36th Annual Meeting
April 24-27, 2013
Sheraton Denver Downtown
Denver, Colorado

SESSION D WORKSHOPS
Friday, April 26, 2013
3:00 –4:30 PM

WD01 Hand-Overs: Coaching Residents to Avoid the Fumble
WD02 Teaching and Using Patient-centered Interviewing: Improving Satisfaction, Efficiency and Effectiveness
WD03 Candid Conversations: Talking with Patients about Sexual Health
WD04 Oh Say Can You C: Training Generalists for Their Roles as Front Line Hepatitis C Screeners, Counselors, and Treaters in the New Era of Birth Cohort Screening
WD05 Overcoming Bias, Building Resilience
WD06 "RePlay Health": a serious game for understanding US health system dynamics and policy interventions
WD08 Enhance Your Negotiation Skills: Leadership Development for GIM
WD09 Teaching Professionalism in Social Media
WD10 Getting to Professor: Strategies for Promotion for Minority Faculty
WD11 Bringing it at the Bedside: Innovative strategies for Teaching the Physical Examination with Confidence
WD12 Managing Change and Redesigning Systems: Strategies to Identify, Prioritize and Sustain Innovative Practice
WD13 Innovative methods to adjust for confounding in observational studies
WD14 Assessing Resident Entrustable Professional Activities: The Patient Centered Medical Home as an Example
WD15 Teaching Cost-Conscious Patient Care

## WD01

**Hand-Overs: Coaching Residents to Avoid the Fumble**

**Online Registration Title:** Hand-Overs: Coaching Residents to Avoid the Fumble

**Coordinator: Deepa Bhatnagar, MD**, Department of Medicine, Tulane University
**Additional Faculty: Ryan Kraemer, MD**, University of Alabama, Birmingham; **Michael D. Landry, MD**, Tulane University; **Lisa L. Willett, MD**, University of Alabama, Birmingham

**Session Summary**

Dramatic increases in transfers of care are seen across training programs nationwide with duty hour restrictions. In this workshop, we review the current literature and offer practical strategies on hand-overs of care. Through a focus on patient safety, we work on "real world" skills to ensure effective communication between physicians.

**Measurable Learning Objectives**

- To provide strategies on both written and verbal hand-overs to improve transitions of care during shift change
- To review the need for efficient and effective transfers of care to promote patient safety
- To recognize how transfers of care fail
- To provide methods for peer evaluation and feedback on hand-offs

**Session Agenda:**

1. Introduction – PowerPoint (5 mins)
    a. Frequency of hand-offs in residency programs
    b. Importance of hand-offs to avoid compromising patient safety
2. Discuss where errors are made in transfers of care through large group discussion (20 mins)
    a. Share stories of when you received a bad hand-off or sign-out --- what did you wish you knew
    b. List stories
    c. Categorize the errors into failures in communication processes and content omissions
3. Learn components of effective written sign-out (30 mins)
    a. PowerPoint to review key components
    b. Small group exercise – 1 moderator and 4-5 residents per group – up to 4 groups

c. Two activities

i. Extract information into written sign-out template from sample patient clinical scenario with 4 different patients

ii. Evaluate written sign-out to identify errors

iii Compare the patient clinical scenario to the sample written sign-out

d. Large group wrap-up: Each moderator can share one unique characteristic the group may have come up with

4. Review components of effective verbal hand-off (30 mins)

a. PowerPoint to review key components and frequently used verbal evaluation tools

b. Role plays – skits of sample check outs (bad and good samples)

c. After each role-play – large group discussion: If this were a hand-off you observed, how would you provide feedback? What components were addressed or not addressed?

5. Wrap-up and evaluations (5 mins)

## WD02

**Teaching and Using Patient-centered Interviewing: Improving Satisfaction, Efficiency and Effectiveness**

**Category**: *Clinical Decision-Making and Economic Analyses*

**Online Registration Title:** Teaching and Using Patient-centered Interviewing

**Coordinator: Auguste H. Fortin, MD, MPH**, Department of Medicine, Yale School of Medicine

**Additional Faculty: Francesca C. Dwamena, MD, MS**, Michigan State University; **Richard M. Frankel, PhD**, Indiana University; **Stephen Holt, MD, MS**, Yale School of Medicine; **Robert C. Smith, MD, MS**, Michigan State University

**Session Summary**

Because of a lack of emphasis in all levels of medical education, many general internists have not mastered the powerful skills of patient-centered interviewing. In this interactive and skill-based workshop we will briefly review the rationale and evidence for patient-centered interviewing and present a 5-step, evidence-based method that has been shown in RCTs to be easily learned, efficient and effective in improving patients' health status and satisfaction. Participants, in small groups, will each be able to practice the method in role-play with a colleague and receive expert coaching. How to teach patient-centered interviewing at the UME and GME level will also be discussed.

**Measurable Learning Objectives:**

- Describe a 5-step method for patient-centered interviewing
- Practice the method in a mentored role play
- Experience teaching strategies for patient-centered interviewing

**Session Agenda:**

0-5 introductions, learning goals
5-15 presentation of the rationale and evidence for patient-centered interviewing
15-35 presentation and demonstration of the 5-step model
35-45 Q and A
45-90 break into small groups for mentored practice of model using role-play.

