

and easily implemented educational innovation that enhances residents' confidence in dermatologic diagnosis. Gamified, image-based learning could also be scaled and used to teach other visually-oriented topics in graduate medical education.

Table 1: Mean Responses

Survey Question	Mean Rating (1-5 Likert Scale)
How comfortable were you with dermatologic diagnosis in the ED before playing the game? [Least Comfortable – Most Comfortable]	2.7
The rules of the game were easy to understand. [Strongly Disagree – Strongly Agree]	4.5
The game mechanics (card board, informational slides) were intuitive to use. [Strongly Disagree – Strongly Agree]	4.5
Compared to traditional study methods (lectures, flashcards, etc.), this format was [Much Less Engaging – Much More Engaging]	4.7
After playing, I feel more confident in approaching a patient with a rash in the ED. [Strongly Disagree – Strongly Agree]	4.2
Overall, how satisfied were you with this game? [Not Satisfied – Extremely Satisfied]	4.9

69 Implementation of a Novel Interfacility Transfer Curriculum

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Introduction/Background: An Interfacility Transfer (IFT) arises when care exceeds the capability of a facility. IFT is the intersection of clinical judgement, policy, regulations and EMS capability. IFTs are governed by the complex Emergency Medical Treatment And Labor Act, but the sending physician must also navigate local protocols, EMS availability, and clinical needs. EM graduates are not exposed to IFTs through formalized curricula and little in practice. Our team was awarded a competitive institutional grant - the Frymoyer Scholars Program - to create a two-year, iterative curriculum filling the educational gap surrounding IFTs in GME.

Educational Objectives: List the elements required for a transfer. Describe the sending provider's legal and clinical obligations. Differentiate patients' IFT transfer needs. Contrast ED and Inpatient transfers. Weigh benefits and risks of EMS levels. Illustrate Transfer Center Workflow

Curricular Design: Educational Objectives were created after a needs assessment with stakeholders including: transfer centers, EMS, legal, residents, rural and tertiary attendings. Residents, Attendings, and Advanced Practice Providers were invited to participate. We created three, one-hour problem-based didactics on legal obligations, transfer center logistics, and EMS capabilities. One month after didactics, learners participated in one two-hour SIM of four challenging transfers cases involving active labor,

patients' cultural concerns, change in stability and EMS/ED staff interaction. The curriculum spanned six weeks. For assessment, participants completed a post/pre-survey and an hour-long mediated focus group following a discussion guide. Transcripts were analyzed for opportunities to improve. Gift cards were provided for participation.

Impact/Effectiveness: Despite the ubiquity of IFT in EM, core textbooks only briefly cover the process and few curricula exist in the literature. Additionally, a recent ACGME proposal for IFT curricula makes our curriculum a timely addition to EM education. Our curriculum provides the knowledge and skill to navigate the process of IFT, improving patients' timely access to higher level of care. The curriculum was implemented in Fall of 2025, data collection is underway, and anecdotal reception has been positive.

70 Code Camp: Training Confident Resuscitators through Small-Group Simulations Using Iterative Learning

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Introduction: Leadership training in cardiac resuscitation is essential in EM education. A resident and post-graduate needs assessment demonstrated low confidence in leading codes. Code Camp is a longitudinal simulation curriculum designed to improve resident confidence in resuscitation leadership and medical decision making.

Objectives: Increased confidence in leading cardiac resuscitations, delegating and coordinating team roles, managing EMS-to-ED transfers and executing ACLS in various cases (PEA, shockable rhythm, respiratory arrest).

Curriculum Design: Using Kern's curriculum design framework, participants (5-6 per group) rotated

Figure 1 : Total confidence in running cardiac arrests

