

## EDITORIAL **Time to Care: The End of the Rushed Primary Care Visit**

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**D**o you often feel rushed through visits with your patients? Do you usually find yourself running late? While the average primary care office visit lasts less than 20 minutes, the number and complexity of clinical issues addressed has increased dramatically in recent years. A typical patient in an internal medicine practice will present with: one acute problem (e.g. low back pain), three or more chronic illnesses (e.g. diabetes, high blood pressure, and heart disease), and a myriad of opportunities for cancer screening and disease prevention. During your visits, you may find yourself focused on a computer screen, fingers tapping at the keyboard in a desperate attempt to record the growing mountain of information required to meet documentation requirements while struggling to locate important information in the increasingly complex electronic health record. You might not like this focus on the “electronic” patient or the rushed feeling of having too many boxes to check off someone else’s priority list. It turns out most doctors—and likely most patients—agree with you.

What are the consequences of being rushed? In an article published online in the *Journal of General Internal Medicine*, we describe these consequences and promote mechanisms to fix the system. During the rushed visit, physicians have insufficient time to consider whether certain tests really need to be ordered. We may postpone opportunities for preventive care, hoping there will be more time at the next visit. And

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# Health Policy Committee Annual Meeting Update: Goals for the Coming Year and Opportunities to Make a Difference

Thomas O. Staiger, MD

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**“In the middle of difficulty lies opportunity.”**  
—Albert Einstein

**A**t our annual meeting in Toronto, members of the Health Policy Committee (HPC), Subcommittees (Clinical Practice, Education, Research, and Outreach), and Interest Group engaged in a series of lively and inspiring conversations directed at identifying opportunities to influence health policy. We identified three major committee objectives: fair and equitable Medicare reimbursement policies, adequate funding for health professions training, and support for health services research.

## Alignment of HPC Objectives with SGIM’s Mission and National Health Priorities

We discussed the alignment of the HPC’s objectives and SGIM’s mission with the national health agenda of meeting the Triple Aim—improving the patient experience of care, improving the health of the population, and reducing the per capita cost of care. We noted that “the availability of primary care is positively and con-

sistently associated with improved outcomes, reduced mortality, lower utilization of health care resources, and lower overall costs of care,” which provides us an outstanding opportunity to advocate both for better care for our patients and for our objectives.<sup>1</sup>

We identified the following goals and areas of focus for the coming year:

1. To have the Centers for Medicare and Medicaid Services (CMS) accept a proposal that has been submitted by an SGIM-led coalition—and endorsed by 16 specialty societies as of June 2015—to redefine and reevaluate outpatient evaluation and management (E/M) service codes and to develop new documentation expectations for E/M services;
  2. To cultivate better partnerships and a broader coalition to support our objectives;
  3. To organize SGIM Hill Day in March 2016, increase attendance, and continue the HPC orientation and education program during the evening prior to visiting members’ offices;
  4. To develop a learning collaborative of teachers of health policy intended to share curricula, resources, learning objectives, evaluation tools, and other educational strategies (This collaborative is being led by the Outreach Subcommittee.);
  5. To submit health policy programming for the 2016 Annual Meeting, including a workshop
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## Who is SGIM? Focusing on Six Strategic Priorities

Marshall H. Chin, MD, MPH

...with several other medical societies having areas of overlap, it is important to define the areas in which we are “best in class” and work to deliver that value.



At the April 2015 annual meeting in Toronto, the SGIM Council and chairs of committees and task forces identified answering the question “Who is SGIM?” as a top priority. SGIM Council discussed this question extensively at its June 2015 retreat and further honed the strategic priorities I described in last month’s *Forum* column. I will review Council’s exploration of this question and explain Council’s updated six strategic priorities.

Council first tried to understand what the question “Who is SGIM?” means. Part of the question is literal: SGIM is doing many different things, and communication can improve members’ awareness of all these activities. Filling that knowledge gap about what SGIM is doing is part of the issue. However, Council thought that the question also posed a more fundamental inquiry into what SGIM should be.

SGIM is diverse. We are active in education, research, clinical care, management, and policy. We cover the gamut of women’s health, inpatient and outpatient medicine, health equity, geriatrics, quality of care, behavioral health, and countless other areas. While SGIM’s breadth may make it harder for us to define ourselves, Council felt strongly that diversity is one of our great strengths and that the range of areas we engage in should be reassuring rather than angst inducing to us.

Nonetheless, energy and resources are limited, and with sev-

eral other medical societies having areas of overlap, it is important to define the areas in which we are “best in class” and work to deliver that value. Council then considered if we could define ourselves more clearly. We started by looking at the 2012 and 1998 versions of SGIM’s mission statement. The first clarification is that, as expressed in the 1998 statement, our focus is academic general internists. Virtually all SGIM members take care of patients, and clinical care is the soul of our jobs. However, a number of other societies focus on providing services to non-academic practicing general internists. Our special focus is general internists and related colleagues who have some combination of teaching, research, scholarship, administration, and policy work as part of their jobs. Thus, a key mission of SGIM is to help provide resources and opportunities for members to grow in these different facets through training, networking, and opportunities to present and share work.

A key theme during the Council discussions was that SGIM must not be a static organization but instead must be a thought and change leader that advocates for patients, learners, the health of the population, and the innovation and policy that spur that change. We must push the field ahead. Our efforts are geared toward making things better by reshaping the academic health center so it does a bet-

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ter job delivering care to patients and populations, re-engineering workflow to improve provider satisfaction and sanity, developing the best ways to train learners, performing research to improve quality of care and health outcomes, partnering with the community to advance health equity, and informing the health policies that have the greatest impact on the nation’s health. SGIM as leader and change agent is a core concept. We need to create the future of general internal medicine for the next generation. We all want to make a difference in our careers and do work that innovates, improves care, and advances social justice.

In light of this fundamental discussion about “Who is SGIM?”,

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## A Medical Education Interest Group Among Internal Medicine Residents

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Many internal medicine (IM) trainees plan careers as clinician-educators and aim to develop as teachers during residency. Unfortunately, opportunities to gain experience and mentorship in the field during this busy time are often difficult to visualize and seize. To meet the needs of Massachusetts General Hospital (MGH) IM residents with interests in teaching and education, we founded the Residents Interested in Medical Education (RIME) group in January 2013. We believe that this resident-led group has had a positive impact on our residency program and that other IM programs without a designated medical education track could benefit from the organization of such a group.

