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not significant change from posttest to retention (p = 0.99).

Conclusions: EM faculty respondents identified 20 core ECG findings imperative for a first year EM resident to recognize. Our flipped classroom approach was effective in enhancing senior medical students' recognition and retention of these core ECG findings.

Figure 1.

Item	N	% Correct, Pre-Test	% Correct, Post-Test	Exact p
Ant MI	74	86.4	99.0	0.01
NSR	74	59.5	81.0	0.01
RBBB	73	84.0	99.0	0.001
AFlut	74	92.0	98.8	0.06
Brady	74	95.7	97.1	0.99
1st deg	74	74.0	85.0	0.17
3rd deg	74	74.0	96.0	<0.001
HyperK	74	96.4	99.1	0.63
Tachy	70	84.3	91.4	0.23
Inf MI	74	73.1	87.0	0.052
Lat MI	74	37.5	62.0	0.002
Post MI	74	34.8	75.0	<0.001
2nd degT1	74	80.7	93.0	0.02
Vtach	74	90.4	98.5	0.07
Vfib	74	94.4	98.4	0.38
Asyst	74	69.7	97.8	0.45
SVT	74	60.0	99.0	0.001
LBBB	74	50.4	84.0	<0.001
Afib	74	85.4	92.0	0.27
2nd degT2	74	69.1	92.0	<0.001
Mean		80.0	92.5	<0.001

Note: Significance (*p*) is determined using an exact version of McNemar's dependent chi-square test.

38 Identifying Communication Behaviors Associated with Higher ED Patient Satisfaction Scores

Finefrock D, Patel S, Nyirendra T, Zodda D, Nierenberg R, Ogedegbe C, Feldman J / Hackensack University Medical Center, Hackensack, NJ

Background: While it is known that certain behaviors of medical providers correlate with higher patient satisfaction, there is insufficient data on which behaviors are most important. We implemented a training program called PatientSET "satisfaction every time" consisting of 4 hours of online, video CME education that included the following communication behaviors during the initial ED interaction between providers and patients: Pause before entering, Smile, Introduce yourself, Shake hands, Acknowledge the wait and apologize, Begin with open-ended question such as "How can I help you?", Overestimate Time and Perform at least 1 non-medical gesture.

Objectives: The primary objective of this study were to identify discrete positive physician-patient communication behaviors and their correlation to physician patient satisfaction scores. Additionally, providers with low compliance to the positive behaviors were retrained in order to observe the effect of the training program on behavioral compliance.

Methods: This is a retrospective review of 272 observations of 19 emergency department providers (16 physicians, 2 physician assistants and 1 nurse practitioner) at a high volume, high acuity ED. Providers were included if they had N>30 Press Ganey (PG) surveys from the previous 4 consecutive quarters and excluded if they had N<30 PG surveys. High performers were defined as having PG scores > 40th percentile while low performers were defined as having PG scores < 40th percentile. The high performers had an average PG score of 69% (N=412 total PG surveys) while the low performers had an average PG score of 14% (N=491 total PG surveys). The Low performers were observed again 6 months later after completion of the PatientSET training program. Any associations with the number of times the clinicians exhibited the positive behavior was examined using Poisson regression analysis. This analysis was conducted to compare number of times providers exhibited behaviors 1. Between high performing provid

Results: Our results detailed 8 high performing providers and 11 low performing providers as related to frequency of PatientSET behavior use. Each provider had bedside observations completed by trained observers. The results showed that being a high performing provider was associated with significantly higher frequency of 6 PatientSET behaviors (RR ranging from 1.55 to 16.76), including all behaviors except "Pause before entering" and "Introduce yourself". High performers had a higher frequency of PatientSET behaviors across 6/8 categories with a mean p value of <0.0001.

Observations were obtained 6 months later for 8 of the 11 low performers after the education intervention. After their educational intervention, low performing provider's compliance with the PatientSET improved in 4 behaviors with relative ratios (RR) ranging from 2.3 to 10.0. Overall their compliance with the PatientSET improved across all behaviors with a mean p value <0.01.

Conclusions: We conclude that using a provider education tool like PatientSET is effective in identifying behavioral modifiers that lead to improved ED provider-patient interactions. Among our high and low performing providers, the high performing providers consistently performed the positive PatientSET behaviors. In addition,

when low performers were observed 6 months later after the education intervention, they significantly improved their compliance. These specific positive behaviors may be used by ED providers to improve the patient experience.

39 Implementation of a Learner Centered Teaching Curriculum in an Emergency Medicine Residency Program

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Background: Lectures are a passive learning technique thus limiting knowledge transference and retention. Active learning formats are increasingly popular in graduate medical education as they are more engaging and preferred by learners. The effect of implementing an active learning curriculum in an Emergency Medicine (EM) residency on objective measures of knowledge, like the In-Training Exam (ITE), is unknown.

