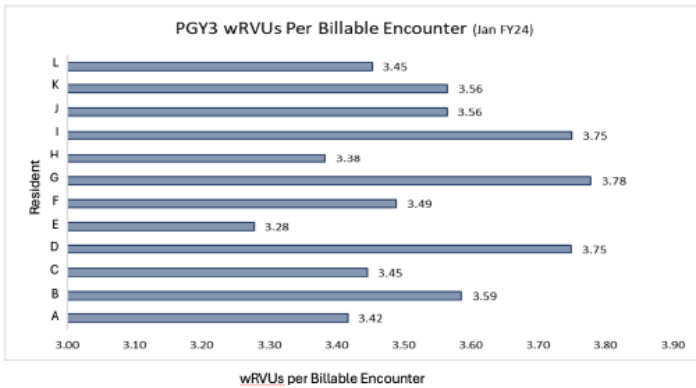


Image 1. Resident (PGY3) wRVUs per billable encounter.



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.

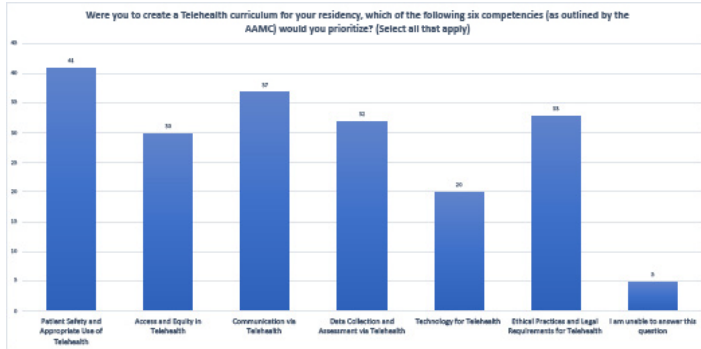
Objectives: This study examines the implementation of AAMC Telehealth competencies in emergency medicine residency programs across the U.S.

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

low response rate, based on the near uniformity of data, we suspect there is validity to these findings. Time constraints impede integration of Telehealth into residency curricula. There is a demand for resources on ethical practices and legal requirements and patient safety and appropriate use of Telehealth, highlighting areas for future development.



41 Relationship between Gender Identity and Underrepresented-In-Medicine Identity on Emergency Medicine Resident Feedback

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Introduction Effective delivery of feedback is critical to enhancing learning, clinical performance, and professional growth among residents. However, disparities may exist in how feedback is given to different learner groups.

Objectives: To determine if resident gender or underrepresented-in medicine (UiM) identity influenced the likelihood of receiving feedback.

Methods: This was a retrospective study of feedback delivery at an academic, four-year, emergency medicine residency program over a 28-month period in New Haven, CT. All resident physicians in the EM program were eligible for inclusion. Generalized estimating equation models were performed to assess the odds of receiving feedback, feedback delivery, feedback content, or use of deliberate practice with respect to resident and assessor gender identity and UiM identity, or resident-assessor gender identity or UiM identity concordance.

Results: The data set contained 3,480 consecutive feedback entries from interactions between 127 unique residents and 102 unique assessors during the study period. Resident gender identity (OR 0.96; 95%CI 0.84-1.11) and UiM identity (OR 1.02; 95%CI 0.81-1.27) were not associated with differences in receiving written feedback. Analysis among those who received face-to-face feedback revealed no significant differences in feedback delivery method by gender (OR 1.13; 95%CI 0.83-1.52) or UiM

identity (OR 1.40; 95%CI 0.97-2.02). There were no significant differences in the use of deliberate practice (gender OR 0.94; 95%CI 0.81-1.09 and UiM OR 1.009; 95%CI 0.77-1.33). Neither faculty-resident gender concordance (OR 0.95; 95%CI 0.83-1.08) nor faculty-resident UiM concordance (OR 1.07; 95%CI 0.92-1.24) were significantly associated with receiving written feedback.

Conclusions: In this single-center, retrospective study, there were no significant differences in the odds of receiving feedback, feedback delivery, self-reported feedback content, or use of deliberate practice with respect to resident gender identity and resident UiM identity, or resident-faculty gender or UiM concordance. Further research with larger, multi-site datasets is needed to draw more definitive conclusions regarding disparities in these areas on a larger scale and to further assess the quality of the feedback being delivered.



42 A Low-Fidelity, Active Learning Approach to Resuscitation Leadership Education

Damia Michael Sobin, Peter Prescott, Brett Todd, Danielle Turner-Lawrence

Introduction: Effective resuscitation leadership is crucial in improving the quality of resuscitation efforts and patient outcomes. Despite its importance, formal curricula for cultivating resuscitation leadership skills are lacking. Existing published resuscitation leadership training programs predominantly rely on high-fidelity simulations, while low-fidelity options remain underrepresented in the literature.

Educational Objectives: This curriculum aimed to improve resident resuscitation leadership knowledge and skills using active learning techniques. We utilized the Leadership Behavior Description Questionnaire (LBDQ) as learning objectives.

Curricular Design: We designed a three-part guided discussion series employing active learning techniques to cover and review the learning objectives. The sessions utilized a flipped-classroom model, with learners engaged in self-directed learning before participating in case-based