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programs were more likely to provide PL information on their websites [$\chi^2(1, N = 285) = 5.91, p = 0.015$; $\chi^2(1, N = 285) = 5.95, p = 0.015$]. We found no significant association between PD gender, program length, or program region and the presence of PL information.

Conclusions: Our findings reveal substantial gaps in parental leave and pregnancy accommodation information on EM and GME websites, highlighting the need for greater transparency to support prospective residents who may hesitate to ask about these policies during interviews.

6 Beyond the Bedside: Exploring Social Determinants of Health through the Eyes of Emergency Medicine Clerkship Students

Mark Olaf, Keith Willner, Devon Bremer, Jennifer Spinozzi

Background: Social Determinants of Health (SDH) are critical elements in the effective delivery of value-based care. The ED presents a unique opportunity for medical students to understand the impact of SDH on the delivery of care. Published curricula exist to address SDH undergraduate education in the ED but may be resource intensive.

Educational Objectives: We aimed to develop clinically based, EM-centered, constructive learning opportunity to emphasize and teach students about SDH principles and to assess its efficacy through a qualitative approach.

Curricular Design: Using a constructivist learning theory framework, we instituted a SDH shift into our clinical curriculum and asked students to reflect on their experiences. Students identified a patient in the ED whose visit was related to SDH factors, interviewed the patient, and worked with a social worker or care manager to address those needs during that visit. Students then submitted reflections about SDH factors and resources based on these experiences. We then performed a qualitative analysis using a constructivist learning theory framework using phenomenological methods adapted to the reflections provided by this experience.

Impact/Effectiveness: 115 students completed the exercise and all responses were analyzed. Identified themes included the effects of poverty including housing instability identification, access to healthcare, financial constraints, and cultural and language barriers to the delivery of care; stigma around substance use and mental health conditions; as well as the impact of location on care rendered. The development of this curricular content appears to have generated thoughtful insight into elements of SDH in the clinical environment. Future work should focus on integrating these experiences with SDH principles learned elsewhere in their medical school curricula, and to further develop undergraduate curricula that incorporate SDH principles and experience while measuring patient centered outcomes based on such curricula.

7 From Data to Development: Formative Feedback via Electronic Health Record-Derived Metrics

Ashley Rider, Josh Hughes, Loretta Matheson, Luke Morris, Sara Krzyzaniak

Introduction: Residents benefit from diverse feedback sources to guide their clinical progression. Traditionally, feedback comes from a convenience sample of attendings after a given shift, which can introduce bias and subjectivity. In contrast, Electronic Health Record (EHR)-derived clinical metrics provide longitudinal, quantitative performance data based on thousands of data points.

Objectives: 1. Provide supplementary feedback on resident efficiency and breadth of exposure. 2. Familiarize residents with clinical metrics they may encounter as attendings. 3. Extract and deliver data in a responsible and psychologically safe manner.

Curricular Design: Metrics were selected based on literature, industry standards, and stakeholder input. The metrics

Resident Report: NAME HERE

Dates of Report

Resident year: PGY X. Total residents in cohort: X

Patient Figures

Patients per hour (pph)

Your pph: 1.7

RY median: 1.7

RY IQR: 1.6 - 1.8



Minutes from patient roomed to resident registration

Your median room-to-reg: 426

RY median room-to-reg: 406

RY IQR for room-to-reg: 345.8 - 476.5



Minutes from resident registration to first disposition

Your median reg-to-dispo: 152.2

RY median reg-to-dispo: 152.2

RY IQR for reg-to-dispo: 132.8 - 196

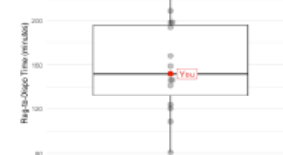


Image 1. Example of a Partial Metrics Report (acuity, procedures, consults, total patients, total hours, and 72-hour return visits not included).

included patients per hour, sign-up to disposition times, patient acuity, procedures, consults, and bouncebacks. A guide was created to explain the rationale and derivation of these metrics. Departmental data analysts extracted the relevant EHR data and created individualized reports for each resident that included class-year comparisons using medians and interquartile ranges. Metrics were shared quarterly with all 60 residents over 2023-2024 through individualized Google Drive folders.

