Results: A total of 941,253 ED encounters were identified; 797,093 nonhallway patients and 25,927 hallway patients met the inclusion criteria. Compared to patients in non-hallway locations, hallway patients had higher odds of 7-day return to the ED (1.4 [1.3, 1.5]), 7-day return with inpatient admission (1.4 [1.3, 1.5]), 30-day return to the (ED 1.2 [1.2, 1.3]), and 30-day return with inpatient admission (1.3 [1.2, 1.3]). Hallway patients had lower odds of 30-day mortality after the index visit (0.6 [0.5, 0.7]).

Placement of patients in the hallway was associated with being male (OR 1.31 [1.27, 1.34]), non-white (OR 1.26 [1.23, 1.30]), having self-pay insurance (1.22 [1.16, 1.28]), and current tobacco use (1.33 [1.30, 1.36]). Hallway patients had lower odds of having a history of CAD (0.73 [0.70, 0.76]), CHF (0.78 [0.74, 0.82]), or prior stroke (0.79 [0.75, 0.84]). The top CCS diagnostic categories for the ED diagnosis in hallway patients were alcohol-related disorders (9.5%), abdominal pain (4.2%), sprains/strains (4.2%), back pain (3.8%), substance-related disorders (3.6%), superficial injury/contusion (3.6%) and non-specific chest pain (3.5%). Among hallway patients discharged from the ED who returned to the ED or required admission within 7 days, "alcohol-related disorders" was by far the most common diagnostic category (26.4%).

Conclusion: Hallway patients have increased odds of return to the ED and inpatient admission within 7 days and 30 days of their index visit. Male, non-white patients are more likely to be placed in hallways, and the largest subset of hallway patients (13.1%) have an ED diagnosis of alcohol or substance use.

Table. Hallway patient outcomes

	Non-Hallway (n=797,093)	Hallway (n=25,927)	Mean Difference (95% CI)	OR [95% CI]
7-day Return to ED	8.1	11.0	-2.9 [-3.3, -2.5]	1.4 [1.3, 1.5]
7-day Return with Admission	3.1	4.2	-1.1 [-1.4, -0.9]	1.4 [1.3, 1.5]
30-day Return to ED	20.6	24.0	-3.4 [-4.0, -2.9]	1.2 [1.2, 1.3]
30-day Return with Admission	9.1	11.4	-2.3 [-2.7, -1.9]	1.3 [1.2, 1.3]
30-day Mortality	1.2	0.7	0.5 [0.4, 0.6]	0.6 [0.5, 0.7]

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332 "They're the Experts. So, How Involved Could I Be?": Patient Perspectives on Oral Anticoagulation Decisionmaking

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Study Objective: Venous thromboembolism (VTE) and pro-thrombotic diseases, eg, atrial fibrillation (AF), have significant mortality and morbidity. Emergency department (ED) physicians vary in the degree to which they involve patients in oral anticoagulation (OAC) decisionmaking. We evaluate patient perspectives on this process.

Methods: Research assistants prospectively identified and consented patients with new AF or VTE, 7am to 11pm, seven days/week at a tertiary care academic ED, Sept 2015-Dec 2016. Patients were interviewed ≤30days of their ED encounter using a semi-structured interview guide, with prompts to examine factors influencing their OAC decisionmaking. Digital recordings were transcribed and analyzed by two methodologists using NVivo software. A qualitative, modified-grounded theory framework was applied to data collection and analysis. Qualitative processes were reviewed using the Consolidated Criteria for Reporting Qualitative Research checklist.

Results: We interviewed 22 patients, 10 with AF and 12 with VTE, with an average age of 57 years (range 29-88), and 10 females. There were no differences in patterns of responses between VTE and AF patients; thus, combined results are presented. Three major themes arose. 1) Patient Education: Patients felt adequately informed, if not "more than I needed"; or resolved remaining questions with other health care providers, eg, pharmacists. 2) Patient Involvement: Without exception, patients stated they were as involved in treatment decisions as they wanted to be. However, the level of involvement ranged widely. Some patients deferred to ED provider decisions because "the doctor knew more than I did". 3) Discussion of Treatment Options: Providers did not often discuss multiple treatment options; a more typical experience was that providers suggested only one treatment. Even though patients described an overall low level of decisionmaking involvement, most did not seek to alter their ED treatment plans except when subsequently concerned about medication costs.

Conclusion: Among our cohort of VTE and AF patients, there was minimal evidence of shared decision making; however, most patients felt adequately informed/included in the decisionmaking process and trusted their physician's expertise. Further research is needed to determine which conditions and settings are more suited for "shared decisionmaking."

333 Improving Burnout With Resident Shift Adjustments: A Wellness Innovation

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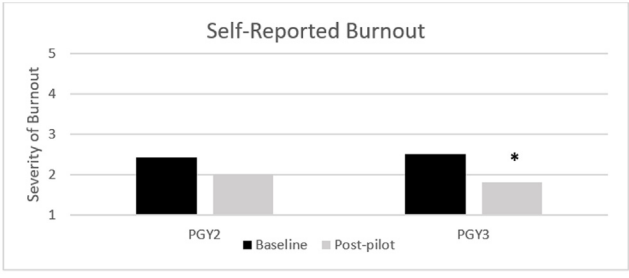
Study Objectives: According to the 2017 National Emergency Medicine (EM) Wellness Survey, 76% of EM residents report symptoms of burnout. Shift work, physician workload, and emergency department (ED) crowding are commonly cited contributors to burnout. At our institution, post-graduate year (PGY) 2s and PGY3s work 10-hour shifts, and arrival data suggest that a single PGY3 covers a large portion of the ED during some of the busiest times of the day. The objective of this innovation is to improve resident self-reported burnout by adjusting the existing staffing models.

Methods: In response to a residency needs assessment revealing concerns over long shift lengths and resident understaffing in certain time periods, a pilot 4-week schedule was created. This initiative reduced PGY2 and PGY3 resident shifts to 9 hours, including a one-hour sign-out overlap. Using arrival data, additional residents were scheduled during historically busier times. De-identified data was collected from all residents via a Qualtrics survey from January through March of 2020. In addition to residency-specific questions regarding shift work, multiple previously validated surveys were administered: the Mini-Z, Professional Fulfillment Index (PFI), Patient Health Questionnaire 9 (PHQ-9), Generalized Anxiety Disorder 7 (GAD-7), Pittsburgh Sleep Quality Index (PSQI), and International Physical Activity Questionnaire (IPAQ). Following the intervention pilot block which ran during the month of February, a repeat survey was sent to those residents who participated in the pilot. Results were analyzed using two-sided t-tests.

Results: The response rate of the initial survey was 77% (46 of 60 residents), and the response rate to the follow-up survey was 59% (10 of 17 residents). Eighty-five percent of residents believed that ten-hour shifts were too long, and 77% believed there was not enough resident coverage in the ED. Baseline survey results revealed that the majority (59%) of residents reported feeling under stress, and an additional 36% reported experiencing true burnout. Following the pilot schedule intervention, there was a significant improvement in self-reported burnout in the PGY3 class from 2.5 to 1.8 on a 5-point scale (p=0.02), although no such improvement was observed in the PGY2 class. Depression and anxiety levels were both initially low, with 84% of residents reporting mild or no anxiety and 89% reporting mild to no depression. Exercise levels met or exceeded the American Heart Association recommendations at baseline, and sleep quality varied widely. There were no significant changes noted in any of these measures.

Conclusions: Resident-centered scheduling changes resulted in statistically significant improvements in self-reported burnout.



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