We will be using poll everywhere during our presentation, please do the following to join our polls and participate...

When poll is active, respond at PollEv.com/kikichamberl895

Text KIKICHAMBERL895 to 22333 once to join
APDIM Workshop #403: Implementation of Chief Resident Led Direct Observation and Evaluation of Internal Medicine Residents in an Outpatient Clinic Setting

The Ohio State University, Department of Internal Medicine
2017-2018 Chief Residents: Zachary Garrett, Patrick Dooling, Kristin Koenig
APD: Jared Moore
How many faces do you see in this picture?
Nine!

http://positivemed.com/2016/03/07/see-9-faces-on-this-picture/
Let’s get to know each other…

- Poll Everywhere questions

When poll is active, respond at PollEv.com/kikichamberl895

Text KIKICHAMBERL895 to 22333 once to join
Learning Objectives

1. Explore the feasibility of implementing increased direct observations in your residency continuity clinic.

2. Troubleshoot an example milestone-based standardized direct observation tool for components that will enhance your program’s competency assessments.

3. Generate ideas for improving assessment, feedback and coaching of resident progress on the relevant milestones in your program’s continuity clinic settings.
What’s happening in your institution with regards to direct observations in outpatient clinics? What are your thoughts on direct observations of residents?

- Poll Everywhere questions

When poll is active, respond at PollEv.com/kikichamberl895

Text KIKICHAMBERL895 to 22333 once to join
Our experience at Ohio State - background

- Direct observation is critical in assessing residents’ readiness to practice independently
- History of observations at OSU
  - Dr. Friedman’s contributions

- OSU’s Categorical Resident Clinic structure
  - ~30 residents are in clinic during any given month
  - Any given resident is in clinic every 3 months
    - 8+4 structure
Our barriers to direct observations in clinic

- Preceptor availability
- Preceptor time constraints
- Consistent evaluations among different preceptors
- Multiple clinic locations
How we developed our direct observation program

- Chief Medicine Residents (CMRs) observe a resident during an outpatient clinical encounter
- ACGME milestones and core competencies are assessed
  - Patient communication
  - History taking
  - Physical exam
  - Assessments and plans
- The CMR uses a standardized form that focuses on these milestones
  - Form was created by the CMRs with faculty guidance using frame-of-reference
Direct Observation Evaluation Form:

Chief Direct Observation:

Date: ____________________  Learner: ____________________  Evaluator: ____________________
Encounter type: New / Established / Return / Acute
Clinic Location: MMH / CPE

Communication:
Communication with patients and inter-professional team (ICS1, ICS2, SBP1)

Physician-Patient Relationship

<table>
<thead>
<tr>
<th>Develops counter-therapeutic relationship with patient</th>
<th>Attempts to develop therapeutic relationship, but unsuccessfully</th>
<th>Establishes therapeutic relationship</th>
<th>Quickly establishes therapeutic relationship with patient, including persons of different socioeconomic and cultural backgrounds</th>
<th>Role models effective communication and development of therapeutic relationship in a challenging situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Communication Effectiveness

<table>
<thead>
<tr>
<th>Fails to recognize patient’s central clinical problem and fails to effectively communicate plan</th>
<th>Recognizes patient’s central clinical problem(s), but fails to effectively communicate plan</th>
<th>Recognizes patient’s central clinical problem(s), but communicates plan using medical jargon</th>
<th>Recognizes patient’s central clinical problem(s) and effectively communicates plan without using medical jargon</th>
<th>Accurately and effectively communicates central clinical problem(s) and plan without preceptor input</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Staff/Inter-professional relationships

<table>
<thead>
<tr>
<th>Develops/maintains a counter-productive relationship with staff</th>
<th>Attempts to develop/maintains a working relationship with staff, but unsuccessful</th>
<th>Establishes/maintains a working relationship with staff</th>
<th>Works and communicates efficiently with staff in a way that makes clinic more productive</th>
<th>Role models effective communication and cooperation even in challenging situations. Builds personal rapport with staff that enhances the clinic environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

Comments: ____________________
### Time Management:

