

with atorvastatin. CV events were identified as hospitalizations with a primary CV diagnosis, and were assessed starting 13 months after the index date until the end of follow-up (up to 36 months). Cox proportional hazard models were estimated to examine the association between continuation of atorvastatin therapy and the risk of CV events adjusting for demographics, comorbid conditions, use of cardiovascular medications, and use of preventative services. **Results:** The study included 94,287 atorvastatin users (79,010 for primary and 15,277 for secondary prevention). In both populations, approximately one-half of patients discontinued atorvastatin therapy after one year. During follow-up, approximately 2% of primary prevention and 9% of secondary prevention patients experienced CV events. After adjusting for demographic and clinical characteristics, continuers in the primary prevention group had a significantly lower risk for CV events compared to discontinuers (Hazard Ratio [HR]: 0.82, 95% CI: 0.74-0.91). In the secondary prevention population, continuation of atorvastatin was also associated with lower risk of CV events (HR: 0.74, 95% CI: 0.66-0.82). These findings were consistent following a series of sensitivity analyses focusing on varying the definitions of continuation to atorvastatin therapy as well as the specification of preventative services. **Conclusion:** The findings from this analysis suggest that continuous use of atorvastatin beyond 1 year can prevent CV events. Quality of care intervention should be targeted in improving persistence to therapy.

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P152 Patient Satisfaction at America's Worst Performing Hospitals

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Background: Previous studies have identified hospitals with significantly lower performance for cardiac care than the national average. Little is known about patient satisfaction at these consistently low performing hospitals. **Methods:** We used 2006-08 Hospital Compare data to identify hospitals that reported acute myocardial infarction (AMI) and heart failure (HF) process measures. We calculated performance scores as the total number of patients receiving recommended therapies divided by the total number of eligible patients for AMI and HF respectively. We classified hospitals as low performing (lowest decile for all 3 years [N= 92 for AMI, N= 177 for HF]), top performing (highest decile for all 3 years [N= 43 for AMI, N =123 for HF]), and intermediate hospitals (all others [N= 2440 for AMI, N =3283 for HF]). We obtained hospital characteristics from the AHA 2006 survey. We used 2008 Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data to determine the proportion of patients who 1) definitely recommend the hospital to others and b) rate hospital care as ≥ 9 on a scale of 1 - 10. We compared patient satisfaction ratings across hospital categories. **Results:** Low performing hospitals had significantly lower performance scores (77% vs. 95% vs. 100% for AMI, 43% vs. 85% vs. 99% for HF), had fewer beds (142 vs. 261 vs. 319 for AMI, 59 vs. 207 vs. 244 for HF), and were less likely to be teaching hospitals (0% vs. 11% vs. 11% for AMI, 0% vs. 8% vs. 12% for HF) as compared to intermediate and top performing hospitals ($p < .01$ for all). Low performing hospitals were more likely to not report HCAHPS data as compared to intermediate and top performing hospitals (15% vs. 0% vs. 0% for AMI, 28% vs. 5% vs. 5%, $p < .01$). Among those reporting, low performing hospitals had lower rates for recommending a hospital (60% vs. 67% vs. 70% for AMI, 64% vs. 67% vs. 70% for HF, $p < .01$) and rating the hospital at least 9 out of 10 (58% vs. 62% vs. 65% for AMI, 62% vs. 63% vs. 65% for HF $p < .01$). **Conclusion:** Consistently low performing hospitals are less likely to report patient satisfaction data. Among those reporting, patients at low performing hospitals have significantly lower satisfaction. Efforts to improve hospital quality should focus both on improving performance and satisfaction with care.

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P153 Factors Influencing Admissions to America's Lowest Performing Hospitals for AMI Care

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Background: Research has identified a group of hospitals with consistently poor performance for acute myocardial infarction (AMI) care as compared to other US hospitals. Factors influencing patients' selection of these hospitals are unknown. **Methods:** We used 2004-06 Hospital Compare data to identify hospitals reporting AMI process performance measures. We calculated composite AMI performance scores and classified hospitals as low performing (lowest score decile for all 3 years, $n = 100$), top performing (top score decile for all 3 years, $n = 64$) and intermediate (all others, $n = 2595$). We used 2004-05 Medicare data to identify AMI patients living within 5 miles of low performing hospitals and alternative hospitals within 30 miles of patient residence. We used conditional multinomial logit models to evaluate the likelihood of choosing a low performing hospital over alternative hospitals. Models accounted for distance from patient residence to available hospitals, provision of revascularization (based on Medicare CABG volumes), and patient characteristics including age, race and residential social disadvantage (derived from US Census data). **Results:** AMI patients admitted to low performing hospitals were older (mean age 80 vs. 79, $p < .01$), more likely female (56% vs. 51%, $p < .01$). These patients were more likely to live in zip codes with high (top quartile) social disadvantage (46% vs. 34%, $p < .01$) and closer to a low performing hospital (1.6 vs. 2.9 miles, $p < .01$). In multivariate models adjusting for distance and the presence of hospital revascularization services, patients were overall less likely to be admitted to low performing hospitals over alternative hospitals (HR 0.28, 95%CI 0.25 - 0.31, $p < .01$). However, patients living in areas with high disadvantage were relatively more likely to be admitted to low performing hospitals as compared to patients from intermediate and low disadvantage areas (HR 2.72 95% CI 2.24 - 3.30, $p < .01$), even after adjusting for age, race, and sex. **Conclusion:** AMI patients are less likely to seek care at low performing hospitals except patients who live in zip code areas with high social disadvantage. Disincentives for poor performance against low performing hospitals could adversely impact care for this vulnerable population.