## WD03

**Candid Conversations: Talking with Patients about Sexual Health**

**Submitted in Conjunction with**: Institute of Healthcare Communication

**Online Registration Title:** Candid Conversations: Talking with Patients about Sexual Health

**Coordinator: Shakaib U. Rehman, MD,** Professor of Medicine, Medical University of South Carolina/RHJ VAMC

**Additional Faculty: William T. Branch, MD,** Emory University; **Monica Broome, MD**, University of Miami; **Dennis W. Cope, MD, FACP**, UCLA San Fernando Valley Program; **Elizabeth Kachur, PhD**, Medical Education Development

**Session Summary**

Sexual health is an important part of our patient's overall health and is an included topic in our healthcare interviewing format. However, health care practitioners consistently underestimate the prevalence and importance of their patients' sexual concerns. Few providers incorporate questions about patients' sexual health as part of routine histories. This may be due to discomfort based on embarrassment or lack of preparation, time constraints or a belief that sexual history is not relevant to the patient's chief complaint. Incorporating a sexual history promotes a more comprehensive picture of patients' physical and emotional health and well-being, informs appropriate discussion about risk management and

builds trust. In this workshop we will explore underlying barriers to the communication of this topic, and offer tools to increase ones comfort and confidence when discussing sexual concerns with their patients. The workshop will provide learners with specific communication skills and enhanced confidence to elicit meaningful sexual histories from patients. More than 80 percent of the workshop is devoted to experiential learning via large and small group exercises. In this supportive and non-judgmental setting, learners practice specific communication techniques and taking a sexual history. Didactic presentations and video patient cases supplement the experiential learning techniques. Workshop will help health care professionals to have candid, consistent, and nonjudgmental conversations with their patients about sexual issues.

Measurable Learning Objectives:

- Identify three evidenced-supported reasons for the importance of proactively and routinely talking with patients about their sexual health
- Describe the four phases of the Ex-PLISSIT practice model
- Describe at least three distinct communication tools for discussing sexual health issues with patients
- Demonstrate the ability to apply the ASK-TELL-ASK model of providing patient education and assessing comprehension
- Demonstrate increased confidence in discussing the sexual health needs of patients

Session Agenda: Introduction.

- Needs assessment: Trigger tapes will be shown to the whole group to stimulate the discussion followed by large group interactive session using faculty role play and flip charts to identify barriers of communication of sexual issues.
- Key concepts, available models and techniques from literature, Ex-PLISSIT communication tool - Power Point Presentation.
- Experiential practice small group breakout session:
- Participants will break out into “helping trios” and practice taking a sexual history on each other/switch, observer will be utilized for added feedback/discussion. Participants will devise the strategies using simulated situations or case studies. We will provide 3-4 short scenarios of common sexual problems or participants will use their own case studies. Role play, simulation and behavioral rehearsal will be used to strengthen participants' skills and small-group format will encourage active participation. Workshop participants will complete several exercises to enhance their skills in utilizing “Ask-Tell-Ask” and “Ex-PLISSIT” communication
- Large Group session-Reflection/Feedback/Q&A: Each small group will have the option of either reporting outcomes of learning or demonstrating in a role-play what they have learned or a combination. Participants will discuss/debrief what went well, what is still difficult etc.
- Participants will write down what would they do differently when they go back. Faculty will assist in the assessment of readiness to bring back skills and teaching to home institutions.
- Evaluation

## WD04

**Oh Say Can You C: Training Generalists for Their Roles as Front Line Hepatitis C Screeners, Counselors, and Treaters in the New Era of Birth Cohort Screening**

**Online Registration Title:** Internist-Driven HCV Care

**Coordinator: Jeffrey J. Weiss, PhD, MS,** Mount Sinai School of Medicine

**Additional Faculty: Shelly-Ann Fluker, MD**, Emory University School of Medicine; **Katherine Krauskopf, MD, MPH**, Mount Sinai School of Medicine; **Alain H. Litwin, MD, MPH, MS**, Albert Einstein College of Medicine; **Lesley Miller, MD**, Emory University School of Medicine; **Judith Tsui, MD MPH**, Boston University

**Small Group Discussion Leaders: Donald Gardenier, DNP**, Mount Sinai School of Medicine; **Kristina L. Lundberg, MD**, Emory University School of Medicine; **Keith M. Sigel, MD, MPH**, Mount Sinai School of Medicine

**Session Summary**

Chronic hepatitis C virus (HCV) infection and its sequelae (cirrhosis, liver cancer, liver transplantation) pose a major challenge to our healthcare system and to primary care patients. Up to 3.9 million persons in the United States are chronically infected with HCV, making it the most common chronic blood borne infection in the United States. Chronic HCV infection has become a health crisis as the HCV-infected population ages. Deaths from HCV have already surpassed those from HIV and rates of HCV-related death are not estimated to peak until 2030. Adding to the crisis, 45 – 85% of persons infected are unaware of their infection. Patients born in 1945 – 1965 account for 75% of all HCV infection in the

United States and the CDC recently augmented its previous risk factor based screening guideline and now recommends that all patients born in 1945 – 1965 have one time screening for hepatitis C.

Generalists should be on the front line of this new hepatitis C screening initiative and need to be prepared to have discussions with their patients about screening for chronic hepatitis C, understand how to handle the results of their screening tests, and counsel those patients who test positive about the implications of their diagnosis and the treatment options available to them.

Two new antiviral agents for chronic HCV infection were FDA-approved in May 2011, ushering in a new treatment paradigm. These treatments have increased complexity and side effects, but improved cure rates approaching 80% (from prior rates of about 50%). With improvements in diagnosis and treatment for chronic HCV, the demand for HCV treatment will outpace the supply of HCV providers. New models for HCV care are being explored, many with an expanded role for generalists. The changing climate of medical care delivery, re-focusing on primary care and medical home models, makes general internists well-suited to screen for chronic HCV and, in some instances, directly manage hepatitis C treatment while continuing to care for their patients' primary care needs and provide substance use treatment.

