subspecialty field of Emergency Medicine (EM) could enhance the educational experience of residents, provide a more tailored approach to fulfilling academic requirements provided by the ACGME, and establish a foundation for those residents seeking fellowship or a faculty position after graduation.

Educational Objectives: We describe the systematic development of a professional development track system.

Curricular Design: This curriculum was developed at a PGY 1-4 program based at a suburban health care network training 16 residents a year. After review of the ACGME requirements, the following 5 key areas were identified as being necessary components of a track: QI, PS, Committee Membership, Provision of Education, and Field Specific Additional Professional Development. Table One denotes the tracks developed. The 5 key areas address multiple ACGME requirements including IV.B.1, IV.D.2-3, and VI.A. In preparation for introduction, the residency research director prepared multiple Human Subjects Research Determinations (HSRDs) to allow possible dissemination.

Impact/Effectiveness: Table Two demonstrates exemplar activities in the identified 5 key areas. For ACGME CLER visits, the tracks provide systematic resident involvement in QI and PS. Work in QI has been identified by residents and faculty as the central driver of both work within the track and dissemination, making HSRD's central to track success. Being linked to ACGME requirements, including scholarly output, track work directly feeds into programmatic WebADS submissions. Measurable and ACGME reportable output includes presented/published abstracts at regional and national meetings, published articles, grand rounds for both EM and external departments, educational presentations at regional and national meetings, membership on hospital/regional/national committees, book chapters, and participation/completion of nationally certified fellowships. Feedback from faculty and residents is that PS work is difficult in some tracks. To that end, PS is being removed from the tracks and centralized with linkage to network work on high reliability.

Table 1. Tracks developed.

Toxicology	POCUS	Critical Care	EMS	Med ED (UME vs. GME focus)	ERM/ Implementation
Simulation	Wilderness Med	Admin/Operations	Informatics (in development)	Global EM (in development)	PEM
Peer Review/Patient Safety	Palliative Care	DEI/Health Equity	Research	Sports Medicine	

Table 2. Exemplar track output.

Quality Improvement	Patient Safety	Education	Committee	Field Specific Training
Critical Care: Lab Reduction (ACEP Poster)	Patient Safety: M+M Cases	EBM: 52 Articles Project	Critical Care: Network Code Blue Committee	Wilderness Medicine: FOAM Certification
Tox: TOXIC Registry (NACCT Posters)	EMS: Trench Rescue Case Report	Wilderness Medicine: EM Grand Rounds, PACEP Competition	Research: PACEP Research Committee	Med ED: ACEP Teaching Fellowship
POCUS: Rapid Education Event (Published)	PEM: ACEP Readiness	Tox: Regional Newsletter & Presentations	Patient Safety: Network Quality Council	Simulation: Sim Wars

4 Remote Point-Of-Care Ultrasound Training for Physicians in Low-Resource Countries

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Background: The use of point-of-care ultrasound (POCUS) in clinical practice is rapidly evolving. Classically, POCUS training has been done in person and is resource-intensive, which poses challenges to those in resource-limited settings. We have developed a comprehensive remote education program focused on POCUS for physicians in low-resource settings that allows training through a virtual platform.

Educational Objectives: The primary objective is to determine if providing a structured training platform via telehealth technology to physicians with limited resources and limited prior ultrasound training will improve their ability to perform and interpret POCUS. Additionally, we aim to determine if the course increases physicians' confidence and willingness to use POCUS to evaluate and manage their patients.

Curricular Design: Physicians from a remote hospital in Bhutan were enrolled in a six week course with weekly lectures that covered high-yield POCUS topics. Each lecture was followed by a hands-on component and time allotted to review cases. During the hands-on component, the physicians utilized Butterfly hand-held ultrasound devices to obtain images on volunteer-simulated patients. We reviewed the images in real-time and gave guided feedback via the telehealth platform provided by the World

Telehealth Organization. This maximized our ability to guide participants in improving their ultrasound skills.

