

**2016 APDIM Spring Meeting**  
**"Are Learners Getting What They Need?"**  
**April 19-20, 2016**  
**The Mirage Hotel and Casino**  
**Las Vegas, NV**

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***Research Abstract 1***

**Impact of Transitioning into a "6+2" Block Schedule on Residents, Preceptors, Clinic Staff, and Hospitalists**

Alec B O'Connor, Catherine F Gracey, Marc Berliant, Donald R Bordley, University of Rochester Internal Medicine Residency Program

**Background**

"Block scheduling" is increasingly being used to try to improve medicine residents' ambulatory training, but there are few studies assessing the impact of a residency program transitioning into block scheduling.

**Aim**

Assess the impact on residents, preceptors, clinic staff, and hospitalists of transitioning from a traditional ½ day per week continuity clinic model into a "6+2" block schedule.

**Methods**

We surveyed residents, faculty preceptors, clinic staff, and hospitalists about their impressions before and 1 year after implementation of our "6+2" block schedule. Respondents were asked to respond to statements using the following scale: "Strongly Disagree," "Somewhat Disagree," "Neutral," "Somewhat Agree," and "Strongly Agree"; "Somewhat Agree" and "Strongly Agree" were combined to report the percentage that agreed with the statement. The survey response rates exceeded 80% across the groups.

**Results**

Residents' experiences (post-change survey compared to pre-change survey) were markedly improved in most domains, including satisfaction with ambulatory training, ability to focus on outpatient education, and reduction of clinic interference with inpatient experiences. Residents' interest in a career in primary care increased 250% in the block model (from 7.7% to 27.1%), and more than twice as many residents agreed that "outpatient general medicine is an enjoyable field" following the change (23.1% to 46.7%). 95% of senior residents preferred the block schedule.

In contrast, our continuity clinic preceptors reported substantial decreases in continuity with their residents, feeling of teamwork, ability to form mentoring relationships with residents, and overall enjoyment of precepting residents. Nearly all preceptors felt the block scheduling had worsened the preceptors' experiences.

Clinic staff impressions were largely unchanged, while hospitalists reported substantial decreases in clinic interference with residents' ability to provide high quality care and to discharge patients early in the day, and with education on the inpatient service.

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*Research Abstract 2*

**Bedside Ultrasonography Curriculum for Internal Medicine Residents (BUC-IM)**

Teja Gundala, Huiwen Chen, Scott Yen, West Suburban Medical Center

**Background**

Bedside ultrasonography is a powerful tool with numerous diagnostic and procedural applications. While a large body of evidence suggests successful integration of formal ultrasonography curriculum in emergency medicine training, there is limited data regarding its effective use in a community based internal medicine training program.

**Aim**

The aim of this study is to evaluate the utility of incorporating a hands-on ultrasonography curriculum, taught by both core internal medicine and subspecialty faculty leveraging already available hospital equipment, in a resource limited community based internal medicine program.

**Methods**

We randomly selected 13 of 30 internal medicine residents (43.3%) to participate in a series of intervention group workshops, with 12 residents in the control group. Both the control and intervention groups were surveyed before the start (pre-curriculum) and at the end of the ultrasonography series (post-curriculum), taking place over a 3 month period, to evaluate their self-reported knowledge and ability to perform procedural and diagnostic ultrasonography and its overall impact on patient care.

**Results**

Hundred percent of the control and intervention resident groups completed the surveys. In the control group, we find no significant difference ( $p = 0.87$ ) between the pre-curriculum and post-curriculum survey questions. In the intervention group, we find a significant increase ( $p < 0.001$ ) in survey scores across the board between the pre-curriculum and post-curriculum survey questions. Further multivariate regression analysis was also performed for individual survey questions to control for post graduate level, age and sex.

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*Research Abstract 3*

**'4+1' Ambulatory Block Scheduling in Resident Continuity Clinic: Effects on Internal Medicine Resident Care Quality Measures**

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**Background**

Many internal medicine residency programs have transitioned to block inpatient/outpatient schedules to improve ambulatory care training. However a need exists for studies that evaluate the effect of the block ambulatory schedule on the quality of care delivery.

**Aim**

To evaluate the effects of changes in ambulatory clinic scheduling from a traditional weekly half-day format to '4+1' ambulatory block scheduling on resident panel management with regard to Healthcare Effectiveness Data and Information Set (HEDIS) screening measures of breast cancer screening and cervical cancer screening.