In this workshop we will:
1) Review the epidemiology of chronic HCV and disease sequelae
2) Review the screening guidelines for hepatitis C with a focus on the rationale for the new CDC birth cohort screening guideline
3) Discuss screening and diagnostic tests for chronic hepatitis C
4) Review current standard of care for treatment of chronic hepatitis C and the side effects and medication interactions of these therapies
5) Highlight four innovative generalist run HCV treatment programs to demonstrate how generalists can move beyond screening and diagnosis to comprehensive care for patients with chronic hepatitis C.

Measurable Learning Objectives:
At the conclusion of this workshop, participants will:

1. Be familiar with basic epidemiology of, risk factors for, and sequelae of chronic HCV in the United States
2. Be familiar with the current CDC screening guidelines for HCV and be comfortable discussing screening for HCV with their patients, particularly those in 1945 – 1965 birth cohort
3. Be comfortable with appropriate testing for screening and diagnosis of chronic HCV and discussing these results and implications of a positive test with their patients
4. Understand ways in which hepatitis C treatment can be integrated into primary care and substance use treatment settings and be provided by general internists

Session Agenda:
I. Overview of the epidemiology of chronic HCV, disease sequelae and unmet treatment needs (15 Minutes)
    a. Risk factors/prevalence in general and vulnerable populations
    b. Details of disease course and burden to patient and liver disease progression
    c. Current screening recommendations, statistics about undiagnosed patients and new screening paradigm
II. Overview of new chronic HCV treatment strategies (10 minutes)
    a. Broad overview
    b. Emphasis on improved outcomes, increased complexity of treatment, and adherence challenges including a summary of common treatment side effects and medication interactions
III. Challenges of engaging HCV-infected patients in care (5 minutes)
    a. Review of traditional models of HCV management and why they may no longer be adequate
    b. Profile of complex comorbid medical, psychiatric and conditions
    c. Linking to (specialty) care
    d. Potential growing patient population (not due to incident infection but to incident diagnoses and potential for more patients presenting for care in light of new medications)
IV. Individual Sites: practical models of HCV care in response to patient needs (20 minutes)
Each site will present their model of care for HCV-infected patients. Key points will include:

- How the clinic fits into the framework of patient needs and primary care/substance use treatment

- Who they treat
- How patients are referred to their care
- How patients are determined to be "treatment-ready"
- How patients are supported on treatment (Focus on clinic structure, services and related educational elements for patients and trainees)
- Business model for supporting and running the clinics (funding, staffing, administrative buy-in, etc.)

V. Small Groups (25 minutes)

Small groups will review cases taken from our patient practices that will highlight:

a. Appropriate screening tests and interpretation of screening test results
b. Diagnostic testing for patients with positive screening test and interpretation of results of diagnostic testing
c. Counseling of patients who test positive for chronic hepatitis C
d. Side effects and medication interactions of hepatitis C therapies

VI. Discussion, Q&A, & Workshop Evaluation (15 Minutes)

a. Questions
b. Summarize the key points of the workshop and provide general HCV screening and treatment resources for internists.
c. Workshop evaluation

## WD05

**Overcoming Bias, Building Resilience**

**Submitted in Conjunction with**: SGIM Disparities Task Force

**Online Registration Title:** Overcoming Bias, Building Resilience

**Coordinator: Karen R. Horowitz, MD**, Department of Medicine, Louis Stokes Cleveland VAMC, Case Western Reserve University School of Medicine

**Additional Faculty: Tracie Collins, MD, MPH**, John H. Stroger Jr. Hospital of Cook County, Rush Medical College; **Benjamin Mba, MD**, University of Kansas School of Medicine; **Monica E. Peek, MD, MPH**, University of Chicago School of Medicine; **Robert Saqueton, MD**, Advocate Illinois Masonic Medical Center

**Session Summary**

Elimination of unintentional (implicit) bias in healthcare has been identified as an important target for improving health disparities. In this workshop, we will present an agenda for developing an awareness of one's own implicit biases as well as a format for departments of medicine to act as change leaders in affirming egalitarian goals, identifying and confronting moral challenges with regard to implicit bias and stimulate cultural change within their institutions. Participants will be asked to perform an independent personal assessment of bias using a validated screening tool prior to the workshop.

The workshop will begin with discussion of the personal assessment. This will be followed by a didactic session focused on implicit bias, moral distress and the impact of each on the delivery of healthcare. Video case presentations will utilize the Schwartz Rounds model to illustrate an interactive format for confronting bias and moral distress in a clinical conference setting. Participants will be asked to reflect on critical incidents in their own clinical practice which triggered moral distress or were potentially related to implicit bias in the clinical encounter. Strategies to deal with implicit bias and moral distress will be shared with the group.

**Measurable Learning Objectives**

- To raise awareness of an individual's subconscious bias in interpersonal interactions
- To enhance leadership in GIM by modeling an educational tool to address bias in clinical interactions
- To stimulate reflection and problem solving with regard to bias in the medical encounter
- To explore the relationship between moral distress and implicit bias in clinical encounters.

**Session Agenda**

1. Self assessment exercise (15 min)
2. Didactic presentation (includes slides and video clips) (30 min)
3. Small group interaction and discussion (15 min)
4. Small group reports/ debriefing (20 min)
5. Conclusion, lessons learned, references/ information (10min)

**WD06**

**"RePlay Health": A Serious Game for Understanding US Health System Dynamics and Policy Interventions**

**Online Registration Title:** "Thrive": a serious game for US health system reform

**Coordinator: Patrick T. Lee, MD**, Director, Global Primary Care Program, Department of Medicine, Massachusetts General Hospital

**Additional Faculty: Mary Flanagan, PhD**, Dartmouth Tiltfactor Game Research Lab; **Bobby Milstein, PhD, MPH,** Fannie E. Rippel Foundation; **Max Seidman**, Dartmouth Center for Health Care Delivery Science

**Session Summary**

Complicated health policy concepts are often difficult to communicate. As a result, ideas tend to circulate among a limited group of cognoscenti, even as vital concepts fail to disseminate to the broader health care community and the general public. This challenge becomes even more acute when mainstream media and political pundits tend to dominate the conversation.

