PHS175
DESCRIPTING EBM ORDER SET REVIEW AND APPROVAL CYCLE TIME
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OBJECTIVES: Problems were lack of a coordinated approach to review and approval of order sets across the 4-hospital division; lack of consistent formal review process; wide variability in utilization of order sets, and therefore opportunities for errors and misalignment with regulatory compliance. Order set review and approval cycle time (defined as from the time an order set is drafted or received from the system level to when the approval bodies have approved it and it is ready for build, QA, and implementation) was also lengthy, impacting key stakeholder productivity and deployment of order sets. For Computerized Provider Order Entry (CPOE) Objectives: to create one improved process for all four hospitals within the division, with 100% of new order sets compliant with the improved process going forward, process cycle time decreased to less than 60 days in a national, survey-embedded randomized virtual experiment with individuals utilizing the improved process included Lean Six Sigma tools as project charter, Voice of the Customer (VOC), stakeholder analysis, communication plans, SIPOC, elevator speeches, project work plan, Value Stream Mapping of the current and future processes, data definitions and collection plan, data analysis including XMR control charts and capability analyses, fishbone/cause and effect diagram, Improvement Plan, Control Plan, and computer-based learning of order set treatment therapy. The following successful phased implementation of the improved process, results were a decrease in cycle time from an average of 77.1 days at baseline to an average of 18.1 days in the post-improvement data collection period. In addition to decreased cycle time, the benefits of an improved process to review and approve order sets include decreased colleague time spent on the process, increased colleague understanding of terms and process of order set development, increased goodwill with physicians due to more timely approval of requested order sets, potential decrease in regulatory issues and increase in quality of care, and improved CPOE adoption.

PHS176
PATIENT VALUATION OF DIFFERENT APPROACHES TO MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT
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OBJECTIVES: Treatment rates for mental health and substance use disorder (MH/SUD) conditions are low in the U.S. We assessed consumers’ monetary valuation of primary care and collaborative care models for treating MH/SUD relative to usual care as a potential strategy for improving treatment rates. METHODS: We conducted a nationally-representative survey of adults in the U.S. We assessed consumers’ monetary valuation of primary care and collaborative care models for treating MH/SUD relative to usual care as a potential strategy for improving treatment rates. The 2,146 participants were randomized to view one of three treatment vignettes: primary care (N=719), treatment VPA concentrations (SD) age of children was 8.48±0.43 yrs. The major cause was Neurocysticercosis (NCC) in 90% (n=68), epilepsy due to developed education, increased goodwill with physicians due to more timely approval of requested order sets, potential decrease in regulatory issues and increase in quality of care, and improved CPOE adoption.

PHS178
HOSPITAL COST AND QUALITY TRENDS BEFORE AND AFTER ACO ADOPTION
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OBJECTIVES: Providers who have had favorable cost and quality trends may be more likely to form Accountable Care Organizations (ACOs) because they expect to profit from changes that are already underway within their organization. We examine trends in hospital cost per discharge and in-hospital mortality rates among hospitals before and after ACO adoption using data from the 2002-2013 HCUP hospital discharge databases. METHODS: We calculated as the horizontal distance between the linearized inverse demand lines through the inverse demand curves. Participants’ average incremental value was calculated as $9.00 for errors and misalignment with regulatory compliance. Order set review and approval cycle time (defined as from the time an order set is drafted or received from the system level to when the approval bodies have approved it and it is ready for build, QA, and implementation) was also lengthy, impacting key stakeholder productivity and deployment of order sets. For Computerized Provider Order Entry (CPOE) Objectives: to create one improved process for all four hospitals within the division, with 100% of new order sets compliant with the improved process going forward, process cycle time decreased to less than 60 days in a national, survey-embedded randomized virtual experiment with individuals utilizing the improved process included Lean Six Sigma tools as project charter, Voice of the Customer (VOC), stakeholder analysis, communication plans, SIPOC, elevator speeches, project work plan, Value Stream Mapping of the current and future processes, data definitions and collection plan, data analysis including XMR control charts and capability analyses, fishbone/cause and effect diagram, Improvement Plan, Control Plan, and computer-based learning of order set treatment therapy. The following successful phased implementation of the improved process, results were a decrease in cycle time from an average of 77.1 days at baseline to an average of 18.1 days in the post-improvement data collection period. In addition to decreased cycle time, the benefits of an improved process to review and approve order sets include decreased colleague time spent on the process, increased colleague understanding of terms and process of order set development, increased goodwill with physicians due to more timely approval of requested order sets, potential decrease in regulatory issues and increase in quality of care, and improved CPOE adoption.

ACOs experienced a 1.95% increase in cost per discharge between 2011 and 2012, while cost per discharge among jointly-led ACOs fell by only 1.27%. Analysis of in-hospital mortality rates did not reveal persistent trend differences. CONCLUSIONS: Hospitals that adopted the ACO model had more favorable cost trends between 2008 and 2011 than hospitals that did not adopt the model, which suggests non-random selection of providers opting to participate in ACO initiatives. In the post-ACO adoption period, hospitals that were part of jointly-led ACOs had the lowest cost growth, suggesting that this ACO structure may be the most effective.

PHS179
READMISSION PATTERNS IN MEDICARE BENEFICIARIES HOSPITALIZED FOR HEART FAILURE
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OBJECTIVES: Determine 30-, 60- and 90-day readmission pattern in patients hospitalized for heart failure (HF). METHODS: A 5% (n=3,493,434) national sample of Medicare beneficiaries was used to assess the frequency of all-cause readmission following an HF hospitalization. The data were restricted to individuals enrolled in fee-for-service Medicare (Medicare Advantage Program). The majority of the studies on epilepsy have been done on adults and few studies are available on children with symptomatic epilepsy (SE). This study aims to fill this gap by analyzing the effectiveness of anti epileptic drug (AED) therapy in children with SE. METHODS: Study was conducted in pediatric outpatient neurology clinic at two tertiary care hospitals. The children aged 2-18 undergoing AED treatment > 3 months and diagnosed with SE were included. Effectiveness parameters included, complete seizure remission (CSR) for 2 years and adverse drug reactions (ADR). Those children who did not achieve CSR for 2 years or with normality of electroencephalogram were considered for stopping AED treatment. RESULTS: 123 children who completed the follow up were included, 73 (59%) were boys and mean (±SD) age of children was 8.48±4.3 yrs. The major cause was Neurocysticercosis (NCC) in 77 (63%), followed by cryptogenic epilepsy 25 (20%), birth asphyxia 7 (6%), infection 4 (3%), congenital structural defects 3 (3%) tuberculoma 3 (2.4%) and stroke and hypoxic encephalopathy 2 (1.6%). The children were divided into two groups: Biapenem and Meropenem. Biapenem was found significantly efficacious in children with SE. Though two-third of the children had CSR only 50% of them were willing to pay for those initially indicating they were not willing, randomly assigned as $10, $30 or $50) or were paid (for those initially indicating they were willing, and then if they had to pay (for those initially indicating they were willing). The low-