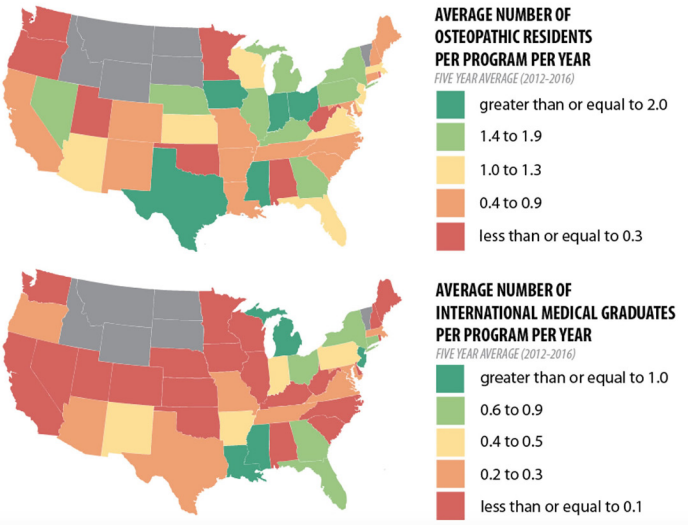

Image 1. Average Number of Matched Osteopathic (DO) and U.S. International Medical Graduates (IMG) Per ACGME Accredited Residency Program Per Year By State From 2012-2016.

Table 1. Average Number of Matched Osteopathic (DO) and U.S. International Medical Graduates (IMG) Per ACGME Accredited Residency Program Per Year By State From 2012-2016.

State	DO	IMG	State	DO	IMG
Alabama	0.2	0.0	Missouri	0.8	0.3
Arizona	1.0	0.2	Nebraska	1.6	0.0
Arkansas	0.4	0.4	Nevada	1.4	0.0
California	0.5	0.1	New Hampshire	0.6	0.0
Colorado	0.4	0.0	New Jersey	1.1	1.4
Connecticut	0.7	0.6	New Mexico	0.4	0.4
Delaware	1.0	0.0	New York	1.6	0.9
District of Columbia	0.2	0.0	North Carolina	0.4	0.1
Florida	1.3	0.6	Ohio	2.1	0.8
Georgia	1.6	0.6	Oklahoma	0.0	0.0
Illinois	1.5	0.1	Oregon	0.0	0.2
Indiana	2.3	0.4	Pennsylvania	1.8	0.4
Iowa	2.4	0.0	Puerto Rico	0.0	1.2
Kansas	1.0	0.0	Rhode Island	0.0	0.0
Kentucky	1.4	0.0	South Carolina	0.5	0.0
Louisiana	0.4	1.3	Tennessee	0.4	0.3
Maine	0.4	0.0	Texas	2.3	0.3
Maryland	0.6	0.3	Utah	0.2	0.0
Massachusetts	1.2	0.2	Virginia	1.1	0.2
Michigan	1.4	1.1	Washington	0.0	0.0
Minnesota	0.3	0.1	West Virginia	0.0	0.0

24 How do Emergency Medicine Programs Structure Resident Evaluations? A Survey

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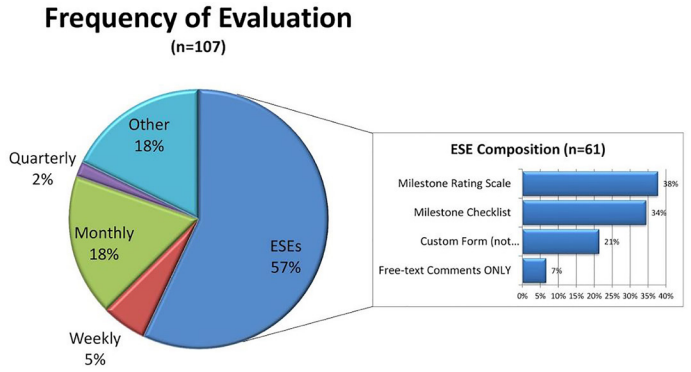
Background: Timely resident evaluation is not only important for residents' progress and development, but also a requirement of the Accreditation Council for Graduate Medical Education (ACGME). In 2013, the ACGME and the American Board of Emergency Medicine introduced the Emergency Medicine (EM) Milestone Project, a collection of competency-based developmental outcomes intended to demonstrate resident progression during training. Our program expects faculty to complete milestone-based end-of-shift evaluations (ESEs) for each resident shift. It is unknown what evaluation methods other programs utilize.