We approached the above challenge by building a serious game that embeds key lessons from a validated regional health policy model into a fun, easy-to-learn, and time-efficient game.

The proposed workshop may be a 'first' for SGIM.

Participants will play a game called, "Thrive," which models key aspects of the US health system from the perspective of ordinary people. "Thrive" puts players in the driver's seat for decisions that affect their own health and the broader health system. Players' choices alter system dynamics in ways that reveal deep-seated problems in the status quo as well as promising avenues for regional interventions and policy reform. Players from different stakeholder groups experience how their choices impact one another and the health system, raising questions about stewardship and governance.

The central player experience of negotiating personal and system-level tradeoffs is the game's main teaching tool. All of the key lessons derive from the interface of this player experience and the game mechanics — a fundamentally different proposition than the usual competencies, learning objectives, pedagogy, and evaluation model of curriculum design.

In "Thrive," players must decide how to allocate their time between the main activity (scoring points by tossing beanbags accurately) and the need to manage their worsening health status (which makes the beanbag toss harder and reduces their overall score). The latter endeavor takes them away from the main activity for a period of time and exposes them to the inefficiencies and potential harms of primary, specialty, and emergency care.

Between rounds, players get together and strategize ways to overcome problems they encountered as a group, effectively making new rules for the following round. The range of policy interventions modeled in "Thrive" includes payment reform, coordinating care, introducing community health workers, and targeting social determinants such as smoking or exercise. Winning strategies and scores are comparable across groups nationally and through an online community, enabling cross-group learning and discussion of promising policy innovations.

"Thrive" is the result of a novel collaboration between the Dartmouth Center for Health Care Delivery Science, Rippel Foundation's ReThink Health Network, and Dartmouth's Tiltfactor game research lab. It seeks an accessible, learner-driven approach to teaching the central lessons of the ReThink Health model, an evidence-based health policy tool that simulates the impact of combinations of policy interventions on health outcomes and costs over time in several US populations.

Measurable Learning Objectives.:

1. By the end of the workshop, participants will be able to describe the rationale and methodology for deploying serious games to educate, advocate, and communicate key concepts in US health system reform
2. By the end of the workshop, participants will agree or strongly agree (on a 5-point Likert scale) that they feel prepared to facilitate "Thrive" gaming sessions at their home institutions
3. By the end of the workshop, participants will be able to discuss at least two implications of serious games and the game design process for innovating new models of health professional education.

Session Agenda:

| | |
|---|---|
| 5 minutes | Welcome and brief introductions (Dr. Patrick Lee) |
| 15 minutes | Lecture (Dr. Patrick Lee and Dr. Mary Flanagan): “Rationale and methodology for serious games for US health system reform” |
| 40 minutes | Gameplay (Dr. Mary Flanagan and Max Seidman): “Thrive: modeling US health system dynamics and policy interventions in an hour” |
| 20 minutes | Group discussion (Moderators: Dr. Patrick Lee, Dr. Mary Flanagan, and Dr. Bobby Milstein): "What are the implications for educating, advocating, and communicating key concepts in US health system reform?" |
| 10 minutes | Closing remarks and feedback |

Summary

The workshop begins with a 15-minute lecture by Dr. Lee and Dr. Flanagan on: (i) the rationale for deploying serious games to educate, advocate, and communicate key concepts in US health reform; and (ii) a brief overview of the methodology behind designing these games.

Following the lecture, participants will play 4-5 rounds of “Thrive,” lasting approximately 40 minutes. They will be asked to both immerse themselves in the player experience, and ‘observe’ themselves and their colleagues from the perspective of a medical educator or health administrator who may wish to foster a deeper conversation around the key concepts articulated by “Thrive.” Max Seidman and 2 Tiltfactor game research lab interns will lead participants through the first example round and moderate subsequent rounds.

Stand-alone game instructions and all necessary materials for playing “Thrive” (except for bean bags, or bean bag equivalents) are available for download at: www.playTHRIVE.com.

Following the gameplay, Dr. Lee, Dr. Flanagan, and Dr. Milstein will facilitate a 20-minute group discussion, unpacking lessons learned from “Thrive” in two domains: (i) the implications for teaching usually opaque policy concepts to a general US audience, and (ii) the implications for innovating new models of health professional education.

Finally, Dr. Lee, Dr. Flanagan, and Dr. Milstein will wrap up with takeaway lessons in modeling health policy interventions, building serious games for health, and innovating new models of health professional education. Information about and links will also be provided to the underlying ReThink Health system dynamics model.

Participants will be asked to complete their SGIM session evaluation prior to the end of the workshop.

## WD08

**Enhance Your Negotiation Skills: Leadership Development for GIM**
**Submitted in Conjunction with**: ACLGIM
**Online Registration Title:** Enhance Your Negotiation Skills
**Coordinator: Deborah L. Burnet, MD, MA**, Department of Medicine, University of Chicago
**Additional Faculty: Tracie Collins, MD, MPH**, University of Kansas, Wichita; **Karen Kim**, The University of Chicago**; Jennifer Smith, MD**, Stroger-Cook County Hospital, Cook County Health & Hospitals System; **Monica Vela, MD**, The University of Chicago; **Lisa M. Vinci, MD, MS**, The University of Chicago
**Session Summary**

Academic physicians and researchers complete rigorous training in scientific and medical disciplines. However, we often lack formal training in negotiating and other management skills essential for developing and leading educational programs, academic or clinical units, and research programs. This workshop, offered in conjunction with the Association of Chiefs and Leaders in General Internal Medicine (ACLGIM) will introduce a framework and resources for enhancing negotiation skills in academic general internists and researchers. Workshop faculty will include successful leaders from several institutions, including division chiefs, a department chair, director of a large clinical operation, an associate dean for multicultural affairs, and a vice chair for women.

