and poor understanding of the key components of QI. We developed a two-hour course that stresses individual thought and hands-on expert guided experience to empower residents to start their own meaningful QI projects.

Curricular Design: An expert in value based care led two 1-hour sessions to teach our residents components of QI and review key principles of our institutions transition to value based care: Care Variation, Waste in Care, Appropriate Setting of Care, Quality, Access and Advanced Analytics. For the first 1 hour session, key institution wide examples of each focus area were introduced to residents in chart form for 15 minutes. For 30 minutes residents were then separated into groups of 3 and they compiled their own ED specific examples for each focus area. For the final 15 minutes each small group shared their examples with the entire group. Several weeks later a second 1 hour session reviewed key principles in value process mapping. In preparation for the activity, residents were asked to process map some of their original ideas from the first session and send them to the instructor (senior VP and chief quality officer). Our expert reviewed each process map with the group and made suggestions for improvement. Results of both sessions were documented and reviewed with residents during PD led individual meetings regarding QI projects.

Impact/ Effectiveness: These two introductory activities have resulted in increased resident engagement in QI activities with a specific improvement in confidence to develop and implement meaningful QI projects in our department.

Emergency Medicine	Quality & Patient Experience Improvement	Reducing WSH Operational Costs (Expenses) & Reducing Costs to the Payor
Reduce Care Variation	• Overaggressive evaluation of high risk complaints (stroke, blood cultures). Potentially do MRI and dc. • Clinical tool checkpoints used more effectively and more broadly • Order sets for other clinical presentations • Share decision making with imaging utilization • Standardize use of evidence based pathways (pecarn, nexus, heart pathway, afib)	• Nursing home policies with "fall" without injury. May not need to be in ED (some literature supports this). • "Choking episode" needs to come to ED • Knowing Code status ASAP to help reduce unnecessary care • PCP taking more ownership and decreasing ED referrals (liability reform needed) • Listing cost for additional studies (contrast in CT scan, lfts, blood cultures, urine and urine cultures)
Remove Waste	• Procedure kits (too many additional supplies also missing some, frequently open multiple kits) • Crisis evaluation labs etc (strong evidence base that its not helpful or meaningful to patient care) • Coronary CT to reduce hospitalization, rapid outpt follow up for low risk chest pain	• Solve/ develop standardized treatment plan for Frequent ED visit patients to reduce unnecessary testing and evaluation • Inappropriate use of coronary CT scan or other evaluations or does it lead to overtesting/ use of the resource.
Site of Service	• EMS triaging patients to determine if patient needs to come to ed or could go somewhere else (or psyche patients directly to pscyhe facility). • Education patients what can be done at urgent care proactively • Expand hospital at home (regional restrictions, only available certain hours of the day) • Community paramedic program	• Rabies vaccine at ED unnecessary • Psyche unit in ED to reduce resources • Psychiatry available in the ED to reduce unecessary time and resource utilization
Quality & Experience	• Inappropriate end of life care that potentially could be avoided with earlier GOC conversations • Name and picture cards in the room so they know their treatment team	• Overutilization of stroke ordersets and p1 imaging and the eyeball process. • Reduce traveler nursing (higher cost and many times lower scope of practice, less efficient) • Nursing ability for ultrasound guided Ivs • Concern raised about risk to patient and physician with change in practice and less use of other resources or over reliance on ordersets.
Access	• Short term access to Behavioral health, pcp, and subspecialty follow up to decrease unnecessary hospitalizations • Physician lines rather than nurse lines for referral to ED. Overtriaged by nursing algorithms.	• Telehealth, teletriage ed visits
Advanced Analytics	• Refocus sepsis remote monitoring team out of ED to less monitored patients for higher impact and value	• Earlier idenfitication of htn and dm patients and appropriate referral • Earlier involvement in palliative care team and advanced decision making discussions by primary team

Figure.

49 Implementation of a Dedicated Social Worker/Coach for Emergency Medicine (EM) Residents

Jennie Buchanan, Sarah Meadows, Jason Whitehead, Gannon Sungar, Todd Guth, Barbara Blok, Katie Bakes, Christy Angerhofer, Malorie Millner, Megan Stephens, LaVonne Salazar, Abraham Nussbaum, Bonnie Kaplan

Learning Objectives: The pandemic exposed the mismatch between trainee mental health needs and their access to support services; therefore, the objective of our innovation was to support an opportunity for residents to work with a social worker/coach who could provide coaching on an emergent, urgent, or regular basis.

Introduction/Background: EM training requires sleep-wake disruptions, includes potentially traumatizing encounters, all during the COVID-19 pandemic while many residents relocate away from their customary psychosocial supports for training. The shift-based training model limits access to psychosocial care and services, so trainees need just-in-time resources which can support them before mental health concerns develop.

Educational Objectives: The objective of our innovation was to support an opportunity for our residents to work with a professional social worker who could provide coaching on an emergent, urgent, or regular basis.

Curricular Design: The leadership team identified a clinical social worker and trained coach to provide small group and individual coaching sessions to residents (4-year urban safety-net program with 68 residents) budgeted at an initial cost of $15,000. It was agreed that what was shared in the discussion would not be shared without consent and legal limits to confidentiality were followed.

Impact: From October 1, 2020 when implemented to October 1, 2021 there were 49 group and 73 individual sessions. After implementation in 2021, we compared this rotational mean score as ranked by all residents to all other wellness initiatives. Overall response rate was 80.88%. The overall mean score of the initiative was 2.25 (1-lowest and 4-highest) versus 3.73, the mean of all other wellness initiatives. Summary comments from the residents revealed the innovation was useful but shared concern regarding ability to attend sessions and capacity of social worker to relate with them. If other programs are considering implementation of a similar program recruiting someone with ED/graduate medical education experience or making sure they are oriented is key. Application of a social worker coaching program in an EM residency appears to be a feasible novel wellness intervention with potential to improve well-being, but needs framing to benefit trainees.

50 Improving Physician Well-Being and Reducing Burnout Using a Peer-to-Peer Recognition Program

Jenny Chang, Alexis Cortijo-Brown, Vinay Saggar, Simiao Li-Sauerwine, Katie Rebillot, Michael Jones, Jill Corbo

Learning Objectives: The objective of our study is to utilize a peer-to-peer recognition program to reduce burnout and improve well-being in our residency program by demonstrating a 10% increase in the Stanford