The mission of RIME is to unite residents interested in medical education in order to develop their teaching skills, facilitate medical education research projects, support career planning, and promote positive curricular changes for the larger community of residents and medical students. The group includes residents from all three classes and is led by three upper-level residents. In addition to meeting roughly quarterly, the group communicates frequently over an e-mail listserv that includes more than 70 residents as well as interested faculty members and administrators.

In order to implement its aims in resident skills and career development, curriculum redesign, and educational research, RIME has assumed several core roles:

- *Advertising and facilitating access to available teaching activities.* We created a cloud-based, modifiable spreadsheet that lists each teaching activity across the residency program and medical school on a separate page. The leaders for each individual activity utilize the centralized spreadsheet for scheduling and generating group e-mail lists from which to solicit involvement in future sessions. Each page provides a description of the teaching role, relevant contact information, and an up-to-date schedule that identifies open slots and allows for enrollment on the same page. Teaching opportunities include intern simulation sessions, medical student case conferences, chalk talks at student-run clinics, and physical exam rounds.
- *Liaising with residency program and medical school clerkship leadership to create new roles for resident-teachers.* By advocating for residents' roles as educators, RIME has helped create new teaching opportunities such as resident-led case presentations at noon conference, one-on-one medical student coaching, and resident-authored case summary notes from daily case conferences.
- *Increasing resident participation in existing faculty development opportunities.* Many academic institutions have robust faculty development programs that include didactics and workshops in educational topics. Residents are often welcome to attend but remain unaware of these sessions. Increasing this awareness via an e-mail listserv or easily accessible posting location—such as the spreadsheet mentioned above—allows residents to take advantage of existing resources to improve teaching skills.
- *Creating and running a residents-as-teachers elective.* Given a high level of interest for intensive resident-as-teacher training in our program, we designed a two-week immersion elective that is offered twice each academic year. Each iteration has included 10 to 15 residents and more than 10 faculty members. In addition to training residents, the course also serves as a springboard for medical education research, as its methodologies are being studied and presented at conferences.
- *Helping to redesign residency curricula.* After gathering residents' feedback on the current residency didactic curriculum, group members met with program leadership and subspecialty core faculty members to improve existing content. Through these conversations, we designed new formats for didactic information delivery such as interactive small-group case-based noon conference sessions and hands-on physical exam "skills reports" instead of case-based sessions during resident conference.
- *Generating medical education research projects.* RIME group members developed several medical education research projects on subjects such as peer observation among residents, noon conference effectiveness, and debriefing training for simulation sessions.
- *Enhancing the medical student experience.* RIME members worked with clerkship directors and administrators to improve written logistical guides to ward services, conduct orientation sessions, and work with students individually on clinical skills and presentations.

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## Beyond “Good Job!”: Using EPAs to Improve Resident Feedback

John H. Choe, MD, MPH

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“Good job.” This was the extent of the feedback that I received from most of my attending preceptors and supervisors as an internal medicine resident in the late 1990s. If they were feeling especially expansive, I occasionally would get the suggestion, “Read more.” I was reminded of how unsatisfying this feedback was when I recently met with an intern to review her training progress. We were reading her evaluations from her attending physicians when she suddenly burst out, “Why can’t my attendings ever say anything more than ‘good job’!” Her frustration—and mine from more than 15 years ago as a resident myself—has nagged at me; why do we continue to repeat this phrase, which damns with such faint praise?

“Good job” does not give the learner anything to improve upon. Using education-speak, “good job” provides a summative assessment of the past performance of the learner rather than giving formative guidance for future improvement. It comes from a grading—not coaching—perspective. Even the best golfers in the world continue to work with swing coaches since there are always ways to improve their game. Why should learning the much-more-complicated practice of medicine be any different? We obviously need to help those residents who struggle, but the majority of residents who truly are doing a good job—and even those who are “superstars”—deserve the benefit of coaching for improvement.

“Good job” does not require much work from the supervising physician. To be fair, most of us have never received training on how best to deliver meaningful feedback. The phrase “good job” is familiar and non-threatening. And although we mean this to be reassuring, ultimately it feels dishonest to both the

trainee and the supervising physician—surely, not everything went perfectly during the rotation. Providing more constructive substance to trainee feedback requires us to more carefully listen and watch our residents, to identify their strengths and deficits, and to suggest the next steps for improvement; in short, providing meaningful coaching feedback is hard work and requires us to do more than deliver stock phrases.

Postgraduate medical education programs across different specialties have been working for close to two decades to shift to truly competency-based education. While most would agree that graduating residents based not on the number of years in training but instead on their ability to care for patients across the full spectrum of internal medicine clinical contexts is a worthwhile goal, our ability to provide feedback that helps residents attain this has not kept pace. Resident hour restrictions and associated work compression on the wards and in clinics has only made it more difficult to find those quiet moments to give meaningful and substantive feedback and intensifies the need for honest criticism when we finally do sit down with our residents.

For those of us who have struggled to find the right ways to give more meaningful feedback to our medicine residents, entrustable professional activities (EPAs) represent an opportunity to fill this void. EPAs were first described by Olle ten Cate as a way to operationalize the idea of competency-based assessment linked to the authentic real-world activities essential to the practice of each specialty.<sup>1-3</sup> Attending physicians already assess learners’ skills—often subconsciously integrating multiple dimensions of competence such as medical knowledge, patient care skills, communication, and professionalism—before entrusting trainees

to perform clinical activities without supervision. Residency training programs can take this a step further by identifying certain representative activities, or EPAs, for special attention from residents and supervising physicians.

The Education Redesign Committee of the Alliance for Academic Internal Medicine identified 16 of these EPAs from the perspective of a graduating medicine resident ready to enter unsupervised practice.<sup>4</sup> These end-of-training EPAs are easily recognizable as central to the practice of general internal medicine (Table 1) and can help training programs and residents alike as they consider what skills should be in place at the end of three years of training. Alternatively, EPAs can also be identified from the perspective of a trainee within a particular clinic or inpatient rotation. For example, at the University of Washington we have identified EPAs from the perspective of each core rotation and clinic experience (Table 2). Some of these rotation-specific EPAs (also called observable practice activities by other authors)<sup>5</sup> overlap with the end-of-training EPAs, but most are narrower in scope.

