

each discrete survey question showed p-values from 0.42 to 0.77, indicating no significant difference between groups.

**Conclusion:** The CAT survey administered to ED patients generally reported positive resident and attending assessments. This suggests that current tools may not effectively differentiate between the communication skills of physicians, highlighting the need for a more discerning method to evaluate resident communication.

### 37 Gender-Coded Language in Recruitment Materials Influences Student Choices during Application to Summer Externships and Residencies

*Chloe Jeanmonod, Adriana Facchiano, Genevieve Schmitt, Christopher DeFeo, Marykate Decker, Jonathan Pester*

**Introduction:** Research in technology and finance has shown that gender-coding in advertisements impacts the gender make-up of the applicant pool. We have previously shown that emergency medicine physician job recruitment materials are frequently masculine-coded. We sought to determine whether gender-coded language in pre-medical summer programs and residency recruitment materials influence pre-medical and medical student choice during the application process.

**Methods:** Generic advertisements (not for specific specialties) for summer programs and residency programs were generated using artificial intelligence, and modified to include gender-coded language as per Gaucher's prior research on gender-coded words, creating highly masculine-coded and highly feminine-coded ads. Premedical and medical students were recruited to complete anonymous web-based surveys. College students were recruited via email to 200 college programs chosen at random, with emails sent to the coordinators for their medical professional interest groups. Medical students were recruited via email to 200 medical schools chosen at random, with emails sent to the dean of students and to the director of diversity, equity, and inclusion, if the school had such a position. Students were also recruited on shift at the primary study site via QR codes hung prominently in the emergency department. Choices between male-identifying and female-identifying students were compared using chi square. The study was reviewed by the IRB and found to be exempt.

**Results:** Two hundred seven students have been recruited to date. Of these, 64 identify as male, 142 identify as female, and one identifies as non-binary. The non-binary student was excluded from further analysis. 67.6% of female students would choose to apply to feminine-coded programs over masculine-coded programs. 53% of male students would also choose to apply to feminine-coded programs over

masculine-coded programs, although female students showed a statistically significant preference ( $p=0.03$ ).

**Conclusion:** Gender-coding in recruitment materials for students may influence the gender make-up of the recruitment pool.

### 38 Calculating Work Relative Value Units for EM Residents: Another Piece of the Productivity Puzzle

*Susan Owens*

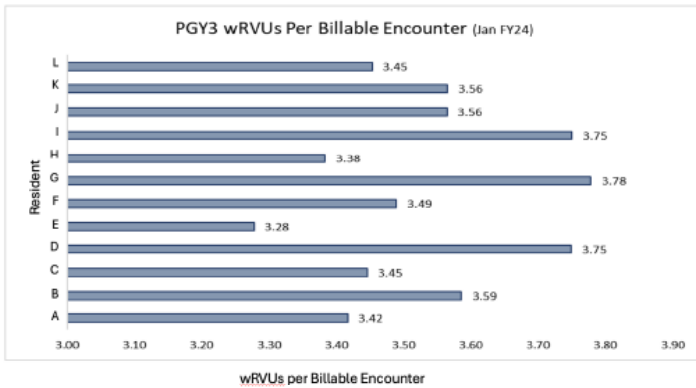
**Introduction:** In EM, efficiency and productivity are key to success in clinical practice. The current measure for productivity in clinical practice is relative value unit (RVU) generation, a topic lacking direct instruction at the residency level. At the University of Kentucky (UK) patients per hour is the efficiency metric used to evaluate residents, which does not reflect how productivity is measured in clinical practice. The work component of the RVU (wRVU), a numerical value that represents the medically necessary work performed and documented in a patient encounter, could be a more holistic measurement of resident productivity and efficiency. At UK there is no direct mechanism to obtain resident wRVUs despite senior resident requests for this information.

**Educational Objective:** Develop a process to determine resident wRVUs

**Project Design:** At UK the billing department assigns wRVUs to the last EM attending to sign a provider note in the encounter but they receive no data regarding residents. I developed a process to connect the resident data from the electronic medical record (EMR) to the data provided by the billing department. I generated a list of all ED encounters in January 2024 (8,000 charts) then removed encounters completed by non-EM residents. I manually assigned a billing resident to each encounter (5,500 charts) and worked with a relative cycle manager to generate total wRVUs, wRVUs per billable encounter, and wRVU per hour for each resident in addition to coding curves for each class (Image 1, Table 1). There is no reasonable way to parse out individual procedure wRVUs for the residents; the assigned billing resident was awarded all wRVUs for the encounter. This project consumed 75 hours.