**Methods**

Data for HEDIS measures for mammography screening and cervical cancer screening were assessed in the resident continuity clinic both pre-intervention and post-intervention following implementation of a 4+1 block schedule. Rates of screening for resident panels were measured for two time periods, pre-intervention in September 2014 and post-intervention in September 2015. During both the pre- and post-intervention period, residents were given instructions to utilize the Military Health System Population Health Portal (MHSPHP) CarePoint 4G healthcare database to perform a performance audit on their panel patients in order to target patients due for breast and cervical cancer screening. Resident physicians followed US Preventive Services Task Force screening guidelines for breast and cervical screening. HEDIS compliance was calculated by the disease management department using standardized MHSPHP methodology. In the post-intervention group, the 4+1 block scheduling change allowed for one half day of protected time during their ambulatory week for panel management and care quality improvement.

**Results**

After implementation of 4+1 scheduling, screening rates for breast cancer with mammography for resident-enrolled patients (n = 897 eligible for breast screening and n=1440 eligible for cervical screening) were calculated. Comparisons of pre- and post-intervention screening rates between September 2014 to September 2015 were calculated using the student T-test. Screening rates for breast cancer with mammography improved significantly: 66% vs 80% (p=0.0006). Screening rates for cervical cancer with Papanicolaou testing also improved significantly, from 66% to 74% (p=0.03).

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***Research Abstract 4***

**Impact of an X+Y Residency Training Schedule on the Continuity Clinic Experience**

Anoop Agrawal, Chirayu Shah, Steffanie Campbell, Larry Laufman, Richard Hamill, Baylor College of Medicine

**Background**

Changes in ACGME requirements for residency training has created challenges in the current traditional model. Duty hours, inpatient service requirements and ambulatory training needs often are competing for the trainee's attention. The traditional scheduling model has residents attending half-day continuity clinics weekly while on hospital-based clinical rotations. Ambulatory training has suffered in the context of these requirements.

The internal medicine residency program implemented a new scheduling model known as '4+1' in July 2014. Residents rotated on 4-week inpatient rotations followed by week-long ambulatory blocks rather than the traditional weekly half-day clinic. Presently, there is limited data assessing the implications of this new system.

**Aim**

To assess the continuity clinic experience of Internal Medicine (IM) residents before and after implementation of a 4+1 residency training schedule.

**Methods**

An 18-question, Web-based anonymous survey was administered to all categorical IM residents in June 2014, prior to implementing the 4+1 training schedule in July 2014. The survey was repeated as an end-of-year assessment in June 2015. Only residents that experienced both scheduling systems were included in the analysis. Response rates for the June 2014 and June 2015 surveys are 96% (n=85) and 88% (n=77), respectively. Results were analyzed using analysis of variance and the non-parametric Mann-Whitney U and Wilcoxon Signed Rank tests. The survey received Baylor IRB exemption.

**Results**

Residents reported a number of statistically significant changes after implementation of the 4+1 training schedule. They saw more patients during continuity clinic, with fewer interruptions due to inpatient responsibilities ( $p<0.05$ ). They could spend more time with their patients ( $p<0.05$ ). The number of patients per clinic and the number of patients seen more than once were significantly higher ( $p<0.05$ ). Compared with training under the traditional schedule, they felt more confident they could practice general internal medicine after graduation ( $p<0.05$ ). 75% of the residents indicated they preferred the 4+1 schedule for a positive continuity clinic experience.

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*Research Abstract 5*

**How do Incoming Internal Medicine Interns Self-Assess their Confidence in Performing the Entrustable Professional Activities (EPAs)?**

Chase Correia, Melissa Bussey, Kevin Simpson, Loyola University Medical Center

**Background**

The US medical education system is designed to teach trainees to practice medicine with progressive independence. To evaluate this progression, the Association of American Medical Colleges (AAMC) identified thirteen entrustable professional activities (EPAs) that all medical students should be able to competently perform prior to graduating medical school. Observation within our residency program suggests varying degrees of competence and confidence among incoming trainees.

**Aim**

This study investigates how incoming internal medicine interns self-assess their confidence in performing the EPAs.

**Methods**

Incoming categorical and preliminary internal medicine interns (n=53) at an academic medical center were invited to participate in a cross-sectional survey on the first day of intern orientation. The survey utilized a Likert scale to assess confidence in performing the EPAs. The completion rate was 100%.