The EPAs provide discrete windows through which we can peek into the competence of our residents. Having a list of EPAs helps supervising physicians identify opportunities to directly observe residents in these pre-defined clinical activities. At the University of Washington, faculty members are encouraged to review this list of rotation-specific EPAs with their residents when attending on the wards or precepting in clinics. When the opportunity arises to watch a resident perform one (e.g. “Safely discharge a patient in a way that reduces his/her chances of readmission”), the attending physician is asked to

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## How to Conduct a Workshop: Nine Steps for the First-time Workshop Leader

Somnath Mookherjee, MD, and Daniel Cabrera, MD, MPH

*Dr. Mookherjee is assistant professor of medicine, and Dr. Cabrera is clinical instructor of medicine at the University of Washington.*

Leading a workshop is one of the highest-yield academic efforts that a faculty member can undertake: It can help build a regional reputation, generate opportunities for collaboration with colleagues, and establish an educational niche. Proposing and leading a workshop may seem like a daunting task in the face of competing commitments. This article provides specific steps to develop a successful workshop.

### Step 1: Consider the topic, target audience, and goal.

Our professional lives are replete with opportunities to improve our practice: clinical care, quality improvement, teaching, leadership, or any number of aspects of physicianship. Determine which of these topics synergize with your own goals and interests. It is not necessary to be an expert on the topic; you can always collaborate with content experts, and you will gain expertise as you develop the workshop. Consider the audience for your workshop, and clearly state the overall goal, such as: “To help clinician-educators improve quality improvement education for medical students on the wards,” “To improve the perioperative care of patients with pulmonary hypertension,” or “To increase the number

of workshops offered by faculty.” As you formulate these initial ideas, gather information specific to the venue you are considering (i.e. regional meeting, national meeting, or institutional faculty development). Also consider the length of the workshop, potential meeting themes, and the number of presenters permitted to be on the workshop team.

### Step 2: Make sure that people will be interested.

It is not necessary to perform a rigorous needs assessment for your workshop, but it is essential to have some evidence that the workshop is needed. This is true whether you are considering creating a workshop for a regional or national meeting or a faculty development workshop for your group or division. Potential sources of input to validate the importance of your project include endorsement of the idea by leadership (e.g. chair, division head), interest in the idea at a faculty meeting, and survey or focus group data showing a need for the topic to be addressed.

### Step 3: Create specific objectives.

The overall goal of the workshop (from Step 1) will most likely be reached if participants achieve spe-

cific well-designed objectives that enable them to reach the goal. To create good objectives, explicitly state the knowledge, skills, and attitudes that participants will attain as a result of attending the workshop. Table 1 summarizes three key tips for writing good objectives.

### Step 4: Make a workshop team.

As you invite partners, consider what needs you are seeking to fill. Do you need a content expert or someone with prior workshop experience? Keep in mind that the workshop process is also an opportunity to develop a relationship with a mentor or create a connection with faculty at a different institution. As with any project, it is important to delineate roles and expectations beforehand. Table 2 outlines specific components that are helpful to include when inviting a colleague to join your team.

### Step 5: Brainstorm strategies, and start creating the content.

Ask yourself: What is the best way for the participants to achieve the learning objectives? Effective workshops employ active learning strategies—this is really what makes a workshop a workshop rather than a

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**Table 1. Three Tips for Writing Good Workshop Objectives**

1. Make objectives relevant to the actual professional practices of participants.	2. If objectives are not practice oriented, make sure that they are anchored on demonstrable and measurable skills and behaviors.	3. Avoid common pitfalls.
<ul style="list-style-type: none"> <li>• “By the end of the workshop, participants will be able to treat decompensated heart failure.”</li> <li>• “By the end of the workshop, participants will be able to teach students how to estimate jugular venous pressure.”</li> </ul>	<ul style="list-style-type: none"> <li>• “By the end of the workshop, participants will be able to summarize the three key components of heart failure management.”</li> <li>• “By the end of the workshop, participants will be able to demonstrate how to estimate jugular venous pressure.”</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Don't be boring.</i> No one wants to attend a workshop to be able to “list” something at the end.</li> <li>• <i>Avoid non-action words</i> like “describe” or “discuss” as objectives.</li> <li>• Remember, objectives are not a description of what you or the participants will be doing during the workshop but rather what the participant <i>will be able to do</i> as a result of attending.</li> </ul>

## The Ideal Morning Report: Expectations of Foreign Medical Graduates

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The morning report is a fundamental educational feature of internal medicine residency training. Little is known about the expectations that international medical graduates (IMG) in US medicine residency programs have about morning report as compared to American medical graduates (AMGs). The American Medical Association estimates that foreign-born physicians constitute about 27% of the national physician workforce.<sup>1</sup> The majority complete residency training in the United States before engaging in independent practice. Although there is some literature on the content of morning reports, only two studies have sought to obtain residents' perspectives and expectations about the morning report experience. The first study surveyed 74 residents in a single university residency program<sup>2</sup> but did not report demographic information. The second study surveyed 356 residents from 13 residency programs across seven states.<sup>3</sup> Of the 356 respondents, 74% were AMGs, and just 24% were IMGs. To our knowledge, no published study has surveyed IMGs regarding their attitudes toward and expectations of morning reports in US training programs.

### Participants, Materials, and Methods

We surveyed 137 residents (i.e. PGY1, PGY2, PGY3) in the Internal Medicine Residency Program at the John H. Stroger Jr. Hospital of Cook County (formerly Cook County Hospital) between October 2013 and January 2014. The study met criteria for exemption by our institutional review board.

Participants completed a 57-item survey to assess residents' preferences and attitudes toward morning report using many of the same domains referenced in previous research.<sup>2,3</sup> The questions were framed to capture what the house officers would want their ideal morning report to look like. Morning report preferences were measured relative to purpose, audience and format, content of discussion, teaching with highest educational yield, and attributes of the moderator.

### Results

Of the 112 participants who responded (82% response rate), 77% were male; 92% (103/112) were IMGs. More than 70% (80/112) planned on specialty fellowship training, 21% (23/112) planned on a hospitalist career, and 8% (9/112) planned on a primary care career (Table 1). All respondents agreed or strongly agreed that the purpose of the morning report was to promote critical thinking, and 97% agreed it was to promote high-value care (Figure 1). Regarding the attributes of the moderator, the majority of respondents (86%) preferred that a general internist lead the morning report (Figure 2). A good fund of general medicine knowledge was considered an important attribute of a moderator by most respondents (77%), followed by the ability to generate thought-provoking questions (68%) and incorporate evidence-based medicine (EBM) (57%).