In an interactive format, presenters will engage participants in discussion of basic negotiation principles - What is negotiation? Where does it occur? What kind of preparation sets the stage for effective negotiation? How can I identify valuable options and strategies? What negotiation styles and skills are best for various situations? What steps make up a successful negotiation? How can I learn to negotiate better?

Participants will organize into small groups around interests such as clinical operations, education and training, academic administration, and research. Participants will use role play to practice negotiation strategies in their arena of interest, then work in pairs to develop a plan for negotiating around a particular issue in their own workplace setting. Examples will be shared with the larger group. A bibliography of resources will be provided, including description of various leadership development programs for physicians and researchers.

**Measurable Learning Objectives:**

- Recognize the value of negotiating; identify numerous opportunities to negotiate in your professional and your personal life
- Identify key elements of negotiating and understand settings in which certain elements are particularly useful
- Practice successful negotiation strategies using role-play format.
- Develop plan to implement a negotiation strategy in a current workplace situation.

**Session Agenda:**

| | |
|---|---|
| 10 minutes | Welcome and Intro |
| 20 minutes | Background, Key Elements of Negotiating |
| 30 minutes | Role play exercises (small groups) |
| 10 minutes | Develop plan for using Negotiating skills in a current workplace situation (pairs) |
| 20 minutes | Plenary debrief, wrap up, session evaluation |

## WD09

**Teaching Professionalism in Social Media**

**Online Registration Title:** Teaching Professionalism in Social Media

**Coordinator: Neil Mehta, MBBS, MS**, Cleveland Clinic Lerner College of Medicine of Case Western Reserve University
**Additional Faculty: J. H. Isaacson, MD**, Cleveland Clinic; **Frances J. Mao**, Cleveland Clinic

**Session Summary**

Social media (SM) holds tremendous potential for medical education and for personal learning. Unfortunately SM comes with a risk for professional misconduct which can severely damage a person's career and also hurt the image of the profession. Inappropriate use of SM can lead to inadvertent disclosure of a patient's protected health information. A number of medical students have used SM during school and college and need to relearn appropriate use of SM as they enter the medical profession.

Medical educators, unfamiliar with the nuances of various SM sites/tools like blogs, Twitter and Facebook find it difficult to relate to their students' use of these tools. They may thus not be able to guide them in appropriate use of SM or be comfortable discussing issues of professionalism in SM.

A number of professional organizations including the AMA have issued guidelines on professionalism in SM but like all guidelines need to be applied on a case-by-case basis. Medical educators need to be sufficiently familiar with the gray areas in these guidelines to help their students interpret these appropriately.
Participants will be able to experience first-hand a workshop that they can take back to their institutions and use with their own students.

The workshop will offer a brief overview of SM sites and tools and the AMA guidelines on professionalism in SM. Using real life case scenarios and guiding questions participants will work in small groups to discuss how to apply the AMA guidelines to each case. They will then present each group's consensus to the large group and debrief.

Participants will be provided a toolkit of real-life cases of unprofessional conduct and controversies in SM, guiding questions for small group discussions on each case and a copy of the AMA guidelines.
They will be able to conduct similar workshops at their own institution.

**Measurable Learning Objectives:**

- Review real life cases of unprofessional conduct on Social Media sites like Twitter, Facebook and Blogs
- Summarize the AMA guidelines on Professionalism in Social Media
- Discuss how to apply these guidelines to real life cases of Social Media controversies
- Experience a workshop that they can take back to their own institution to use with their trainees

**Session Agenda:**

| | |
|---|---|
| 0-5 | Introduction |
| 6-10 | Professionalism in Medicine |
| 11-15 | Overview of AMA guidelines on professionalism in social media |
| 16-25 | Summary of Real life cases of unprofessional conduct in Social Media - Audience response system to poll participants on these cases. |
| 26-55 | Small group discussion - each group with a different case and guiding questions |
| 56-65 | Report back to Large group |
| 66 -80 | Large group discussion and consensus development |
| 81-85 | Questions |
| 86-90 | Feedback/Evaluations |

## WD10

**Getting to Professor: Strategies for Promotion for Minority Faculty**

**Submitted in Conjunction with:** SGIM Disparities Task Force; SGIM Minorities in Medicine Interest Group

**Online Registration Title:** Getting to Professor: Strategies for Promotion for Minority Faculty

**Coordinator: Valerie E. Stone, MD, MPH**, Department of Medicine, Massachusetts General Hospital

**Additional Faculty: Lisa A. Cooper, MD, MPH**, Johns Hopkins; **Giselle Corbie-Smith, MD, MSc**, University of North Carolina, Chapel Hill; **William Cunningham, MD, MPH**, University of California, Los Angeles; **Alicia Fernandez, MD**, University of California, San Francisco; **Eliseo J. Perez-Stable, MD**, University of California, San Francisco**; Wally R. Smith, MD**, Virginia Commonwealth University; **Donna L. Washington, MD, MPH**, Greater Los Angeles VA Medical Center

**Session Summary**

Currently, under-represented minority (URM) faculty are 8% of all medical school faculty, but comprise only 1% of senior faculty at U.S. medical schools. Recent research has shown that even with similar levels of Federal grant funding and publications, URM faculty are less likely to be promoted to senior rank. While the personal experience for many URM faculty mirrors these data, an increasing number and percentage of URM faculty in general internal medicine have been promoted to full professor. These faculty are uniquely qualified to advise URM trainees, Instructors, Assistant Professors and Associate Professors about how they too can successfully "get to Professor."

