

assigned a set of academic effort values and a series of modulators to describe the strength and weakness of an activity. Only ongoing productive activities were measured, and no allowances were made for tenure or previous achievements.

Results: All activities had effort apportioned to them. Publications were modulated by type, author position, and journal impact factor. Presentations were modulated by level of participation, meeting type and continuing medical education credit. Grants were weighted by funding source, annual income, and investigator classification, whereas clinical trials were assessed by status of recruitment and financial reimbursement. Teaching was based on defined activities, contributions to the curriculum, and learner scores. When faculty members were assessed and their budgeted time allocations compared, all the faculty exceeded their effort requirements. Examples of the system applications to a clinician, clinician administrator, clinician educator and clinician researcher will be shown.

Conclusions: Adoption of a universal system of measuring academic performance is necessary to facilitate faculty focus and development and allow for a rational budgeting of academic time and effort. Production and validation of the aRVU will allow for constructive and appropriate recognition of activity and contributions to the academic mission.

Author Disclosures: **J. Bismuth:** Nothing to disclose; **M. G. Davies:** Nothing to disclose; **H. F. El-sayed:** Nothing to disclose; **U. Fischer:** Nothing to disclose; **A. B. Lumsden:** Nothing to disclose; **E. K. Peden:** Nothing to disclose; **A. Sigdel:** Nothing to disclose; **M. Unruh:** Nothing to disclose; **H. K. Younes:** Nothing to disclose.

PS130.

Clinical Feasibility and Financial Impact of Same-Day Discharge in Patients Undergoing Endovascular Aortic Repair (EVAR) for Elective Infra-Abdominal Aortic Aneurysm (AAA)

Vincent Moscato, Monica O'Brien-Irr, Maciej Dryjski, Linda Harris. Department of Surgery, Buffalo General Medical Center, Buffalo, NY

Objectives: To evaluate the potential feasibility and financial impact of same-day discharge after elective endovascular aneurysm repair (EVAR) for abdominal aortic aneurysm (AAA).

Methods: All elective EVAR patients from January 2012 to June 2013 were identified. Demographics, comorbidities, complications, nursing care, financial data, and length of stay (LOS) were analyzed (SPSS 21).

Results: The Table presents care received in 67 elective EVAR (70% percutaneous EVAR/61% of AAA). Intraoperative and postoperative complications were type I endoleak, 1.5%; thrombosis, 3%; blood loss requiring transfusion, 4.5%; urinary retention, 4.5%; myocardial infarction, 3%; and hemodynamic/rhythm alterations, 37% (evident in 24 [88%] <6 hours; 13% required therapy). Monitoring only was needed in 28 (42%), intensive care unit in 13.4%. Postoperative day 1 discharge occurred in 73%; 9% <30-day readmission. Total hospital costs: \$29,479: operating room, 80.3%; anesthesia, 2.2%; preadmission, 1%; postanesthesia unit, 3.1%; intensive care unit,

1.9%; floor, 4.7%; laboratory/diagnostic tests, 1.2%; pharmacy, 1.4%; and other, 4.2%. Total cost was similar for those discharged <24 or >25 hours postoperatively ($P = .88$) and for monitoring only vs others (\$28,146 vs \$30,545; $P = .12$). Costs for pharmacy (\$351 vs \$509; $P = .05$) and laboratory (\$86 vs \$354; $P = .01$) and diagnostic testing (\$3.96 vs \$254; $P = .02$) were lower for uncomplicated cases.

Conclusions: Same-day discharge is clinically feasible in >40% of elective EVAR, but requires coordination for adequate postoperative monitoring. Significant savings is unlikely because most cost is operating room- and device-related, and further reduction of costs in uncomplicated cases is unlikely.

Table. Postoperative care in elective EVAR patients: Mean number of hours treatment was utilized or time initiated

Indicator	(%)	Mean Hours Postop
Oxygen	98.5	19
Telemetry	100	12
Arterial catheter	27.3	6
Continuous IV	86.4	12.5
IV fluid bolus	16.7	3.5 (initiated)
IV medication	52.4	
Indwelling urinary catheter	67.2	19
Straight catheterization	4.5	14 (initiated)
<3 Laboratory tests	76.2	
Diabetic management	37.3	

Author Disclosures: **M. Dryjski:** Nothing to disclose; **L. Harris:** Nothing to disclose; **V. Moscato:** Nothing to disclose; **M. O'Brien-Irr:** Nothing to disclose.

PS132.

Mitigating Mortality in Abdominal Aortic Aneurysmal Disease Through the Use of a Risk Register: Indications for EVAR vs Open Repair

Sapan S. Desai², Anahita Dua¹, SreyRam Kuy¹, Gilbert R. Upchurch³. ¹Medical College of Wisconsin, Milwaukee, Wisc; ²Department of Surgery, Duke University, Houston, Tex; ³University of Virginia, Charlottesville, Va

Objectives: This study aimed to determine risk factors associated with perioperative mortality in patients undergoing abdominal aortic aneurysm (AAA) repair nationally and use these risk factors to create a scoring system and risk register to determine mortality rate based on risk scores.

Methods: A retrospective analysis was completed using the National Inpatient Sample (NIS) from 2000 to 2010. A discriminant analysis was used to predict in-hospital mortality once predictor variables were identified using a multivariate analysis. A risk register was created using established rates of rupture for various AAA sizes and estimating the average mortality for those patients. This risk was then compared with the in-hospital mortality risk using our discriminant analysis to make recommendations on minimizing overall mortality as a function of aneurysm size and predictors of mortality.

Results: In the past decade in the United States, 101,978 patients underwent an AAA repair, of which 95,098 survived and 6,780 (7%) died. The following