Results: During the eight years of the study period, there were a total of 115 graduating residents: 73 men (63%) and 42 women. Nearly all of them (109; 95%) had allopathic medical degrees; the remainder had osteopathic degrees. Table 1 shows the distribution of the final consensus ranking of the residents. The inter-rater reliability of the initial rankings was strong with an ICC = 0.845 ($p < 0.01$).

There was a poor, but statistically significant, correlation between our ranking of clinical performance and the Step 2CK score. There was not a statistically significant correlation between clinical performance and the Step 1 score. (See Table 2).

Conclusions: Neither USMLE Step 1 nor Step 2CK were good predictors of the actual clinical performance of residents during their training, we feel that their scores are overemphasized in the resident selection process.

Table 1. Final ranking of residents

Category	Number	Percentage
Top	38	33.0%
Middle	44	38.3%
Bottom	33	28.7%

Table 2. Correlation between clinical performance and examination scores

	USMLE Step 1	USMLE Step 2CK
Correlation Coefficient	0.067	0.205
P Value	0.49	0.04
N	109	106

36 USMLE Step 1 Minimum Score Thresholds as an Applicant Screening Filter by Emergency Medicine Residency Programs

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Background: The number of residency applications per applicant has risen dramatically. A 2016 survey of residency program directors by the AAMC showed that 75% of residency programs across all specialties use filters or minimum thresholds when selecting applicants to interview, including 54% of emergency medicine (EM) programs. This agrees with a 2014 survey conducted on the CORD listserve which found that of programs using filters, 56% filter by Step 1 failures or minimum score. Students cannot make targeted and informed residency application decisions without transparent data to assess their competitiveness for a given program.

Objectives: The purpose of this investigation is to describe the use and minimum thresholds of USMLE Step 1 scores by emergency medicine residency programs.

Methods: Data regarding the USMLE Step 1 score below which programs would generally not grant an interview and invitation of applicants who have failed Step 1 in the past 3 years were extracted from EMRAMatch.org, a collaborative, searchable, filterable residency directory created by EMRA, CORD, CDEM, and ACEP. The data on EMRA Match was initially populated through a survey via the CORD listserve and programs are automatically prompted to update their information.

Results: Of the 239 residency programs listed, 100% provided information regarding consideration of applicants who had previously failed Step 1 and 85% responded with minimum thresholds for Step 1 scores. Overall, 30% invited applicants with previous Step 1 failures to interview. One-third of programs indicated that all applicants are considered regardless of their Step 1 score, while 17% of programs used a minimum of 200, 17% used 210, 13% used 220, and 1.5% used 230. Another 17% of programs declined to disclose a minimum threshold indicating that while filters are used, they will not share this information.

Conclusions: Sixty-five percent of EM programs filter by Step 1 score, higher than previously reported. One method to address over application to residency programs is to provide applicants with the information needed to assess their competitiveness. Efforts should be made to encourage the 17% of programs that do not currently disclose their minimum thresholds to do so. For applicants who have previously failed Step 1, they should be encouraged to target programs that have interviewed applicants with Step 1 Failures.

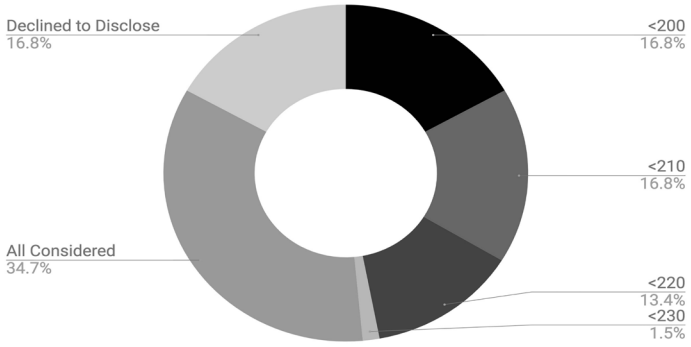

Figure 1. The use, disclosure, and distribution of minimum USMLE Step 1 score thresholds by emergency medicine residency programs for consideration of applicants.

