per shift, but the differences were not statistically significant.

Conclusions: Working with residents improves ED attending productivity in terms of patients seen per hour and total patients seen per shift. We did not compare the different postgraduate training levels.

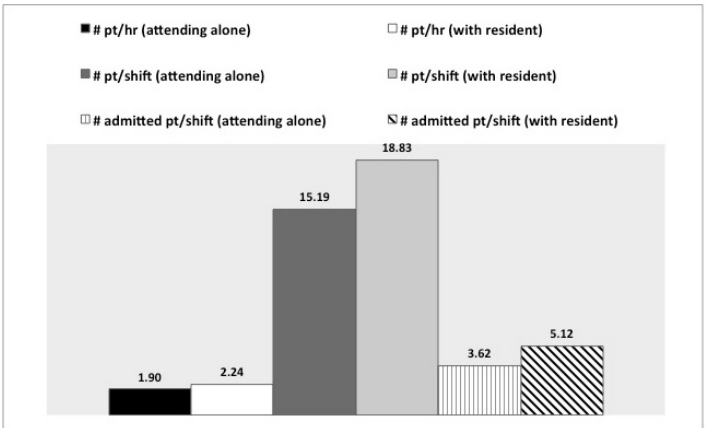

Figure 1. A graphical comparison of mean number of patients.

73 The I-TRAC Curriculum: Individualized Training of Residents through Assessment and Clinical Competency

Fredette J, Bounds R / Christiana Care Health System, Newark, DE

Background: Graduate medical education has become more competency-based and emergency medicine (EM) is leading this transition. Milestones, daily feedback, formative evaluations, and Clinical Competency Committees (CCC) have provided educators with more accurate assessments of resident performance, but programs still tend to use a "one size fits all" model. Each resident, regardless of their mastery, or difficulty, in achieving competencies, is provided the same clinical experience.

Objectives: With specific and timely performance metrics available to educators, there is a clear benefit of having a flexible clinical curriculum tailored to each resident's competency level in order to maximize the value of their training.

Design: Our postgraduate year (PGY) 1-3 block curriculum was evaluated by a group of faculty and resident leaders, with attention to educational value and achievement of goals and objectives, then modified to create flexibility. Interns are given added time in the emergency department (ED) to allow for earlier assessments of competency. Then, based on CCC evaluations, the block curriculum for PGY2 and 3 residents becomes individualized along one of 3 tracks.

Track 1 is the standard curriculum in which the graduation of responsibility is appropriate for the majority of the residents. Track 2 allows a focus on areas where deficiencies are identified and EM time is tailored to address specific needs. Finally, Track 3 is designed for residents who are mastering competencies earlier than expected. Residents in Track 3 will benefit from the acquisition of advanced skills such as ED flow management, bedside teaching, operational leadership, or clinical research.

Impact: The I-TRAC curriculum replaces the standardized block curriculum in which all residents graduate with the same skill set. This novel individualized curriculum responds to resident's strengths and weaknesses and allows educators to apply milestone-based assessments in a way that targets specific areas of need and maximizes residents' potential.

74 The Patient Care Continuum: Transition of Care to the Discharged Patient

Choudhri T / George Washington University, Washington, DC

Discharging patients is not usually recognized as a transition of care, nor is it imbedded in curriculums. Engel et al. found that among patients surveyed about their discharges, top knowledge deficits were home care and when to return to the emergency department (ED). Learning how to discharge patients is vital to education to foster a culture of accountability,and to highlight medical-legal considerations that are inherent in discharging.

Objectives: Review common discharge errors/ misconceptions; provide tools to give and write discharge instructions by outlining components of adequate instructions; strengthen current skills by allowing practice and critique of common ED scenarios.

