in 2010 was also correlated with increase proportion of plans set their eligibility threshold at 8 part D drugs, the maximum number allowable. CONCLUSIONS: Changes to the eligibility thresholds may have been barriers for increases in MTM enrollment. CMS needs to find alternative strategies to increase MTM enrollment.

PHS165
THE IMPLEMENTATION OF MEDICARE PART D AND THE HEALTH IMPLICATIONS OF MEDICATION THERAPY MANAGEMENT ELIGIBILITY CRITERIA
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OBJECTIVES: To determine whether the implementation of the Medicare Part D in 2006 was associated with changes in differential racial and ethnic disparity patterns between the individuals ineligible for medication therapy management (MTM) services and MTM-eligible individuals. METHODS: Data from the Medicare Current Beneficiary Survey were analyzed. A generalized difference-in-differences analyses, difference-in-differences in medication utilization measures. Future research should examine strategies to remediate the effects of MTM eligibility criteria on racial and ethnic disparities.

PHS167
OUTPATIENT VISITS TO THE CATH LAB FOR CORONARY ANGIOGRAPHY RESULTING IN MINIMAL ACTION IN THE SHORT TERM
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OBJECTIVES: To understand the clinical care pathway and patient characteristics of those patient visits that use the catheterization laboratory (cath lab) but do not result in a percutaneous coronary intervention (PCI) and/or coronary angiography. METHODS:This database contains complete patient billing, hospital and coding histories from more than 600 hospitals and ambulatory facilities throughout the United States. In 2012, patients were aged 45 at the time of their coronary angiography visit, and must have had one of the following primary diagnosis of Atherosclerosis or chest pain using the International Classification, 9th Revision (ICD-9): 414.01, 759.66, 759.67, 759.68, 759.69. Patient visits where patients were taken to angiography for an operation or stroke/thrombo-inemic attack were excluded. Patients that died during the visit were excluded as well. RESULTS: Of 354,790 coronary angiography visits identified, 68,026 visits (19.2%) met the inclusion criteria. Only 7% of patient visits (4,786) resulted in a return visit within 60 days for a PCI (71%), CABG (71%), or both (7%). Less than 2% (81) came back to the hospital through the ER. Total median coronary angiography cost per visit for the group of interest was $2,565, with the cardiology department accounting for 57% ($1,470) of costs. Left heart cardiac catheterization was the most common procedure (86%). CONCLUSIONS: There appears to be a substantial population receiving elective coronary angiography, with no immediate action resulting from that visit. Technologies that could enable another clinical pathway to avoid the cath lab and an invasive procedure may lead to lower hospital costs.

PHS168
EFFECT OF ADMISSIONS ON TREATMENT REGIMENS IN PATIENTS WITH TYPE 2 DIABETES
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OBJECTIVES: Inpatient admissions may represent an important opportunity for the review and revision of treatment of type 2 diabetes mellitus (T2DM) patients. This paper described the multi center, retrospective study seeking to compare the con- modification of T2DM pharmacotherapy regimens. METHODS: A retrospective cohort of Humana Medicare Advantage Prescription Drug (MAPD) and commercial patients with T2DM, matched on age, gender, plan enrollment and diabetes complication score. The primary outcome of interest was treatment modification, defined as an addition, switch or discontinuation of an anti-diabetic or drug class with at least 30 days of treatment. RESULTS: The study cohort comprised 34,624 patients with T2DM (17,312 matched pairs). The IPH group had