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6 The Social Emergency Medicine Mini-Curriculum: A Novel, Multifaceted Immersive Approach to Resident Education in Social EM

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Learning Objectives: 1) To design, implement and evaluate the feasibility of a replicable multifaceted Social EM curriculum for EM residents 2) To increase EM residents' level of awareness related to Social EM and increase their ability to identify/intervene on social determinants of health in clinical practice

Background: Emergency Medicine (EM) physicians are in a unique position to impact both individual and population health needs. Despite this, EM residency training lacks a formalized education on social determinants of health (SDoH) and social EM (SEM). The need for such a curriculum has been previously recognized, however there is a gap in the literature related to the feasibility of such a curriculum addition. This innovation seeks to address this need.

Curricular Design: A taskforce of EM clinician-educators with expertise in SEM developed a 4.5-hour educational curriculum for use during a single Emergency Medicine resident didactic block (1/2-day session). The curriculum (Table 1) included asynchronous learning via a podcast, four SEM subtopic lecture didactics, guest speakers from ED social work and a community outreach partner representative, and a poverty simulation with interdisciplinary debrief. The curriculum was delivered via videoconference due to COVID-19 restrictions. Pre- and post-curricular intervention participant surveys were obtained.

Impact: Post-survey results (Table 2) demonstrated improved awareness of SEM concepts and increased confidence in participant's knowledge of community resources and ability to connect patients to these resources following the curricular intervention. In addition, post-survey assessment demonstrated significantly heightened awareness and clinical consideration of SDoH among participants and increased comfort in identifying social risk in the ED. Overall, all components of the curriculum were evaluated as meaningful and specifically beneficial for EM training. The community partner presentation and subtopic lectures were ranked highest, followed closely by the poverty simulation, ED social services presentation, and asynchronous podcast component. This pilot curricular integration study demonstrates the feasibility and perceived participant value of incorporating a SEM curriculum into residency training.

Table 1. Social emergency medicine mini-curriculum.

Component	Description	Time allotted
1. Pre-didactic asynchronous learning	Announce Podcast "Episode 4 – Social Determinants of Health and Unmet Needs in the Emergency Department" https://www.socialempact.com/announce-podcast/sdoh	30 minutes
2. Sub-topic Lectures	PowerPoint slide presentations 1. Intro to SEM/Asynchronous Debrief 2. Incarceration 3. Firearm Violence 4. Homelessness	60 minutes (10-15 minutes each)
3. Guest speaker from community partner	The executive director of a local homeless shelter spoke about the many resources provided by this shelter as well as about the population that the shelter serves and the interaction between this population and the medical community.	30 minutes
4. ED care coordination presentation	Members from the ED Care Coordination and Social Services team spoke about available resources for ED patients and how providers can connect patients with these resources	30 minutes
5. Poverty simulation	Led by the UAB Office of Interprofessional Simulation, the Poverty Simulation introduces participants to the realities of poverty. While this simulation is typically an in-person event, given COVID restrictions, an online interactive simulation, SPENT, was used and the interprofessional debriefing took place by video conferencing. SPENT online poverty simulation: http://playspent.org	2 hours
6. Service Activity	Deferred due to COVID restrictions	-----

Table 2. Survey results, [n(%)].

Survey question	Pre-survey response (n=32)	Post-survey response (n=18)
The Emergency Department (ED) is an appropriate venue to connect patients with community resources.		
Strongly agree/Agree	30 (93.75)	17 (94.44)
Strongly disagree/Disagree	2 (6.25)	1 (5.56)
I feel comfortable identifying social need (ex: homelessness, food insecurity) in the ED.		
Strongly agree/Agree	28 (87.50)	17 (94.45)
Strongly disagree/Disagree	4 (12.50)	1 (5.56)
I feel comfortable identifying social risk (ex: risk of worse health outcome for certain race) in the ED.*		
Strongly agree/Agree	24 (75.00)	17 (94.45)
Strongly disagree/Disagree	8 (25.00)	1 (5.56)
I have been trained to identify and intervene on social determinants of health (SDoH).*		
Strongly agree/Agree	10 (31.25)	14 (77.78)
Strongly disagree/Disagree	22 (68.75)	4 (22.22)
I am aware of and familiar with local community resources to address social determinants of health.*		
Strongly agree/Agree	18 (56.25)	16 (88.89)
Strongly disagree/Disagree	14 (43.75)	2 (11.11)
I feel confident in my knowledge about community resources and ability to connect patients to them.*		
Strongly agree/Agree	8 (25.00)	15 (83.33)
Strongly disagree/Disagree	24 (75.00)	3 (16.67)
I frequently encounter patients in the ED with social need that impacts their health.		
Strongly agree/Agree	31 (96.88)	18 (100.00)
Strongly disagree/Disagree	1 (3.13)	0 (0.00)
I frequently encounter patients in the ED with social risk that impacts their health.		
Strongly agree/Agree	31 (96.88)	18 (100.00)
Strongly disagree/Disagree	1 (3.13)	0 (0.00)
I frequently consider SDoH when providing treatment for my patients in the ED.*		
Strongly agree/Agree	21 (65.63)	17 (94.45)
Strongly disagree/Disagree	11 (34.38)	1 (5.56)

*$p<0.05$