Design: Residency leadership identified that residents do not understand the importance of discharging a patient and the legal/patient care ramifications inherent to this process, and implemented this module during Grand Rounds. Using JCAHO/CMS standards for discharging, a self-assessment tool was used to identify weaknesses, followed by a lecture of common errors of physicians and the existing evidence based medicine regarding discharges. Utilizing American College of Emergency Physicians module-Planning Safe and More Effective Aftercare, components of instructions were outlined as they correlate with JCAHO/CMS standards. Residents divided into groups to practice on common ED scenarios, and then presented to the large group for critique. One month following this, a survey showed 100% of respondents felt this session was "Very Important" or "Important" to their education. 75% felt this module changed their practice - 50% of which said it changed both their verbal and written discharges. Discharging patients is a component of every specialty, and without appropriate instructions our patients are not receiving quality aftercare and thus, have a high likelihood for return visits and bad outcomes. This was created using standards all physicians should adhere to, and was focused into ED specific scenarios that easily translates to any emergency medicine residency across the country.

1. Are the discharge instructions typewritten (printed by computer)?
2. Are they legible? (If two or more people cannot read them, they are illegible.)
3. Are they written in a language and at a reading level the patient understands?
4. Do they include the physician's name?
5. Do they include an explanation of the injury or illness or discharge diagnosis?
6. Do they include a list of signs and symptoms to be aware of and what to do if they occur? (For example, call your primary care physician, call 911, or come back to the emergency department.)
7. Do you document patient understanding?
8. Do you document that the patient was given the opportunity to ask questions?
9. Do they specify a date, time, and provider for a follow-up visit or that a follow-up appointment was made before the patient left the emergency department?
10. Are they signed by the patient or the patient's authorized representative?

Figure 1. Self assessment of discharge instructions.

75 The Use of Uniform Clinical Scenarios to Produce Milestone Proficiency Scoring

Bradford-Saffles A, Merrill R, Cregar C, Bosman E, South A, Fire F, Brown J / Akron General Medical Center, Akron, OH; The Ohio State University, Columbus, OH

Introduction: The Accreditation Council for Graduate Medical Education (ACGME) requires reporting of Milestone proficiency levels, based on objective assessment. Programs have struggled with assessment methods. We report on a method of objective assessment in which clinical scenarios are presented to a resident, and scored using the Milestone framework. This satisfies multiple educational needs of the resident and residency.

Educational Objectives: There were several objectives of this initiative. The first was to present uniform teaching points related to clinical care to all residents individually. The second was to assess management of each clinical scenario using the Milestone framework. This process was facilitated by the bank of Council of Emergency Medicine Residency Directors clinical scenarios.

Curricular Design: Each clinical faculty was assigned to two clinical cases. A total of 48 cases were chosen, with 12 designated to emergency medicine (EM) 1 level, and 18 each to EM2 and EM3 levels based on perceived complexity. Faculty were assigned to four specific conference days a year in which 4-6 faculty would present one of their cases to individual residents. A separate scoring sheet for each clinical scenario was developed using 12 of the 23 Milestone subcompetencies.(Table 1) Scoring was anchored to Needs Improvement, Meets Expectations, and Above Expectations, equated with Levels 2, 3, and 4 for each subcompetency, respectively.

Impact/Effectiveness: From July, 2014 through November 2014, EM1, EM2, and EM3 residents completed 60, 95, and 88 clinical scenarios, respectively. Scoring demonstrated progressive improvement by year level. (Table 2) Within each year level there was variation by resident. This project benefits residents and the residency. All residents are exposed to the same 48 clinical scenarios, making training more uniform. Each attending becomes relatively expert in their two cases. The residency benefits by increased scheduled conference attendance by attendings as well as an additional methodology for Milestone proficiency scoring.

Table 1. Clinical scenario scoring results by PGY level.

Subcompetency	PGY1	PGY2	PGY3
Emergency stabilization (PC1)	3.05	3.26	3.36
Performance of focused history and physical exam (PC2)	3.19	3.18	3.43
Diagnostic studies (PC3)	3.13	3.27	3.10
Diagnosis (PC4)	3.20	3.12	3.49
Pharmacotherapy (PC5)	2.93	3.21	3.23
Observation and reassessment (PC6)	3.21	3.17	3.45
Disposition (PC7)	3.05	3.39	3.36
Medical knowledge (MK)	3.00	3.11	3.30
Professional values (PROF1)	2.87	3.13	3.12
Accountability (PROF2)	3.14	3.20	3.43
Patient centered communication (ICS1)	3.06	3.22	3.36
Team management (ICS2)	3.01	3.14	3.19

PGY, postgraduate year; *ICS*, interpersonal and communication skills;