clinicians' more aggressive treatment of CHF patients with elevated BP.

320 | A Cancer-Modified Pulmonary Embolism Severity Index Score Expands Outpatient Eligibility

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Background and Objectives: Many society guidelines recommend the validated Pulmonary Embolism (PE) Severity Index (PESI) to identify low-risk patients who may be eligible for outpatient care. In the original PESI, active and inactive cancer are treated as equivalents. Adverse outcomes in PE patients, however, correlate more with active cancer (e.g., metastatic) than remote inactive cancer (e.g., only local disease, excised 10 years prior, without recurrence). A few studies and clinical pathways have modified PESI (mod-PESI) by assigning cancer points only for active disease. The degree to which mod-PESI expands outpatient eligibility has not been explored.
Methods: This is a secondary analysis of a retrospective cohort study conducted across 21 U.S. community hospitals from 2013 to 2019. It included ambulatory adults diagnosed with PE in primary care to evaluate outpatient management (discharge home) both from the clinic and, for those referred, from the emergency department (ED). We included only those with vital signs (VSs) in the clinic or ED, using the most abnormal values for scoring. Active cancer was metastatic disease or recent (< 12 months) diagnosis, anticancer treatment or palliative care. We compared proportions of low-risk patients (mod-PESI vs. PESI) in clinic and the ED using McNemar exact test and calculated marginal Wald-type confidence intervals (CIs) on the differences in proportions. We reported 30-day major bleed, recurrent venous thromboembolism (VTE), and mortality among those reclassified.
Results: Of 652 patients in the parent study, 16 were excluded for lacking VSs. Of the remaining 636, median age was 65 years (interquartile range 51–74), 52% were male. Overall, 132 (20.8%) had cancer: 49 (7.7%) active and 83 (13.1%) only inactive cancer; 175 had only clinic VSs, 50 had only ED VSs (after a virtual clinic visit), and 411 had both. In the clinic ($n = 586$), mod-PESI classified more patients as low risk than PESI: 72.7% versus 64.5%, difference 8.2% (95% CI 5.9%–10.5%) ($p < 0.001$). Similarly in the ED cohort ($n = 461$): mod-PESI 70.9% versus PESI 63.3%, difference 7.6% (95% CI 5.1%–10.1%) ($p < 0.001$). There were no 30-day outcomes among those reclassified.
Conclusion: Mod-PESI, using an active-only cancer definition, classified a statistically significantly greater proportion of ambulatory PE patients as low-risk. Effect of mod-PESI use on disposition among unselected ED patients in different settings merits study.

321 | Estimating the Supplemental Nutrition Assistance Program Gap in the Emergency Department

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Background and Objectives: Food insecurity (FI) is an adverse social determinant of health (aSDoH) associated with increased emergency department (ED) utilization and poorer health outcomes. Screening for FI in primary care settings can identify patients in need of resources such as Supplemental Nutrition Assistance Program (SNAP), yet screening remains inconsistent, and patients without primary care may go unidentified. Patients who are eligible for SNAP but not enrolled are considered to be in the SNAP Gap. Our goal was to estimate the potential SNAP Gap to assess the population who could benefit from SNAP enrollment support in the ED.
Methods: We conducted a cross-sectional study of Massachusetts residents who visited a large academic ED in 2024, and a secondary analysis that screened patients for FI. We performed descriptive analyses of demographics and SNAP enrollment among screened individuals, both overall and among those with Medicaid (a proxy for SNAP eligibility) and identified FI. Using estimates from the screened cohort and secondary analysis, we estimated the potential target population for SNAP enrollment as both the identified and potential SNAP Gap.
Results: Among 288,919 patients, 38,608 (13%) were screened for FI, while 250,311 (87%) were not. Among those screened, 12,559 (33%) were enrolled in Medicaid, compared to 66,285 (26%) not screened. Of screened Medicaid patients, 3481 (28%) were identified as FI. Secondary analysis found that 35% of patients with public insurance were FI. Among screened, Medicaid-insured, FI patients, 1539 (44%) were enrolled in SNAP, while 1942 (56%) were not or did not respond, representing the identified SNAP-Gap. We estimate 18,560–23,056 patients (28%–35%) in the unscreened Medicaid population may be FI, of whom 10,393–12,911 were potentially SNAP eligible.
Conclusion: A large portion of patients, particularly those insured by Medicaid, experience FI and may not be enrolled in SNAP; these findings highlight the potential reach of targeted ED-based support to facilitate SNAP enrollment. Integrating FI screening and SNAP enrollment assistance into ED workflows may represent a critical opportunity to address aSDoH.

322 | Period Poverty and Menstrual Product Access in Atlanta: An Exploratory Study Among Emergency Room Patients

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Background and Objectives: Menstrual hygiene product access remains limited for many individuals due to financial, geographic, and educational barriers. Because availability of products often depends on local policy implementation along with community advocacy, support varies widely across communities. This study serves as a needs assessment for menstrual