rotations can better prepare future physicians

Table 1.

Practice changing statements from medical students after completion of modules
Asking law enforcement officers to leave the room during H&P of a patient in custody
Respecting patients' right to privacy
Knowing what necessary PHI to disclose to law enforcement
More consideration for the limits of our relationship with law enforcement
Engage in patient care with a better understanding of the law
Not being afraid to advocate for patients even under custody
I feel more comfortable seeing a patient in the ED presenting with a psychiatric complaint
Asking police to turn off recording devices during patient visits
I understand the details of when a 5150 hold is appropriate
Systematically approaching de-escalation
I feel more confidence in advocating for patient's rights in these vulnerable populations
More compassion to people in custody

31 Do EM Residents Value Peer Support? Preliminary Evidence from Our Novel Resident Peer Support Program

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Background: Emergency medicine residents encounter traumatic situations throughout training and may be uniquely affected by these events. To better support our residents, we developed a novel Peer Support Program that proactively connects residents with a trained co-resident peer supporter after an adverse clinical encounter. However, it was unclear if residents would identify the program as a source of support.

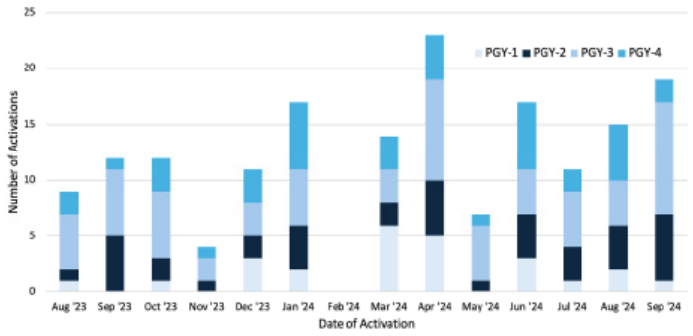
Objective: Evaluate the utilization of a Resident Peer Support Program and assess whether EM residents find value in this program after stressful events.

Methods: We performed a cross-sectional analysis of all peer support activations from August 2023 to October 2024. Activation data were extracted from a program database, including the date for each referral and activation, the referred resident's rank, and event details. We administered anonymous pre- and post-implementation surveys and compared responses using chi-squared tests.

Results: There were 171 resident peer support activations. A peer supporter was activated within 24-48 hours in 91.2% (n=156) of these events. Most referrals were made by residents (n=101, 59.1%), and senior residents more frequently received peer support (Figure 1). The most common reasons to be referred include involvement in a challenging adult case (n=74, 43.4%), Morbidity and Mortality conference (n=59, 34.5%), or a challenging pediatric case (n=35, 20.5%). There were 22 (37.9%) and 18 (31%) survey respondents to the pre- and post-surveys, respectively. In the pre-survey, 40% of trainees reported direct support from the residency after a difficult clinical experience, compared to 68% after program implementation. Most respondents (82%) found the program helpful.

Conclusions: Our Resident Peer Support Program has been widely accepted by our residents. Most referrals were made by residents, which, together with our survey data, suggests that residents value the program as a tool to support one another after stressful events

Table 1. Monthly peer support activation by supported resident year.



32 Knowledge Gaps in Billing and Documentation Following the 2023 Evaluation and Management Services Guideline Changes

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Background: In January 2023, the evaluation and management (E/M) billing and coding guidelines changed to emphasize complexity of medical decision-making. The ACGME requires EM residencies to teach these skills under the systems-based practice milestone. Few studies have evaluated residents' educational needs under the new guidelines.

Objectives: This study aimed to assess EM resident, residency graduate, and faculty knowledge and perceptions of the 2023 E/M billing guidelines and their integration into residency curricula. We hypothesized these groups would reveal knowledge gaps and a need for improved billing education.

Methods: We developed a cross-sectional survey based on previous research. After piloting and cognitive interviewing, we sent the anonymous survey to 26 second-year residents, 24 third-year residents, 34 recent graduates, and 124 residency faculty from our 3-year EM program. Responses were collected from September to October 2024.