**Results**

The participants self-assessed their confidence to be lowest in performing three EPAs: entering and discussing orders, giving or receiving patient handovers to transition care, and performing the general procedures of a physician. Females reported higher confidence than males in performing transitions of care, but this did not achieve statistical significance (p=0.08). Graduates from our affiliated medical school reported higher confidence in performing the general procedures of a physician compared to graduates from other medical schools, but this did not achieve statistical significance (p=0.07). EPA scores were then summed to create a "total EPA confidence score" for each intern. USMLE 1 or 2 scores, age, and medical school did not affect total EPA confidence score. Males tended to have a total EPA confidence score in the lowest 25% of total EPA confidence scores but this did not achieve statistical significance (OR =4.50; 95%CI 0.97-20.83).

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*Research Abstract 6*

**Resident Satisfaction After Implementation of the I-PASS Handoff Bundle**

Brian Wood, Talya Bordin-Wosk, Alina Popa, University of California, San Diego

**Background**

The ACGME requires residency programs provide training in communication and safe transitions of care. At UCSD we implemented the I-PASS handoff bundle, an evidence based, standardized approach to improving handoffs that includes a comprehensive handoff curriculum, a standardized printed tool with the I-PASS elements, and direct observation and feedback of interns by faculty.

**Aim**

This study aims to evaluate resident satisfaction with handoff training at UCSD, as well as satisfaction with their colleagues' handoffs before and after implementation of this new curriculum.

**Methods**

This is a retrospective pre- and post-intervention cohort study. Pre-implementation email surveys were sent to all residents with questions to evaluate satisfaction with handoffs. The majority of residents, including all incoming interns, then received I-PASS training. Four months later, the same email survey was sent to residents to re-evaluate their satisfaction with handoffs. The post-intervention survey was separated into interns and senior residents.

**Results**

63 residents responded to the pre-intervention survey, 59 responded to the post-intervention survey. Resident knowledge of a standardized format for handoffs increased from 31% of residents to 90% of interns. Prior to implementing the program, 73% of residents reported being observed during sign-out as an intern, whereas afterwards 91% of interns reported being observed. Before implementation, 20% of residents were very satisfied with sign-out training; this improved to 68% of new interns post-intervention. Residents also reported a perceived decrease in issues overnight not included on sign-out, from 76% pre-intervention to 36% post-intervention.

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*Research Abstract 7*

**Building Resilient Teams: Senior Resident Experience with Difficult Clinical Events**

Michelle Martinchek, University of Chicago; Amber-Nicole Bird, University of Pennsylvania; Amber Pincavage, University of Chicago

**Background**

Building resilience is one promising method to help mitigate professional burnout, which is experienced by many physicians. Few curricula on increasing trainee resilience exist. Resilience skills may be useful after difficult clinical events.

**Aim**

This study aims to assess residents' baseline resilience and experiences with difficult clinical events.

**Methods**

Cross-sectional surveys were given to Internal Medicine (IM) residents. Baseline resilience was assessed using the Connor-Davidson Resilience scale (CD-25) and categorized as low (<70), intermediate (70-79), and high (80-100). Residents were surveyed on burnout, stress, and reflection after difficult events.

**Results**

41 of 62 (66.1%) IM residents completed the survey. 14.6% had high resilience, 46.3% intermediate, and 39.0% low. 11 residents (26.8%) reported at least one burnout symptom. There was no association between high or low resiliency and burnout ( $p=0.27$ ). 51.2% of residents experienced difficult clinical events several times a month, 24.4% several times a week, and 9.8% daily. The top difficult events were unanticipated patient deaths, medical errors, systems issues and poor team dynamics. 100% of residents report stress after these events. 22.0% of residents prefer to discuss events with their team immediately, 56.0% later that day, 19.6% in the following days to weeks, and only 2.4% prefer not to discuss. Residents individually reflect on these events very often (41.5%), often (29.2%), or sometimes (19.5%), whereas only 9.8% reflect rarely. After events, residents talk with interns and students very often (17.1%), often (39.0%), or sometimes (39.0%), but with attendings only rarely (41.5%) or sometimes (41.5%). Only 14.6% talk with attendings often. 68.3% of residents think difficult events affect their well-being at work and 58.6% want more training to help their team cope after difficult events.

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*Research Abstract 8*

**7 Habits of Highly Effective Teaching Hospitalists**

Sean P LaVine, John Raimo, Hofstra North Shore LIJ School of Medicine, Nirvani Goolsarran, Stony Brook University Hospital

**Background**

Teaching Hospitalists provide a large proportion of medical education for Internal Medicine Residents with varying levels of training and success.