Table 1. Consideration of applications who have previously failed USMLE Step 1 and use of minimum score thresholds by EM residency programs by accreditation type.

Step 1 Minimum Threshold	ACGME	AOA	Overall
Response Rate	*n = 189*	*n = 13*	*n = 202*
<200	33	1	34
<210	32	2	34
<220	25	2	27
<230	3	0	3
All Applicants Considered	66	4	70
Declined to Disclose	30	4	34
Consideration of Step 1 Failures	**ACGME**	**AOA**	**Overall**
Response Rate	*n = 207*	*n = 32*	*n = 239*
Yes	68	3	71
No	139	29	168

37 Utilizing Departmental Policy to Promote Faculty Evaluation of Residents

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Background: It is a requirement of Emergency Medicine (EM) residency training programs accredited by the Accreditation Council for Graduate Medical Education that faculty evaluate resident performance in a timely manner and document this evaluation. Residents are expected to incorporate this feedback into daily practice. Although feedback is essential for performance improvement, lack of receiving enough of it in a timely manner remains an issue among residents.

Objectives: We aimed to determine if implementation of a departmental policy requiring faculty to complete at least one electronic resident evaluation per shift would lead to an improvement in the number of evaluations per month. Faculty were advised that failure to comply would result in the loss of privilege to work with residents.

Methods: We conducted a pre- and post-intervention retrospective observational study at our institution. The participants were 28 full-time EM attendings who had been on staff for at least the past two consecutive years. We compared the number of evaluations per shift each faculty completed for nine months before and nine months after the new policy went into effect in February 2017. We compared the months of February to October 2016 and February to October 2017 to control for seasonal variability in evaluation completion. We then calculated the pre-intervention and post-intervention averages per faculty and calculated absolute and relative changes. Comparisons were made using a paired t-test.

Results: We found that every month after the policy was implemented had an increased average number of evaluations completed per attending. The pre-intervention average faculty evaluations per shift was 0.334 which increased to 1.216 post-intervention for an absolute increase of 0.882 ($p<0.01$). No faculty lost the privilege of working with residents.

Conclusions: Our results indicate that implementing a policy requiring faculty to complete a certain number of evaluations per shift with a potential punishment of the loss of privilege to work with residents can lead to a significant increase in the number of evaluations provided to residents. Important limitations of this study are the small sample size and the short duration of observation.

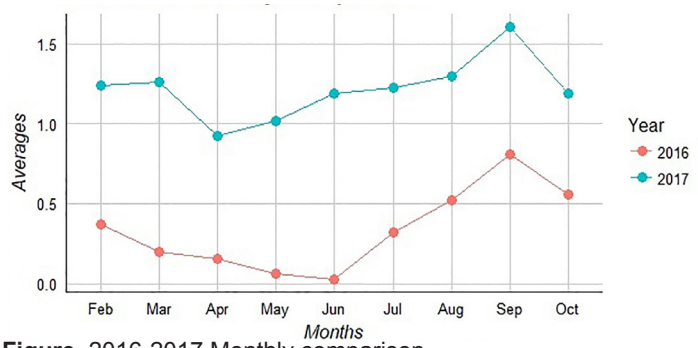

Figure. 2016-2017 Monthly comparison.

38 Validation of a Question Bank as Preparation for the Emergency Medicine In-Training Examination

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Background: The American Board of Emergency Medicine (ABEM) In-Training Examination (ITE) is designed to determine resident preparedness for ABEM certification. ABEM highlights the correlation between ITE and Qualifying Examination scores and this statement has been validated in the literature.3 Board review courses and clinical performance have not been shown to be effective predictors of ITE performance 1,4 while United States Medical Licensing Examination (USMLE) scores have demonstrated some correlation.5 There has not been consistency, however, as to which resource best prepares residents for the ITE. When surveyed, residents prefer question-based preparation over text-based resources.2 In our study we examined resident performance using a question bank to see if there was a measurable outcome on ITE performance.

Objectives: Our hypothesis was that improved performance using a question bank will lead to higher scores