and few reported problems obtaining or taking prescribed medicines (Table 2).

Conclusion: Patients successfully reached by phone within 72 hours after discharge are significantly less likely to return for further ED care within 72 hours or seven days compared to patients who were unable to be reached or not called. While our data do not suggest clarifying instructions or assisting with medications helps, phone call may assist with reassurance leading to lower likelihood of return. Discharge follow-up communication via phone may be a useful method of targeting high-risk patient groups. In addition, recognizing that few patients needed clarification on instruction or significant assistance, automated methods of outreach may be more cost-effective for employment and maintenance.

Table 1. Patient demographics regarding telephone outreach after pediatric emergency department visit.

	Total discharges	Called		Reached (of attempted calls)	
		n	%	N	%
Total	25152	7378	29.3	4110	55.7
Age (Years)					
0-1	7492	2270	30.3	1274	56.1
2-5	7482	2205	29.5	1239	56.2
6-11	5596	1669	29.8	917	54.9
12-18	4582	1234	26.9	680	55.1
Sex					
Female	11743	3437	29.3	1890	55.0
Male	13408	3941	29.4	2220	56.3
Race					
Black	4166	1380	33.1	753	54.6
Asian	4019	1096	27.3	645	58.9
White	6603	2133	32.3	1139	53.4
Hispanic/ Latino	6487	1586	24.4	910	57.4
Mixed/Other	3369	1023	30.4	585	57.2
Unknown	508	160	31.5	78	48.8
Insurance					
Public	13437	3690	27.5	2125	57.6
Private	10939	3491	31.9	1895	54.3
Self-Pay	776	197	25.4	90	45.7
Median Income					
$14k-$70k	9374	2700	28.8	1561	57.8
$70k-$125k	13810	4096	29.7	2238	54.6
$125k+	1518	475	31.3	253	53.3
Unknown	450	107	23.8	58	54.2

Table 2. Successful telephone contact after visit to pediatric emergency department.

	Call Attempt		Call Success	
	OR	95% CI	OR	95% CI
Age (Years)				
12-18 vs 0-1	0.85	0.78-0.92	0.97	0.84-1.12
Race				
Black vs White	1.21	1.1-1.33	0.92	0.78-1.07
Asian vs White	0.83	0.76-0.91	1.2	1.03-1.39
Hispanic/ Latino vs White	0.76	0.7-0.83	1.09	0.94-1.25
Insurance				
Public vs Private	0.82	0.76-0.87	1.12	1.0-1.25
Uninsured vs Private	0.82	0.68-0.98	0.73	0.54-0.99

OR, odds ratio; *CI*, confidence interval.

21 The Impact of a Liaison Program on Patient Satisfaction in the Emergency Department

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Background and Objective: Improving patient satisfaction is paramount to a successful emergency department (ED). Individualized patient navigators can be useful in providing immediate service recovery, but they can be costly. A patient liaison program adapted to ED needs and flow may be able to elicit consistent, structured feedback and result in increased patient satisfaction ratings.

Methods: This quality improvement project was conducted in the ED of an urban, academic, community hospital. Trained patient experience liaisons engaged patients at multiple points during their ED course and administered a survey that elicited opportunities for immediate service recovery. Engaged patients who also completed a validated patient satisfaction survey (Quality Reviews, New York, NY) were case-matched 1:1 by age, gender and ED arrival time with patients who were not encountered by the patient advocate. Topics on the survey included wait times, cleanliness, overall experience, and "likelihood to recommend."