### Discussion

Morning report is a fundamental fixture in most internal medicine residency programs. Thomas et al. surveyed 124 departments of medi-

**Table 1. Characteristics of Respondents**

Characteristics	n=112	(%)
<b>Gender</b>		
Male	77	69
Female	35	31
<b>Age Group (years)</b>		
24-28	59	53
28-32	38	34
32-36	15	13
<b>Level of Training</b>		
PGY1	33	29
PGY2 or PGY3	79	71
<b>Medical School Training</b>		
US Graduates	9	8
Foreign Graduates	103	92
<b>Career Plans</b>		
Fellowship	80	71
Hospitalist	23	21
Primary Care	9	8

cine with a response rate of 94%.<sup>4</sup> A daily morning report occurred at 115 out of 117 US medical schools. The Accreditation Council for Graduate Medical Education (ACGME) does not prescribe a set format for morning reports, allowing morning report to serve different purposes in different institutions.

Our survey is unique in that it captures attitudes and preferences for the morning from a large number of IMGs. Respondents agreed

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(highest to lowest) that the purpose of morning report was to promote and evaluate critical thinking, promote high-value care, convey medical knowledge, assist in the management of complex cases, and improve camaraderie. In a study of a predominately AMG cohort, respondents agreed that the purpose of morning report was to convey medical knowledge, promote camaraderie, inspire clinical research, and evaluate house staff performance.<sup>2</sup> A stand-out feature of our survey was that 97% of respondents strongly agreed that the purpose of morning report was to teach high-

value care, which suggests that incorporating a high-value cost-conscious care (HVCCC) curriculum into the morning report will be viewed favorably. We found that the six goals of morning report identified by our respondents relate to key ACGME competencies:

1. Promoting critical thinking improves practice-based learning.
2. Promoting high-value care endorses systems-based practice.
3. Conveying medical knowledge builds medical knowledge.

4. Evaluating critical thinking fosters professionalism.
5. Assisting in the management of complex cases improves patient care.
6. Promoting camaraderie develops interpersonal communication skills.

Our study is limited in that it surveyed residents from a single training program. We do not presume that our findings are representative of all IMGs, and we are aware that the training environment and culture in each training pro-

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Figure 1. Purpose of the Morning Report

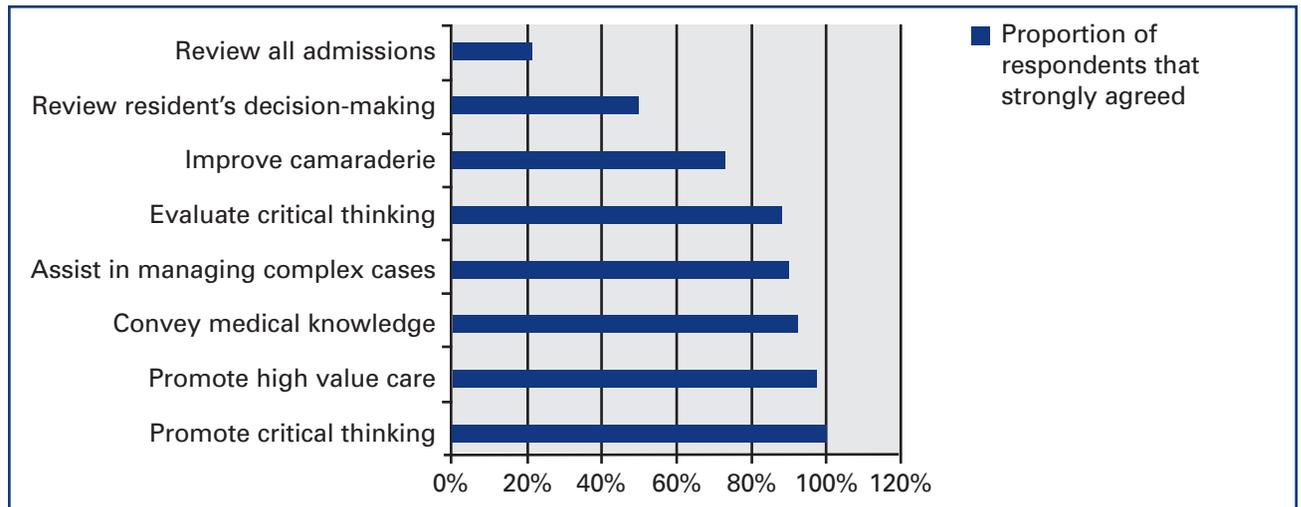
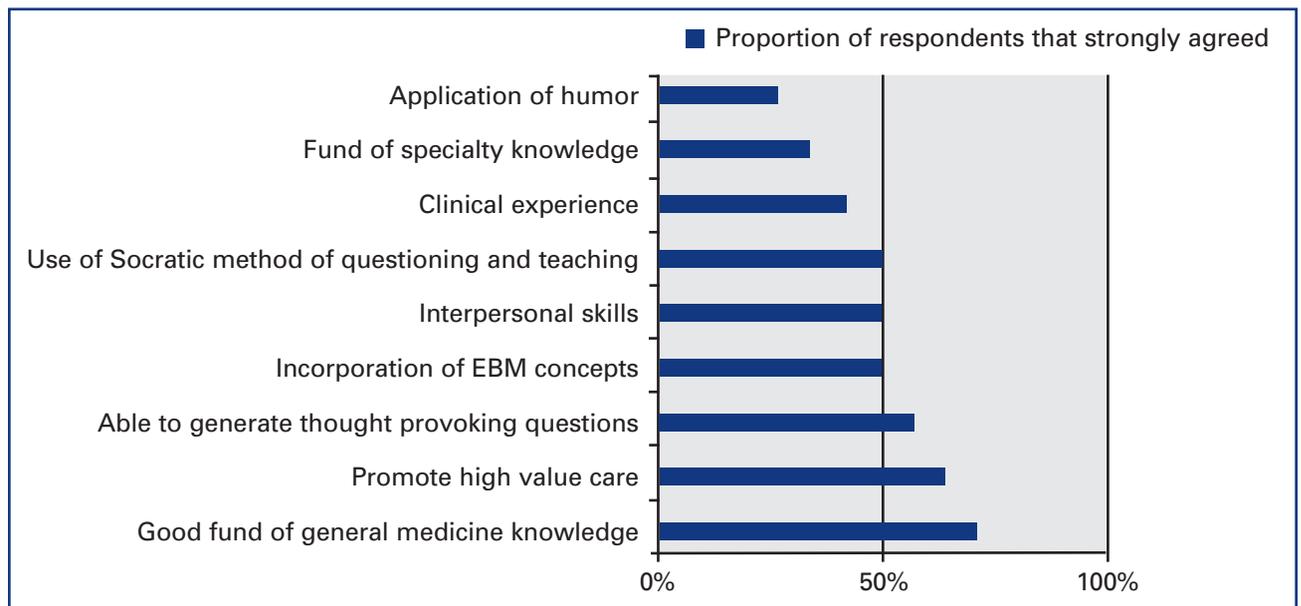


Figure 2. Attributes of the Morning Report Moderator



## EDITORIAL

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we may lack the time to fully engage patients in their care. Time pressure also creates a need for additional visits to address what was initially missed. In this manner, the great value of primary care to keep people healthy is lost. Good primary care takes time. In fact, having enough time with your primary care patients is irreplaceable.