**Clinic Preparedness and Time Utilization during Patient Encounters (ICS)**

<table>
<thead>
<tr>
<th>Computer Utilization</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>Minimal or no patient interaction while using the computer such that it is detrimental to the physician-patient relationship.</td>
<td>Maintains patient interaction while using the computer but spends the majority of the visit facing the computer.</td>
<td>Effectively utilizes the computer while maintaining appropriate patient interaction.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Visit Preparedness</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA, New patient without prior history</td>
<td>Unfamiliar with key aspects of the patient’s prior history such that it delays the visit.</td>
<td>Prepared enough to effectively discuss active problems with the patient.</td>
<td>Prepared enough to effectively and quickly utilize the patient’s prior history in medical decision making.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agenda Setting</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not set agenda: allows patient to monopolize the visit with multiple problems. Does not address problems based on medical severity. Visit goes longer than scheduled.</td>
<td>Sets agenda at beginning of visit, but does not adhere to agenda as visit progresses. Visit lasts longer than scheduled.</td>
<td>Sets agenda and is able to redirect patient such that problems are addressed within the time scheduled for that visit.</td>
<td>Sets agenda incorporating patient preference as well as physician preference when setting agenda.</td>
<td>Actively solicits patient’s preferences as well as physician preference when setting agenda. Given patient expectation of how long visit will last. Actively redirects patient to complete visit addressing problems based on patient concerns and medical necessity within the allotted time.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Efficient Documentation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not document anything in EMR during patient interview.</td>
<td>Documents some important elements of history/physical while waiting to interview. This activity only minimally interferes with active communication.</td>
<td>Documents most of important details during interview while maintaining high level of active communication.</td>
<td>HPI or interval history is documented by the end of the patient interview visit. Efficiently documents in the EMR while utilizing active communication such that it enhances the patient-physician interaction.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Redirecting Patients

<table>
<thead>
<tr>
<th>Does not redirect, patient dictates the visit.</th>
<th>Occasionally redirects patient, however does so at expense of clinical relationship or patient quickly returns to previous topic.</th>
<th>Is able to redirect patient and finish visit in timely manner, with minimal negative impact to clinical relationship</th>
<th>Quickly recognizes and intervenes in redirecting patient. Patient concerns are heard within the allotted clinic visit or collaborates with the patient to discuss additional problems at a future visit.</th>
<th>Explores patient’s concerns and redirects the patient to the previously set agenda. Asks thoughtful, targeted lines of questions that obviate the need for redirecting patient. When redirection needed, it is done quickly and skillfully preserving clinical relationship.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### Workflow

<table>
<thead>
<tr>
<th>Does not understand clinic workflow, this negatively impacts clinic visit and forces staff to spend extra time on unnecessary tasks.</th>
<th>Understands clinic workflow but wastes time with unnecessary waiting, repeated steps, or frequent staff questions.</th>
<th>Uses some of the built-in workflow of the clinic to resident’s advantage. Has some difficulty with completing AVS and entering orders in timely manner.</th>
<th>Places orders while interviewing patient, changes flags in the room to prompt staff to prepare for POC testing. Staffs visit completes AVS, and enters orders in timely manner.</th>
<th>Is able to complete majority of documentation and order entry during visit. Utilizes staff appropriately to complete tasks within their scope of practice. Uses dotphrases and the EMR to their advantage to save time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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</tbody>
</table>

**Comments:**

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**THE OHIO STATE UNIVERSITY**

WEXNER MEDICAL CENTER
**History/Physical Examination/Assessment-Plan:**

Gathers/synthesizes essential and accurate information to define and treat each patient’s clinical problem(s). (PCI, PROF3)

<table>
<thead>
<tr>
<th>History</th>
<th>Does not collect accurate historical data</th>
<th>Inconsistently able to acquire accurate historical information in an organized fashion</th>
<th>Acquires accurate and relevant histories from patients</th>
<th>Acquires accurate histories from patients in an efficient, prioritized, and hypothesis-driven fashion</th>
<th>Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

**Physical Exam**

<table>
<thead>
<tr>
<th>Does not use physical exam to confirm history</th>
<th>Does not perform an accurate or appropriately thorough physical exam</th>
<th>Performs accurate and appropriately thorough physical exam but misses key exam findings</th>
<th>Performs accurate physical exams that are appropriately thorough including key physical exam findings</th>
<th>Performs accurate-targeted physical exams and identifies subtle or unusual physical exam findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Assessment and Plan**

<table>
<thead>
<tr>
<th>Fails to recognize patient’s central clinical problem and care plan is inappropriate or inaccurate</th>
<th>Recognizes patient’s central clinical problem(s), but care plan is inappropriate or inaccurate, requires significant attending oversight</th>
<th>Recognizes patient’s central clinical problem(s) and care plan is appropriate and accurate with attending oversight</th>
<th>Recognizes patient’s central clinical problem(s) and care plan is appropriate and accurate with minimal attending oversight</th>
<th>Recognizes patient’s central clinical problem(s) and care plan is appropriate and accurate without attending oversight, anticipates future management</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Individualized Assessment and Plan**

