for EM programs.

Objective: The objective was to explore if there are differences in scores between the SLOE 2.0 and SNEP.

Methods: From the 2022-2023 application cycle data, we performed a multi-institution, retrospective, cross-section study looking at all 4 week EM rotation SLOEs that were submitted to one of the 5 EM programs that were part of the study. Duplicate applicants were eliminated by cross referencing Association of American Medical Colleges numbers among the 5 programs. Exclusions for the SLOEs were: not written by a faculty group of other qualified person, letter writers wrote <5 SLOEs last year, incomplete data, or subspeciality or OSLOE. Since Part A and C1 provided qualitative data, they were converted to a 3-point scale and a 4-point scale to get quantitative data. We calculated mean scores from the SLOE 2.0 and compared them with mean scores from the SNEPs using a t-test. "Anticipated position on the rank list" was not included since SNEPs do not have that question. We applied a Bonferroni correction, resulting in a p=0.00384 for statistical significance.

Results: 1775 applicants (3690 individual SLOEs) were studied. 3520 (95.29%) were SLOE 2.0s; 170 (4.60%) were SNEPs. The means. standard deviations, and p-values for SLOEs and SNEPs are provided in Table 1.

Table 1. Mean and standard deviation for each standardized letter of evaluation (SLOE) 2.0 and SLOE for non-residency based EM Physicians (SNEP) questions.

	SLOE	SNEP	P-value
Question	**Mean (SD)**	**Mean (SD)**	
A1 Ability to perform a focused history and physical exam (1-3)	2.73 (0.47)	2.91 (0.38)	0.0001
A2 Ability to generate a differential diagnosis (1-3)	2.53 (0.55)	2.64 (0.53)	0.0108
A3 Ability to formulate a plan(1-3)	2.44 (0.56)	2.52 (0.54)	0.0685
A4 Ability to perform common ED procedure (1-3)	2.38 (0.80)	2.38 (0.76)	1.0000
A5 Ability to recognize and manage basic emergent situations (1-3)	2.58 (0.54)	2.65 (0.53)	0.0986
B1 Compassion, sensitivity, and respect towards patients and team members (1-5)	4.31 (0.72)	4.58 (0.87)	0.0001
B2 Receptivity to feedback and ability to incorporate feedback (1-5)	4.28 (0.75)	4.49 (0.84)	0.0001
B3 Dependability, responsibility, initiative, and work ethic (1-5)	4.34 (0.76)	4.63 (0.81)	0.0001
B4 Punctuality, attendance, and preparation for duty (1-5)	4.33 (0.76)	4.60 (0.80)	0.0001
B5 Timeliness and responsiveness in completing administrative tasks (1-5)	4.25 (0.79)	4.40 (0.71)	0.0152
B6 Interpersonal and communication skills with patients and family members. (1-5)	4.31 (0.72)	4.54 (0.85)	0.0001
B7 Interpersonal and communication skills with faculty, residents and healthcare professionals. (1-5)	4.28 (0.80)	4.51 (0.86)	0.0001
C1 Anticipated Guidance (1-4)	3.17 (0.73)	3.42 (0.88)	0.0001

SD, standard deviation

Conclusion: The results show that when comparing SLOE 2.0s to SNEPs, most of the questions showed statistically significant higher mean scores on the SNEPs. EM programs who use data from the SNEPs need to be aware of these inherent differences in scores. Further analysis should look at reasons for and implications of these differences.

12 Does Offering CME Credit Increase Emergency Medicine Faculty Attendance at Weekly Resident Conference?

Justine McKittrick, Ralph Ward, Lindsey Jennings, Kathryn Koval

Aim: Prior studies demonstrated that offering continuing medical education (CME) credits increased faculty attendance at resident lectures. The Medical University of South Carolina (MUSC) Emergency Department increased the amount of CME offered to faculty attending resident conference with the hopes of improving attendance.

Objectives: The purpose of this study is to analyze the effect of increasing CME credit hours offered at resident conference on faculty attendance. It is anticipated there will be a positive correlation between faculty attendance with the amount of CME offered.

Methods: This study was a retrospective analysis of the attendance rates of faculty at resident conference at MUSC between July 2021 to June 2022 (year 1: 2 hours of CME offered monthly) and July 2022 to June 2023 (year 2: 3 hours of CME offered monthly) An interrupted time series analysis was used to determine if the intervention led to an immediate and longer-term change in attendance hours per day. Chi-square analysis was used to compare attendance between years.

Results: In year 1, total hours attended per training day for CME and non-CME sessions had similar baseline rates and both rates were gradually decreasing over time. In year 2, CME attendance appeared to jump initially and then gradually dropped to return to the non-CME attendance rate, while total attendance hours per day was flat over time. The large variation in attendance between weeks resulted in no statistically significant values. Total hours of faculty attendance increased between year 1 and year 2 from 533 to 589, and the percentage of attendees at CME training increased from 24.4% to 35.1% ($p<0.0001$). Much of this increase appeared to occur early in year 2, after which attendance patterns gradually reverted to their earlier values.