### How did it get this way?

While complexity of clinical tasks has increased, care models have not kept pace with these changes. Doctors are paid for piecework, a model that incentivizes quantity rather than quality of care. Making matters worse, reimbursement for procedures is greater than that for cognitive work (e.g. listening to patients' stories, diagnosing their problems, examining them, and helping them make decisions about testing or treatment). This undervaluing of the time spent thinking about patients has led to physicians seeing more patients in a day, while pushing aside activities requiring reflection and interpersonal connection. Meanwhile, phone and e-mail communications that can be useful and convenient for patients are not reimbursed at all. Time spent performing these activities is made up by seeing more patients during shorter visits, while physicians communicate with patients by phone or e-mail in between patients or after hours.

### Attaining a New Paradigm of Excellence in Primary Care

This will require at least two changes. First, the model of care for the physician in office practice can be re-engineered as a continuous healing relationship between the patient and a health care team with nurse practitioners, physician assistants, nurses, pharmacists, and care coordinators. Alternative methods of engaging patients in care (e.g. phone, e-mail, Internet portals) can leverage the potential of patients to be more involved and proactive in their care.

Second, payment models will need to recognize the value of cognitive (i.e. non-procedural) care and to compensate care provided outside in-person visits. Without such reform, pressure to see more patients in shorter visits will persist.

Several recent studies suggest that patient-centered medical homes can decrease costs, even with lengthened primary care visits. Creative new arrangements, including complete financing for a population of patients, will encourage health care systems to reorganize in ways that will give patients and physicians the time and resources they need to complete the work required during a visit. It is our experience that when patients are fully informed about health care options, they will often choose less invasive, less high-tech, and less expensive alternatives.

Adequate time with patients must be recognized as an essential component of primary care. Given the average number of issues to be addressed, most follow-up visits will require at least 30 minutes. If patients are new to us, or if there are many complex issues to discuss, we may need closer to an hour. On the other hand, if a patient has a sore throat or minor injury, we can likely help that patient in a few minutes. In order to increase efficiency, some tasks can be better delegated to team members. Examples include nurses eliciting clinical information or documentation specialists (i.e. scribes) performing the typing.

### How can health systems change to meet this need?

Permitting primary care physicians to spend the time needed with each patient will require a shift away from compensation models based on quantity of services to systems that focus on quality of services and appropriately recognize the critical nature of having enough time with the patient. Alternative payment models focusing on quality rather than quantity of care will be possible now that the Medicare sustainable growth

rate statute has been repealed by Congress and replaced with the Medicare Access and Reauthorization Act. Primary care can also be supported through alternative payment arrangements that better align our overall health goals with a payment system to support their attainment. For example, Accountable Care Organizations should be able to risk adjust their support for primary care based on patients' complex social characteristics as well as their multiple medical problems.

### Longer Visits, Better Care

There are several benefits that can come from longer visits. Physicians can make more reasoned decisions. We can talk more about stressors that affect our patients' health, which can lead to more acceptable treatment plans and increased patient satisfaction. A longer visit can preserve access to care by making it less likely that patients will need an early return appointment. With more complete care, there should be fewer emergency room visits and hospital stays. Finally, longer visits with better interpersonal connections can increase not only patient satisfaction but also physician satisfaction while decreasing burnout—critical outcomes given the shortage of primary care clinicians we are facing in our health systems.

### Creating the Future

Primary care has much to offer our ailing health system. Time is often the missing ingredient that enables primary care to fulfill its potential as the bedrock for high-value care. With enough time, primary care physicians can think deeply about complex problems, help patients choose wisely among a complex array of treatment options, and counsel patients on behavioral changes that can prevent future problems. We call on both physicians and patients to reclaim that sacred space of time—enough time together to do the valuable work of primary care.

## FROM THE SOCIETY: PART I

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- on teaching health policy to students and residents based on the findings collected by the HPC learning collaborative throughout the year;
6. To advocate for the Agency for Healthcare Research and Quality (AHRQ) to become a research agency, the Patient-Centered Outcomes Research Institute (PCORI) to be funded beyond 2019, and for National Institutes of Health (NIH) funding to be substantially increased;
  7. To continue to nominate SGIM members for representation on advocacy-related boards and commissions and for representation on commissions at other agencies and organizations;
  8. To continue writing monthly columns for *Forum*, CongressWeb alerts, virtual Hill Days, and Quick Hits to the membership when appropriate;
  9. To develop a national cadre of health policy advocates, experts, and teachers through a Leadership in Health Policy (LEAHP) Program;
  10. To continue annual advocacy updates at all regional meetings;
  11. To educate members about graduate medical education reform; and
  12. To see an increased understanding of SGIM's advocacy positions on the next membership survey.

### Thank You and Transitions

At the annual meeting, we took time to do the following:

1. We thanked outgoing HPC Chair Mark Schwartz and outgoing Research Subcommittee Chair Gary Rosenthal for their leadership.
2. We welcomed Nancy Keating as chair of the Research Subcommittee and Keith Vom Eigen as chair of the Clinical Practice Subcommittee.
3. We thanked Bobby Baron for his ongoing leadership of the Education Subcommittee and Cara Litvin for her ongoing leadership of the Outreach Subcommittee.
4. We recognized John Goodson and Erika Miller for their outstanding efforts to bring

together a coalition in support of the E/M proposal to CMS.

### Opportunities to Get Involved and Make a Difference

We welcome your participation in the HPC. Expertise in health policy is not required to get involved, but interests in learning and making a positive difference are highly desirable. If you would like to join a HPC subcommittee, please contact Francine Jetton at [jettonf@sgim.org](mailto:jettonf@sgim.org) and ask to be added to the subcommittee's listserv. You may also contact a subcommittee chair or me if you have questions. We also welcome your participation at our interest group meeting or any of the subcommittee meetings at the annual meeting next May in Hollywood, FL. I look forward to seeing you there!