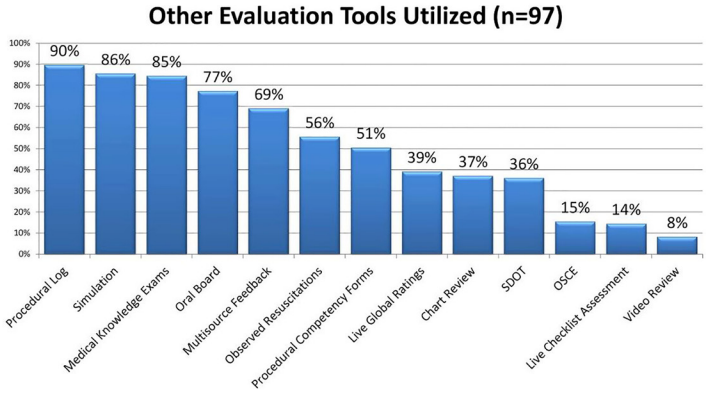
Objectives: We sought to determine what methods Council of Emergency Medicine Residency Directors (CORD) member programs use to evaluate residents, and to determine whether the use of ESEs is associated with higher satisfaction with the evaluation process.

Methods: An 11 item survey was distributed via the CORD listserv and was open from July through October 2016. Each member program was asked questions about the structure of their resident evaluation process. Responses were analyzed with simple descriptive statistics and Likert satisfaction scales using the Student's t-test. Missing data was omitted from analysis (i.e. skipped questions).

Results: 107 of 170 programs responded, yielding a 63% response rate. 57% (61/107) expected faculty to complete ESEs for every shift worked with a resident, 19% used monthly evaluations, and the remainder utilized evaluations ranging from semi-annually to eight times per month. Of programs that employ ESEs, 38% use milestone rating scales (levels 1 through 5), 34% use a milestone checklist with a binary response, 24% employ a custom form that is not milestone-based, and 7% employ free-text only ESEs. 62% (38/61) reported that their ESEs provide useful information to the Clinical Competency Committee. Programs utilize a plethora of additional evaluation tools. 17 programs reported using a financial incentive to encourage faculty compliance. Overall, 60% (58/96) of programs reported being at least "somewhat satisfied" with their evaluation process. There was no association between the use of ESEs and level of satisfaction (p=0.57).

Conclusions: EM programs employ a plethora of strategies to evaluate residents, with a slight majority using ESEs. There is no association between the use of ESEs and level of satisfaction.





25 How do Emergency Medicine Residencies Structure Trainees' Administrative Experience: A Survey

Williamson K, Branzetti J, Cheema N, Aldeen A / Advocate Christ Medical Center, Oak Lawn, IL; University of Washington, Seattle, WA; University of Chicago, Chicago, IL; Presence St. Joseph, Joliet, IL

Background: While the Accreditation Council for Graduate Medical Education (ACGME) mandates that emergency medicine residencies provide an educational curriculum that includes administrative seminars and morbidity and mortality conference, there is significant variation as to how administrative topics are implemented into training programs.

Objectives: No best practices exist for emergency medicine resident administrative experience. We seek to determine the prevalence of dedicated administrative rotations and details about the components of the curriculum.

Methods: In this descriptive study, a 12-question survey was distributed via the CORD listserv in the winter of 2016. Each member program was asked questions concerning the presence of an administrative rotation and details about its components. These responses were then analyzed with simple descriptive statistics.

Results: A total of 114 of the 168 programs responded with complete information, leading to a 68% response rate. Of responders, 73% have a dedicated administrative rotation (95% CI 64.0 to 80.4). Of the programs with an administrative rotation (n=81), 56.8% (95% CI 45.9 to 67.0) had a 4 week rotation, 23.5% (95% CI 15.6 to 33.8) had a 2 week rotation, 9.9% (95%CI 5.1 to 18.3) had a three week rotation; the remaining programs had either one week rotations or longitudinal experiences. A majority of 61.7% of the programs with an administrative rotation dedicate this time in the third year (95% CI 50.8 to 71.6). The content areas covered by the majority of programs with a dedicated program include performance improvement (68), patient safety (n=64), ED operations (n=58), patient satisfaction (n=54), billing and coding (n=47), and inter-professional collaboration (43). Experiential learning activities include review of patient safety reports (n=66) and addressing patient complaints (n=45); only 40 programs report presenting a morbidity and mortality conference as part of the administrative experience. Most of the teaching on the rotation is either in-person (n=65) and/or self-directed reading assignments (n=48). The most commonly attended meetings during the rotation include performance improvement (n=60), ED operations (n=59), and ED faculty (n=44).

Conclusions: Most EM residencies offer a dedicated administrative rotation, but content, duration, and curricula vary significantly.

26 Improving Critical Care Documentation and Coding Using an Online Teaching Module

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Background: Emergency medicine professional reimbursement - in particular, the Evaluation and Management levels - is based on Medicare's rules defining the complexity of care. Services are only reimbursable if they are properly recorded. Therefore detailed documentation is essential for optimal compensation. Critical care follows a different set of rules than other Evaluation and Management levels and a lack of clinician awareness of these rules leads to incomplete documentation and under billing.

Objectives: The goal of this study is to:

1. Identify gaps in critical care documentation knowledge among emergency physicians.
2. Determine if these gaps can be filled via a self-administered online training module.
3. Determine whether improvement in knowledge can improve documentation and enhance reimbursement.

Methods: Critical care charts were examined in an