Results: This retrospective, case-control study included data from 400 participants. Patients in the intervention group had a significantly longer ED length of stay compared to the control group (4.7 hours vs 3.9 hours, $p = <0.001$). In the patient liaison-administered survey, 96.7% and 91.8% of individuals responded positively to

the "likelihood to recommend" and "cleanliness" questions, respectively; 54.4% of patients reported waiting less than 15 minutes to see a physician. Patients in the intervention group had significantly higher mean scores on the validated post-visit survey compared to controls on questions regarding "likelihood to recommend" (4.21, confidence interval [CI] 4.03-4.38 vs 3.82, CI, 3.61-4.02, p = 0.01), overall rating (4.16, CI 4.00-4.33 vs 3.87, CI 3.68-4.06, p = 0.04), waiting time for provider (4.11, CI, 3.92-4.31 vs 3.81, CI 3.61-4.00, p = 0.01), and department cleanliness (4.09, CI, 3.91-4.27 vs 3.80, CI, 3.62-3.98, p = 0.02) (Table1).

Conclusion: An ED-oriented patient liaison program allowed for real-time feedback and opportunities for immediate service recovery, resulting in increased patient satisfaction ratings across multiple indicators.

Table 1. Patient experience ratings and 95% confidence intervals for patients encountered by patient navigators vs case-matched controls.

	Control	Intervention	p-value
"Likelihood to recommend"	3.82 (3.61-4.02)	4.21 (4.03-4.38)	0.010*
Overall	3.87 (3.68-4.06)	4.16 (4.00-4.33)	0.039*
Wait time	3.81 (3.61-4.00)	4.11 (3.92-4.31)	0.012*
Cleanliness	3.80 (3.62-3.98)	4.09 (3.91-4.27)	0.016*

22 "Secure-Preserve-Fight" or "Run-Hide-Fight": Expectations of an Emergency Department Patient Population During an Active Assailant Event

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Objective: We sought to assess the opinions of a general emergency department (ED) patient-family population regarding healthcare providers' life-saving responsibilities during an active assailant event (the traditional "Run-Hide-Fight" paradigm [provider-centric] vs the novel "Secure-Preserve-Fight" [vulnerable patient-centric]) paradigm.

Design and Method: This institutional review board-approved study presented a scenario-based questionnaire to a convenience sample of ED patients and their retinues. Demographic information included prior military service, formal active-shooter training, and prior violent victimization. The randomly selected subjects evaluated four typical patient scenarios of varying severity within which an emergency physician/nurse was in immediate proximity. They were provided four responses addressing their expectations regarding the healthcare provider's actions: provider-centric (namely, "Run-Hide-Fight), or patient-centric (that is, Secure-Preserve-Fight). The frequency of each response was the primary outcome. We employed a non-parametric binomial test as well as SPSS (IBM, Chicago, IL)

Conclusion: For this particular ED population, a significant majority supported the patient-centric "Secure-Preserve-Fight" paradigm over the more provider-centric "Run-Hide-Fight" option. This lay public perspective should spur healthcare staff and administration to reconsider their current active shooter plans and possibly modify them to be consistent with "Secure-Preserve-Fight," especially when dealing with the vulnerable patient.

23 Burnout in Resident Physicians: Correlation with Mistreatment and Workplace Violence

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Background: Research studies show a high burnout level among physicians. Research also shows that mistreatment of medical trainees and workplace violence have potentially long-term, negative effects on the individual. This study examines the correlation between resident burnout and the self-reported incidence of mistreatment and workplace violence.

Methods: Each year, the University of Kansas Medical Center Graduate Medical Education Wellness Subcommittee administers a wellness survey to all 560 residents and fellows. The 71-question electronic survey was originally developed at Stanford University Medical Center. We obtained institutional review board approval for this study..

Results: Of 560 residents and fellows from various specialties who received the survey, 393 completed it (70% response rate); the responses included 147 from female residents (37%) and 246 from males (63%). We found that 20.4% of all resident surveys had responses indicative of burnout. Of the 16 emergency medicine (EM) residents who completed the survey, we found a 37.5% burnout rate. Overall, 35 residents reported being publicly humiliated, and they had a significantly higher burnout rate than those who did not (62.9% vs 16.9%; p value = <0.0001). We also found the following: 55 residents reported being publicly embarrassed, and they had a higher burnout rate than those who did not (52.6% vs 15.5%; p value = <0.0001); 23 residents reported being subjected to offensive sexist