The faculty of this workshop will be comprised of eight (8) URM senior faculty who are Full Professors at U.S. medical schools. These faculty will convey, through a structured program detailed below -- key information, experiences, perspectives and strategies needed to: 1) assist other minority faculty develop a plan to successfully and efficiently reach senior rank, and 2) support and assist faculty mentors and Division Chiefs who are advising minority faculty seeking to successfully navigate the promotion process.

**Measurable Learning Objectives:**

1. Attendees will develop a strategy for overcoming barriers to promotion as minority faculty and for successfully achieving promotion to senior rank
2. Attendees will develop a career strategy which is focused and easy to explain and enhances their likelihood of promotion at their own institution
3. Attendees will become familiar with the diversity of promotion criteria and leave with a determination to learn about those at their own institution and examine their progress to date by those criteria
4. Division Chiefs and other faculty mentors of URM trainees and junior faculty will gain insight and information regarding how best to support URM faculty in their academic endeavors and in their efforts to get promoted.

**Session Agenda:**

1. Overview and Background -- Workshop agenda and key issues.
   Dr. Stone (5 min)
2. Description of the Two Major Promotion Tracks -- Clinician-Educator and Clinician-Investigator
   a) Clinician-Investigator (Dr. Cooper 10 min)
   b) Clinician-Educator (Dr. Fernandez 10 min)
3. Comparing and Contrasting Promotion Tracks and Criteria at 2 medical schools: UCSF and Johns Hopkins
   (Drs. Perez-Stable and Dr. Cooper, 10 min)
4. Developing One's Career Plan and Vision
   a) Defining your research focus and methodology (Dr. Cunningham, 10 min)
   b) The challenge of choosing traditional methods vs. innovative approaches (Dr. Corbie-Smith, 10 min)
   c) The value and trade-offs of leadership roles (Dr. Smith, 10 min)
5. Key relationships: Mentors, Colleagues, Division Chief, and national network
   (Drs. Washington and Stone, 15 min)
6. Discussion / Questions & Answers (10 min)

## WD11

**Bringing It at the Bedside: Innovative Strategies for Teaching the Physical Examination with Confidence**
**Category**: *Organization of Care and Chronic Disease Management*
**Online Registration Title:** Innovative Strategies for Teaching the Bedside Physical
**Coordinator: Lisa B. Bernstein, MD**, Associate Professor of Medicine, Department of Medicine, Emory University
**Additional Faculty: Kimberly D. Manning, MD**, Emory University

**Session Summary**

For Academic Generalists, a premium is increasingly being placed on going back to the bedside, especially as the most effective method of teaching physical examination skills to our medical students and residents. Not only should we be able to teach these skills, but increasingly we are being called on to directly assess them for learners at all levels. The LCME already requires teaching faculty to provide direct observation of competency in the area of clinical skills for all medical students. These learners must then demonstrate proficiency prior to entering residency training by successful completion of the USMLE Clinical Skills Examination. At the graduate medical education level, the ACGME milestones project of competency development and Next Accreditation System will accredit medical residency programs based on national benchmarks for resident physician competence in clinical skills. As leaders in medical education, it falls to us to be prepared to meet this challenge, both through continuing faculty development and innovative curricula. However, Academic Generalists often shy away from teaching or assessment of skills at the bedside because they lack confidence in their own physical examination skills or their ability to teach these skills efficiently and effectively in a time-constrained environment.

While many resources suggest that preparation is a key element to improving clinical examination teaching skills, few give clear directions in how this should be done. The goal of our workshop is to give participants a toolkit for use in teaching physical examination skills at the bedside which will translate into their increased confidence and competence in teaching and assessing these skills in our academic medical centers. We will briefly discuss the importance placed by the LCME and ACGME accrediting bodies on teaching and assessment of the elements of the physical examination in the patient care setting. We will then brainstorm with participants about common barriers to providing bedside instruction in these skills and the drawbacks of physical examination traditional instruction. We will propose adapting this innovative strategy of adapting teaching scripts to teaching the physical exam at the bedside. We will discuss the benefits of advanced preparation and that by employing these simple tools, instructors can build their own toolkit of discrete physical examination teaching experiences that they can master and reuse for learners at all levels.

Also during the workshop we will demonstrate teaching scripts we have developed in action. We will then break out into small groups so that participants can work with each other on developing a sample teaching script that they can adapt to their own academic environment. A few participants will then demonstrate the teaching scripts they have developed and the workshop leaders and other participants will provide constructive feedback and discussion.

