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(P78) Evaluation of Emergency Room Reattendance and Re-hospitalisation Reductions with Our Hospital-to-Home Programme

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and trauma center followed by expansion to select inpatient services. Study inclusion criteria included patients ≥14 years with acute or chronic pain with preference given to high-risk or high-utilization patients. Patients were excluded if in extreme pain prior to initial assessment and treatment, incarcerated, violent, suicidal, or critically ill. A training program and curriculum was developed for inaugural pain educators. Toolkits were customized based on type of pain and interest with a choice of 7 integrative options and 17 educational brochures. Patients were identified through electronic health record (EHR) tracking systems, paging, rounding, shared service patient lists, or by healthcare professional verbal request. All data was stored and managed in REDCap. Beginning in November 2021, patients completed a 30-day post-session phone survey that included questions about frequency of home toolkit use and session feedback. Descriptive statistics, Area Deprivation Index (ADI), medical and pain diagnoses, education and toolkit items provided, challenges, and follow-up survey data were collected and analyzed.

Results: There were 1,492 sessions conducted over two years with 1,295 unique patients receiving pain coach education sessions and discharge toolkits. The average age was 47.8 years (SD 17.2). The majority were female (63.6%), Black (53.7%), and non-Hispanic/Latino (96.6%). Most (43.6%) had a high level of socioeconomic disadvantage (ADI score >85, range 2-100). Sessions occurred in the ED (63.5%), in-patient (28.8%), out-patient (4.6%), and other (2.6%). Pain was reported as acute (55.3%), acute on chronic (28.1%), and chronic (16.6%), with patients often having multiple pain diagnoses (musculoskeletal, 73.4%; abdominal/pelvic pain, 13.8%; and low back pain, 12.8%). During customized educational sessions 89.7% of patients received a “4 flat tires analogy” stress ball, 87.9% hot/cold therapy, 86.9% aromatherapy inhaler/education, 56.6% pain journal with guided questions, 48.7%, virtual reality viewer, 33.4% therapeutic coloring, and 16.5% acupressure device. The top three challenges in conducting pain coaching sessions included medical condition such as nausea or lethargy, 14.5%; time constraints, 7.9%; or too much pain, 6.8% with 65.1% of sessions reporting no challenges. Of the 185 survey respondents, 169 remembered the session and were using toolkit items at home with 147 (86.9%) rating the session as helpful or very helpful and 135 (79.9%) using toolkit items daily or weekly.

Conclusion: Results from this novel ED-based pain coach education/toolkit program provide valuable insights and benefits for development of an international pain coach model. Most patients ranked the program as very helpful/helpful with continued use of integrative toolkit items at one month and qualitative statements of patient satisfaction and improved functionality. Appropriate timing of approach was a key issue. Multidisciplinary project champions and recognition were important to project success along with rounding. All program materials including an implementation guide are available online. Future plans include assessing program outcomes such as readmission and return ED rates, decrease in opioid use, cost effectiveness, and functionality.

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10 (P78) Evaluation of Emergency Room Reattendance and Re-hospitalisation Reductions with Our Hospital-to-Home Programme

Chong Yau Ong, MBBS, MMED Family Medicine; Jieru Lai, MBBS

Poster Presenter: Jean MH Lee, MD, FRCSAE

Objectives: Many patients get readmitted post hospital discharge due to multiple factors. Home visits through hospital-to-home (H2H) programs are targeted at these at-risk patients with complex co-morbidities and high social care needs. We aimed to review the outcome of a H2H program with regard to reducing emergency department (ED) visits and readmissions.

Background: Upon discharge from inpatient wards, patients with high risk of re-hospitalisation are followed up by a heath care team at home visits, with the purpose to identify patient care needs which range from medical to social needs, and they intervene to prevent an avoidable readmission back to the ED or hospital. We also aimed to optimise the well-being of the patient with our multi-disciplinary team approach.

Methods: A retrospective review of patients cared for under the program in a tertiary hospital in Singapore from September 2020–August 2021 was conducted. We studied the demographics of patients three months prior to enrolment into the H2H program and followed up with them for the period of enrolment. The enrolment consisted of two home visits

to the patient which could be conducted virtually if deemed suitable. Thereafter, the cohort was tracked for three more months after the last home visit and the visits to the ED and hospital admissions documented for them. During the home visits, other than following up on the medical issues, we would perform medical reconciliation, conduct Advance Care Planning conversations, and attend to social/financial needs by referring them to social workers or community partners where necessary.

