COPD and bacterial pneumonia. We used chi-square tests and logistic regressions to assess the unadjusted and adjusted relationships between depression and presence of ACHS.

RESULTS: Among all Medicare beneficiaries, 10% had diagnosed depression; “any ACHS” was reported in 5% of all elderly 25% of hospitalized elderly “Any ACHS” was higher in Medicare beneficiaries with depression (11.4%) compared to those without depression (4.5%). Among hospital-based elderly, 28.3% with depression and 24% without depression had “any ACHS.” Among all elderly, those with depression had two times the risk of experiencing “any ACHS” (Adjusted Odds Ratio [AOR]: 2.19, 95% CI: 1.97, 2.43) compared to those without depression. We observed similar findings for “chronic ACHS” (AOR: 2.44; 95% CI 2.10; 2.84), “acute ACHS” and (AOR: 1.98; 95% CI: 1.75, 2.25).

CONCLUSIONS: Our study results indicated that Medicare beneficiaries with chronic physical conditions and depression were at risk for ACHS. Elderly with depression chronic conditions may need to be routinely screened for depression. Future research needs to examine whether treating depression can reduce the risk of ACHS among elderly with depression.

PHS157

ASSESSMENT OF_SPIROMETRY TESTING AND INPATIENT READMISSION IN PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE

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OBJECTIVES: To assess spirometry testing and chronic obstructive pulmonary disease (COPD)-related readmission rates among managed care patients in the US. METHODS: This retrospective administrative claims database analysis included patients with COPD (≥1 inpatient or emergency room claim or ≥2 outpa- tient claims within 30 days with a COPD diagnosis [ICD-9, 492.xx, or 496.xx]), ≥1 month health plan enrollment in 2011 and aged ≥20 years. Two cohorts were formed: 1) ‘Spirometry’ cohort: Patients with 24 months of enrollment and ≥1 spirometry test claim during and after their initial COPD diagnosis year and 2) ‘Non-Spirometry’ cohort: Patients with a COPD-related hospitalization (hospitalization with a primary diagnosis of COPD) and ≥1 month enrollment post-discharge. The proportion of patients readmitted to the hospital within 30 days of a spirometry test claim before and after an initial COPD diagnosis was assessed. Results: The proportion of patients with evidence of spirometry testing (≥1 claim with ICD code: 94010, 94060, 94070, 94150, 94200, 94375, or 94664) within 24 months pre- and post-initial COPD diagnosis was assessed in the ‘Spirometry’ cohort. The proportion of patients with a COPD-related inpatient readmission within 30 days post-discharge (2 months before and after hospital discharge) was assessed in the ‘Readmissions’ cohort. Results were reported at the national, regional, and state levels. RESULTS: A total of 94,778 patients were included in the ‘Spirometry’ cohort, with 37.6% having evidence of spirometry testing (Northeast: 40.3%, South: 37.4%, Midwest: 77.7%, West: 31.6%). Spirometry testing rates varied from 24.6% in Wisconsin to 61.2% in Rhode Island. A total of 49,986 patients were included in the ‘Readmissions’ cohort, with 7.1% having a 30-day readmission (Northeast: 7.9%, South: 6.3%, Midwest: 7.4%, West: 8%). Thirty-day readmission rates varied from 5.0% in South Dakota to 20.8% in Washington, DC. CONCLUSIONS: A large proportion of patients with a COPD diagnosis did not have evidence of spirometry testing to confirm COPD diagnosis. COPD-related hospitalizations may be of concern as well. There is a substantial variation in these rates across US states.

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DEVELOPMENT AND EVALUATION OF A POST-DISCHARGE MEDICATION RECONCILIATION PROGRAM

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OBJECTIVES: Medication-related errors account for many deaths annually, and there is increasing evidence that these errors frequently occur upon hospital admission and discharge. A pharmacist-conducted pilot program was designed to provide medication reconciliation services to high-risk patients shortly after hospital discharge. A pharmacist-conducted pilot program was designed to provide medication reconciliation services to high-risk patients shortly after hospital discharge. High-risk patients were defined as any member recently discharged from the hospital who was: a) receiving a high alert medication (e.g., warfarin); or b) hospitalized for at least one pre-speci- fied condition (e.g., Diabetes Mellitus). Within 2-5 days of hospital discharge, the Concurrent Review Nurses from a local health plan identified the high risk patients using the algorithm and notified the pharmacist. The pharmacist contacted the patient via phone to complete a medication reconciliation and clinical review with either the patient or their caregiver. RESULTS: The program lasted from July 2013 to October 2013. In total, 125 patients were identified as high-risk patients, 47 of whom completed a clinical consult with the pharmacist. The average age of the patients who participated in the service was 66. The use of high-risk meds included warfarin (21%), antipaleptics (34%), digoxin (13%), and insulin (28%). In total, 5 patients in this group (15%) were re-hospitalized within 30 days. CONCLUSIONS: In the future, this pilot program should be conducted on a larger scale and include patients who are followed for a longer period of time. Anecdotal evidence suggested that the service was useful, however a larger number of patients is needed to achieve sufficient power to detect a statistical difference.

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KNOWLEDGE, ATTITUDES AND PRACTICE PERTAINING TO DEPRESSION AMONG GENERAL PRACTITIONERS IN AN INDIAN CITY

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OBJECTIVES: Depression is a leading cause of morbidity and disability worldwide. The population in developing countries is at greater risk. Inadequate trained mental health staff, and unfortunately, low detection rates has been associated with increased morbidity among subjects presenting to primary care. In order to con-