During a median follow-up of 23 months [IQR 9-38], 13 patients reached the primary endpoint. Patients who attained the primary endpoint had similar DCF (30.4g ± 14.7 vs. 28.0g ± 15.3; \( P = 0.601 \)) but a greater amount of GZF (18.1g ± 9.6 vs. 11.9g ± 6.7; \( P = 0.005 \)). On univariate analysis, GZF was associated with the composite endpoint (HR: 1.09 per gram; 95%CI: 1.02-1.15; \( P = 0.006 \)), whereas DCF was not (HR: 1.01 per gram; 95%CI: 0.98-1.05; \( P = 0.571 \)). After adjustment for LVEF, GZF remained independently associated with the primary endpoint (adjusted HR: 1.06 per gram; 95% CI: 1.01-1.12; \( P = 0.035 \)). Decision tree analysis identified 11.9g of GZF as the best cut-off to predict arrhythmic events. The primary endpoint occurred in 11 out of the 35 patients (31.4%) with GZF \( \geq 11.9g \), but in only 2 of the 53 patients (3.8%) with GZF \( <11.9g \) - Figure.

**Conclusion:** The extent of peri-infarct GZF seems to be a better predictor of ventricular arrhythmias than DCF. This parameter may be useful to identify a subgroup of patients with previous myocardial infarction at increased risk of life-threatening arrhythmic events.

**PO-626-05**

**PHARMACIST-LEAD CLASS III ANTIARRHYTHMIC CLINIC: FINANCIAL AND QUALITY OF CARE IMPACT**

Megan Labreck PharmD; Sreedhar R. Billakanty MD, FHRS; Nagesh Chopra MD; Eugene Y. Fu MD, FHRS; Auroa Badin MD; Jaret Tyler MD, FHRS; James M. Kleman MD; Andrea Robinson MSN, ACNP; Jill Swinning MSN, APRN, CCDS; Beth Loessin CNP; Jennifer Lynn James CNP; Victoria Murnane MSN and Anish K. Amin MD, FHRS

**Background:** Class III Antiarrhythmic Drug (AAD) monitoring consumes a large portion of electrophysiology access. Routine drug monitoring as outlined by FDA labeling should be completed every 3-6 months, dependent on the antiarrhythmic drug chosen. Pharmacist-led AAD monitoring and management can facilitate routine outpatient electrophysiology clinician access and has been demonstrated to improve patient safety and adherence. The financial impact of an AAD clinic has not been fully evaluated.

**Objective:** To quantify the financial impact of a pharmacist-led Class III antiarrhythmic drug clinic to the health system measuring downstream revenue generated and cost savings.

**Methods:** Cost savings and downstream revenue from outpatient procedures were captured for the first sixteen months of clinic operation.

**Results:** Class III lab review and documentation has saved an estimated 44.45 business days in physician time over a sixteen-month period. Indirect revenue from outpatient cardioversions and ablations from clinic patients have generated just over $200,000. Outpatient loading of sotalol saves nearly $6800 per patient over inpatient loading. In sixteen months, 71 patients have been loaded through the outpatient program, saving approximately $482,800. Without considering any clinical intervention cost savings or direct billing from face-to-face visits, the addition of a pharmacist lead antiarrhythmic clinic is a financially advantageous model to improve safety and efficiency for AAD monitoring.

**Conclusion:** The utilization of a pharmacist in class III drug monitoring improves patient safety, increases access for acute and non-acute patients, allows for new revenue generation, and provides cost-savings for the institution.

**PO-626-06**

**QUANTITATIVE CHARACTERIZATION OF LEFT ATRIAL POSTERIOR WALL VOLTAGES IN AN AF POPULATION UNDERGOING PVI**

Emerson Liu MD; William A. Belden MD; George Shaw MD, FHRS; Joshua R. Silverstein MD, FHRS; Tharian Simon Cherian MD and Amit J. Thosani MD, FHRS

**Background:** Left atrial fibrosis can serve as an arrhythmogenic substrate for AF. Numerous studies suggest that extensive areas of low voltage (as a marker of fibrosis) in the LA and posterior wall (PW) adversely affect overall success of AF ablation and treatment. However, the extent and distribution of abnormal voltages with respect to different AF phenotypes has not been well characterized.

**Objective:** Systematically quantify the extent of low voltage areas present in an AF population undergoing 1st time PVI, and evaluate their association with specific patient characteristics and AF phenotypes.

**Methods:** In consecutive patients undergoing 1st time PVI, high density bipolar electroanatomic mapping of the LA posterior wall in sinus rhythm was performed preablation, using a PentaRay® and...