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

non-adherence included Hispanic/Latina ethnicity, lack of health insurance, lack of a normal provider of women's health care, and cigarette smoking. Race, education level, method of contraception, age, and body mass index were not found to be associated with adherence.

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Conclusions: The enrollment phase of this pilot RCT found non-adherence rates similar to nationwide rates. The strongest predictors of adherence were having a regular women's health care provider ($p < 0.001$) and having health insurance ($p < 0.013$). The intervention and follow-up phases of this RCT are in progress and will provide robust preliminary data regarding potential efficacy of the behavioral interventions. In addition, the identification of covariates associated with non-adherence will inform the refinement of these interventions. Next steps will include using the foundation provided by this pilot RCT to conduct a large-scale multisite RCT of behavioral interventions to catalyze cervical cancer screening adherence among ED patients.

☐ THE SMILOW CANCER HOSPITAL ONCOLOGY EXTENDED CARE CLINIC: A FACILITY DEDICATED TO MANAGING ONCOLOGIC URGENCIES AND EMERGENCIES

Background: The burden of acute care among cancer patients, estimated to exceed $70 billion by 2020, represents approximately 50% of all costs of advanced cancer care and accounts for 70% of nationwide regional variation in these costs. The Centers for Medicare and Medicaid Services proposed value-driven Rule OP-35 includes a mandate to reduce acute care use among oncology patients. Emergency departments (ED) are the gateway to much acute care use and their 60% oncology patient admit rates are more than double general rates. Keeping oncologic urgencies and emergencies out of the ED has the potential to increase value for oncology care delivery. Here we describe the launch of a dedicated oncology urgent care clinic that offers same-day treatment for oncologic urgencies/emergencies, as well as unplanned supportive care needs and, where necessary, facilitates direct admission to the inpatient service.

Methods: The Smilow Cancer Hospital (SCH) Oncology Extended Care Clinic (OECC) is a six-bed urgent care center dedicated to serving the > 10,000 active analytic cases of the SCH Care Network, which includes a tertiary academic center and 10 Connecticut-wide community practices. The OECC operates 365 days from 7 AM–11 PM with primary staffing by four Advanced Practice Providers and five Registered Nurses and attended by an American Board of Internal Medicine–certified hospitalist in collaboration with the primary oncologist. Situated within the hospital, the OECC can access resources typically restricted to inpatients, including same-day subspecialty consults, STAT diagnostic testing, and care coordination. The OECC can also trigger a Rapid Response Team, which enables caring for high-acuity patients; only respiratory collapse, cardio/cerebrovascular urgencies, and shock are outside the scope of practice.

Results: During the first 13 months of operation, the OECC staffed 2855 visits across 1570 unique patients, including 1089 with solid tumors, 449 with liquid tumors, and 32 patients with benign hematologic needs. While 953 patients visited the OECC once, 145 had four or more encounters. Gastrointestinal oncology (256 patients, 459 visits), leukemia (170 patients, 374 visits), and thoracic oncology (150 patients, 255 visits) frequented the OECC most. Altogether, 863 (30.2%) visits were for clinic overflow (e.g., transfusion) and 1994 visits were for urgent indications. Urgent care visits resulted in a 43.3% admission rate with genitourinary cancer (odds ratio [OR] 1.91; 95% confidence interval [CI] 1.07–3.41), head and neck cancer (OR 3.93; 95% CI 2.26–6.92), and bone marrow transplantation (OR 2.15; 95% CI 1.19–3.88) independently associated with admission. Common indications for admission included intractable pain (102/151 visits, 67.5%), neutropenic fever (94/101 visits, 93.1%), and bowel obstruction (30/41 visits, 73.2%).

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Conclusions: The OECC shows a substantial reduction in overall admission rates in the urgent care setting compared with historic levels. Determination of impact on Smilow patient ED presentation rates and on overall cost of care are ongoing.

☐ CHARACTERISTICS OF UNSCHEDULED EMERGENCY DEPARTMENT REVISITS IN CANCER PATIENTS

Background: The quality of patient care in the emergency department (ED) can be assessed by unscheduled revisits. Identifying characteristics of the patients with revisits may help optimize diagnostic and management strategies. Cancer patients consume more ED resources than non-cancer patients, and identifying the factors that lead to fewer revisits may alter patient outcomes and save expenses for both the patient and the hospital.