**Aim**

We sought to identify common habits of highly rated teaching hospitalists in a variety of areas including bedside teaching, formal teaching, and feedback and communication.

**Methods**

We surveyed high performing daytime hospitalists at 3 teaching sites across 2 academic internal medicine residency programs. Questionnaires were administered to highly rated teaching hospitalists.

**Results**

The top 28 teaching hospitalists (based on resident evaluations) were surveyed with a response rate of 96%. Surveys asked participants to self report on teaching behaviors. 85% (23/27) reported bedside rounding on 50% or fewer of their patients, but 100% bedside round on selected patients. Most responders choose which patients to round on based on severity of illness, interesting cases, and discharges. 70% of responders bring articles to discuss on rounds 1-2 times per week. 66% of responders assign topics to discuss on rounds 1-2 times per week. 70% of responders stay and see all new admissions with their team. 96% of responders give their cell phone to their team to facilitate communication. 93% of responders give feedback more than once per rotation. 100% of responders rarely (25%) or never (0%) have rounds extend into formal teaching sessions. 85% of responders always verbally touch base with their team at the end of the day and 63% always set expectations.

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*Research Abstract 9*

**Cap Assisted Colonoscopy Enhances Quality Based Competency in Colonoscopy among Trainees: A Randomized Controlled Trial**

Daniel S Zhang, Zhouwen Tang, Kalpesh Patel, Baylor College of Medicine

**Background**

Competency assessment in colonoscopy trainees have traditionally been informal and subjective. Recent validated assessment metrics such as the Assessment of Competency in Endoscopy (ACE) tool have revealed that the minimum procedure threshold to reach competency may be higher than once assumed. Cap assisted colonoscopy (CAC) may be a practical method to improve quality based competency measures in trainees but evidence to support this practice is lacking.

**Aim**

We aim to compare quality based competency measures in CAC versus standard non cap colonoscopy (SC) among trainees with no prior experience in a randomized controlled trial.

**Methods**

This study was conducted at a single safety net university teaching hospital in the United States. All colonoscopies performed by three gastroenterology fellows without prior colonoscopy experience in the first three months of training were eligible for enrollment. Patients were excluded if they were of age 90, pregnant, had history of colon resection, diverticulitis within 1 month, current symptoms of colonic obstruction, severe hematochezia, referral for endoscopic mucosal resection, or required an unsedated procedure. Patients were randomized to either CAC or standard non cap colonoscopy (SC) in a 1:1 fashion via a computer randomization algorithm.

Patient demographics, outcome parameters, and ACE tool assessment were recorded for every procedure. All colonoscopies were performed under the supervision of board certified attending gastroenterologists. Primary outcome was cecal intubation time (CIT). Secondary outcomes were independent cecal intubation rate (ICIR), polyp detection rate (PDR), adenoma detection rate (ADR), and ACE tool scores.

**Results**

A total of 203 colonoscopies were enrolled, 101 in CAC and 102 in SC. Baseline characteristics between groups were similar. CAC resulted in was significantly faster CIT at  $13.7 \pm 0.74$  mins compared with  $16.5 \pm 0.88$  mins in SC group ( $p = 0.02$ ). In multivariable regression modeling, this association remained significant after adjustment for accumulated colonoscopy experience. ICIR was also improved at 79.2% in CAC compared to 66.7% in SC ( $p = 0.04$ ). PDR was not significantly different at 52.5% in CAC and 52.9% in SC. ADR was not significantly different at 37.6% in CAC and 43.1% in SC ( $p = 0.42$ ). Distribution of overall motor and cognitive scores on ACE tool assessment were also significantly different between groups.

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***Research Abstract 10***

**Telephone Encounters in an Internal Medicine Residency Clinic**

Saagar Sanghvi, Drew Triplett, Justin Houston, Dean Bricker, Wright State University

**Background**

Telephone encounters are an integral part of communication between internists and patients; 25% of internal medicine (IM) clinic patient contacts occur by telephone. Most residency programs have not established formal curricula or explicit supervision policies for these calls.

**Aim**

Our objective was to evaluate IM resident telephone encounters regarding: (1) reasons for calls, dispositions, accuracy of clinical decisions, quality of documentation, presence of explicit supervision, and (2) potential differences relative to resident training level.