Impact: During biannual surveys, 57 residents responded to the following question, “This year we started providing you with your individual clinical metrics. How have you used this information thus far?” Responses were categorized by an institutional ChatGPT as 39% positive, 46% neutral, and 16% negative. An author independently categorized the responses with 91% agreement; all discrepancies were labeled neutral by ChatGPT and positive by author. Positive themes included motivation to self-reflect, objective benchmarking, and support for performance improvement. Negative themes focused on difficulties accessing and interpreting the data. Collectively, this suggests that metrics can add value to a resident’s experience when properly contextualized.

8 Senior Resident Bootcamp: An Interactive Curriculum for Rising EM Senior Residents

Ashley Landesman, Matthew Magda, David Warshaw, Chinezimuzo Ihenatu, Nikita Pariapati, Michael Abboud

Background: As EM residents progress through training, they take on added responsibilities, including supervising and giving feedback to junior residents and students, performing stroke and trauma evaluations, administrative tasks, and more. Many EM residents do not undergo formal training on these new tasks and responsibilities; instead, they learn on shift. Without formal training, there is variability in comfort, confidence, and experience among senior residents.

Educational Objectives: We sought to identify gaps in training and knowledge, and design a curriculum to address those gaps in the skills and experiences of senior EM residents. We also sought to assess the efficacy of the curriculum in increasing resident preparedness to perform the necessary skills and responsibilities of their new role.

Curricular design: We conducted a needs assessment using interviews with current senior residents to determine areas where they felt most unprepared to handle their new role. This prompted a focus group including residency leadership, medical education fellows, and senior residents, which culminated in the creation of a half-day interactive bootcamp. This curriculum includes formal didactics on performing stroke, trauma, and obstetric evaluations with simulated practice cases, instruction on providing feedback

and supervising junior learners, and hands-on experience with procedural supervision. The efficacy of this bootcamp was evaluated using an anonymous survey immediately pre- and post-intervention, focusing on resident confidence in performing these tasks.

Impact/Effectiveness: Scores from the survey comparing pre- to post-bootcamp responses noted a statistically significant ($p < 0.05$) increase in residents’ self-perceived skills and confidence in their ability to be a senior resident, as well as 7 of 8 specific skills included in the survey (all except giving feedback). Overall, implementation of the senior resident bootcamp curriculum was largely successful in improving the confidence of new senior residents to perform their new duties. Future work could evaluate ways to expand the curriculum to include other areas of need and assess resident performance (rather than self-perceived confidence) in these tasks using an external evaluator.

Skill/Attribute	Pre-Intervention Score (mean)	Post-Intervention Score (mean)	P Value [†]
Skills to be Senior (% Yes)	46.2%	92.3%	0.0108
Confidence	2.08	3.08	< 0.0001
Trauma Evaluation	2.46	3.31	0.0008
Stroke Evaluation	2.23	3.08	0.0008
Obstetric Evaluation	1.77	2.77	0.0003
Medic Command	1.23	2.00	0.0024
Giving Feedback	3.00	3.15	0.3370
Teaching Juniors	2.54	3.15	0.0009
Teaching Procedural	2.23	3.08	0.0001
Supervising Juniors	2.85	3.31	0.0075

All participants were given identical, anonymous surveys immediately pre- and post-intervention. The question focusing on having the skills to be a senior resident was self-assessed as yes or no; all other questions were assessed using a scale 1 (not prepared) to 4 (very prepared).

[†]Paired t-test for continuous values, chi-square test for binary values.

9 Development of a Novel Automated Workflow to Improve Resident Feedback and Evaluations

Matthew Gittinger, Bradley Wallace, Maurice Selby, Annemarie Cardell, Jeffrey Siegelman

Introduction: Obtaining consistent quantity and quality of end of shift evaluations of residents by faculty is a common problem in graduate medical education. Informal polling of our program’s faculty noted the main deterrents to completing evaluations were trouble navigating commercially available evaluation software, length of time required to complete evaluations, and difficulty completing evaluations on a smartphone device.

Objectives: We sought to develop our own online evaluation tool utilizing the Microsoft 365 line of software to improve faculty user experience and improve resident evaluations and feedback. The goal of this workflow was to increase the response rate, while improving the quality of