**Measurable Learning Objectives:**

1) Discuss the importance of and barriers to effective bedside teaching for Academic Generalists

2) Identify elements of a successful physical examination teaching script
3) Create an effective teaching script as a means of promoting professional development by increasing confidence in teaching the physical examination at the bedside

**Session Agenda:**

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| 5 minutes | Intro of Session Leaders |
| 5 minutes | Brief Presentation on the importance of bedside teaching (ACGME Milestones, NAS, LCME, USMLE-CS) emphasized at undergrad and graduate medical education levels |
| 10 minutes | Interactive discussion on common barriers to bedside teaching of the PE |
| 15 minutes | Description of benefits and elements of developing a toolkit of teaching scripts in teaching physical exam skills |
| 10 minutes | Demonstration of teaching scripts in action (session leaders) |
| 10 minutes | Breakout session: Participants develop teaching script in small groups |
| 20 minutes | Demonstration of teaching scripts by participants with feedback and discussion |
| 10 minutes | Q&A and Evaluations |

## WD12

**Managing Change and Redesigning Systems: Strategies to Identify, Prioritize and Sustain Innovative Practice**
**Online Registration Title:** Managing Change and Redesigning Systems
**Coordinator: Bradley N. Doebbeling, MD, MSc, FACP**, VA HSR&D Center on Implementing Evidence-based Practice, Indianapolis VAMC
**Additional Faculty: Steven Asch, MD, MPH**, Stanford School of Medicine; **Blair W. Fosburgh, MD**, Harvard School of Medicine; **Margaret Plews-Ogan, MD**, University of Virginia Health System

**Session Summary**

The aim of this workshop is to discuss and practice methods which can be used to identify, prioritize and manage change in health care organizations, with a focus on improving access. Many organizations have utilized a stepwise approach to transformation to the Patient Centered Medical Home provided by organizations/products such as TransforMed, ACP Medical Home Builder, and the Safety Net Medical Home Initiative to facilitate change. Academic medical centers face the added challenge of implementing change in practices with many part-time providers, including trainees. We will highlight the challenges that one practice in the Academic Innovations Collaborative has faced and the approaches used to overcome these challenges.

One method of identifying the most important issues to address is rapid ethnography. Rapid ethnographic assessment has the ability to provide a rapid, broad overview of a community or sub-culture and by its ability to generate insights which inform or modify program design or delivery. Participants will be introduced to key informant interview methods and analysis, discussing how the results can be used to identify and focus redesign efforts.

Another challenge is engaging providers and staff. We will also describe the method of the Positive Deviance (PD) model from complexity science, which seeks innovative, successful practices of individuals currently working in the healthcare system. PD has demonstrated its efficacy in solving health-related problems in multiple countries around the world. PD is a bottom-up improvement approach that focuses specifically on utilizing a typically untapped resource--frontline staff. The PD philosophy is that the people doing the work are the experts and that in every organization there are certain individuals or groups (‘Positive Deviants’) whose behaviors or practices enable them to find better solutions to prevalent, seemingly intractable problems. Thus, the PD approach is to discover these individuals and engage them in identifying solutions to existing barriers, improving processes, and sustaining change. We will describe approaches to using PD and examples of what we have learned about leading them.

Workshop attendees will participate in break-out sessions, where they will work in dyads and have the opportunity to practice skills. We will focus on improving access to care in clinics, "walking through" a positive deviance approach, moving through discovery to design, and establishing data sets, generating ideas about how to share the data along the way, giving them an experience in ways to "amplify" the positive deviant. The small groups will be simulated as though teams in a given clinic, and will work on different aspects of the problem they choose. The groups will each report out their experiences in the small groups, which will give them experience in all phases.

**Measurable Learning Objectives:**

Learn methods for identifying and prioritizing important performance issues to focus upon
Learn strategies for engaging colleagues and staff in initiating, managing and sustaining change
Practice skills in identifying solutions from within your organization that foster and sustain organizational change.

**Session Agenda**

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| 2 minutes | Outline of the Workshop |
| 3 minutes | Introduction |
| 10 minutes | Review of the Literature Regarding Change Management and Redesign |
| 15 minutes | Identifying the Problem and Prioritizing Change Efforts |
| 10 minutes | Change Management Strategies |
| 10 minutes | Positive Deviance Summary |
| 5 minutes | Questions and Answers |
| 20 minutes | Small Group Exercise |
| 15 minutes | Report Back Discussion, Question and Answer |

## WD13

**Innovative Methods to Adjust for Confounding in Observational Studies**
**Submitted in Conjunction wit**h: SGIM Research Committee
**Online Registration Title:** Methods to adjust for confounding in observational studies
**Coordinator: Eric Mortensen, MD**, VA North Texas Health Care System
**Additional Faculty: Guoqing Chen, PhD, MD**, Michael E. DeBakey VA Medical Center; **Arthur Westover, MD, MSCS**, University of Texas Southwestern Medical Center
**Session Summary**:
This session will discuss three different methods to deal with potential confounders in observational studies with a focus on the proper application and limitation of each method. The session will include 2 frequently used, but frequently misapplied methods, propensity scores and instrumental variables. We will focus on proper application and limitations of these methodologies. In addition we will give examples of how to perform basic analyses using these methodologies using common statistical packages such as STATA and/or SPSS. W\e will also discuss additional resources for those who wish to learn more about these methodologies. Finally we will provide a short description of a new statistical technique to deal with potential confounding- robust latent variable models. This technique uses an exhaustive model space search of both instruments and covariates which includes high-order interactions, excludes misspecified models, and handles model uncertainty by selecting fitted models to inform final estimates. Missing data are not handled by imputation, but rather by parameter estimates that are based on summing over the likelihoods of “all possible realizations” of the missing component. We will provide sources for additional information on this technique
**Measurable Learning Objectives:**

- Know the potential advantages and limitations of propensity scores
- Know the potential advantages and limitations of instrumental variables
- Know the basic commands for how to perform propensity scores and instrumental variables in a common statistical package.
- Describe the potential advantages and limitations of robust latent variable modeling.

