year that included regularly assigned Qbank questions, monthly ITE question review sessions during residency conference, a 4-hour gamified ITE review session one week prior to the ITE, and increased ITE score thresholds for moonlighting privileges. We measured the difference in mean Qbank questions completed and ITE scores before and after the intervention using two-sample t-tests.

Results: There were 89 residents in the pre-intervention group vs. 90 residents in the post-intervention group. The mean number of questions completed pre-intervention was 668 vs. 1072 post-intervention, which was statistically significant ($p<0.0002$). The mean ITE score pre-intervention was 70.6 compared to 70.8 post-intervention, which was not statistically significant.

Conclusions: Our intervention increased the amount of Qbank questions that residents performed but did not influence the average ITE score. These findings call into question the classical advice of maximizing the number of questions done in Qbanks to study. Future work should investigate how to best utilize these resources to improve scores.

12 Improving Resident Chart Completion Rates Through Transparent Performance Feedback

Brittany Botticelli, Laura Welsh, Eric Shappell, Daniel Egan, Derek Monette, Carolyn Commissaris, Marcus Wooten, David Peak

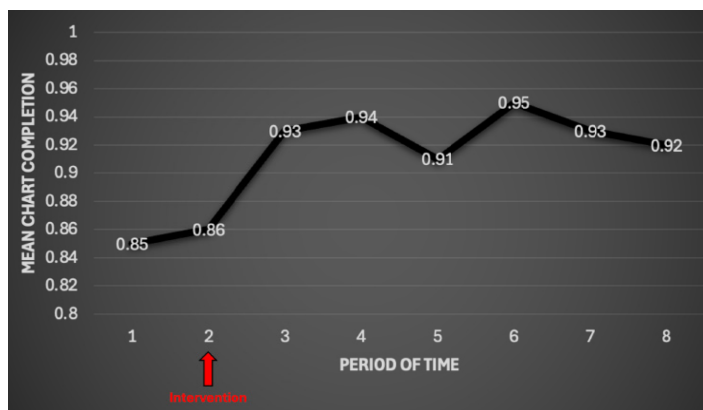
Background: Timely chart completion remains a persistent challenge in EM residency programs, with implications for billing, quality metrics, medicolegal risk, and patient care. Traditional approaches using individual reminders, administrative follow-up, and semi-annual feedback are time-intensive and often ineffective.

Objective: To determine whether sharing individualized performance data and linking compliance with the ability to work extra shifts for compensation improves resident chart completion rates within 72 hours. We hypothesized that the intervention with financial implications would demonstrate improved performance compared to the pre-intervention period.

Methods: We conducted a retrospective cohort study at a single academic EM residency program with 60 residents. Beginning January 2024, residents received scheduled emails containing their individual 72-hour chart completion rate and the program goal. Those who did not complete 80% of charts within 72 hours were not able to moonlight. We compared mean completion rates across two pre-intervention periods (May-December 2023) and six post-intervention periods (January 2024-December 2025) using a two-sample t-test with equal variances. The primary outcome was the proportion of charts completed within 72 hours.

Results: We analyzed 471 resident-period observations (119 pre-intervention, 352 post-intervention) (Figure 1). Mean 72-hour completion rate increased from 0.85 (SD 0.17) pre-intervention to 0.93 (SD 0.11) post-intervention ($p<0.001$). Improvement was sustained across all six post-intervention periods, with mean completion rates ranging from 0.91 to 0.95.

Conclusions: Sharing individual performance data linked to extra compensation eligibility significantly and sustainably improved resident chart completion rates. This approach is easily generalizable to programs with EMR access. Achieving further improvement may require targeted interventions. Limitations include single-site design and lack of a concurrent control group.



13 Clinical Assessment of Medical Students' Abilities Identifying and Mitigating Social Determinants of Health

Andrew Golden, Emily Craft, Justine Li

Background: EDs serve as safety nets for patients vulnerable to social determinants of health (SDH). EM student rotations often integrate curricula on SDH. Despite these curricula, there are little data assessing trainees on their ability to identify and mitigate the impact of SDH.

Objectives: The purpose of this study is to assess the ability of fourth-year acting interns (AIs) to identify and mitigate SDH. We seek to better understand the relationship between this skill and other National Clinical Assessment Tool in EM (NCAT) domains. Finally, we aim to analyze how frequently faculty assess students in this area.

Methods: We adapted the NCAT to include an item about integrating SDH into plans. This is a single center retrospective study of modified NCATs completed by EM faculty for AIs from June 2023 to October 2024. Entrustment ratings on NCAT items, including the SDH item, were extracted by two reviewers and converted to ordinal numbers for analysis (1-4). Interrater reliability (IRR) was evaluated on 30 assessments. Correlation coefficients were calculated between the SDH item and other NCAT domains. Descriptive statistics are reported.