<table>
<thead>
<tr>
<th>Fails to ask about patient preferences, or recognizes patient’s cultural, gender, socioeconomic issues</th>
<th>Asks about patient preference but does not explore in more detail and/or fails to incorporate them into management decisions</th>
<th>Asks about patient preference. Explores in detail but fails to incorporate them into management decisions</th>
<th>Understands patient preferences and recognizes their context as a part of patient’s cultural, gender, socioeconomic issues. Discusses this with the patient, and incorporates them into management decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Comments:**
Next Steps- provide standardized resources related to the “Action Items”
How we developed our direct observation program

- After the encounter, the CMR selects two areas/items for improvement
  - Shares with the resident
  - Shares with the resident’s preceptor for ongoing coaching
- Resident is provided with standardized resources for self-review (CMR provides)
- Currently 1 observation per year, goal of 2x per year
  - We observe PGY-1s, PGY-2s, and PGY-3s
How we developed our direct observation program

- The CMR submits the evaluation form to the resident’s portfolio to be used in their semi-annual reviews and by the Clinical Competency Committee.

- We are surveying our residents and supervising faculty before and after implementing this program.
  - In order to determine the frequency of direct observations and their perceived educational value at our institution.
Now you try!

Please break into small groups

We will be passing out scoring sheets (shortened versions of the standardized forms the CMRs at OSU use for their direct observation evaluations)
Scenario #1
Scenario #1
Small Group Discussion

- How do your individual scores compare?
- What are your thoughts on the evaluation questions?
- What do you think the next steps for improvement for this resident are?
Scenario #2
Scenario #2
Small Group Discussion

• How do your individual scores compare?
• What are your thoughts on the evaluation questions?
• What do you think the next steps for improvement for this resident are?
Scenario #1 and #2
Large Group Discussion

- Completing evaluations real-time vs after the end of the encounter
- Importance of using a standardized tool for evaluations
- What are the barriers to implementing this at your own institution?
- How are other institutions implementing similar evaluation processes?
- How to incorporate this evaluation tool in resident feedback and ongoing coaching?
What did you learn today?

1. Explore the feasibility of implementing increased direct observations in your residency continuity clinic.

2. Troubleshoot an example milestone-based standardized direct observation tool for components that will enhance your program’s competency assessments.

3. Generate ideas for improving assessment, feedback and coaching of resident progress on the relevant milestones in your program’s continuity clinic settings.
Evaluation Tool/Form & Standardized Resources

- Shared through the AAIM phone app
Take Away Points

- You can do it
- You should do it
- This was how we did it
- Feel free to use our tools to do it yourselves
Thank you!

Questions?
Chief Direct Observation:

Date: ______________ Learner: ______________ Evaluator: ______________
Encounter type: New / Established Return / Acute
Clinic Location: MMH / CPE

Communication:
Communication with patients and inter-professional team (ICS1, ICS2, SBP1)

**Physician-Patient Relationship**

<table>
<thead>
<tr>
<th>Not observed</th>
<th>No. Unable to perform reliably, even with close guidance</th>
<th>In progress. Able to perform under ongoing direct supervision</th>
<th>Yes. Able to perform with minimal guidance</th>
<th>Yes. Able to perform independently like a board certified internist</th>
<th>Expert. Able to role model like a seasoned internist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developers counter-therapeutic relationship with patient, has difficulty identifying emotions of others, strong emotion(s) of oneself or others affects performance. Has difficulty asking personal questions in a nonjudgmental way.</td>
<td>Attempts to develop therapeutic relationship, but unsuccessfully. Recognizes emotions but has difficulty managing them.</td>
<td>Establishes therapeutic relationship. Anticipates and identifies emotions, responds to emotions in a professional way that builds trust. Uses verbal and nonverbal communication to build a therapeutic relationship.</td>
<td>Quickly establishes therapeutic relationship with patient. Identifies and manages physical, cultural, psychological, and social barriers to communication.</td>
<td>Role models effective communication and development of therapeutic relationship in routine and challenging situations</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Communication Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Observed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff/Inter-professional relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Observed</td>
</tr>
</tbody>
</table>

| 0 | 1 | 2 | 3 | 4 | 5 |
Chief Direct Observation:

