**Plenary Oral Presentations**

**PL01**

**Creation of the Canadian Heart Failure Risk Scale for acute heart failure patients**

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**Introduction:** Acute heart failure (AHF) is a common, serious condition that frequently results in morbidity and death and is a leading cause for hospital admissions. There is little evidence to guide ED physician disposition decisions for AHF patients. We sought to create a risk-stratification tool for use by ED physicians to determine which AHF patients are at high risk for poor outcomes. **Methods:** We conducted a prospective cohort study in 9 tertiary hospital EDs and enrolled adult patients presenting with shortness of breath due to AHF. Patients were assessed for standardized clinical and laboratory variables and then followed to determine short-term serious outcome (SSO), defined as death, intubation, myocardial infarction, or relapse requiring admission within 14 days. We identified predictors of SSO by stepwise logistic regression and then rounded beta coefficients to create a risk scale. **Results:** We enrolled 1,733 patients with mean age 77.1 years, male 54.5%, and initially admitted 50.1%. SSOs occurred in 202 (11.7%) cases (14.0% in those admitted and 9.3% in those discharged from the ED). We created the CHFRS consisting of: 1. Initial Assessment a) History of valvular heart disease b) On anti-arrhythmic c) Arrival heart rate ≥ 110/d) Treated with non-invasive ventilation2. Investigations a) Urea > 12 mmol/L or Cr > 150 mmol/L b) Serum CO2 > 35 mmol/L or pCO2 > 60 mmHg (VBG or ABG) c) Troponin >5x Upper Reference Level 3. Fails reassessment after ED treatment: (i) Resting vital signs abnormal, (SaO2 <90% on room air or usual O2, or HR >110, or RR >28); (ii) Unable to complete 3-minute walk test. The risk of SSO varied from 5.0% for a score of 0, to 77.4% for a score of 9. Discrimination between SSO and no SSO cases was good with an area under the ROC curve of 0.70 (95% CI 0.66-0.74). There were 3903 patients included sensitivity, specificity, kappa coefficient, t-test, and descriptive statistics with 95% CIs. **Results:** There were 3903 participants: 2153 in the derivation sample and 1750 in the validation sample. In the derivation sample, increasing FI-ED was significantly associated with admission (OR 1.43 [95% CI 1.34-1.52]), death in hospital (OR 1.55 [1.38-1.73]), prolonged hospital stay (OR 1.37 [1.22-1.54]), needs for Comprehensive Geriatric Assessment (OR 1.51 [1.41-1.60]) and discharge to long-term care (OR 1.30 [1.16-1.47]). In the validation sample, results were similar except for long-term care disposition (OR 0.84 [0.75 0.85]). **Conclusion:** The FI-ED conformed to characteristics previously reported in other geriatric populations. It was accurately derived and validated from a brief geriatric assessment feasible in the ED and can be used to predict adverse outcomes. **Keywords:** frailty, geriatric, emergency

**PL02**

**Derivation and validation of a feasible emergency department specific frailty index to predict adverse outcomes**

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**Introduction:** Frailty is an overarching concept in geriatric medicine. However its utility in the emergency department (ED) was not well understood. Objectives were to derive and validate an ED specific frailty index (FI-ED), using a cumulative deficits model; and to evaluate its ability to predict adverse outcomes. **Methods:** This was a large multinational prospective cohort study using data from: The Management of Older Persons in Emergency Departments (MOPED) and the interRAI study. The FI-ED was derived from the Canadian sample and validated in the multinational sample. Inclusion criteria were all patients ≥ 75 years old presenting to an ED. The FI-ED used 24 variables identified in the interRAI ED-Contact Assessment tool, a brief focused geriatric assessment. Its ability to predict adverse outcomes were analysed by logistic regression with odds ratio (OR). **Results:** There were 3903 participants: 2153 in the derivation sample and 1750 in the validation sample. In the derivation sample, increasing FI-ED was significantly associated with admission (OR 1.43 [95% CI 1.34-1.52]), death in hospital (OR 1.55 [1.38-1.73]), prolonged hospital stay (OR 1.37 [1.22-1.54]), needs for Comprehensive Geriatric Assessment (OR 1.51 [1.41-1.60]) and discharge to long-term care (OR 1.30 [1.16-1.47]). In the validation sample, results were similar except for long-term care disposition (OR 0.84 [0.75 0.85]). **Conclusion:** The FI-ED conformed to characteristics previously reported in other geriatric populations. It was accurately derived and validated from a brief geriatric assessment feasible in the ED and can be used to predict adverse outcomes. **Keywords:** frailty, geriatric, emergency