home. Interviews are still underway, with a target of 30 interviews for thematic saturation. Themes are being identified using a grounded theory approach.

Results: Preliminary analysis identifies the need for an explanation of symptoms, as well as fear of dying, as primary reasons for presenting to the emergency department. Patients are often seeking reassurance, and they feel that a physician in the hospital is the most trusted source. Patients value having extensive testing done, and feel reassured by continuous monitoring as well as individualized attention received in the observation unit. Many patients consider the overnight stay as a significant marker of illness severity, especially when compared to prior emergency department visits from which they were discharged home. Patients report mostly positive relationships with their care team, feeling comfortable asking questions when they were confused and generally feeling well cared for. Even when they are not given a clear diagnosis, patients feel better due to the extensive testing they underwent, and the conversations with their doctors regarding their test results. Some patients are determined to work towards a diagnosis with their outpatient doctors whereas others feel comfortable simply knowing their heart is functioning normally. Patients find their symptoms to be a wake-up call of sorts, stating that they are determined to make efforts towards living a healthy lifestyle after leaving the hospital. Patients express concern about recurrence of symptoms after leaving the hospital, and many plan on resting more than usual and withdrawing from some of their usual activities post-discharge.

Conclusion: Patients being evaluated for chest pain in the observation unit arrive at the hospital in search of an explanation or solution for their problem. Some patients leave the hospital with an explanation for their symptoms, though most still do not have a clear diagnosis. Normal test results provide reassurance for some patients and a sense of confusion for others. Many patients endorse the intention to seek further information about the cause of their symptoms in the outpatient world after discharge.

249 Waiting for Care: Differences in Emergency Department Length of Stay and Disposition Between Medical and Psychiatric Patients

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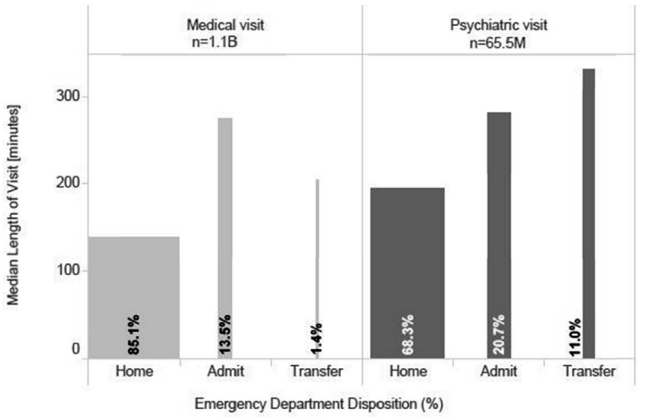
Study Objectives: Psychiatric patients in acute crisis depend on intact, efficient systems of specialized care. With fewer inpatient psychiatric facilities available nationally, there are growing reports of prolonged emergency department (ED) length of stay for psychiatric patients, which contributes to ED crowding. Our objective is to develop a national-level analysis examining patient and hospital factors contributing to prolonged ED length of stay and disposition among patients of all ages.

Methods: We performed a retrospective analysis of ED visits using the National Hospital Ambulatory Medical Care Survey (NHAMCS) from 2001-2011. Patients with any one of the three recorded International Classification of Disease; Ninth Revision (ICD-9) diagnostic codes indicative of substance abuse or primary psychiatric diagnosis were designated as a mental health visit, and all others, as a medical visit. Disposition was categorized as discharge, admission to medical or psychiatric bed, and transfer to any acute facility. Length of stay was defined as time of ED arrival to disposition (min) and further categorized into time periods of >6, >12, >24 hours. We examined demographic- and visit-level factors for psychiatric and medical patients associated with increased ED length of stay by disposition category, using chi-square tests for categorical variables, and f-tests of means for continuous variables.