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SGIM

## COMMENTARY

continued from page 5

carefully consider the question of how much trust he/she has that the resident can perform the activity. In the past, this would happen at an intuitive level. The EPAs, however, force attending physicians to be more conscious of this assessment; for each EPA observed, they now must ask themselves, "How closely do I need to supervise this resident in this activity? Would this resident be able to perform this independently?" These questions about supervision help frame the degree of entrustment given to the resident for an EPA; by extension, this reflects the attending physician's perception of the underlying competence of a resident in this specific context.

Assessing residents' competence through these discrete predefined windows allows us to ground our feedback in the context of the real-world essential work of the practicing general internist. Instead of generically offering a "good job" as feedback, we can now provide recommendations for improvement relevant to their rotation (e.g. "I currently feel that when you discharge patients, you require very little supervision. In order for you to be independent in this activity, I would want you to also call the patient's primary care doctor to alert them to pending final culture results.").

Providing feedback more meaningful than "good job" still requires careful observation and hard work by

the supervising physician. EPAs provide, however, a framework to structure this hard work in a way that is easily adoptable by faculty physicians since decisions about "entrustment" already happen every day when an attending physician works with a resident. By focusing feedback on how the resident can become independent in these EPAs, we shift from summative backward-looking grading feedback and instead can deliver formative forward-looking coaching feedback. After decades of the same praise, EPAs finally give us a chance to move beyond the tired phrase to instead be able to say, "Good job.... Now here's what you can do to get even better."

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## COMMENTARY

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SGIM

**Table 1: End-of-training Internal Medicine EPAs from the Alliance for Academic Internal Medicine**<sup>4</sup>

- Manage care of patients with acute common diseases across multiple care settings.
- Manage care of patients with acute complex diseases across multiple care settings.
- Manage care of patients with chronic diseases across multiple care settings.
- Provide age-appropriate screening and preventive care.
- Resuscitate, stabilize, and care for unstable or critically ill patients.
- Provide perioperative assessment and care.
- Provide general internal medicine consultation to nonmedical specialties.
- Manage transitions of care.
- Facilitate family meetings.
- Lead and work within interprofessional health care teams.
- Facilitate the learning of patients, families, and members of the interdisciplinary team.
- Enhance patient safety.
- Improve the quality of health care at both the individual and systems level.
- Advocate for individual patients.
- Demonstrate personal habits of lifelong learning.
- Demonstrate professional behavior.

**Table 2: Examples of Rotation- and Clinic-specific Internal Medicine EPAs from the University of Washington**

***From a General Medicine Ward Rotation***

- Manage a hospitalized patient with decompensated liver disease.
- Recognize clinical deterioration and manage it promptly and efficiently.
- Coordinate discharge for a patient in a way that will reduce his/her chances of readmission.
- Coordinate an admission for an undifferentiated patient from the emergency department.

***From a Medical ICU Rotation***

- Manage a patient with shock.
- Effectively and compassionately guide a patient-centered discussion about goals of care.

***From an Outpatient Geriatrics Elective***

- Diagnose, prevent, and manage cognitive and affective disorders in older adults.
- Prescribe medications appropriately for older patients to minimize harm.

***From an Outpatient Continuity Clinic***

- Coordinate the transition of a recently discharged patient to outpatient care.
- Guide a patient to a decision about screening.
- Manage a patient with chronic joint or musculoskeletal pain.
- Effectively manage care and continuity of patients while not in clinic.

## FROM THE SOCIETY: PART II

continued from page 4

- *Recruiting prospective interns.* After recognizing that advertising program offerings in medical education could aid recruitment of desirable intern candidates, members of RIME started co-leading medical education interest sessions for applicants on interview days. Every applicant also receives a brochure created by RIME members that details teaching and skills development opportunities in our program.
- *Optimizing career development opportunities.* RIME has created a formal community for like-minded residents interested in medical education. The group enables members to interact with faculty as project or career mentors, creating valuable relationships and networks. Residents considering careers in medical education gain understanding of and support for possible career paths.

Maintaining a broad vision of the RIME group's purpose taught us many valuable lessons. We learned that centralization of teaching opportunity enrollment on our cloud-based spreadsheet increased the overall involvement of residents in peer and medical student teaching; more than half of our 160 residents volunteered for at least one advertised teaching session in 2013-2014. We

gained significant support from program leadership as they saw a high level of interest from residents. The group also became an important resource to program leadership by providing feedback on existing curricula, generating a pool of peer educators, and stimulating innovation and quality improvement in residency curricula. The two-week resident-as-teacher elective has achieved maximal resident enrollment since its inception, and teaching faculty remain very interested in leading workshops during the course. Above all, RIME remained resident-led with group members initiating all projects and liaising directly with faculty members.

Despite our successes, there were also opportunities for improvement. When we started the group as residents, we did not conduct an initial needs assessment, which may have helped us better target our efforts. Next, the group has remained entirely resident run but could benefit from more focused faculty involvement to ease the yearly transition of resident leadership. Finally, more regular group meetings (e.g. every one to two months) in the last year have enhanced communication among members and accountability from project leaders.

RIME has had a positive cultural impact across the IM residency program, increasing the focus and enthusiasm surrounding education.

With benefits to residents, students, and the institution as a whole, a group similar to RIME can be an asset to any training program. Based on our experience, we have identified the following tips for those interested in creating a similar group at their institution:

- Identify a core group of residents from all classes who are interested in medical education and in serving as group leaders.
- Identify a core group of enthusiastic, experienced, and available faculty to serve as mentors, including an official faculty sponsor.
- Conduct a program-wide needs assessment to address medical education activity and innovation.
- Write a clear mission statement.
- Set specific annual goals for the group with embedded structural mechanisms to assess progress.
- Identify pre-existing resident teaching opportunities, and publicize these in a centralized location.
- Work with faculty and chief residents to identify new venues for resident-led teaching.
- Create a structure for networking, mentorship, and career development.
- Consider supplementing existing resident-as-teacher curricula within the program.

SGIM

## Destination: Cleveland Midwest Regional SGIM Meeting 2015

AUGUST 27-28 2015

CLEVELAND CONVENTION CENTER, CLEVELAND, OH

Theme: "Engaging patients in the 21st century: Innovations in models of care, education, and research."

