Methods: This was a retrospective review of all patients presenting to triage for the calendar year 2012. Data were gathered from the electronic medical record for six months preceding and following the institution of the opioid prescribing guidelines on July 1, 2012. Demographics and LWBT rates were compared between the two groups with chi-square and t-tests. A LWBT sub-analysis was also performed for patients with the chief complaints of back pain, dental pain, and medication refill.

Results: There was no significant difference for age and sex between the two groups. There was a statistically significant increase in LWBT rate for all patients after the institution of opioid prescribing guidelines (10.8% vs. 11.9%, $p < 0.0001$). There was a decline in the LWBT rate of patients seeking medication refill (15.2% vs. 14.2%, $p = 0.04$). There was no change in the LWBT rates of patients seen for back pain (11.8% vs. 12.3%, $p = 0.07$) or dental pain (13.2% vs. 15.9%, $p = 0.7$).

Conclusion: Implementation of official ED opioid prescribing guidelines at our ED may have contributed to increased overall LWBT rates. Conversely, for patients seeking medication refill the LWBT rate declined, suggesting opioid prescribing guidelines or policies may discourage patients from casually using the ED for the purpose of obtaining opioid prescriptions.

660 Performance of an Augmented Pulmonary Embolism Severity Index in Identifying ED Patients at Low Risk for 5-day Inpatient Adverse Events

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Background: Although the PE Severity Index (PESI) score can identify acute pulmonary embolism (PE) patients at low risk of 30-day mortality (classes I and II), two single-center studies suggest that some of these patients (up to 8%) still experience short-term adverse inpatient events. We explored the addition of outpatient ineligibility criteria, identified in the ED, to low-risk PESI scores to identify a subset of patients at very low risk of both inpatient events and 30-day mortality.

Objectives: To compare the incidence of short-term (<5 days) inpatient adverse events, and 30-day all-cause mortality, among low-risk PESI ED patients with and without outpatient ineligibility criteria.

Methods: We conducted a retrospective cohort study of PE patients with low-risk PESI scores at three community hospitals from 2011 to 2012. We identified outpatient ineligibility criteria from prior studies, broadly grouped as: (1) PE-related factors (e.g., syncope, right ventricular strain); (2) comorbidities (e.g., renal failure, other indications for admission); and (3) barriers to adherence. Adverse inpatient events, defined a priori, included cardiopulmonary deterioration (e.g., need for additional ventilatory support or pressors), PE events (e.g., inpatient thrombolysis), and death.

Results: Among 191 ED patients with low-risk PE, mean age was 51.5 ±15.9 years; 61.7% were female. A total of 123 (64.4%) patients had at least one outpatient ineligibility criterion, mostly PE-related factors (n=87; 45.5%) or comorbidities (n=58; 30.3%). Among patients with these criteria the incidences of inpatient events and 30-day mortality were both 1.6% (2/123; 95% confidence interval 0.1% to 6.1%). One patient had concomitant pneumonia and was admitted directly to the intensive care unit; the other presented with syncope. Among patients without criteria (n=68; 35.6%) there were no inpatient events or 30-day deaths (95% upper confidence limit 6.4%). The difference in inpatient events between the groups was not significant (p=0.54) due to limited sample size and rare events.

Conclusion: Outpatient ineligibility criteria were common in our cohort of ED patients with low-risk PE. Adverse inpatient events were rare, even in patients who met ineligibility criteria. The addition of these criteria to low-risk PESI scores identified a subset of patients with no inpatient events or 30-day mortality.

661 GEDI WISE: Notifications about Geriatric ED Visits via Health Information Exchange is Feasible and May Reduce Admissions

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Background: Older patients are at high risk for admission and healthcare resource utilization. The GEDI WISE initiative aims to reduce admissions and revisits among seniors by instituting care plans, services, and follow-up from our emergency department (ED). However, if a patient is later taken to another ED, these services and plans may not be communicated to those EDs' providers.

Objectives: Working with a local health information exchange (HIE), Healthix, we developed a notification system for GEDI WISE patients who subsequently visit other facilities within the HIE. We hypothesized that ED visit notifications would arrive in a timely fashion, and that a significant portion would concern ED visits that led to brief inpatient admissions, and thus, be amenable to intervention by GEDI WISE care coordinators.

Methods: This was an observational evaluation of HIE notifications concerning GEDI WISE patients. Logs for ED visit, inpatient admission and inpatient discharge notifications were manually reviewed from 3/11/13 to 11/30/13. Notifications were de-duplicated, classified, and sequenced to determine whether ED notifications led to inpatient admissions and how long the inpatient visits lasted. In November, GEDI WISE care coordinators began responding to HIE notifications received from 8a-8p with calls to external ED providers.

Results: 267 notifications on 133 unique patients visiting 20 institutions were received. 118 of the notifications involved ED visits and 26 (22%) led to inpatient admissions, 18 (69%) of which were for ≤ 2 days. Average time to receipt of notifications was 10 minutes 18 seconds after event timestamps. Notification frequency rose with increasing GEDI WISE enrollments over time (Figure 661). Two hospital admissions were averted in the first month since the program became fully operational.

Conclusion: GEDI WISE ED notifications arrived in a timely fashion. A significant portion resulted in brief inpatient admissions. Notifications received by GEDI WISE clinicians who are able to inform external institutions of care plans may prevent unnecessary testing or admissions. As implementation of the notification system matures and care transition communications improve, it is anticipated this rate will increase.

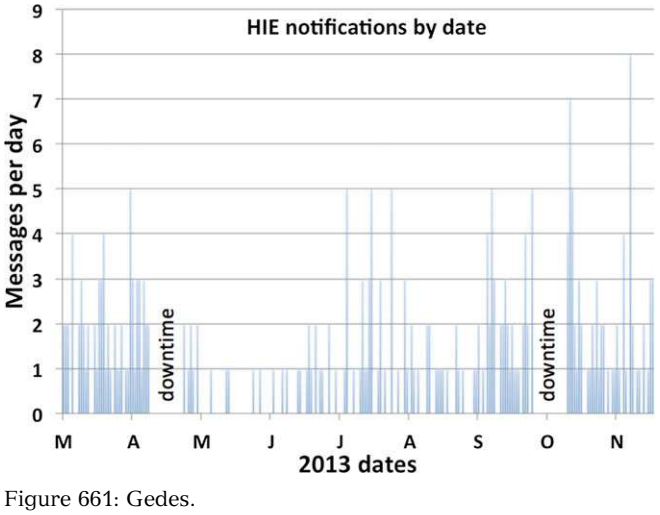

Figure 661: Gedes.