Conclusions: Increased CME did not appear to be correlated with a long-term shift in faculty attendance. One major study limitation was incomplete logging of attendance.

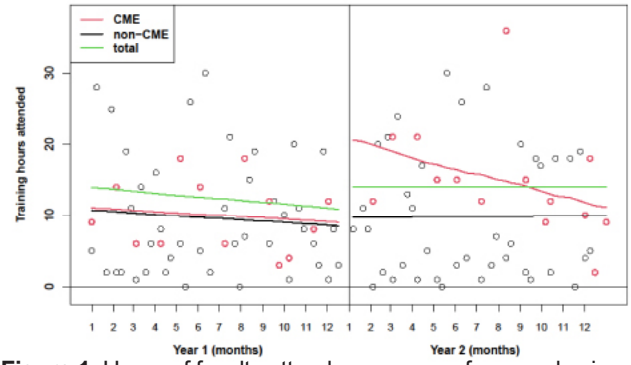

Figure 1. Hours of faculty attendance per conference day in pre-intervention period (Year 1) vs post-intervention period (Year 2).

Table 1. Parameter estimates for Interrupted Time Series Analysis.

Parameter	Estimate	Standard Error	Probability	Confidence Interval Lower Limit	Confidence Interval Upper Limit
Baseline non-CME	10.75365	2.59	<.0001	5.6773	15.83
Slope non-CME first year	-0.05323	0.1033	0.6074	-0.2557	0.1492
Interruption non-CME	1.215265	3.7053	0.7436	-6.0471	8.4776
Slope change year 2 non-CME	0.058925	0.1553	0.7052	-0.2455	0.3633
CME baseline difference from non-CME	0.341894	5.4782	0.9504	-10.3955	11.0792
CME slope difference first year	0.004289	0.2156	0.9842	-0.4184	0.4269
CME interruption difference from non-CME	10.62122	7.8616	0.1797	-4.7875	26.03
CME slope change difference from non-CME slope year 2	-0.24109	0.3048	0.4309	-0.8385	0.3564

13 A Double-Edged Sword: A Qualitative Study of the Minority Tax in Academic Emergency Medicine Faculty

Edgardo Ordonez, Jeremiah Ojha, Adedoyin Adesina, Annika Bhananker, Moises Gallegos, Dick Kuo, Melanie Molina, Dalia Owda, Vivian Ramont, Ynhi Thomas, Beatrice Torres, Anita Chary

Background: The 'minority tax' is the additional burden placed on minoritized faculty in advancing diversity, equity, and inclusion (DEI). Given the paucity of research, we examined the various impacts of the minority tax in academic emergency medicine (EM) faculty.

Objectives: To investigate the minority tax in academic EM by exploring pathways to DEI leadership, assessing its impact on professional development, personal experiences, and strategies for addressing and mitigating its effects.

Methods: Using a phenomenological framework, we explored the lived experiences of the minority tax by EM faculty through virtual semi-structured interviews. We identified participants through purposive sampling and included 21 diverse academic EM faculty from various academic departments with leadership experience in DEI. We coded transcripts of participant interviews and developed themes via consensus.

Results: Participants reported varied impacts of the minority tax on professional advancement, describing DEI work as often undervalued. Emotional toll and potential for burnout were significant, often related to feelings of tokenism and underrepresentation in leadership roles. However, positive aspects included personal fulfillment and networking opportunities. Most participants actively mentored others, emphasizing mentorship being critical for career progression and personal support. Strategies suggested for addressing the minority tax included increased leadership support, improved compensation for DEI work, and increased involvement of non-minoritized colleagues in DEI initiatives.

Conclusions: The minority tax in academic EM presents a complex challenge with both negative and positive aspects. While it may offer opportunities for academic advancement, it also poses risks for burnout and professional stagnation. Effective solutions require systemic changes, including recognition of DEI efforts in career progression and broader engagement across all faculty demographics.

Table 1. Themes and quotes from qualitative analysis of semi-structured interviews.

Theme	Illustrative Quotes
Pathways to DEI Leadership	"I never set out in the open to be [a DEI leader] one day, it was never the plan ... I feel like my own internal pressure to do it because if I don't, it won't get done." "There was no one else there to do the work. And this is stuff that I'm passionate about."
Professional and Personal Impacts	"You're there representing or at least demographically representing someone, but you don't have voice to do anything different. And when you would raise issues, you would create some tension." "There are these pressures, when you're sort of like managing early, when you see a need, you feel this responsibility to step up, and no one else will or it won't get done."
Strategies to Address and Mitigate the Tax	"People have this assumption that you can only be involved in diversity stuff if you're a minority. And I think that's actually horrible. I think DEI efforts need to be everyone. Equity is something that should apply to literally every single person, that's part of the definition of equity." "I feel like with a lot of diversity things, we talk about them within our diversity circles. So, the same people get it over and over again. I think our allies have to be more engaged ... sometimes you have to put your neck out there to support and help your minoritized colleagues."