COPD and bacterial pneumonia. We used chi-square tests and logistic regressions to assess the unadjusted and adjusted relationships between depression and presence of ACSH. **RESULTS:** Among all Medicare beneficiaries, 10% had diagnosed depression; "any ACSH" was reported in 5% of all elderly 25% of hospitalized elderly. "Any ACSH" was higher in Medicare beneficiaries with depression (11.4%) as compared to those without depression (4.5%). Among hospitalized elderly, 28% with depression and 24% without depression had "any ACSH". Among all elderly, those with depression had two times the risk of experiencing "any ACSH" (Adjusted Odds Ratio(AOR): 2.19; 95% Confidence Interval(CI): 1.97, 2.43) compared to those without depression. We observed similar findings for "chronic ACSH" (AOR: 2.44; 95% CI: 2.10, 2.84), "acute ACSH" 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 ACSHs. 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 ACSH 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 inpatient 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 outpatient claims with a COPD diagnosis [ICD-9-CM diagnosis codes 491.xx, 492.xx, 494.xx, or 496.xx]), ≥1 month health plan enrollment in 2011 and aged ≥40 years. Two cohorts were formed: 1) 'Spirometry' cohort: Patients with 24 months of enrollment before and 6 months after their initial COPD diagnosis and 2) 'Readmissions' cohort: Patients with a COPD-related hospitalization (hospitalization with a primary diagnosis of COPD) and ≥1 month enrollment post-discharge). The proportion of patients with evidence of spirometry testing (≥1 claim with a CPT-4 procedure code: 94010, 94060, 95070, 94070, 94150, 94200, 94375, or 94664) within 24 months pre- and 6 months 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 (30-day readmission) 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: 37.7%; West: 31.6%). Spirometry testing rates varied from 24.6% in Wyoming 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: 7.1%). Thirty-day readmission rates varied from 2.0% 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 30-day readmissions may be of concern as well. There is a substantial variation in these rates across US states.

PHS158

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 to decrease medication-related errors. The primary objective is to evaluate the impact of a post-discharge quality improvement medication reconciliation service. **METHODS:** An algorithm was developed to identify patients at high-risk for readmission following 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); and/or b) was hospitalized for at least one pre-specified 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 patients 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%), antiplatelets (34%), digoxin (13%), and insulin (28%). In total, 5 patients in this group (11%) 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.

PHS159

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 case detection has been associated with increased morbidity among subjects presenting to primary care. In order to compound this public health problem, general practitioners (GPs) may play a major role to fill this treatment gap. **METHODS:** A cross-sectional survey of 220 GPs was undertaken in Chandigarh City, India. The 20-item Depression Attitude Questionnaire (DAQ) was used to determine their knowledge, attitude and practice towards depression and its management in primary care settings. **RESULTS:** GPs had a limited knowledge of depression, with the majority (77.8%) expressing difficulty working with depressed patients. They exhibited moderately stigmatizing attitudes towards individuals with depression. GPs were conservative in their use of antidepressants and believed that psychotherapeutic approaches were useful. **CONCLUSIONS:** These findings suggest a need for further education of general practitioners on the nature, diagnosis and management of depressive disorders.

PHS160

DEVELOPING A POPULATION-BASED PALLIATIVE AND END-OF-LIFE CARE DECISION-ANALYTIC POLICY MODEL

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OBJECTIVES: To develop a population-based decision-analytic model to support decision-making with end-of-life care policy questions. **METHODS:** *Design:* Microsimulation state-transition model with one-day cycle. *Population:* Patients and their family *Outcomes:* Dying at home, resources used, costs, and quality-adjusted survival. *Perspectives:* Societal and health system. *Time horizon:* last year of life and 1-year bereavement. *Costs:* health system, out-of-pocket, and costs of time loss from paid-work. *Effects:* health-related quality of life (HRQOL, including valuation of leisure time) and quality-adjusted life days. *Model structure* – Stratified by end-of-life trajectory (below) and risk of dying, simulated individuals might receive curative, palliative or hospice care (including combined care) at home (including "home care"), long-term care homes, ERs, hospitals (including ICU), complex-continuing-care facilities, palliative care wards, or non-home hospices. *Input data sources* –a cohort study using linked Ontario health administrative databases and literature for HRQOL estimates associated with trajectory (e.g., cancer) and interventions (e.g. reduced hospital and ICU days). *Model validation* –Modeled projections were calibrated to observed data to ensure consistency. **RESULTS:** The study cohort stratified 256,284 Ontarians who died between Jan-2007 and Dec-2009 into: sudden death (4%), frailty (30%), terminal illnesses (31%), and organ failure (31%). Over the time horizon, approximately 60% of the simulated patients were at home with primary/community/home care support, and 75% spent ≥1 day in hospitals, costing the health system on average approximately $31,000 (or in aggregation, approximately 6% of the annual health care budget). Simulated patients died at home (22%), long-term-care homes (18%), in ERs (6%), hospitals (47%), and complex-continuing-care facilities (7%). **CONCLUSIONS:** Upon further validation, our model can be used to evaluate the cost-effectiveness of broad integrated palliative care approaches from a proposed national framework, and specific evidence-based interventions (related to communication/decision-making, care models, determinants of place of dying, education, and life-sustaining care) identified through systematic reviews conducted by Health Quality Ontario.

PHS161

LOW INCIDENCE OF VENOUS THROMBOEMBOLISM IN MOBILE POPULATIONS

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OBJECTIVES: DVT can lead to significant co-morbidity with post-thrombotic syndrome, and has the potential to cause life threatening pulmonary emboli. The national institute for clinical excellence (NICE) implemented stringent guidelines to improve screening for DVT and optimise management (NICE 2012). The Royal London Hospital was the designated teaching hospital receiving attending public, foreign dignitaries and athletes during the 2012 Olympics. We conducted a prospective audit to assess incidence of DVT in a mobile population during the 2012 Olympics, and assess adherence to NICE guidelines. **METHODS:** Patients presenting with symptoms of DVT over 7 weeks during the 2012 Olympics were seen by a senior nurse. A clinical proforma identifying risk factors was employed. D-dimer and USS results were obtained from clinical reporting systems. Analysis undertaken on excel. **RESULTS:** 69 patients with a suspected DVT underwent investigations. Only six patients had a DVT on Doppler USS. One DVT was deemed unprovoked in a young patient with upper limb DVT. In this patient CT abdomen/pelvis was not warranted, though tested for antiphospholipid syndrome, serum calcium was not measured. In the D-dimer positive scan negative cohort, a repeat USS Doppler at 6-8 days was not undertaken in 71% of patients. However, the initial scan was undertaken within 24hrs (86%). D-dimer has low sensitivity for DVT diagnosis (14%), but high specificity (100%) albeit within limited sample size. Further, utilising risk factors (Wells score) alone had a better sensitivity (28%). **CONCLUSIONS:** We note a low incidence of DVT in this young mobile population, in comparison to the general population. A repeat Doppler USS 6-8days after presentation, when D-dimer was positive, is not adhered to; however none performed were positive (9). We are uncertain if this approach would add to a reduction in morbidity/mortality (BMJ 2012). The D-dimer is not a sensitive marker of DVT, and risk stratification through identification of risk factors appears more sensitive.

PHS163

COMPARING PUBLIC INFLUENZA IMMUNIZATION PROGRAMMES IN ONTARIO AND QUÉBEC, CANADA

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