Conclusions: Recommendations for optimal reading performance for IBL technologies include 14 point font size, Veranda or Arial typeface, font smoothing, positive polarity, increased interletter spacing, and shorter line lengths.

Table 1. Summary of design features and learning outcomes.

	Legibility	Reading Time	Reader preference	Mental Workload	Accuracy & Performance
Character size					
Larger size (10-14 pt)	+	+	+	+	+
Typeface					
Veranda	+		+	+	+
Arial	+		+		+
Times New Roman	--		--		--
Courier New		+			
Frutiger	+				
Eurostile	--				
YingHei	+				
Computer Type					O
Kai Type					O
Text Enhancement					
Boldface	+				
Italic	--				
Font Smoothing	+		+	+	
Text Color					O
Text Case					--
Polarity					
*Positive polarity	+		+		+
Text-on-Screen Color					
Blue-on-yellow			+		M
Purple-on-red			--		--
Red-on-white					M
Blue-on-white					M
Green-on-white					M
Brightness					
Increased glare				--	O
Increased luminance					M
Spacing					
Increased interletter		--			+
Increased interword		+			M
Line Length					
Increased line length		+	--		--
Display Type					
RSVP					+
Scrolling		+			
Display Speed					
Increased WPM					M

*black text on white background

Legend	
+	Improves
--	Worsens
O	No change
M	Mixed results
	N/A (no data)

9 A Novel and Well-Received Process for Tracking the ACGME 15 Key Index Procedures

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Background: The ACGME has created minimum procedural requirements for graduation. Tracking of these procedures is cumbersome and fraught with inconsistencies. A simplified means for residencies to track procedures is needed.

Objectives: We sought to implement a simplified tracking system and determine how residents viewed this Procedural Achievement Count Evaluation (PACE) score to track procedural progress vs a traditional counting method.

Methods: The setting was a three-year ACGME-approved residency with 25 residents and an annual census of 96,000. We performed a prospective analysis of a procedural tracking system using residents' progression. Data were imported from New Innovations into a Google spreadsheet. The total number of procedures required for each procedure was divided by 36 (total months of residency) and then multiplied by the resident's month of residency, creating an expected number of procedures that a resident should have completed at that specific time. We calculated this number for each of the resident's 15 core procedures. We termed this the PACE score. Residents can be 1) below the PACE (too few procedures for level of training); 2) at PACE (at the expected number for level of training); or 3) above PACE (exceeding the expected number for level of training). The cumulative resident PACE score spreadsheet was distributed to all the residents. Subsequently, we analyzed the perception of residents on this scoring system. We used a chi-squared test on the proportions along with differences and calculated 95% confidence interval (CI).

Results: All 25 residents completed the evaluation, of whom 72% (N=18) were male. One additional resident resided in the PGY3 year. Sixty-eight percent of residents said that the PACE score was more beneficial than a count of procedures, compared to 8% who said it was less beneficial (Difference 60%, 95% CI, 34-76; p<0.0001). Thirty-six percent said that seeing other residents' PACE scores was motivating, compared to 8% who said it was not motivating (Difference 28%, 95% CI, 5-48; p<0.05). Ninety-six percent of residents said that they were neutral or not offended by having their PACE scores shared with the other residents compared to one resident (4%) who said he or she was "slightly offended" (Difference 92%; 95% CI, 70-97; p<0.0001).

Conclusion: Calculating a PACE score is an easy way to track residents' procedural progress, and it is motivating and well-received by residents.

10 Impact of an Emergency Department Resident Sign-Out Checklist on Attending Assessments of Quality

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Background: Education and assessment of transition of care during emergency department (ED) shift change constitute essential elements of emergency medicine (EM) training.

Objectives: To determine if using a sign-out (SO) checklist (CL) resulted in improvement in the quality of transfer-of-patient responsibilities and impacted the consistency of attendings' assessments.

Methods: Oncoming and departing attending physicians prospectively assessed EM residents' unstructured morning SO for 38 consecutive days. They then assessed their CL-guided, structured, morning SO over the subsequent 39 days. Assessments included SO duration, SO patient quantity, SO quality visual analog scores (VAS), patient management issues, and oncoming and departing attending interobserver agreement.

Results: Oncoming and departing attendings made 548