**Methods**

The study comprised a cohort of all patients seen in outpatient clinic from January 2-12, 2015. We analyzed the sample population's 2014 telephone encounters (n=503) regarding: (1) resident training level (R1, R2, R3), (2) type of telephone call received, (3) patient management decisions, and (4) documentation of attending physician discussion, supervision, or co-signature. A single, blinded attending physician reviewer assessed cases for decision accuracy and quality of documentation.

**Results**

Of 503 encounters reviewed, 56 (11.1%) were fielded by R1's, 191 (38.0%) by R2's and 256 (50.9%) by R3's. An attending staffed 21 (4.2%) of telephone encounters. R1 residents more frequently engaged attendings than R2 or R3 residents (10.7% vs 3.7% vs 3.1%; p = 0.033). R1 residents were more likely to start new medications than R2 or R3 residents (23.2% vs 11.5% vs 6.3%; p = 0.001). R2 and R3 residents refilled more medications (36.2% to 21.4%, p= 0.028) than R1 residents. R3 residents adjusted the dosing more frequently (9.0% to 4.5%, p= 0.043) than R1 and R2 residents. The attending agreed with decisions in 79.7% of unstaffed encounters, disagreed in 16.9%, and found sub-optimal documentation in 23.7% of encounters.

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***Research Abstract 11***

**A Healthy Discharge: Decreasing COPD Readmission Rates**

Tanveer Singh, Anissa Rahman, Farhana Sharmeen, James Gardner, Corina Marcu, Robert Brown

**Background**

Chronic obstructive pulmonary disease (COPD) is the third leading cause of death in U.S. claiming around 130,000 lives per year. Centers for Medicare & Medicaid Services considers 30 day readmission rate for various chronic diseases as a measure of the quality of care provided by the hospital. At our hospital the 30 day readmission rate for COPD was 25.11% in the fiscal year 2014.

**Aim**

To design a chronic care disease model involving house staff and reduce 30 day COPD readmission rate

**Methods**

A multidisciplinary team including house staff, respiratory therapists, pharmacists and case managers was formed. Patients who were discharged from the emergency department and urgent care were provided education regarding the symptom management and adequate post discharge follow up was ensured by appointment with the primary care physician and/or post discharge follow up call. On readmission, patients had an interview identifying potential gaps leading to the admission and those gaps were addressed during the hospital stay and checked in a checklist called discharge readiness tool. Subsequently patients were stratified according to Global Initiative for chronic obstructive lung disease guidelines and appropriate post discharge plan was devised based on the disease severity. The post discharge plan included proper handoff to the primary care providers prior to discharge phone calls and home visits within 1 week (depending upon the disease severity), caregiver education etc. A follow up was also ensured for the underprivileged and uninsured patients in the hospital's family health center.

**Results**

The initiative rolled out starting August 2014 and was fully operational by November 2014. The initial results which include data of fiscal year 2015 show that 30 day COPD readmission rate for our institution was reduced from 25.11% to 18.12%. The data from Connecticut Hospital Association show that our readmission rate was superior to the state average.

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***Research Abstract 12***

**The Hospitalist Elective National Survey (HENS)**

Steven Ludwin, James Harrison, Sumant Ranji, Bradley Sharpe, University of California, San Francisco, Patrick Kneeland, University of Colorado

**Background**

As the hospital medicine specialty grows, internal medicine residency programs are building hospitalist-specific rotations that teach skills and knowledge relevant to the field. To date, little is known of the prevalence and characteristics of hospitalist rotations.

**Aim**

To survey internal medicine training programs to better understand the prevalence, objectives, and structure of hospitalist rotations in the United States.

**Methods**

An 18-question survey was sent electronically to residency leadership of the 100 largest ACGME internal medicine residency programs. Each program had at least 81 residents. The survey contained items that assessed the goals, structure, and perceived benefits of hospitalist rotations.

**Results**

Eighty-two residency program leaders responded to the survey (82% response rate). Among responders, the prevalence of hospitalist-specific rotations was 50% (41/82), of which 85% (35/41) were elective rotations and 15% (6/41) were mandatory rotations. A lack of a well-defined model was the most frequently reported barrier for programs without a hospitalist-specific rotation.

The most common clinical responsibilities were admitting new patients and performing common medicine procedures. The most common curricular elements were teaching evidence-based practice, career counseling, and quality improvement.

Most programs with rotations (95%, 39/41) felt their hospitalist rotation filled at least one gap in traditional residency curriculum, and identified gaps as the need for progressive clinical autonomy (59%, 24/41), learning about quality improvement and high value care (41%, 17/41), and preparation in becoming a hospitalist physician (39%, 16/41). Most respondents (66%, 27/41) felt that the rotation helped to prepare trainees for their first year as an attending.