**Date:** ___________  **Learner:** ___________  **Evaluator:** ___________

Comments:

### Time Management:

**Clinic Preparedness and Time Utilization during Patient Encounters (ICS3)**

#### Visit Preparedness

<table>
<thead>
<tr>
<th>Not observed</th>
<th>Could improve on knowledge of patient’s previous medical history.</th>
<th>Has adequate knowledge of previous medical history to help guide history taking.</th>
<th>Prepared enough to effectively and quickly utilize the patient’s prior history in medical decision making and in forming treatment plans.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

#### Agenda Setting

<table>
<thead>
<tr>
<th>Not observed</th>
<th>No. Unable to perform reliably, even with close guidance</th>
<th>In progress. Able to perform under ongoing direct supervision</th>
<th>Yes. Able to perform with minimal guidance</th>
<th>Yes. Able to perform independently like a board certified internist</th>
<th>Expert. Able to role model like a seasoned internist</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Could improve patient visit by setting agenda and addressing problems based on clinical severity. Visit lasted longer than scheduled.</td>
<td>Sets agenda but could improve adhering to this agenda. Visit went longer than expected.</td>
<td>Sets agenda and is able to redirect patient such that problems are addressed within the time scheduled for that visit.</td>
<td>Sets agenda incorporating patient preference as well as triage of medical problems. Redirects patient to complete visit in timely manner.</td>
<td>Actively solicits patient’s preferences as well as physician preference when setting agenda. Gives patient expectation of how long visit will last. Actively redirects patient to complete visit addressing problems based on patient concerns and medical necessity within the allotted time. When redirection needed, it is done quickly and skillfully preserving clinical relationship.</td>
</tr>
<tr>
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<td>2</td>
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</tbody>
</table>

2
### Chief Direct Observation:

<table>
<thead>
<tr>
<th>Efficient Documentation</th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Observed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not document in EMR during patient interview.</td>
<td>Documents some elements of visit in EMR, however, could improve active communication</td>
<td>Documents some important elements of history/physical while with patient. This activity only minimally interferes with active communication.</td>
<td>Documents most of important details during interview while maintaining high level of active communication. This activity does not interfere with active communication.</td>
<td>HPI or interval history is documented by the end of the patient interview/visit. Efficiently documents in the EMR while utilizing active communication such that it enhances the patient-physician interaction</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Workflow</th>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Observed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not understand clinic workflow, this impacts the clinic visit and forces staff to spend extra time on tasks.</td>
<td>Understands clinic workflow but does not use this to their advantage.</td>
<td>Uses some of the built-in workflow of the clinic to resident's advantage. Has some difficulty with completing AVS and entering orders in timely manner.</td>
<td>Places orders while interviewing patient, changes flags in the room to prompt staff to prepare for POC testing. Staffs visit. completes AVS, and enters orders in timely manner.</td>
<td>Is able to complete majority of documentation and order entry during visit. Utilizes staff appropriately to complete tasks within their scope of practice. Uses dotphrases and the EMR to their advantage to save time.</td>
<td></td>
</tr>
</tbody>
</table>

| 0 | 1 | 2 | 3 | 4 | 5 |
Chief Direct Observation:

Date: __________ Learner: ___________ Evaluator: ___________

**History/Physical Examination/Assessment-Plan:**
Gathers/synthesizes essential and accurate information to define and treat each patient’s clinical problem(s). (PC1, PROF3)

### History

<table>
<thead>
<tr>
<th>Not observed</th>
<th>No. Unable to perform reliably, even with close guidance</th>
<th>In progress. Able to perform under ongoing direct supervision</th>
<th>Yes. Able to perform with minimal guidance</th>
<th>Yes. Able to perform independently like a board certified internist</th>
<th>Expert. Able to role model like a seasoned internist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Takes a limited history and could improve on collecting more accurate historical data</td>
<td>Able to acquire accurate historical information, but misses key components and could improve on collecting data in an organized fashion</td>
<td>Acquires accurate and relevant histories from patients including all key components but could improve on collecting data in more organized fashion</td>
<td>Acquires accurate histories from patients in an efficient, prioritized, and hypothesis-driven fashion</td>
<td>Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### Physical Exam

<table>
<thead>
<tr>
<th>Not observed</th>
<th>Does not use physical exam to confirm history</th>
<th>Performs an appropriate but not thorough physical exam</th>
<th>Performs an appropriate and thorough physical exam, but could improve on examination technique(s)</th>
<th>Performs an appropriate and thorough physical exam and performs all exam maneuvers correctly</th>
<th>Performs targeted physical exams and identifies subtle or unusual physical exam findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### Assessment and Plan