Impact/Effectiveness: 12 physicians participated in our course. Subjective data was collected pre-intervention and post-intervention via survey. Learners' confidence in performing and interpreting POCUS improved from a mean of 6.16 (SD 2.79) to 8.41 (SD 1.76) on a 10 point likert scale; $t(11)= 4$, $p = 0.0019$. Objective data regarding the technical skill of each physician before and after the course was measured via their performance in obtaining images on a standardized patient. Images were graded on a scale of 1 (poor) to 5 (excellent). This data is pending the end of our final skills test. We believe this novel approach will allow us to maximize the benefits of ultrasound teaching without the restrictions of traditional resources.

5 The Impact of Physician Online Medical Control on High Acuity Patients Arriving to a Community Teaching Hospital

Joslyn Joseph

Background: Emergency Department (ED) Online Medical Control (OLMC) programs enable direct communication between paramedics and ED physicians for real-time patient care guidance. Our community teaching hospital implemented an OLMC program in September 2023, with attending physicians and senior residents available for consultations for the most critical calls and patients. This study investigates whether having OLMC available influenced paramedics' decisions to transport critically ill patients to our ED relative to other hospitals.

Objective: To evaluate if the initiation of OLMC increased the transport of critically ill patients to our ED.

Methods: Senior EM residents were trained via lecture, training videos, and simulated practice on how to perform OLMC. A reference guide and guide cards were posted near phones to look up protocols rapidly. This was followed by a period of ten supervised calls by EMS leadership. We conducted a before-and-after study following the OLMC program's launch. We analyzed Electronic Medical Records for EMS arrivals over six months before (3/1/2022 to 8/31/2022) and after (9/1/2023 to 2/28/2024) implementation. We collected data on Emergency Severity Index (ESI) triage levels, focusing on ESI Levels 1 and 2 as indicators of high acuity. Data was also compared with control periods from previous years to account for seasonal variations and COVID-19 impacts.

Results: Following OLMC initiation, 4,819 out of 11,762 patients arriving by EMS were high acuity (ESI 1 or 2), compared to 5,083 out of 12,129 before the program ($p=0.142$). In control periods, there were 4,850 high acuity patients out of 11,765 ($p=0.589$) and 4,811 out of 11,247 pre-study ($p=0.180$).

Discussion: Our study found no significant increase in critically ill patients transported to our ED post-OLMC implementation. Limitations include reliance on ESI levels without detailed complaint categorization and potential exclusion of patients arriving via Basic Life Support (BLS). While OLMC did not increase high acuity patient arrivals, its effects on ED-EMS collaboration and patient outcomes warrant further investigation. Other studies suggest enhanced collaboration may improve mortality rates in high-acuity cases, highlighting the need to explore OLMC's broader benefits.

6 Evaluating the Evaluators: Who Can You Trust with Entrustability?

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Background: The Association of American Medical Colleges has established 13 core entrustable professional activities (EPA's). The EPA's describe objective, observable behaviors which should be present in all medical school graduates.

Objectives: The purpose of this study was, using core faculty as the gold standard, whether non-core faculty and residents are more or less likely to determine medical students (MS) as entrustable.

Methods: This IRB approved study was conducted at an independent academic center hosting a PGY 1-4 EM residency with 16 trainees per year. A Delphi process identified EPA's 1 (H+P), 2 (Diff dx), 3 (Diagnostic testing), 6 (Oral presentation), 9 (Teamwork) and 10 (Emergent care) as possible to measure in a 4-week MS 4 rotation. An overall performance category was included as well. Evaluations used a 1-3 scale defined as: 1 above the level of their peers, 2 at the level of their peers, and 3 below the level of their peers. N/A or unable to assess was an option.

Results: Evaluations (N= 983) submitted in academic years 2021-2023 are presented in Figure 1. Use of the "below peers" score was globally less than "above peers". In the overall performance category, PGY 4's were the most likely group to submit a "below peers", using this response 33.2% of time. PGY 2's were the most common group to note an inability to evaluate an EPA and most infrequently identified below average performance.

Conclusions: In this single institution cohort, PGY4's were found to be the strictest graders followed closely behind by core faculty in almost all EPAs. Collectively, senior resident (PGY3 and 4's) evaluations of entrustability are similar to those of core faculty. As such, programs may consider incorporating senior resident feedback into student evaluation of entrustability. Non-core faculty, in this cohort,