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Abstracts from 2019 Oncologic Emergency Medicine Conference

☐ TELETRIAGE AT A HIGH-VOLUME SPECIALTY CANCER CENTER URGENT CARE: ALIGNING PATIENT VOLUME AND NEED WITH AVAILABLE RESOURCE

Background: Memorial Sloan Kettering Cancer Center (MSK) sees a high volume of patients at its 21-bed urgent care center (UCC), frequently functioning over capacity, despite operating 24 h/day, 7 days per week with up to five attending physicians and two physician assistants. Approximately 51.2% of UCC patients are admitted (n = 11,810). Walk-in patients accounted for 36.2% of admissions (n = 4279). In contrast, 63.8% of admissions (n = 7530) were referred to the UCC by their oncologist: 59.3% (n = 4466) after speaking with their oncologist's office by phone; and 37.1% (n = 2796) after a visit to their oncologist's office. A small number of patients (n = 267, 3.5%) were referred from other locations. By applying a teletriage strategy, we aim to reduce the number of over-capacity days and streamline patient flow through the UCC.

Methods: Teletriage was initiated with the Gastrointestinal (GI) Medical Oncology Service. During weekdays between 9:00 AM and 4:30 PM, GI patients deemed to require a UCC assessment, including those who called their oncologist's office from home and those who presented to their oncologist's office, were enrolled in the UCC teletriage program. Exclusion criteria included: 911-appropriate patients, local hospital–appropriate, acute-subacute stroke (symptoms for 0–24 h), non–English-speaking (unless with interpreter), or outside of operating hours. Upon referral, the patient was informed that a UCC provider would contact him or her by telephone within the next 30 min. An electronic notification listing the patient information and presenting complaint was sent to the UCC teletriage provider by the oncologist's office. The UCC provider then called the patient and conducted an initial assessment of the presenting complaint. Laboratory tests and radiology was ordered as indicated. Stable patients scheduled for radiology would proceed for imaging prior to check-in at the UCC.

Results: From July 23–October 31, 2018, 173 GI medical oncology patients were referred to UCC teletriage; 79.8% arrived from home (n = 138), 17.9% from clinic (n = 31), and 7.5% from other locations (n = 7.5%). Ninety patients were admitted (52%), 60 patients were discharged (34.7%), 2 left against medical advice (1.2%), 10 were no-shows (5.8%), and 1 patient was transferred to another hospital (0.6%). Forty-six patients were scheduled for radiology (computed tomography, magnetic resonance imaging, x-ray, or ultrasound) and 59% (n = 27) received their imaging before their UCC check-in. Teletriage patients were contacted, on average, 11.26 min after UCC notification. Non-teletriage patients who presented to the UCC during the same time period had their first contact with a provider an average of 4.37 h after notification. Thus, first provider contact with teletriage patients occurred 4.25 h sooner with teletriage. Patient UCC check-in to release of final disposition occurred 31 min sooner with teletriage patients, this increased to 47 min in teletriage patients arriving from home. For teletriage patients who received radiology prior to check-in, final disposition occurred 1.22 h sooner than non-teletriage patients.

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Conclusions: The majority of UCC teletriage patients from the GI medical oncology service called their oncologist's office from home. More than one-half of patients were admitted. First provider contact with teletriage patients occurred 4.25 h sooner compared to standard notification and patient presentation to the UCC. Teletriage patients received earlier final disposition compared to non-teletriage patients, which was attributed to

patients arriving at the UCC with a documented history and testing ordered. Furthermore, earlier disposition was greater in teletriage patients who received radiologic imaging prior to UCC assessment. We have begun to transition from telephony to video triage assessment. We anticipate additional triage advantages with visual assessment of patients.

