Kuhn G, Courage C, Hill-Rice V / Wayne State University Detroit Medical Center, Detroit, MI

Introduction/Background: Use of tobacco products is the most common cause of preventable death globally. Giving first-year medical students opportunities for clinical experiences has been shown to be highly effective and results in long-term retention of knowledge and skills.

Educational Objectives: We report a curriculum designed to provide first and second-year medical students didactic and experiential learning counseling patients on smoking cessation in the emergency department (ED) setting.

Curricular Design: A needs assessment was performed via a literature search and discussion with a group of medical students. The curriculum contained three elements: a two hour lecture providing students with knowledge about the burden of disease, diseases associated with smoking, pharmacotherapy aids for quitting smoking, and counseling patients using the "Five As" recommended by the Agency for Healthcare Research and Quality (AHRQ). Former smokers discussed quitting difficulties and answered questions. An orientation included a tour of the ED, Health Insurance Portabliity and Accountability Act training, and discussion of professionalism. The authors modeled patient counseling and use of AHRQ booklets. Guided practice was provided until students were comfortable counseling patients. Continued mentorship and guidance were provided via e-mail and meetings on an as-needed basis. All students were contacted after their first independent counseling session to identify problems, need for additional information, number of patients counseled, and impressions of learning.

Impact/Effectiveness: This model curriculum requires minimal supervision after initial training, is generalizable, and provides medical students with both didactic information and experiential learning. Student feedback resulted in program modifications.

Table 1. OPERATION DON'T SMOKE: Cumulative results (2009-2013).

	N
Number of student volunteers	154
Total number of patients counseled	471
Hours volunteered by students	
Total	706
Mean(SD)	6(1.4)
Median	6
Range	1-44

Table 2. Themes in student feedback (n=42).

	N
Enjoyment/enthusiasm/support for project	29(69.0%)
Surprise at patients' openness/receptiveness to quitting	19(45.2%)
Acknowledged clinical/career relevance	16(38.1%)
Felt the need to provide patients with more information	13(31.0%)
Suggested different methods of getting message across to patients	10(23.8%)
Felt students needed more guidance/ assistance/information	9(21.4%)
Students felt they made a lasting impact on patients' health	8(19.0%)
Difficulty or concerns	5(11.9%)
Felt preparatory materials/lecture were effective	4(9.5%)
Other suggestions provided	4(9.5%)

53 Patient Perceptions of Medical Provider Communication Skills as Influenced by Openness and Personal Characteristics

Burkhardt J, Perry M, Zink K, London K, Floto O, Santen S / University of Michigan, Ann Arbor, MI

Background: Communication is a key ability for medical professionals and previous research has demonstrated that patient characteristics may play a role in the successful establishment of the provider/patient relationship.

Objectives: Patient and physician personal characteristics, including openness on the part of the provider about their own lives, have an important role in establishing effective communication in the clinical setting and shape patient perception of this interaction.

Methods: Emergency medicine provider/patient interactions were observed in an academic setting. Surveys were distributed regarding perceived provider communication ability and demographic information. A multinomial logistic regression was estimated with outcomes of below average to average (1-3), good (4), and very good (5) communications scores. Independent variables were patient age, race and ethnicity, patient gender, patient education, patient pain score, provider role, and whether the provider talked about themselves. This study received institutional review board approval.

Results: The multinomial logistic regression was statistically significant at the $p<0.01$ level. Patient age, patient gender, mid-level providers, and whether the provider talked about themselves were all significantly correlated with provider communication scores (Table 1). Providers who talked about themselves were 4.79 (95% CI:[0.29, 2.84]) times more likely to score very good (5) than below average to average (1-3) on patient perception of communication. Similarly, Mid-level Providers (Residents and Physician Assistants) compared with Faculty were 3.79 (95% CI:[0.22, 2.45]) times more likely to score very good (5) than below average to average (1-3) on the same scale.

Conclusions: Providers who talked about themselves and were in a mid-level provider role were correlated with

Table 1. Multinomial logistic model.

