

**O-010 INFLUENCE OF THROMBECTOMY VOLUME ON NON-PHYSICIAN STAFF BURNOUT AND ATTRITION IN NEUROINTERVENTIONAL TEAMS**

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**Introduction** Burnout takes a heavy toll on healthcare providers. We sought to assess the prevalence and risk factors for burnout among neurointerventional (NI) non-physician procedural staff (nurses and technologists) given increasing thrombectomy demands.

**Materials and Methods** A 41 question online survey containing questions including the Maslach Burnout Inventory-Human Services Survey for Medical Personnel was distributed to NI nurses and radiology technologists at 20 U.S. endovascular capable stroke centers.

**Results** 244 responses were received (64% response rate). Median (inter-quartile range) composite scores for emotional exhaustion were 25 (15–35), depersonalization 6 (2–11) and personal accomplishment 39 (35–43). Fifty-one percent of respondents met established criteria for burnout. There was no significant relationship between hospital thrombectomy volume, call frequency, call cases covered, or length of commute. On multiple logistic regression analysis, feeling underappreciated by hospital leadership (OR 4.1; P<0.001) and working with difficult/unpleasant physicians (OR 1.2; P=0.05) were strongly associated with burnout. At participating centers, nurse and technologist attrition was 25% over the last year. Over 50% of respondents indicated they had strongly considered leaving their position over the last 2 years.

**Abstract O-010 Table 1** Independent predictors of burnout

Multiple Logistic Regression Outcome: Burnout Classification	Coefficient	Odds Ratio [95% CI]	P-value
Happiness in Career Choice	-0.59	0.55 [0.43–0.69]	<0.001
Feeling Under-Appreciated by Hospital/Department	1.4	4.10 [2.07–8.31]	<0.001
Physicians More Difficult to Work With	0.19	1.21 [1.00–1.48]	0.05
Increasing Effect of Work on Family Life	0.13	1.14 [1.01–1.30]	0.04

**Conclusion** This survey of United States NI non-physician procedural staff demonstrates a self-reported burnout prevalence of 51%. This was driven more by interaction with leadership and physician staff than by thrombectomy procedural volume and stroke call. Attrition among NI non-physician procedural staff is high.

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**O-011 DRIVERS OF VARIATION IN 90-DAY EPISODE PAYMENTS AFTER MECHANICAL THROMBECTOMY FOR ACUTE ISCHEMIC STROKE**

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**Introduction** Although mechanical thrombectomy for acute ischemic stroke from a large vessel occlusion is now the standard of care, little is known about cost variations in stroke patients following thrombectomy.

**Methods** We evaluated claims data for thrombectomy-performing hospitals within Michigan through a registry that includes detailed episode payment information for both Medicare and privately insured patients. We aimed to

**Abstract O-011 Table 1** Sample characteristics for terciles of hospital's thrombectomy spending. P values from ANOVA and Chi Squared tests

	Hospital Thrombectomy Spending Tercile			P-value
	Low (N=218)	Medium (N=477)	High (N=381)	
Hospitals, n	5	6	5	
Age, mean ± SD	74.7 ± 12.7	74.8 ± 13.0	73.6 ± 12.4	0.3429
Male, n(%)	81 (37.2)	216 (45.3)	180 (47.2)	0.0490
High 6-month prior spending, n (%)	101 (46.3)	230 (48.2)	170 (44.6)	0.5746
Payer, n (%)				
Medicare FFS/Medicare Advantage	166 (76.2)	359 (75.3)	285 (74.8)	0.9349
BCBSM PPO and BCN	52 (23.9)	118 (24.7)	96 (25.2)	
Mean Count of HCCs per patient, mean ± SD	5.9 ± 3.3	6.0 ± 3.0	6.0 ± 3.3	0.9372
Major HCC Categories, n (%)				
Chronic Kidney Disease	12 (5.5)	11 (2.3)	20 (5.25)	0.0407
Cancer	29 (13.3)	64 (13.4)	47 (12.3)	0.8872
COPD	39 (17.9)	116 (24.3)	85 (22.3)	0.1679
CHF	84 (38.5)	166 (34.8)	116 (30.6)	0.1179
Diabetes	80 (36.7)	175 (36.7)	132 (34.7)	0.7998
Vascular Disease	50 (22.9)	132 (27.7)	117 (30.7)	0.1236
Respiratory Dysfunction	18 (8.3)	37 (7.8)	22 (5.8)	0.4165
Neurologic Disorders	183 (83.9)	404 (84.7)	315 (82.7)	0.7263