**Impact/Effectiveness:** The data from this project was confidentially shared during a monthly faculty meeting and with residency leadership. The data provided a reasonable approximation of wRVUs generated by the residents and anecdotally was received well by the residents, particularly senior residents entering community practice. This project also allowed for review of thousands of resident notes which generated a conference didactic series on documentation and informed major changes to the EM provider note template.

**Image 1.** Resident (PGY3) wRVUs per billable encounter.



### 39 Fascia Iliaca Block vs Combined Fascia Iliaca Block with Femoral Nerve Block for Pain Control for Proximal Hip Fractures in the Emergency Department

*Austin Poulson, Joseph Betcher, Benjamin Black, Alexander Glogoza, Oliver Snyder*

**Introduction:** There is conflicting evidence in the literature on the effectiveness of fascia iliaca and femoral nerve blocks for pain control in patients with proximal hip fractures. This study sought to determine if a combined fascia iliaca with femoral nerve block would improve pain control compared to the standard fascia iliaca block.

**Objectives:** To compare pain scores of proximal hip fracture patients 30 minutes after undergoing fascia iliaca plus femoral nerve block or standard fascia iliaca block.

**Methods:** A retrospective cohort study included all isolated proximal hip fracture patients greater than or equal to 18 years of age who underwent regional anesthesia by ultrasound fellowship-trained emergency physicians in a community hospital emergency department between 1/1/2022 and 9/26/2024. Institutional review board approval was obtained. Patients with distal femur fractures, those who received additional pain medications within 30 minutes of the block, or could not reliably relay a pain score were excluded. The primary outcome was subjective pain scores (scale 1-10) after undergoing regional anesthesia.

**Results:** Eighty-nine patients underwent regional anesthesia for proximal hip fracture; 20 patients were excluded. Thirty-one fascia iliaca blocks and 38 combined blocks were performed. Patient age, weight, and pre-procedure scores were similar between the groups (Table 1). Females were more predominant in the fascia iliaca block group. On average, patients who received the combined block rated their post-procedure pain score 1.4 points lower than those who received a fascia block (3.8+2.4 vs 5.2+2.0; p=0.011).

**Conclusions:** Undergoing combined fascia iliaca + femoral nerve block was associated with lower pain scores

after 30 minutes compared to isolated fascia iliaca block in patients with proximal hip fractures. Proximal hip fracture patients may benefit from using this single-injection procedure for improved pain control.

	Fascia + Femoral Block n=38	Fascia Block n=31	p-value
Age	76.2 ± 13.8	74.6 ± 11.6	0.601
Weight (kg)	71.8 ± 19.6	73.7 ± 21.0	0.709
Sex, % female	42.1%	67.7%	0.034
Pre score	7.9 ± 2.4	7.8 ± 2.2	0.867
Post score	3.8 ± 2.4	5.2±2.0	0.011

### 40 Tele - Telemedicine Education Landscape Evaluation

*Destinee Soubannarath Gwee, Christopher Reisig, Neel Naik*

**Introduction:** The integration of Telehealth into medical care is reshaping healthcare delivery, with the American Association of Medical Colleges (AAMC) providing guidelines for its incorporation into medical education.

**Objectives:** This study examines the implementation of AAMC Telehealth competencies in emergency medicine residency programs across the U.S.

**Methods:** We conducted a literature review and found a lack of surveys on Telehealth education following the 2021 AAMC guidelines. To address this, we developed a survey, refined through cognitive interviews and external feedback. The survey was distributed to program directors of U.S. Emergency Medicine residency programs.

**Results:** Of the 280 programs contacted, the response rate was 24%. Of the 68 responses, 93% (63 programs) reported not having a formal Telehealth curriculum. Regarding the importance of Telehealth education, 16% (11 programs) deemed it “not at all important,” while 84% (57 programs) recognized varying degrees of importance. Among the five programs offering formal Telehealth training, Real-Time Telehealth was the most common method (4 programs). For those with a formal curriculum, 80% would like access to educational content on the topic of “Ethical Practices and Legal Requirements for Telehealth.” Among those without a curriculum, 68% would like access to educational content on “Patient Safety and Appropriate Use of Telehealth.” Of the 63 programs without a curriculum, 77% do not consider it a priority, and 66% cited having insufficient faculty.

**Conclusion:** Most Emergency Medicine residencies lack a formal Telehealth curriculum. While we recognize the