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P154 Warfarin International Normalized Ratio Patterns Following Total Hip Arthroplasty

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Objectives: To investigate the distribution of international normalized ratio (INR) levels in warfarin-treated patients following total hip arthroplasty (THA). **Methods:** A retrospective cohort analysis was conducted using an electronic medical record database. Patients who had undergone a THA procedure between January 1, 2004 and January 31, 2009, in whom warfarin was initiated within 3 days after surgery, and who had at least one INR measurement were identified and followed for up to 90 days. All identified patients' INR data were assessed. However, because INR values would not be expected to stabilize until at least 5 days of warfarin therapy (allowing for slow onset of action by warfarin), full analyses were performed on Day 5 and onward. INR results were categorized based on the American College of Chest Physicians (ACCP) guidelines: in the recommended range (2-3), below range (<2), or above range (>3). For patients with two or more available INR values, the number of in-range INR levels, presence of at least one in-range INR level, and time to first in-range INR level were determined. **Results:** A total of 1509 eligible patients overall were identified, of whom 1500 had at least one available INR within the first 4 days after surgery. Of these patients, 83% (1246 of 1500) had no INR value within the recommended range. For patients who had received warfarin for at least 5 days and who had at least two available INR measurements ($n=653$), 72% (470) had at least one INR in the recommended range; 92% (598) had at least one below range INR. Furthermore, the median number of INR levels per patient in each category was two in range, three below range, and zero above range, while the median time to first in-range INR was 6 days (range 1-80 days). **Conclusions:** In this retrospective study, variability was observed in warfarin INR values, with all INR measurements classified into ACCP-defined 'below range' and 'in range' categories. Given the high proportion of INR values that were below range (<2) after 5 days of continuous warfarin, an assessment of the relationship between venous thromboembolism (VTE) incidence and an INR lower than the ACCP recommended range (2-3) in the THA population is warranted, with the further goal of helping clinicians achieve adequate VTE prophylaxis after THA.

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P155 Perioperative Intra-aortic Balloon Pump Counterpulsation And Outcomes In Very Elderly

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Introduction: Indications for use of intra aortic balloon pump (IABP) are low ejection fraction, shock, left main stem disease, unstable angina, refractory angina and redo operation. These were supported by trials which included few very elderly patients (older than 80). Octogenarians are increasingly undergoing Coronary artery bypass surgery often needing IABP use. **Hypothesis:** we plan to test the utility and effectiveness of IABP in improving outcomes in very elderly patients undergoing isolated coronary artery bypass grafting (CABG). **Methods:** We performed a retrospective analysis of very elderly patients who underwent coronary artery bypass from 01/2001 to 12/2008. Statistical analysis is performed by STATA. **Results:** A total of 450 patients older than 80 underwent CABG during eight years. The mean age of the total subjects was 83.16 +/- 2.48. A total of 35 (7.78%) patients underwent perioperative IABP of whom 14 (40%) died. Mortality among Non-IABP group was 7.47% (31/415). This was statistically significant at $p < 0.000$. Higher mortality in IABP group was seen across all the subset of patients with accepted guideline based indication including shock, low EF, Left main stem disease, Unstable angina. Higher mortality was also seen in other risk factors like CHF, renal failure. Patients who underwent IABP placement experienced other adverse outcomes like longer mean extubation time of 151.6 hrs (CI 24-301) compared to 27.03 hrs (CI 19 - 34.07) in Non-IABP group. Need for more than two inotropes was 44% (11/25) in IABP whereas it was 4.84% (17/351) in Non-IABP group. No clear relation to postoperative atrial fibrillation was found. Post operative renal failure was 9.38 (3/32) in IABP group compared to 2.24(9/401) in Non IABP group with a $p < .01$. We didn't had enough power to look into post-operative Cerebrovascular accident. In multivariate regression analysis after adjustment for confounding variable placement IABP has higher mortality with an OR 2.31 (1.14-3.48) $p < .0001$ **Conclusions:** In very elderly patients mortality rate is very high even for indications supported by ACC/AHA guidelines. We need prospective studies focusing on very elderly patients.

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P156 The Impact of Healthcare Insurance Type on 30-Day Readmission Rates after Percutaneous Coronary Intervention

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Background: Approximately 47 million Americans do not have health insurance. Differences in health insurance have been associated with disparities in patient access, treatment, and outcomes. We studied whether differences in health insurance were associated with 30-day readmissions after percutaneous coronary interventions (PCI). **Methods:** We identified 15,908 PCIs from from January 1998 through June 2008 at Mayo Clinic, Rochester, Minnesota meeting inclusion criteria. Demographic,