<table>
<thead>
<tr>
<th>Not observed</th>
<th>Does not recognize patient’s central clinical problem</th>
<th>Recognizes patient’s central clinical problem(s), but could improve the appropriateness and accuracy of the care plan, requires significant attending guidance</th>
<th>Recognizes patient’s central clinical problem(s) and care plan is appropriate and accurate with attending guidance</th>
<th>Recognizes patient’s central clinical problem(s) and care plan is appropriate and accurate without attending guidance</th>
<th>Recognizes patient’s central clinical problem(s) and care plan is appropriate and accurate without requiring attending guidance, anticipates future management</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tbody>
</table>
Chief Direct Observation:

Date:______________  Learner:_______________  Evaluator:_____________

**Individualized Assessment and Plan**

<table>
<thead>
<tr>
<th>Not observed</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not ask about patient preferences, or recognize patient's cultural, gender, socioeconomic issues</td>
<td>Asks about patient preference but could explore them in more detail</td>
<td>Asks about patient preference and explores them in detail but could improve on incorporating them into management decisions</td>
<td>Asks about and understands patient preferences. Incorporates preferences into management decisions.</td>
<td>Asks about and understands patient preferences and recognizes their context as a part of patient’s cultural, gender, socioeconomic issues. Incorporates preferences into management decisions.</td>
<td></td>
</tr>
</tbody>
</table>

0 1 2 3 4 5  

Comments:

**OVERALL COMMENTS:**

**Next Steps:**

*Below are two areas of opportunity identified during your observation. The next steps are to collaborate with your preceptor and review the educational materials provided to you by the chief resident to build upon these skills.*

1.  

2.  


List of Resources Available to provide to the resident to work on “next steps”

**Communication: The Patient-Physician Relationship**

- **Vital Talk** has great videos (~1-2 minutes each) and a quick set of resources that are primarily gauged for oncology/palliative care. However, the majority of their content is very applicable to developing efficient relationships with our patients. Within their videos, they discuss how to navigate emotions, break difficult news, and how to establish rapport with patients. In order to access the free content, go to [http://vitaltalk.org/resources/](http://vitaltalk.org/resources/).
  - Under communication tools, you will find several sets of very brief videos and guides. We recommend viewing the following (but feel free to watch them all!)
    - Establish Rapport
    - Track and Respond to Emotion and the guide (“NURSE” mnemonic)
    - Defuse Conflicts and the guide
    - Stay Strong

**Communication: Shared decision making**

- **Shared Decision Making: A Model for Clinical Practice**, this is a great article by Elwyn et al that summarizes a three step model for shared decision making (“choice talk, option talk, and decision talk”) See the attached article. Pubmed ID: 22618581

**Time Management: Visit Preparedness**


**Time Management: Agenda Setting**


**Time Management: Efficient Documentation**

- General Internal medicine HPI dot phrases
  - .gimhpibackpainacute (acute back pain)
  - .gimhpithtnew (new hypertension)
  - .gimhpithnest (established hypertension)
  - .gimhpitobacco (tobacco usage)
  - .gimhpisinusitis (sinusitis)
**History/Physical Examination/Assessment-Plan: History**

- GIM HPI dot phrases (as above)

**History/Physical Examination/Assessment-Plan: Physical Exam**


**History/Physical Examination/Assessment-Plan: Assessment and Plan**

- Hopkins Modules, Internal Medicine Curriculum [https://ilc.peaconline.org/](https://ilc.peaconline.org/)
- [https://www.sgim.org/File%20Library/SGIM/Meetings/Annual%20Meeting/Meetign%20Content/AM%202014%20handouts/WD07-Amanda-Clark.pdf](https://www.sgim.org/File%20Library/SGIM/Meetings/Annual%20Meeting/Meetign%20Content/AM%202014%20handouts/WD07-Amanda-Clark.pdf)
- GIM Division Website Mini-Grand Rounds Series: [https://onesource.osumc.edu/departments/GIM/Pages/Faculty-Development.aspx](https://onesource.osumc.edu/departments/GIM/Pages/Faculty-Development.aspx)

**History/Physical Examination/Assessment-Plan: Individualized Assessment and Plan**

- Cultural competency handouts
- Vital Talk [http://vitaltalk.org/resources/](http://vitaltalk.org/resources/)