Results: 284 patients had complete data and were included in the analysis. 90% of the patients were above age 60. The median length of enrolment in the program was five months (0-7 months). Compared to the three-month pre-enrolment period, there was a 47.5% reduction in ED re-attendances during the program enrolment period. The after-effect was also observed whereby there was a further 18% reduction in ED re-attendances at three months post-discharge from the program. Compared to the pre-enrolment period, enrolment in H2H studied three months later resulted in the highest number of ED re-attendance reductions among the groups with three ED visits (8 patients down from 46) and four and above ED visits (6 down from 30).

Conclusion: Home visits through a hospital-to-home program can reduce the number of ED re-attendances, and the benefit can still be observed after three months post-discharge from the program.

11 (O-G2) Laboratory Testing Is Indicated for Older but Not Younger Emergency Department Psychiatric Patients

John R. Allegra, MD, PhD; Marielle Daclan, MD

Oral Presenter: Barnet Eskin, MD, PhD

Objectives: To assess the value of laboratory testing for emergency department (ED) psychiatric patients of different ages by examining the fraction of those patients admitted medically instead of psychiatrically.

Background: Previous studies have shown that routine laboratory testing has low yield for identifying unsuspected medical conditions for most ED patients who present for psychiatric problems. About 20% of ED psychiatric patients are over 65 years old, and these patients are more likely to have chronic medical conditions than younger patients. These conditions may worsen during exacerbations of psychiatric illnesses and, in fact, may contribute to these exacerbations. We hypothesize that a larger proportion of elderly than younger patients presenting for psychiatric problems require medical admission, and that the reasons for such admission are exacerbations of chronic medical conditions.

Methods: Design: Retrospective cohort. Population: Consecutive ED patients presenting with psychiatric conditions in the years 2019-2021. Setting: Suburban ED with an annual ED volume of 90,000 patients, an ED residency, and a separate area for psychiatric patients. This area has specialized psychiatric personnel, including psychiatric social workers and psychiatrists. ED healthcare providers initially evaluate the patients and then request psychiatric consultation. Protocol: A database of ED psychiatric patients is maintained by the hospital. We tallied the number of psychiatric visits and the number of these patients admitted for medical conditions. We calculated and plotted the percent admitted medically by decade of life. We also tallied admissions for specific conditions, namely drug-related diagnoses (including alcohol abuse) and dementia.

Results: The database contained 8018 patients. The median age was 30 years (interquartile range 19-51); 51% were female. Of these, 175 (2.2%) were admitted for medical conditions. The percent admitted medically varied markedly by decade of life, ranging from an average of <1% in the first four decades of life to 15% in the 10th decade. Drug-related diagnoses were found in patients admitted medically in the 3rd-8th decades of life and accounted for 46% of the medical admissions in the 4th-6th decades of life. Of medical admissions in the 8th-10th decades of life, 30% were for dementia.

Conclusion: We found a higher admission rate for medical conditions in elderly than younger psychiatric ED patients. Dementia was the most frequent chronic medical condition in elderly patients that was identified as the reason for medical admission . Our results confirm that the routine requirement for laboratory testing in younger psychiatric ED patients is unlikely to be useful.

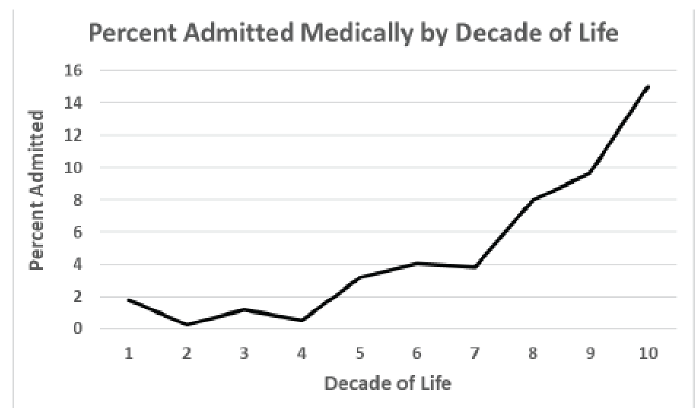

Figure 1. Percent Admitted Medically by Decade of Life

12 (O-D4) Impact of an Electronic Format on the Completion of Evaluations of Medical Students in the Emergency Department

Joshua Easter, MD, MSc

Objectives: To assess the effect of a novel electronic format on the frequency of evaluations completed by faculty and residents for medical students in the emergency