GUEST SPEAKERS:

**Neil Mehta, MBBS, MS**

*Director of Education Technology, Cleveland Clinic Lerner College of Medicine*

**Elizabeth Jacobs, MD, MAPP, FACP**

*Associate Vice Chair for Health Services Research University of Wisconsin-Madison*

ALSO FEATURING UPDATES IN:

General Internal Medicine/Health Policy/National SGIM Initiatives with Marshall Chin, MD

Join us in Cleveland to learn, collaborate, network, and celebrate the accomplishments of our members!

**Register today at [www.sgim.org/meetings](http://www.sgim.org/meetings). We're thrilled to host your party. See you in Cleveland!**

## PRESIDENT'S COLUMN

continued from page 3

Council further developed the initial set of three strategic priorities I discussed in last month's *Forum*:

1. *Improving the work environment.* Council clarified that the environment includes both the clinical practice environment as well as the academic environment for general internists.
2. *Fair reimbursement for primary care providers.* Current payment methodologies do not accurately measure the complex functions of the primary care physician who cares for complicated patients with multiple medical, behavioral, and social comorbidities.
3. *Increasing the value of SGIM for members.* Council added the following three strategies, which primarily describe in more detail key aspects of increasing SGIM's value to members.
4. *Increasing career development opportunities.* These opportunities include skills development, mentoring, leadership, and engagement in SGIM. These topics align well with the three areas for which members wanted more support from SGIM as assessed by the 2014 membership survey: career development, leadership skills, and administrative skills. The 2015-2016 SGIM Annual Program Committee and many of SGIM's committees and task forces have also identified career development as a key priority, and enhancing members' professional development will be an important focus of a significant portion of their work. Some of this work will likely include planning some structured multi-year training pathways and resources to help members develop their professional skills.
5. *Leadership in cutting-edge issues.* Besides developing core professional skills and networking, members tend to

engage in SGIM to help expand opportunities in their fields. The programming of SGIM, including that of its regional and national meetings as well as other offerings in between meetings, needs to help members push their fields forward. This year's program theme of population health is one example of trying to keep SGIM at the cutting edge.

6. *Growing SGIM membership at a healthy rate.* Recruiting and retaining more members who share the mission of SGIM is a good thing. More members bring more resources, allowing SGIM to do more. For example, SGIM could create and expand programs and advocate more successfully. Council felt there are important largely unrealized sources of new members. For the pipeline, the "Proud to be GIM" campaign encourages medical students to enter the field of general internal medicine. Among existing general internists, a large potential growth group is the clinician-educator who primarily takes care of many patients and also has a teaching role. SGIM is the premier organization for academic general internists seeking ways to improve their teaching skills. In addition, Council thought it important to reduce barriers that may impede academic advanced care providers, including nurse practitioners and medical assistants, from joining SGIM.

I will end by recapping why this year's SGIM Council has concentrated so much of its early effort on clarifying SGIM's mission and creating and honing its six strategic priorities for the year. A diverse organization like SGIM needs to balance the strengths of a "let a thousand flowers bloom" approach of nurturing the many exciting interests and initiatives of our incredible membership with the benefits of fo-

cus on the most important issues for our membership. Just like the specific aims section of a grant or the learning objectives of a curriculum, the mission statement and strategic priorities of an organization provide the guidepost that informs every major decision and enables it to maximize its impact and effectiveness with the resources at its disposal. Already this year's strategic priorities have helped tremendously in informing the planning of the Annual Program Committee at its May 2015 retreat, and these priorities also helped Council greatly as it evaluated each committee and task force's requests for funding and staff support over the next year. Other key initiatives will be greatly influenced by the mission and strategic priorities, including SGIM's communications and marketing plan; the growth, development, and evolution of regional efforts within SGIM; and the nature of our partnerships with external organizations.

Council's early work this year has enabled us to build upon outstanding work by prior Councils. We have started a process that has explicitly brought SGIM's committees, task forces, and regional leaders into the strategic planning process. We have reviewed and clarified SGIM's mission and core constituency, identified six concrete strategic priorities, and begun operationalizing them as we provide feedback to the committees and task forces about their plans and resource allocations. We are also trying to create processes and structures that will enable coordination and continuity of planning over time so each newly elected Council can contribute its own innovations within the flow of strategic planning and implementation that spans years. SGIM Council has established a foundation for the work of the upcoming year and looks forward to working with you and SGIM's many committees, task forces, and interest groups on specific initiatives.

## NEW PERSPECTIVES

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**Table 2. Considerations When Inviting Colleagues to Join Your Workshop Team**

Component	Examples
<i>Planning role:</i> You should be clear about how much input you need or want.	<ul style="list-style-type: none"> <li>• “I have a general idea of the topic of the workshop; I invite you to join the team, brainstorm ideas, and help draft the workshop proposal.”</li> <li>• “I have developed the main goal and specific objectives for this workshop; I would appreciate your input on how to best teach the material.”</li> <li>• “Given your extensive workshop experience, I would like to ask you to mentor me through the proposal and presentation process.”</li> </ul>
<i>Workshop role:</i> It is helpful to think about “stage time” before inviting colleagues to join the team.	<ul style="list-style-type: none"> <li>• “Please co-lead the workshop.”</li> <li>• “Please help lead one of the small groups.”</li> <li>• “Your role in presenting the workshop will be determined as we develop the agenda.”</li> </ul>
<i>Time commitment:</i> This should be a realistic estimate; you don’t want to recruit a “big name” if they don’t have minimal availability.	<ul style="list-style-type: none"> <li>• “If you are able to join the workshop team, I would ask that you be available to edit and make comments on the workshop proposal within the next month, join the team for two one-hour meetings to practice prior to the presentation, and attend the regional meeting where we will be presenting the workshop.”</li> </ul>

lecture. Table 3 gives some examples of active vs. passive strategies. Align the teaching techniques with the audience and the objectives. Ask yourself: What gives us the best chance that the participants will achieve the learning objectives at the end of the workshop? Start thinking about creating materials that will enhance the workshop, such as handouts, videos, or materials needed for hands-on activities.

### Step 6: Create a detailed agenda.

This is a critical step in creating a successful workshop. Once you have an idea of the content and teaching strategies you will use, create a chart using the column headings in Table 4. Outline the workshop agenda in detail; improvising never works. One of the most important components of a workshop is the introduction. Create an introduction that quickly engages the audience and makes it clear that your workshop is relevant for attendees. One effective strategy is to ask for a show of hands to questions that highlight the importance of your work-

shop goals and objectives. For example, for a workshop on physical examination skills, you could say, “Raise your hand if you have ever taken care of a patient with new cardiac signs and symptoms. Raise your hand if you are very confident that you know how to accurately estimate the jugular venous pressure. You are all in the right place. By the end of this workshop, you will be able to accurately estimate jugular venous pressure and teach this skill to trainees.”