☐ MANAGEMENT OF ONCOLOGY-RELATED EMERGENCIES AT THE EMERGENCY DEPARTMENT (MORE-ED)—A LONG-TERM UNDERTAKING

Background: Over the years, the emergency department (ED) at the Singapore General Hospital (SGH) has been seeing increasing numbers of patients with oncologic emergencies, such as neutropenic sepsis, metabolic syndromes associated with malignancy, and patients at the end of life from malignancies. This ED has an annual census of 140,000 with an oncology-related attendance of about 4000. The tendency has been to admit such patients to the Medical Oncology Department for further management. Palliative care is currently not widely provided for such patients in the ED. Increasingly, patients are expressing a wish to be managed as outpatients. Decisions on admission/discharge are frequently based on fear of unsafe discharge of such patients or reluctance to admit with signing of a refusal of admission form, with its attendant negative connotations. The aims of this long-term study are to first determine the current state of management of oncology-related emergencies presenting to the ED (MORE-ED) of the SGH and subsequently to focus prospectively on specific areas of intervention required either for identified presentations, such as neutropenic sepsis, the breathless patient, palliative care provision, or to address cancer-specific management issues.

Methods: The first phase involved a retrospective chart review of all cancer-related presentations at the ED over a period of 1 month and determining their profile, clinical presentations, ED length of stay, disposition, and subsequent outcomes.

Results: Of 315 identified oncologic patients during October 2018, 147 (46.7%) were male, with a mean age of 66.95 ± 12.19 years (compared to 61.56 ± 13.70 years for females; $p < 0.001$). Presentations included a wide range of malignancies, including with sepsis, breathlessness, pain, bleeding, metabolic syndromes, and general symptoms. The mean ED length of stay (LOS) for all patients was 3.87 h. Two hundred and ninety-one (92.4%) were admitted as inpatients. Of these, 90 (30.9%) died during their stay in hospital. The mean in-hospital LOS was 4.0 days.

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Discussion: This initial study demonstrated that there was enough time to introduce active interventions for oncologic emergencies during their stay in the ED. Some interventions can lead to symptom relief with potential for continuing ambulatory management in the ED and outpatient follow-up. For others, active interventions, including early palliative care, can potentially improve outcomes; decrease inpatient LOS; and potentially improve patient, family, and staff satisfaction. Conclusions: The MORE-ED studies will provide the framework for enhancing care of oncologic emergencies presenting to EDs in an Asian environment, such as Singapore. The results will be shared with other institutions keen on similar initiatives.

☐ INTERVENTIONS TO IMPROVE ADHERENCE TO CERVICAL CANCER SCREENING RECOMMENDATIONS AMONG EMERGENCY DEPARTMENT PATIENTS: ENROLLMENT DATA IN ANTICIPATION OF INTERVENTIONAL TRIAL RESULTS

Background: Cervical cancer is among the most preventable forms of cancer. Still, only 80.7% of US women aged 21–65 years report adherence to US Preventive Services Task Force (USPSTF) cervical cancer screening recommendations. This rate is far below the Healthy People 2020 target of 93%. Concerningly, this rate of adherence was found to be dropping from 2000–2013, with notable disparities in screening coverage based on socioeconomic factors, including race, level of education, and access to care. The group identified as most likely to be non-adherent with recommended screening protocols are patients who use the emergency department (ED) for their usual source of care.

Methods: We completed the enrollment phase (n = 450) of a randomized clinical trial (RCT) pilot study comparing the efficacies of two structured behavioral interventions in promoting adherence of women aged 21–65 years to USPSTF cervical cancer screening recommendations. Emergency Department Research Associates used the EPIC eRecord system to screen adult patients registered in the ED at the University of Rochester Medical Center for eligibility over a 4-month period. Eligible subjects who provided informed consent were randomized to one of two behavioral interventions: (1) screening and referral and (2) screening, brief mobile technology-based intervention grounded in the Theory of Planned Behavior, and referral. A baseline survey was completed to determine adherence with USPSTF cervical cancer screening recommendations, and those who were found to be non-adherent or with uncertain adherence participated in their assigned treatment arm. Adherent subjects concluded participation at this time. Inclusion criteria were female sex and age 21–65 years. Exclusion criteria were past hysterectomy with cervical removal, known human immunodeficiency virus infection, inability to consent, non–English-speaking, or lack of text-capable mobile phone and/or inability to use text function.

Results: Among the 450 enrollees, 58% were white, 33% were black, and 9% were other. Eleven percent of enrollees were Hispanic. Mean age was 38 years. Overall adherence to screening recommendations was 79%. Factors associated with