Results: The survey had a 61% (126/208) response rate. While 93% (26/28) of residents and 86% (68/79) of faculty reported billing and documentation skills are relevant to an attending's role, only 25% (7/28) of residents and 20%

(16/79) of faculty felt the curriculum sufficiently prepares residents for future billing responsibilities. Residents and faculty identified reimbursement models, critical care billing, and determining encounter-appropriate E/M codes as areas of need (Table 1). Faculty attestations often add information to resident notes for billing (Figure 1), but only 41% (32/79) felt equipped to teach these skills. Graduates reported greater confidence than residents and faculty in most areas (Table 1), and 58% (11/19) felt the billing curriculum prepared them for independent practice.

Conclusions: Residents and faculty indicated a need for improved billing education under the 2023 guidelines and areas for curricular improvement. Graduates felt more confident in their billing knowledge than anticipated

Table 1.

	% Agreeing or Strongly Agreeing		
	Residents (n=28)	Faculty (n=79)	Graduates (n=19)
I understand how the reimbursement model from the Centers for Medicare & Medicaid Services influences billing and coding practices in the emergency department.	36%	53%	79%
I understand how Relative Value Units (RVUs) are related to the medical services I provide.	68%	68%	79%
I understand how Evaluation and Management (E/M) coding levels for emergency department encounters (CPT 99281-99285) are determined.	68%	62%	84%
I understand the requirements for documenting critical care billing (CPT 99291 and 99292).	43%	77%	74%
I am able to determine the appropriate E/M code for my patient encounters.	29%	33%	58%
I adjust my level of documentation based upon the patient's presentation and anticipated E/M coding level.	32%	39%	58%
I utilize tools in the electronic medical record (e.g., smartblocks or smartphrases) to help guide my documentation for improved billing.	64%	61%	95%

33 Physician Perception of Patient-Physician Communication

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Background: Assessing patient satisfaction with physician performance, particularly in communication, is standard in the U.S healthcare system. There is significant variability in residency training regarding specific areas of patient centered communication.

Objective: The objective of this study was to compare resident and attending physician self perceived communication skills and perform a thematic analysis of reported challenges and barriers to good communication.

Methods: This was a cross-sectional mixed methods survey study among resident and attending physicians at a single academic center. We developed a survey, informed by the validated Communication Assessment Tool. Additional questions focused on health equity and open-ended responses. The survey items used 1-5 Likert scales. We gathered content and response process validity prior to distribution. The survey was distributed weekly for 3 weeks, following modified Dillman methods. For quantitative analysis, we compared mean resident vs attending scores utilizing a pooled unpaired sample t test. For qualitative analysis, two study members performed thematic analysis following best practices in qualitative research.

Results: 72% (26/36) of residents and 53% (26/49) of attending physicians completed the survey. There was no statistically significant difference between resident and attending perceptions for any survey items. Thematic categories were consistent across both groups and identified the following challenges: managing expectations, time, and equity concerns.

Conclusion: Patient centered communication is a milestone based competency in which residents should progress, therefore, the lack of difference between resident and attending groups brings to question how best to educate and evaluate communication skills. Both groups rated their training on communication lower when compared to other questions in this study. This study further identifies the need for standardized patient centered communication in training in order to prepare resident physicians.

Table 1.

Question	Attending mean	Resident mean	P-value
(1-13) How do you rate your ability:			
(1) Effective Communication	3.92	3.88	0.8438
(2) Empathy	3.92	3.92	1
(3) Minimize patient misunderstanding	3.61	3.46	0.4134
(4) Convey complex information	3.88	3.54	0.1199
(5) Resolving communication challenges	3.54	3.12	0.0667
(6) Manage patient expectations	3.50	3.19	0.1482
(7) Elicit patient health care concerns	3.65	3.62	0.8587
(8) Develop rapport	3.96	4.27	0.1722
(9) Communicate effectively with non-English speaking patients	2.85	2.88	0.8775
(10) Communicate effectively with patients that share a different gender	3.77	3.85	0.7218
(11) Communicate with patients that have a different race	3.50	3.77	0.1935
(12) Communicate with LGBTQIA+ patients	3.85	3.73	0.6284
(13) Use pronoun-sensitive language with transgender patients	3.35	3.58	0.4195
(14) How would you rank the training (dedicated time during residency focused on patient communication strategies led by core faculty) you have received on patient centered communication?	2.96	2.88	0.7677
(15) How would you rate the simulation experiences you have participated in regarding patient centered communication?	3.19	3.23	0.8864
(16) Do patient evaluations accurately reflect your communication abilities	2.08	2.65	0.0628