Results: A total of 329 assessments for 42 AIs completed by 58 faculty were included in the analysis. There was excellent IRR (kappa = 0.97). The SDH item was left blank in 82 NCATs (24.9%). Mean on the SDH item was 3.0 (SD 0.76). All NCAT items were positively correlated with the SDH item. Five items generated correlation coefficients greater than 0.7, including Plan Completeness (r=0.78), Plan Formulation (r=0.76), Recommendation of Interventions (r=0.75), Differential Diagnosis (r=0.74), and Attention to Abnormal Vital Signs (r=0.74).

Conclusions: Faculty may not be trained to assess AIs' integration of SDH, as almost 25% of assessments left this item blank. When assessed, students are "Mostly Entrustable" at integrating SDH, and this skill is most positively correlated with other items of plan formulation and emergency management.

14 Feedback on Feedback: Targeted Faculty Interventions Improve Narrative Feedback in Resident Assessments

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Background: EM residents perceive a lack of quality feedback on workplace-based assessments (WBAs). Faculty development to address this problem often summarizes best practices without providing targeted feedback to individual faculty.

Objectives: The purpose of this study is to examine the impact of individual feedback to faculty on the quality of their narrative assessments of residents. We hypothesize providing this targeted intervention will increase the quality of feedback while decreasing the quantity of resident WBAs. We hypothesized faculty would submit less WBAs of residents in an attempt to avoid receiving feedback about their narrative assessments.

Methods: This prospective interventional study took place at a single academic institution from July 2023 to June 2025. Narrative comments included in WBAs were coded as Actionable with Guidance (AwG), Actionable without Guidance (AwoG), or Nonactionable (NA). Baseline data were collected from July 2023 to June 2024. Starting July 2024, quarterly metrics showing the individual distribution of assessments using the AwG, AwoG, and NA scale; distribution across all faculty; and exemplar feedback examples were provided to each faculty. Coding of narrative comments continued through July 2025. Descriptive statistics and Chi-square analyses were performed.

Results: A total of 1523 narrative comments completed by 46 faculty were included in our analysis. Pre-intervention, feedback was 49.6% AwG, 32.5% AwoG, and 17.9% NA. Post-intervention, feedback was 66.5% AwG, 22.2% AwoG, and 11.3% NA. The distribution of these ratings was significantly different between years, X2 (2, N=1523)=44.7, p<0.01. The baseline number of WBAs per resident per year was 19.5, increasing to 22.8 post-intervention.

Conclusions: A targeted intervention providing individualized faculty feedback on their narrative assessments of residents increases the quality and quantity of resident WBAs. Future directions include identification and analysis of barriers to high-quality narrative feedback.

15 Evaluating a Tofu-Based Training Model for Fascia Iliaca Block Competency and Skill Retention

Antonious Malak, Cosimo Laterza, Laura Kolster

Background: Ultrasound-guided fascia iliaca compartment block (UGFICB) is an important analgesic procedure for EM residents, but high-fidelity models (HFM) are costly. Low-fidelity models (LFM) offer inexpensive alternatives, yet their educational impact and retention remain unclear.

Objective: To evaluate pre/post-changes in confidence and knowledge after LFM-based training and assess 3-month retention; secondarily, to compare performance on LFM vs HFM. We hypothesized that the LFM would increase confidence, support knowledge retention, and perform comparably to the HFM.

Methods: This prospective simulation study was conducted in 2025 at an academic emergency department in New Jersey. Twenty-two residents participated via convenience sampling. Pre-training assessments measured confidence (100-point VAS) and procedural knowledge (10 items). After instruction, residents performed UGFICB attempts on a tofu-based LFM ($2.41) and commercial HFM ($4,225). Competency was evaluated using a validated 16-item checklist (0–32). Post-training and 3-month follow-up surveys reassessed outcomes. Descriptive statistics, paired t-tests, and 95% CIs were used (α=0.05).

Results: Checklist scores did not differ (LFM: 29.14 vs HFM: 29.23, p=NS). Post intervention, confidence (46.36 points (95% CI: 33.97–58.76; p<0.001) and knowledge (21.82 points (95% CI: 16.32–27.32; p<0.001) improved. At three months, compared with baseline, confidence (+42.95; p<0.001) and knowledge (+0.05; p=0.09) remained higher. Residents reported higher confidence with the LFM (+13.64; 95% CI: 6.65–20.62; p<0.001) and preferred it overall.

Conclusion: A tofu-based LFM is a cost-effective alternative to HFM for UGFICB training, producing comparable competency, increased confidence and knowledge retention, and strong learner preference. Strong confidence retention and a small increase in knowledge support quarterly training frequency. Limitations include evaluator bias, small sample size, and single-institution design. Next steps include multi-institution validation.