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dietary restrictions, lack of disclosure for pricing of the food and no feedback system for the cafeteria were the largest contributors to overall dissatisfaction.

Methods: A small group of post graduate physicians created a petition to highlight residents’ concerns with the cafeteria. A residency-wide petition was published on change.org and sent to the entire resident body. Within a couple weeks the petition had a critical mass of 238 signatures. A focused letter was sent to graduate medical education leadership and hospital leadership outlining the concerns and survey methodology was utilized to demonstrate specific areas demanding attention to improve. Monthly meetings were set in place with all stakeholders including post graduate physicians, graduate medical education leadership, director of cafeteria, vendor service for hospital and administrative leadership.

Results: The initial hospital wide survey focused on offering diverse food options. Of the total 399 post graduate physicians at a large, urban, public safety net hospital, 231 completed the survey, a respondent rate of 59%. Of total respondents 22.08% of residents were vegetarian, 19.05% were halal, and 12.12% were dairy free, and just over 51% had no dietary restrictions. These results indicated that nearly half of our resident body had food restrictions that needed to be, but were not being, addressed. Additional surveys were sent with similar respondent rates concerning clear pricing of items, creating a feedback system to the cafeteria leadership and the hospital so an ongoing process of improvement can occur. Change occurred within one month and the variety of food increased. Kosher and halal meals became available. Vegan and vegetarian options were clearly marked. Several outside vendors were contracted to provide diverse food options during the day, and there was an increase in the "grab and go" options. A survey with a 4% (195/399) respondent rate demonstrated 95.85% of respondents stated that they had seen improvements in the last year, and that 58.75% now felt that their dietary restrictions were being met. Most notably, 96.92% responded the improved food options contributed positively to their wellness.

Conclusion: The health care field is notorious for unpredictable hours and high stress, the ability to have a reliable, healthy, and appealing source for nutrition is important. In the last decade post graduate physician wellness is being scrutinized due to high levels of depression and suicide. Solutions which increase inclusion and equity can be as simple as focusing on the nutrition that is provided in the cafeteria.

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**56 WITHDRAWN**

**57 EMBED: A Pragmatic Trial of User-Centered Clinical Decision Support to Implement EMergency Department-Initiated BuprenorphinE for Opioid Use Disorder**

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Study Objectives: Emergency departments (ED) are a critical access point for individuals with opioid use disorder (OUD). Medications for OUD decrease: (1) mortality after nonfatal overdose, (2) withdrawal symptoms, (3) craving, and (4) illicit opioid use. Buprenorphine (BUP) can be safely initiated in the ED and increases retention in outpatient treatment programs. Adoption of ED-initiated BUP has been slow due to lack of physician knowledge, experience, and time. The study objective was to determine the effect of a user-friendly clinical decision support system (CDS) on rates of ED-initiated BUP in the routine emergency care of individuals with OUD. Study Design/Methods: A parallel group randomized pragmatic trial was conducted in 18 EDs across 5 health care systems in the United States. The EMBED intervention is a user-centered, physician-facing CDS system integrated into the electronic health record (EHR) to facilitate ED-initiation of BUP by: (1) determining a diagnosis of OUD, (2) assessing withdrawal severity, (3) motivating patients to accept treatment, and (4) automating EHR workflow including clinical and after visit documentation, order entry, prescrib, and referral. EDs were randomly allocated to the intervention versus usual care using stratified covariate constrained randomization of clusters to arms with a ratio of 1:1. Constraining covariates included EHR vendor, patient volume, practice setting, ongoing resources for OUD patients, and proportion of attending physicians waivered to prescribe BUP. Participants included adult ED OUD patients meeting a predetermined EHR phenotype for OUD and the attending emergency physicians caring for them. Control site visits associated with attending physicians who practiced at both intervention and control sites were excluded. The primary outcome was the rate of ED-initiated BUP (administration or prescription of BUP). Implementation outcomes as compared to usual care were measured using the RE-AIM (reach, effectiveness, adoption, implementation, and maintenance) framework.

Results: 354, 800 ED visits (166, 184 intervention and 188, 616 control) from November 2019-March 2021 were assessed for eligibility. Overall, 4, 561 OUD patients (2, 457 intervention, 2, 104 controls) under the care of 607 attending physicians (335 intervention, 272 controls) were included in the analysis. Among these patients, 33% and 36% were female and the mean age (SD) was 39.4 y (13.3) and 38.5 y (13.0) in the intervention and control groups, respectively. Though the analysis is not complete at this time, full results are forthcoming and will be available in advance of the ACEP21 Research Forum. Conclusion: This pragmatic trial involving patients with OUD will report the effect of a user-centered CDS system that automates EHR workflow to initiate BUP in the ED.

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**58 Using Machine Learning to Predict Hospital Disposition With Geriatric Emergency Department Innovations Intervention**

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Study Objective: The geriatric emergency department innovations (GEDI) program is a nurse-based geriatric assessment and care coordination program that reduces preventable admissions for older adults and decreases Medicare expenditures. All adults age 65+ in the ED are currently eligible, but only 5% of older adults receive GEDI care due to resource limitations. Currently available geriatric screenings to identify older adults likely to benefit from programs like GEDI perform poorly in the ED. The objective of this study was to predict likelihood of hospitalization accurately and consistently with and without GEDI care using machine learning models to better target the GEDI program.

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