	Good (4)			Very good (5)		
	Log coefficient	Relative risk ratio	Confidence level	Logit coefficient	Relative risk ratio	Confidence level
Patient age	0.02*(0.01)	1.023* (0.01)	-0.00,0.05	0.03*** (0.01)	1.03*** (0.01)	0.01,0.06
URM	-0.08 (0.46)	0.92 (0.42)	-0.98, (0.82)	0.40 (0.45)	1.49 (0.67)	-0.48, 1.28
Female	-1.35*** (0.46)	0.26*** (0.12)	-2.26,-0.44	-1.53*** (0.46)	0.22*** (0.10)	-2.44,-0.63
Above college degree	-0.18 (0.56)	0.84 (0.47)	-1.27, 0.91	-0.52 (0.56)	0.60(0.33)	-1.61, 0.57
Bachelor's degree	-0.06 (0.53)	0.94 (0.50)	-1.11, 0.98	-0.84 (0.53)	0.92 (0.49)	-1.12, 0.96
Some college	0.45 (0.49)	1.57 (0.76)	-0.51, 1.40	0.17 (0.49)	1.18 (0.58)	-0.79, 1.13
Pain score	0.04 (0.06)	1.04 (0.07)	-0.09, 0.16	0.01 (0.06)	1.01 (0.06)	-0.12, 0.13
Residents and PA's	1.05* (0.57)	2.85 (1.63)	-0.08, 2.17	1.33** (0.57)	3.79**(2.16)	0.22, 2.45
"Not sure" if talked about self	1.45 (1.07)	4.26 (4.55)	-0.64, 3.54	1.99*(1.06)	7.28* (7.69)	-0.08, 4.06
"Yes" talked about self	0.93 (0.66)	2.53 (1.67)	-0.37, 2.23	1.57** (0.65)	4.79** (3.11)	0.29, 2.84
Constant	0.87*(0.72)			0.70(0.71)		

higher communication scores. Patient gender and age, but not minority status, were significant predictors of perceived communication ability of providers.

54 Protecting Faculty Time for Direct Observation Shifts in a Large Emergency Medicine Residency Program

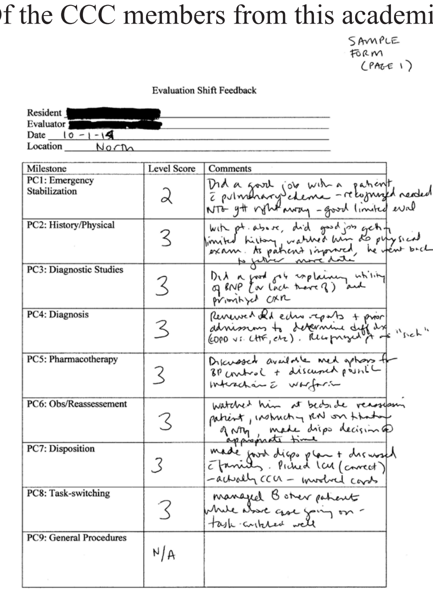
Shoenberger J, Taira T, Tabatabai R, Osterman J / Keck School of Medicine of USC, Los Angeles, CA

Introduction: Direct observation is listed as a suggested evaluation method for 22 of the 23 emergency medicine (EM) milestones. The challenge for the faculty evaluator when attempting to perform direct observation during a clinical shift is doing so in a chaotic environment with many interruptions and other expectations. Many departments have considered protecting faculty time to engage in direct observation but have struggled with the potential cost without clear benefit.

Educational Objective: To implement a program to protect faculty time to perform direct observation and give high quality feedback to residents.

Design: In July 2013, the program started at a large single-site EM residency. Two to three 8-hour shifts per week were added to the clinical schedule as "observation shifts". Only core faculty are eligible to participate and participation is voluntary. These shifts are counted as part of the faculty member's clinical shift count. During the observation shift, faculty are assigned minimal clinical duties as the emphasis is on direct resident observation. On average, faculty evaluate 3-4 residents per shift. To prevent duplication, each faculty member is given a summary sheet listing residents still in need of observation and which milestones need to be observed. After performing dedicated direct observations, faculty members spend time giving residents high quality, real time feedback. They are also able to simultaneously educate the residents on the EM milestones. The observation forms are used during Clinical Competency Committees (CCC) evaluations.

Impact: Residents had the opportunity to evaluate the new observation shift on the end-of-year program evaluation form in June 2014 and the comments were >90% positive. Residents responded most positively to the feedback portion of the shift. Of the CCC members from this academic year


SAMPLE FORM (PAGE 1)

Evaluation Shift Feedback

Resident [redacted]
Evaluator [redacted]
Date 10-1-14
Location North

Milestone	Level Score	Comments
PC1: Emergency Stabilization	2	Did a good job with a patient c̄ pulmonary edema – recognized needed NTG gtt right away – good limited eval
PC2: History/Physical	3	with pt. above, did good job getting limited history, watched him do physical exam. As patient improved, he went back to gather more data
PC3: Diagnostic Studies	3	Did a good job explaining utility of BNP (or lack there?) and prioritized CXR
PC4: Diagnosis	3	Reviewed old echo reports + prior admissions to determine diff dx (COPD vs. CHF, etc). Recognized pt as "sick"
PC5: Pharmacotherapy	3	Discussed available med options for BP control + discussed possible interaction c̄ warfarin
PC6: Obs/Reassessement	3	watched him at bedside reassessing patient, instructing RN on titration of NTG, made dispo decision @ appropriate time
PC7: Disposition	3	made good dispo plan + discussed c̄ family. Picked ICU (correct) – actually CCU – involved cards
PC8: Task-switching	3	managed 8 other patients while above case going on – task-switched well
PC9: General Procedures	N/A	

Figure 1.