

obesity (30.7%), hypertension (21.0%), diabetes (18.3%). Only 7.4% met SIRS criteria. Mean LOS in ED U/S group and RPS group was 334 minutes (95%CI 303.5-364.3) and 390.6 minutes (95%CI 352.2-429) (P = 0.023) respectively. In the ED U/S group, mean LOS in patients with a surgical consult (11.6%) and without was 500.4 mins (95%CI 412.3-588.4) and 312.2 minutes (95%CI 281.3-343.1) (P = 0.0003), respectively. Hospital admission in the ED U/S group (23.1%) accounted for a mean LOS of 460.1 min (95%CI 394.5-526.7) compared to 300.1 minutes (95%CI 332.1-268.1) (P < 0.005) for patients with ED discharge (76.9%).

**Conclusions:** ED U/S use was associated with a 56.6 minute shorter LOS in the study population, which was statistically significant when compared to patients who had RPS, exemplifying the potential of ED U/S to expedite ED disposition in a county setting. These reductions in LOS were consistent across all PGY levels. Variables such as surgical consult and hospital admission influenced the potential of ED U/S to reduce LOS.

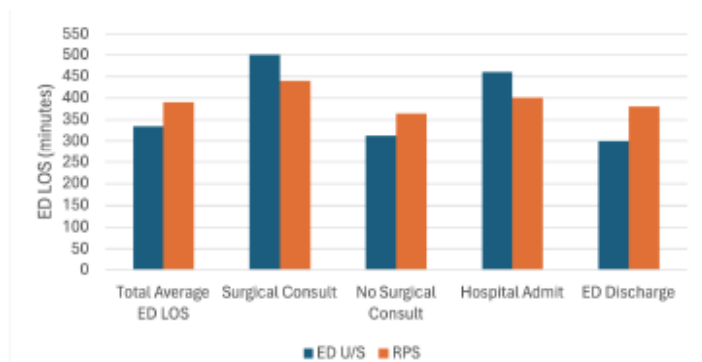


Figure 1. Factors influencing ED LOS.

## 61 Teaching the ABCs

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**Introduction:** One of the most important skills to learn early in residency is identifying “sick” or “not sick” patients and initiating stabilizing interventions. Starting EM Interns have differing levels of experience in these domains, which may lead to anxiety and poor performance clinically. Our residency identified a need for a structured program to develop these skills at the beginning of intern year. Educational Objectives: 1. Interns will learn and practice identifying sick patients and initiating stabilizing interventions using the “EM Rapid Assessment” cognitive aid as a structured approach. 2. The team leader will practice key leadership tasks, including verbalizing assessment steps, delegating tasks, and conveying information promptly. Curricular

**Design:** The “EM Rapid Assessment” cognitive aid

(Image 1) was developed for use in an EM intern “bootcamp” simulation by the author and vetted by a group of critical care and EM educators. It includes the identification of sick vs not sick by outlining the explicit actions of expert clinicians. Next are the “ABCs”, the five critical systems to assess when first evaluating an ill patient, and it explicitly outlines the exam findings to look for and interventions to initiate. The third section of the cognitive aid includes the team’s next steps once the patient is stabilized. Interns learned this framework through lectures and simulations, practicing patient stabilization, including fluid resuscitation, bag-valve-mask ventilations, and managing hypoglycemia and opioid overdose.

**Impact:** Ten EM interns participated in the simulation during their first residency month, all demonstrating skills aligned with EM Milestone Patient Care 1: Emergency Stabilization Level 2. All interns completed a post-event survey. 10/10 felt the activity enhanced clinical quality and safety, with 8/9 reported feeling either very (4) or extremely (4) confident in applying their training in a clinical setting. The cognitive aid and simulation event successfully introduced our EM interns to the initial stabilizing steps of resuscitation and team leadership skills

FIRST SECONDS	RAPID ASSESSMENT	HEAD to TOE
<b>LOOK</b> Scan for scene safety, alarms, abnormal color, posture, level of alertness, or general appearance.	<b>CIRCULATION</b> <ul style="list-style-type: none"> <li>Absent central pulse</li> <li>Poor peripheral perfusion</li> <li>Syncope/pre-syncope</li> <li>Hypotension (MAP &lt;65)</li> <li>Severe Bradycardia (&lt;40) or Tachycardia (&gt;150)</li> </ul>	<b>REPEAT</b> Repeat the Rapid Assessment as needed to address abnormal findings or due to changes in condition
<b>TALK</b> Verbally engage, escalate as needed. Focus inquiry on any severe symptoms.	<b>AIRWAY</b> <ul style="list-style-type: none"> <li>Choking</li> <li>Stridor</li> <li>Not managing secretions</li> <li>Swelling or trauma to face</li> </ul>	<b>EXAM</b> Complete a physical exam with attention to causes of the patient's condition and time sensitive diagnoses
<b>TOUCH</b> Make physical contact to assess for abnormal temp, diaphoresis, and pulse if needed.	<b>BREATHING</b> <ul style="list-style-type: none"> <li>Agonal</li> <li>Very slow &lt;8 or shallow</li> <li>Very fast and/or r/woes</li> <li>Hypoxic (&lt;88%)</li> <li>Abnormal or absent breath sounds</li> </ul>	<b>POCUS</b> Consider using bedside US evaluation
<b>ACTIVATE</b> Alert team to sick patient	<b>DISABILITY</b> <ul style="list-style-type: none"> <li>Low GCS</li> <li>Abnormal pupile</li> <li>New loss of motor function</li> <li>Aphasia</li> <li>Seizure activity</li> </ul>	<b>REVIEW</b> Confirm identity of the patient, perform a chart check of the patient if possible or applicable
<b>DESIGNATE</b> Identify leader and assign roles (monitor, IV access, oxygen, meds, recorder, family liaison)	<b>EXPOSURE</b> <ul style="list-style-type: none"> <li>Hypo or hyperthermic</li> <li>Injuries, wounds</li> <li>Rash</li> <li>Medical equipment or alert bands</li> </ul>	<b>ORDERS</b> Place any additional orders needed to complete workup
<b>LEADER RECAP</b>		

## 62 Analyzing Trends in DO Match Rates for Primary vs. Non-Primary Care (2020-2024)

Christopher Reilly, Amir Jafari

**Objectives:** The aim of this study is to analyze match rates of DO seniors into primary care specialties, compared to non-primary care specialties over the past five years (2020-2024). It seeks to determine overall match rates of DO seniors, analyze trends in match rates over the five-year period, and assess if primary care specialties are matched into more favorably. Given that osteopathic programs have