Methods: We conducted a single site interventional study among patients 40–75 years old who presented to the ED for chest pain from 3/8/23 to 5/25/23 and were not already on a lipid-lowering drug. A lipid panel was obtained in the ED and the estimated 10-year ASCVD risk was determined using the American College of Cardiology's risk calculator based on the Pooled Cohort Equations. Patients with known ASCVD, LDL-C ≥ 190 mg/dL, or 10-year ASCVD risk ≥20% were started on a high-intensity statin (rosuvastatin 40 mg). Patients with 10-year ASCVD risk ≥7.5% but <20% and those with known diabetes were started on a moderate-intensity statin (rosuvastatin 10mg), while patients with 10-year risk <7.5% were not prescribed a statin. Seven days after ED discharge, research staff called the patient's pharmacy to determine if the prescription had been filled. At 30 days from the ED encounter, patients returned to research clinic for a lipid panel. Outcomes were the rate of prescription pick-up within 7 days and percent change in LDL-C at 30 days.

Results: During the 10-week pilot, a 20 patient convenience sample was enrolled. The population was 65.0% (13/20) female, 70.0% (14/20) African American, and had a median age of 53.5 (IQR 49.5–58.0) years. The median index LDL-C measure was 110 mg/dL (IQR 89.5–144.5). Among these, 80.0% (16/20) qualified for a statin (8 for high-intensity, 8 for moderate-intensity). Within 7 days of discharge, 94.0% (15/16) picked up their prescription. At 30 days, 69.0% (11/16) returned for a repeat lipid panel, with the median 30-day LDL-C being 84.0 mg/dL (IQR 60–111). Among patients with index and 30-day lipid measures, the median percent change in LDL-C was -16.5 percentage points (IQR −50.6 to −3.8).

Conclusion: An ED-based HLD screening and treatment program is feasible. Most patients filled their statin prescription and the cohort had a lower median LDL-C at 30-days.

397 | Impact of emergency department decision support on initiation of atrial fibrillation thromboprophylaxis

David R. Vinson[1], Margaret Warton[2], Edward J. Durant[1], Adina S. Rauchwerger[1], Daniel D. DiLena[1], Matthew D. Solomon, Bory Kea[3], Mary E. Reed[2], Dustin G. Mark[4]

[1]*Kaiser Permanente*, [2]*Kaiser Permanente Division of Research*, [3]*OHSU School of Medicine; OHSU Center for Policy and Research in Emergency Medicine*, [4]*The Permanente Medical Group*

Background and Objectives: Thromboprophylaxis for patients with atrial fibrillation or flutter (AFF) at elevated stroke risk reduces ischemic stroke by two-thirds but is underused. Efforts to increase oral anticoagulation (OAC) initiation on emergency department (ED) discharge have had mixed results. As part of a larger trial, we evaluated the impact of AFF clinical decision support (CDS) on OAC initiation <30 days among home-going patients at elevated stroke risk using CHA2DS2-VASc.

Methods: In a stepped-wedge, cluster-randomized trial of physician education and CDS for ED AFF patients from 07/01/2021 through 04/30/2023, we randomly assigned 9 clusters (13 community EDs) to staggered dates for one-way crossover from control (usual care) to intervention phase. CDS identified those at elevated stroke risk and recommended shared decision-making, OAC if suitable, and close follow-up. The primary outcome was OAC initiation (either on discharge or post-discharge but <30 days) among eligible patients discharged home. Analysis was intention to treat, defined by CDS exposure. We used a GEE model to calculate odds ratio (OR), adjusting for trial and exposure months with random effects for clustering by facility and patient.

Results: Excluding the 2-month transition, 3388 ED cases with primary AFF and elevated stroke risk were discharged home: 2185 (64.5%) on pre-arrival OAC and 1203 (35.5%) eligible for OAC initiation. Among initiation-eligible cases, median age was 74.0 years (IQR 68.0–82.0), 48.6% were women, and median CHA2DS2-VASc score was 4.0 (IQR 3.0–5.0). Among 387 initiation-eligible controls, 243 (62.8%) received OAC: 190 (49.0%) at discharge and 53 (13.7%) <30 days. Among 816 initiation-eligible intervention cases, 555 (68.0%) received OAC: 428 (52.4%) at discharge and 127 (15.5%) <30 days. Adjusted OR was 1.36 (0.68–2.70; $p = 0.36$). During intervention, CDS was used in only 26.6% of study cases and was associated with OAC outcome: 75.6% with vs. 65.8% without CDS use; $p < 0.01$). Including pre-arrival OACs, 86.2% of control and 88.8% of intervention cases were treated with OAC by 30 days.

Conclusion: Among ED patients with primary AFF at elevated stroke risk discharged home, CDS access promoting thromboprophylaxis improved OAC initiation, though not statistically significantly. CDS use, however, significantly increased OAC initiation. Relatively high baseline thromboprophylaxis rates and CDS underuse may have dampened overall impact.

398 | Safety and efficacy of the HET (History, Electrocardiogram, and Troponin) score vs HEART (History, Electrocardiogram, Age, Risk Factor, and Troponin) score in a multisite United States cohort

Powell Stephen[1], Michael W. Supples[2], Nicklaus P. Ashburn[3], Anna C. Snavely[4], Brandon R. Allen[5], R. Gentry Wilkerson[6], Bryn E. Mumma[7], Troy Madsen[8], Robert H. Christenson[9], Jason P. Stopyra[3], Simon A. Mahler[2]

[1]*Wake Forest Baptist Health*, [2]*Wake Forest School of Medicine*, [3]*Wake Forest University Baptist Medical Center*, [4]*Wake Forest University School of Medicine*, [5]*University of Florida*, [6]*University of Maryland School of Medicine*, [7]*University of California, Davis*, [8]*University of Utah*, [9]*University of Maryland*

Background and Objectives: Recently, the history, electrocardiogram, and troponin (HET) score has been proposed as a simplified alternative to the history, electrocardiogram, age, risk factor, and troponin (HEART) score for risk stratifying emergency department (ED) patients with chest pain. This study aims to evaluate the safety and efficacy of the HET score in a multisite US cohort and compare its performance to the traditional HEART score.