As you work on the detailed agenda, keep the following tips in mind:

- Be prepared for variation in group size. Have a contingency plan whether there are five attendees or 25 attendees.
- Transitions between parts of the workshop can be awkward. Write down key transition phrases so these go smoothly during the workshop. Have a transition slide in your presentation to make transitions explicit and intentional.
- For active learning activities, give

precise instructions to participants. How many times have you been to a workshop where participants look at each other and ask, “What are we supposed to be doing?”

- Remember that it is much better to be too short than too long; leave plenty of time for discussion.
- Account for variations in the venue. Room size and table and chair arrangements may not be as expected.

### Step 7: Practice and fine tune.

Run through the entire workshop at least once with the entire team prior to presenting so that all team members are comfortable with their roles. If some team members are in different locations, timing should be arranged ahead of time by phone rather than waiting for the day of the presentation. You will likely find that certain parts take longer than you expected. Strongly consider seeking out lower-stress opportuni-

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**Table 3. Passive and Active Learning Strategies to Achieve Workshop Objectives\***

Passive Learning				Active Learning			
Pure lecture/ non-participatory didactics	Audience response systems	Large group discussion	Reflection, sharing with a partner and sharing with the group	Large group brainstorming, case studies	Small group discussion/ tasks and sharing with the group	Simulation and role-playing	Hands-on activities (experience- based learning)

\* Based on the work of Chris O’Neal and Tershia Pinder-Grover at the Center for Research on Learning and Teaching, University of Michigan, and adapted with their permission. Original document available at: [http://www.crlt.umich.edu/sites/default/files/resource\\_files/02\\_Active%20Learning%20Continuum.pdf](http://www.crlt.umich.edu/sites/default/files/resource_files/02_Active%20Learning%20Continuum.pdf)

## NEW PERSPECTIVES

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**Table 4. Column Headings for Detailed Workshop Agenda**

Slide No.	Section	Content	Important phrases	Speaker	Objectives addressed	Minutes
	Introduction, objectives, didactic, activity, etc.	What's going on right now?	What to say to highlight relevance in the introduction? How to transition from didactics to learning activity?	Who says what and when?	Is all the content somehow directed toward achieving learning objectives?	Estimate how long it will take; revise after practicing.

ties to present the workshop prior to the "main event." Oftentimes, workshop topics are appropriate for resident lunch meetings or faculty meetings.

### Step 8: Master the logistics.

Logistical snafus can sour what would otherwise be a successful workshop; realize that it is ultimately your responsibility to make sure that things run smoothly. This means, whenever possible, testing equipment at the venue beforehand, having a back-up plan for audiovisual glitches, and being self-sufficient

with equipment, such as laser pointers and speakers. Be sure to have your materials printed out ahead of time.

### Step 9: Use feedback and reflection to modify future presentations.

Immediately after the workshop, take a few minutes to enjoy the high points of the experience, and reflect on what specific modifications would improve the next presentation. While most conference workshops request evaluations of participants, an evaluation you create specifically for your

talk may be more useful. Consider handing out your own evaluation form that asks for feedback on how well your stated objectives were achieved, leaving space for constructive feedback.

### Conclusion

Offering a clinical or educational workshop is a highly rewarding activity for faculty at all levels. Not only do your colleagues have the benefit of your teaching, conducting a workshop enhances your visibility and can open the door for future opportunities.

SGIM

## SIGN OF THE TIMES

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gram impacts residents' expectations of the morning report. A multi-site survey of institutions with large numbers of IMGs would shed more light on differences in expectations and attitudes.

The morning report has and will always remain an extremely important aspect of post-graduate clinical education in internal medicine across the United States. However, given the lack of a standardized format for morning reports nationwide and the inability to actually measure the effectiveness of morning report as a teaching tool,<sup>5</sup> institutions are left to modify their morning reports to suit the needs and expectations of their house staff and faculty. House staff opinions and expectations alone should not drive the structure of morning report. At the same time, we believe that residents gain the most benefit from morning report if their expectations are largely being met.

### Conclusion

The attitudes and expectations of our predominantly IMG respondents were similar to their AMGs counterparts relative to the purpose, educational value, content, and format of morning report. Differences were noted in preferences for who led the morning report; AMGs preferred chief residents while IMGs preferred attending physicians. Additionally, AMGs rated interpersonal skills and humor much more highly than IMGs. We found that the purpose of morning report aligned with the various ACGME competencies and look forward to future research that underscores how specific morning report strategies can improve competency levels of residents.

*Acknowledgements:* We would like to acknowledge and thank Larissa Verda, MD; Rafael Turbay, MD; and Maryam Sanati, MD, for their help in creating the survey used for this study.

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# SGIM FORUM

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## University of Cincinnati College of Medicine General Internal Medicine Opportunities as Academic Hospitalist

The Section of Hospital Medicine at the University of Cincinnati College of Medicine, Cincinnati, Ohio, is seeking Board Eligible Internists to join our faculty as academic hospitalists. Hospitalist faculty are members of the Division of General Internal Medicine, **which performs the bulk of resident and student teaching for the Department of Medicine.**

### Responsibilities include:

- Providing patient care in several settings, including attending on traditional resident-led ward teams, attending on the resident-led medical consultation service, and leading a hospitalist team including an intern;
- Teaching in our Internal Medicine Residency program which has been granted status as an ACGME Educational Innovations Program; and
- Teaching medical students on clinical rotations.

### Academic opportunities include:

- Direct teaching of medical students in all four years of our new clinical curriculum;
- Collaboration with researchers in our Center for Clinical Effectiveness and Center for Health Informatics; and
- Participation in Hospital quality improvement activities.

Opportunities also exist for training in Improvement Sciences and traineeships with mentored research experiences in Outcomes and Clinical Effectiveness leading to a Master's degree in Clinical and Translational Research.

Our hospitalists **are leaders in improving both patient care and clinical processes** at the University of Cincinnati Medical Center and have a **passion for teaching and improving patient care.**

Salaries are competitive, with opportunities for increases based on productivity.

If you are interested in joining the University of Cincinnati in Hospital Medicine, applicants should contact: Mark Eckman, Director, Division of General Internal Medicine via email at [Mark.Eckman@uc.edu](mailto:Mark.Eckman@uc.edu).

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