characteristics. Inclusion criteria included: 1) first time primary prevention ICD, with no history of sustained ventricular tachyarrhythmia; 2) ischemic or non-ischemic etiology; and 3) past myocardial infarction (MI) with an ejection fraction $\leq 30\%$, or, congestive heart failure (CHF) with an ejection fraction $\leq 35\%$. Subjects were considered outside trial evidence with either recent MI (<40 days), recent CHF diagnosis (<90 days), or advanced CHF symptoms (New York Heart Association class IV). Patients receiving cardiac resynchronization therapy ICDs were not included in this analysis. **Results:** Among 1726 subjects meeting inclusion criteria, 301 (17%) had one or more exclusion criteria, mostly a recent MI or CHF diagnosis. Having one or more exclusion criteria was more common among men than among women (19% [254/1345] vs. 13% [47/375], $p=0.009$), but did not differ by race (17% [190/1106] among whites vs. 18% [110/610] among non-whites, $p=0.75$). Subjects outside of trial-based evidence for implant were slightly older than those with no exclusion criteria (median age 68 vs. 67 years, $p=0.01$). **Discussion:** About 1 in 6 primary prevention ICD patients in the CVRN LSICD fall outside of trial-based evidence for implantation, which is a smaller proportion than the 22% previously reported in the U.S. national population.

Keywords: Implantable Cardioverter Defibrillators; Cardiovascular Disease
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PS1-28:

Psychosocial Factors Associated With Angina Occurrence, Physical Limitation, and Diminished Quality of Life After Hospitalization for an Acute Coronary Syndrome: Preliminary Data from TRACE-CORE

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Background/Aims: Depression, anxiety, and perceived stress are common in patients with coronary heart disease (CHD) and are associated with an increased risk for dying after an acute coronary syndrome (ACS). Data are needed on how these psychosocial factors relate to quality of life, physical functioning, or anginal status after hospital discharge in ACS patients. **Methods:** Adults admitted with an ACS at 3 medical centers in MA and GA were interviewed during their hospitalization and again at 1-month (1M) after discharge as part of the Transitions, Risk, and Actions in Acute Coronary Events: Center for Outcomes Research and Education (TRACE-CORE). At enrollment, patients completed standardized assessments of depression (PHQ-9; cut-point: >4), perceived stress (PSS-4; cut-point: >7) and anxiety (GAD-8; cut-point: >4). At 1M after discharge, participants ($n=281$) completed the Seattle Angina Questionnaire, including questions regarding frequency of angina, physical limitation, and disease-specific quality of life (QoL). Tertiles representing the worst physical limitation and QoL scores defined high limitation and low QoL, respectively. Presence of angina, physical limitation, and low QoL at 1M were examined in relation to in-hospital psychosocial factors. **Results:** Approximately one-third of participants were women (98 of 281), 77% were non-Hispanic white (216 of 281), and their mean age was 61.3 ± 11.0 years. At 1M after discharge, 44% (36 of 281) reported angina. Those depressed at baseline (45%, 126 of 281) were significantly more likely to report low QoL, high physical limitations, and angina at 1M than those without depression ($p < 0.05$ for all). Enrollees with anxiety (46%, 131 of 281) at baseline were more likely to report low QoL, and high physical limitation, than patients without anxiety ($p < 0.001$ for all) at 1M. Participants with highest baseline perceived stress (25%, 60 of 281) were significantly more likely to report lower QoL, high physical limitations, and angina than participants with lower perceived stress at 1M (p for all < 0.001). **Discussion:** Depression, anxiety, and perceived stress during ACS admission are related to CHD-specific functional status, angina, and QoL 1M after hospital discharge. These psychosocial factors may help identify patients at higher risk for poor outcomes after an ACS.

Keywords: Cardiovascular Disease; Acute Coronary Syndrome
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PS1-30:

Post-discharge Survival and Rehospitalization Associated With Heart Failure Program Participation

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Background/Aims: The Essentia Health Heart Failure Program (HFP) began in 1998, with the primary goal of improving care, with the expectation that both mortality and rehospitalization would be better controlled. This effort reviewed the electronic health records (EHR) of Essentia Health East heart failure patients ages 65 and over (65+), following hospital discharge, to assess the relationships between HFP participation and post-discharge survival (all-cause mortality) 30 days, six months and one year, and rehospitalization at 30 and 60 days. **Methods:** A case series design used EHR to identify heart failure patients, DRG 291-293, ages 65+, admitted to St. Mary's Medical Center, Duluth, MN, discharged alive between January 1, 2006 and December 31, 2010. Discharges to hospice were excluded. HFP electronic data classified participation within each post-discharge study period. Due to age and sex differences in HFP participation, logistic regression was used to evaluate sex and age (<85 vs. $85+$ years) adjusted odds ratios and associated 95% confidence intervals (CI) for survival at 30 days, six months and one year, and rehospitalization at 30 and 60 days. **Results:** EHR review identified 770 patients meeting inclusion/exclusion criteria, 397 (51.6%) were male and 257 (33.4%) were 85 years of age and over. HFP participation was 231, 258, 281, and 288 during the first 30 days, 60 days, 6 months, and 1 year post-discharge, respectively. Adjusted odds ratios (CI) for survival were 2.39 (1.19, 4.82), 1.73 (1.21, 2.48), and 1.41 (1.03, 1.93), at 30 days, 6 months and 1 year, respectively. Adjusted odds ratios (CI) for any rehospitalization were 0.58 (0.32, 1.05) and 0.95 (0.59, 1.55), at 30 and 60 days, respectively. **Discussion:** HFP participation was consistently associated with increased rates of survival, with the association decreasing over time. The association between HFP participation and 30 day rehospitalization was marginal, with the odds ratio well below 1.00, but the CI barely including 1.00. No apparent association existed between HFP participation and 60 day rehospitalization. The 60 day readmission rate is potentially affected by elective readmission for device therapy. Further evaluation including disease characteristics, characteristics of rehospitalizations and underlying cause of death is warranted.

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CB1-01:

Prevalence of HT in Children: Comparison Between Task Force Recommendations and Average of Multiple Measurements Over 2 or 4 Years

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Background/Aims: Identification of persistently elevated blood pressure (BP) in children can be challenging because BP measurements are subject to biological fluctuation and measurement error. The National High Blood Pressure Education Program 4th Working Group (NHBPEP) Guidelines define hypertension (HT) as BP that is ≥ 95 th percentile for sex, age and height on 3 consecutive clinic measurements on different days. However, HT is a chronic condition, and it is not clear whether a definition incorporating multiple measures over a longer period of time would alter the prevalence compared to the present definition of HT. **Methods:** Subjects included all children and adolescents, 3 to 17 years old, who received care at a Midwestern medical group and had three or more BP percentile measures taken between 1 January 2007 and 31 December 2010. All data were collected from an electronic medical record. We compared the prevalence of HT based on BP ≥ 95 th percentile on 3 consecutive visits with the prevalence based on the average of multiple BP percentile measurements over the previous 2 or previous 4 years. **Results:** Among the 22,173 children and