Results: Psychiatric visits represented ~6% of all ED visits, amounting to 65 million visits. A larger percentage of psychiatric patients were uninsured (22% versus 15%) and had been seen in the same ED within the prior 72 hours (4.6% versus 3.6%). Larger proportions of patients presenting for psychiatric compared to medical reasons required admission (21% versus 13.5%) or transfer (11% versus 1.4%). For all dispositions, more psychiatric (23%) compared to medicine (10%) patients had length of stay >6 hours. Seven percent of psychiatric and 2.3% of medical patients had length of stay >12 hours and 1.3% of psychiatric and 0.5% of medical patients had length of stay >24 hours. Mean length of stay was longer for all psychiatric than medical patients (194 versus 138 min respectively, $p<0.01$) and those being transferred (331 versus 203 min, $p<0.01$); but not for admitted patients (281 versus 274 min).

Conclusions: ED psychiatric patients are admitted and transferred more frequently compared to medical patients and experience significant disparities in length of stay. In a time of decreasing psychiatric in-patient beds, insufficient outpatient psychiatric centers, and increasing ED crowding, these findings portend a growing crisis of unmet psychiatric need. While obvious that psychiatric patients will suffer, all ED patients will be affected. These results compel us to further investigate the potential causes of prolonged length of stay in psychiatric patients and to further characterize the population of psychiatric patients most at risk of prolonged stays.



250 Predictors of Opioid Analgesic Administration for Abdominal Pain in the Emergency Department

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Study Objective: Abdominal pain is the most common reason for visiting hospital-based emergency departments (EDs) in the U.S. The last decade has seen dramatic increases in the use of opioid analgesics in U.S. EDs. We study trends in and predictors of opioid analgesic use in ED visits for abdominal pain.

Methods: A retrospective review of data from the National Hospital Ambulatory Medical Care Survey, 2007-2011 was performed. All encounters with a reason for visit related to abdominal or pelvic pain were included; pregnancy and trauma-related complaints were excluded. We studied trends in the use of opioid analgesics (both administered in the ED and prescribed at discharge) and examined predictors of opioid analgesic use based on patient and hospital characteristics, including age, sex, payment type, geographic region, hospital type, disposition, procedures, imaging studies, and reported severity of pain using logistic regression analysis.

Results: There were an estimated 18.7 million visits for abdominal pain in 2007 and 23.0 million in 2011. Opioid analgesic use increased 11.9%, from 35.2% of visits in 2007 to 39.4% in 2011, $p=0.01$. Patient characteristics associated with opioid use included age <65 years, white race, a report of severe pain (pain score ≥, 8), having a procedure or imaging study during the visit, and a disposition of hospital admission to a medical or surgical floor. Patients admitted to the intensive care unit (ICU) were much less likely to receive opioid analgesics. Geography was also a significant predictor, with greater use of opioids outside of the Northeast U.S., and particularly in the Western and Southern U.S. and in the city (ie, metropolitan statistical areas [MSA]). There was no difference in opioid use based on insurance status.

Conclusion: There was a significant increase in opioid analgesic use in U.S. EDs for abdominal pain from 2007-11. Patient report of severe pain was the strongest predictor for opioid use, whereas severity of illness requiring ICU admission was associated with less opioid use. Older adults and non-whites were less frequently treated with opioid analgesics.

Table. Predictors of ED Opioid Use for Abdominal Pain

Variable	Odds Ratio	95% CI
Age 65+ years	0.44	0.37-0.52
White (versus nonwhite)	1.60	1.43-1.78
Private insurance (versus self-pay)	1.10	1.00-1.22
Midwest (versus Northeast)	1.40	1.16-1.68
South (versus Northeast)	1.51	1.26-1.80
West (versus Northeast)	2.14	1.78-2.56
Urban (versus rural)	1.30	1.01-1.67
Admitted to floor (versus discharged)	1.26	1.11-1.42
Admitted to ICU (versus discharged)	0.59	0.45-0.77
Procedure	1.93	1.74-2.14
CT/MRI	3.00	2.75-3.28
Ultrasound	1.62	1.43-1.83
Severe pain	3.33	3.07-3.62