Objectives: We hypothesize that the addition of active learning to an EM residency curriculum will result in improved knowledge acquisition and retention, as measured by performance on the ITE.

Methods: This was a single center, single group, pre-post study of the effect of changing to a Learner Centered Teaching (LCT) curriculum in an EM residency training program. All residents with both 2014 (pre-) and 2015 (post-) ITE scores were eligible for inclusion. Starting in July 2014 the LCT curriculum was implemented with approximately half of the core content lectures replaced with small group discussions that included pre-discussion homework submitted in advance. Performance on the ITE was evaluated for all residents completing both 2014 and 2015 exams. The mean change in Percentile Rank on the ITE and the mean Distance from Target score, how far the subject was from their year specific goal, were evaluated with a paired t test. A secondary outcome evaluated was change in Percentile Rank and Distance from Target for the residents Below Target in 2014.

Results: 23 residents were enrolled. The mean change in percentile rank was -1.2 (95%CI -9.5-7.2, p=0.77) for all subjects and +7.4 (95%CI 3.5-18.2, p=0.13) for residents Below Target in 2014. The mean change in Distance from their Target Score was 0.7 (95%CI -1.1-2.5, p=0.44) for all subjects and 2.2 (95%CI -0.5-4.9, p=0.09) for residents Below Target in 2014.

Conclusions: Implementation of an LCT curriculum did not show a statistically significant change in ITE performance. There was a trend toward greater improvement in both Percentile Rank and Distance from Target score for residents who were below target in 2014. This study was not adequately powered to show a significant difference in ITE performance among the sub-set of residents below their target score in 2014. The impact of an LCT curriculum on ITE performance for this population is an area for further study.
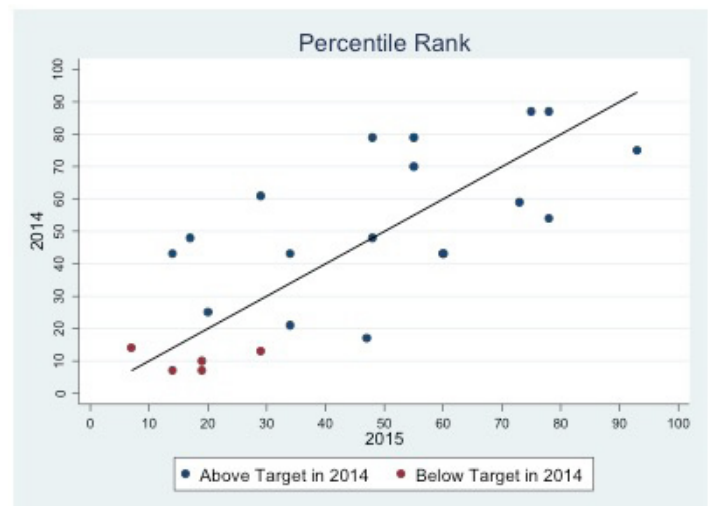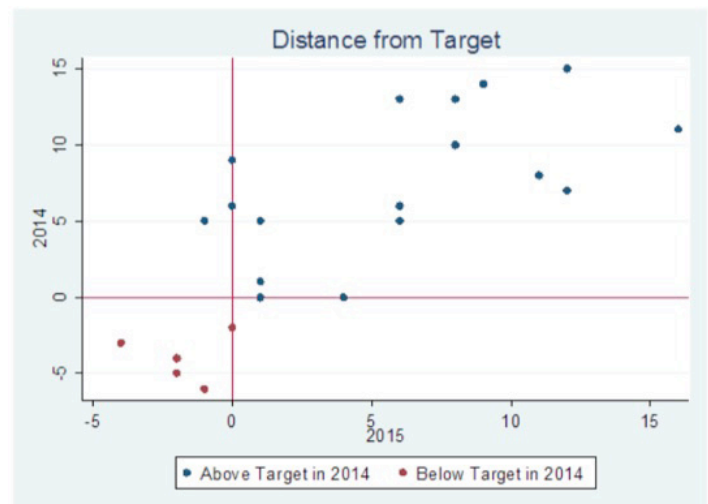

Figure 1.

Figure 2.

40 Incorporation of Images on Presentation Slides Positively Impacts Continuing Medical Education Conference Speaker Evaluations

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Background: Although continuing medical education (CME) presentations are common across health professions, it is unknown whether slide design impacts audience evaluations of the speaker.

Objectives: Based on the conceptual framework of Mayer's theory of multimedia learning, this study aimed to determine whether text density and image use on slides affect overall speaker evaluations.

Methods: This retrospective analysis of six sequential CME conferences (two annual emergency medicine