**Session Agenda:**
Introduction to session- 2-5 minutes
Propensity scores- 25 minutes
Instrumental variables- 30 minutes
Robust latent variable models- 20 minutes
Closing questions- 10 minutes

## WD14

**Assessing Resident Entrustable Professional Activities: The Patient Centered Medical Home as an Example**
**Online Registration Title:** Assessing Resident EPAs: The PCMH as an Example
**Coordinator: Anna Chang, MD**, University of California San Francisco
**Additional Faculty: Judith Bowen, MD**, Oregon Health & Science University; **Kelly Caverzagie, MD**, University of Nebraska Medical Center; **Shobhina G. Chheda, MD, MPH, FACP**, University of Wisconsin School of Medicine and Public Health; **Michael Green, MD, MSc**, Yale University School of Medicine; **Michael J. Rosenblum, MD**, Baystate Medical Center
**Small Group Discussion Leaders: Elizabeth Eckstrom, MD, MPH**, Oregon Health & Science University; **Richard M. Frankel, PhD**, Indiana University School of Medicine

**Session Summary**

Background:

The Next Accreditation System (NAS) has led to simultaneous efforts in the definition of entrustable professional activities (EPAs) for internal medicine residents. One recent example is the list of EPAs for the patient centered medical home (PCMH). How will we assess residents for their ability to perform these essential clinical tasks prior to independent practice? How do these EPA frameworks fit into each other, and into the NAS?

Purpose:

Accurate and efficient assessment of our learners with respect to EPA's will require collaboration not only between institutions but also among clinician educators with varying perspectives. This workshop is a forum for internal medicine residency program leaders and teachers from the hospital and ambulatory care settings to actively participate in designing assessment strategies to address the entrustable professional activities that are being defined. Thought leaders in this area guide the discussions on creative, practical, and effective assessments for EPAs for implementation at participants' home institutions. Participants will also explore potential collaborations to further understand assessment of EPA's.

Session Outline:

The workshop begins with an introduction to the PCMH EPAs (pending publication in upcoming weeks), as well as a brief update on the status of the AAIM end-of-training EPAs and the NAS. Workshop faculty then lead small group discussions, with participants at each small group table focusing on one EPA and responding to several relevant questions: What are practical assessment strategies? What are challenges? What are best practices? How do we move to implementation? Are there cross-institution collaboration opportunities? The session participants then gather again to share innovative assessment strategies from their small group discussions. The session concludes with summary and reflective comments from faculty and participants.

**Measurable Learning Objectives:**

- Identify the lists of internal medicine resident end-of-training EPAs and the patient centered medical home EPAs
- List one feasible and effective assessment strategy for each of the selected PCMH EPAs
- Discuss challenges and opportunities for implementation of assessment strategies for EPAs in the context of the Next Accreditation System

**Session Agenda:**

Large Group A (5 minutes): Introduction to workshop (Chang)
Large Group B (10 minutes): Entrustable Professional Activities – PCMH, End-Of-Training, and the Next Accreditation System (Bowen and Caverzagie)
Small Groups (45 minutes): Choose an EPA – How to assess? How to fit into Accreditation? (Chang, Bowen, Caverzagie, Chheda, Eckstrom, Frankel, Green, Rosenblum)
Large Group C (20 minutes): Small group share innovative assessment strategies. (Chheda, Green, Rosenblum)
Large Group D (5 minutes): Final Commentary and Wrap-Up (Bowen and Caverzagie)
Large Group E (5 minutes): Session Evaluation (Chang)

**WD15**

**Teaching Cost-Conscious Patient Care**

**Online Registration Title:** Teaching Cost-Conscious Patient Care

**Coordinator: Ryan Kraemer, MD**, Assistant Professor of Medicine, Director of General Internal Medicine, University of Alabama, Birmingham

**Additional Faculty: Deepa Bhatnagar, MD**, Tulane University; **Michael D. Landry, MD**, Tulane School of Medicine, Tulane University; **Brita Roy, MD, MPH, MS**, University of Alabama, Birmingham; **Benjamin Taylor**, University of Alabama, Birmingham

**Session summary:**

Health care costs are increasing unsustainably in the United States. Although there are numerous reasons for this increase, physicians play a very important role in determining the value and cost of care delivered to their patients. A substantial portion of precious health care resources are wasted each year on low value, high cost diagnostic testing, services, and treatments. Medical education has traditionally placed a higher emphasis on thorough diagnostic workup and completeness than on cost containment. Practice habits are formed during training and persist long into an individual's career.

In this workshop, we aim to increase participants' awareness of this critically important and often neglected area of medical education. We will discuss the reasons underlying low value care. We will familiarize the audience with the key components of a cost-conscious care curriculum as well as available resources for teaching cost-conscious care. Finally, we will demonstrate several different educational approaches to teach medical students, residents, and fellows cost-conscious care.

**Measurable Learning Objectives:**

- Become familiar with common reasons unnecessary tests and services are ordered by trainees
- Introduce the major components of a cost-conscious care curriculum
- Demonstrate several different methods for teaching cost-conscious care

**Session Agenda:**

Introduction: (10 min)

1. Review of current trends in health care spending in the United States
2. Review of various components of health care spending

Large group discussion (15 min)

1. Reasons behind wasteful health care spending
2. Reasons behind trainees ordering unnecessary tests and services

Didactic: (15 min)

1. Review of major components of a cost-conscious care curriculum
2. Keys to success in teaching cost-conscious care
3. Review available resources for teaching cost-conscious care

Cost-conscious Care Teaching Sessions: Attendees will participate in several different types of sessions used to teach cost-conscious care at our institutions (25 min)

1. Video Demonstrations
2. The Price Is Right game
3. Discharge Medication Selection Exercise

Small Group Activity: (20 min)

1. Discuss what participants have done at their home institutions to teach cost-conscious care
2. Discuss ideas for implementation of workshop sessions at each participant's home institution
3. Large group discussion

Wrap-up and evaluations (5 min)