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*Research Abstract 13*

**Flipping the Quality Improvement Classroom in Residency Education**

Sara Bonnes, John Ratelle, Andrew Halvorsen, Luke Hafdahl, Mayo Clinic, Kimberly Carter, KUMC, Amy Wang, UCLA Medical Center, Jayawant Mandrekar, Amy Oxentenko, Thomas Beckman, Christopher Wittich, Mayo Clinic

**Background**

The flipped classroom (FC) involves delivering curricular content prior to class and devoting class-time to discussing and applying the content. The FC model has the potential to improve residency education, yet there are few studies of the FC model in medical education

**Aim**

Our aims were to 1) develop and validate an instrument to measure residents' perceptions of a quality improvement (QI) FC, 2) determine residents' perceptions of the FC curriculum, and 3) determine associations between resident characteristics, FC perception scores, and QI knowledge.

**Methods**

This was a prospective validation study of all internal medicine residents (N=148) at Mayo Clinic in 2014-2015. A FC perception instrument (FCPI) was developed based on existing literature and iterative revision. Post-graduate year (PGY) 1 and 3 students participated in the FC curriculum. Institute for Healthcare Improvement (IHI) online modules were reviewed by residents before class. In-class time was devoted to discussing the IHI content and applying it to a QI project. PGY-2 residents participated in a non-flipped QI patient safety curriculum and served as controls.

**Results**

Factor analysis revealed a two-factor structure (Cronbach alpha): "pre-class activity" (0.81) and "in-class application" (0.88). Post-course FCPI scores increased for 3 of 8 items (all  $p < 0.05$ ). Validated QI knowledge scores increased by 5.1 (3.2) points ( $P < 0.0001$ ) among residents who experienced the FC. The percentage of modules completed was associated with a significant change in FCPI score (mean; SD): 0-74% completed (-0.06; 0.36); 75-100% completed (0.19, 0.47),  $P = 0.04$ . Previous FC exposure was associated with a significant change in QI knowledge score: prior exposure (3.1, 2.7); no prior exposure (6.1, 3.0),  $P = 0.002$ .

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*Research Abstract 14*

**Minimizing Harm, A Novel Approach to Teaching Safety Using a Team Based, Interprofessional Simulation Model in Residency Training**

Nirvani Goolsarran, Carine Hamo, Wei-Hsin Lu, Stacey Frawley, Colby Rowe, Susan Lane, State University of New York at Stony Brook

**Background**

Teaching and learning patient safety requires demonstration of competencies such as teamwork, communication skills and recognition of systems error.

**Aim**

The goal of this project was to design, implement and assess the effectiveness of a Team Based Learning (TBL) exercise on patient safety and quality care concepts with interprofessional simulated application scenarios.

**Methods**

A series of interprofessional patient safety training workshops were offered to internal medicine interns and nursing students. A pretest–posttest quasi-experimental design was used to assess TBL of patient safety concepts. During the workshops, the trainees were grouped into interprofessional teams. Individual Readiness Assurance Test [IRAT] followed by an identical Team Readiness Assurance Test [TRAT] with his/her team members was completed. Following the IRAT/TRAT, the interprofessional teams went through a series of simulation cases. Trainees received immediate debriefing and feedback from multidisciplinary faculty members on teamwork and error prevention. Learning outcomes were evaluated using IRAT/TRAT. Safety checklists were used to identify omissions in safety tasks. Readinesses for interprofessional Learning Scale (RIPLS) before/after the workshop and a post workshop satisfaction survey were also completed.

**Results**

A total of 76 trainees participated and twenty interprofessional teams were created. An independent samples t-test was conducted to compare the IRAT/TRAT scores. The TRAT scores (Mean=7.7, SD=1.8) were significantly higher than the IRAT scores [Mean=5.6, SD=1.7;  $t(94)=-4.9$ ,  $p=.001$ ]. Chi-square tests were used to compare the number of correct responses for each IRAT/TRAT question item. A significantly higher number of correct responses were selected on the TRAT compared to the IRAT on questions related to patient safety concepts. The RIPLS scores for Teamwork and Professional Identity were higher on the post workshop survey compared to the pre workshop survey; the differences were not statistically significant. Over 90% of the participants “strongly agreed” that the safety concepts they learned would likely improve the quality of care they provide to future patients

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