

incorporated the program director, program coordinator, and residents into each roadshow experience.

We began by using geographic filters to focus on applicants with ties to our 3-state region for the roadshow. After review of application credentials, we selected an average of 90 candidates for interviews. We then identified 4 regional cities that are home to academic medical centers (Augusta, Greenville/Spartanburg, Chapel Hill, and Charleston). Candidates were selected for individual days based on geographic proximity (FIGURE). Recruitment Roadshow days were divided into morning and afternoon sessions to minimize candidate time away from campus. All informational material, including information on current residents, program policies, local attractions, and contact information, were given to candidates in electronic format on a customized USB flash drive.

The program director, program coordinator, and at least one resident representative with prior educational connections to the city-specific academic medical center traveled to each roadshow location. Information sessions and interviews were held at hotels in close proximity to each academic medical center. Two additional on-campus interview days with associated “open houses” at our institution were offered for applicants who were unable to attend the regional interviews, or for those regional participants who wanted to visit our institution in person.

Outcomes to Date

In the 3 years since the Residency Recruitment Roadshow inception, 157 candidates have been interviewed through this program. An additional 94 applicants were scheduled for interviews on open house days at our institution. A total of 210 of 252 candidates (92%) attended medical school in either Georgia, South Carolina, or North Carolina. Nearly 85% of candidates (132 of 157) traveled less than 30 minutes to attend the interview. Feedback from applicants was universally positive regarding this regional interview concept.

We present the Residency Recruitment Roadshow as a potential strategy for other residency programs to emulate for successful regionally targeted, candidate-centered recruitment. Our approach reduces time and financial burdens on applicants while still providing in-person interactions with key program leadership and current residents as they embark on their graduate medical education journey.

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ReadMI: An Innovative App to Support Training in Motivational Interviewing

Setting and Problem

Substance misuse is not consistently addressed within the scope of routine medical practice. More than 90% of primary care physicians fail to diagnose substance misuse when presented with early symptoms of alcohol or drug misuse in an adult patient. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an integrated, evidence-based approach aimed at delivering early intervention in medical settings for drug and alcohol misuse. An integral component of SBIRT is motivational interviewing (MI), a brief, evidence-based, interventional practice that has been demonstrated to be highly effective in triggering change in high-risk lifestyle behaviors. MI is a patient-focused conversation between a practitioner and a patient that reinforces a patient's motivation to make positive changes in any targeted health behavior. Due to ineffective training, MI is underutilized. The MI approach is very difficult to teach to practitioners who are accustomed to taking a directive approach with patients, asking closed-ended questions (which require yes/no answers), and doing most of the talking. To implement MI and SBIRT widely, there is a critical need to improve the MI training process in graduate medical education.

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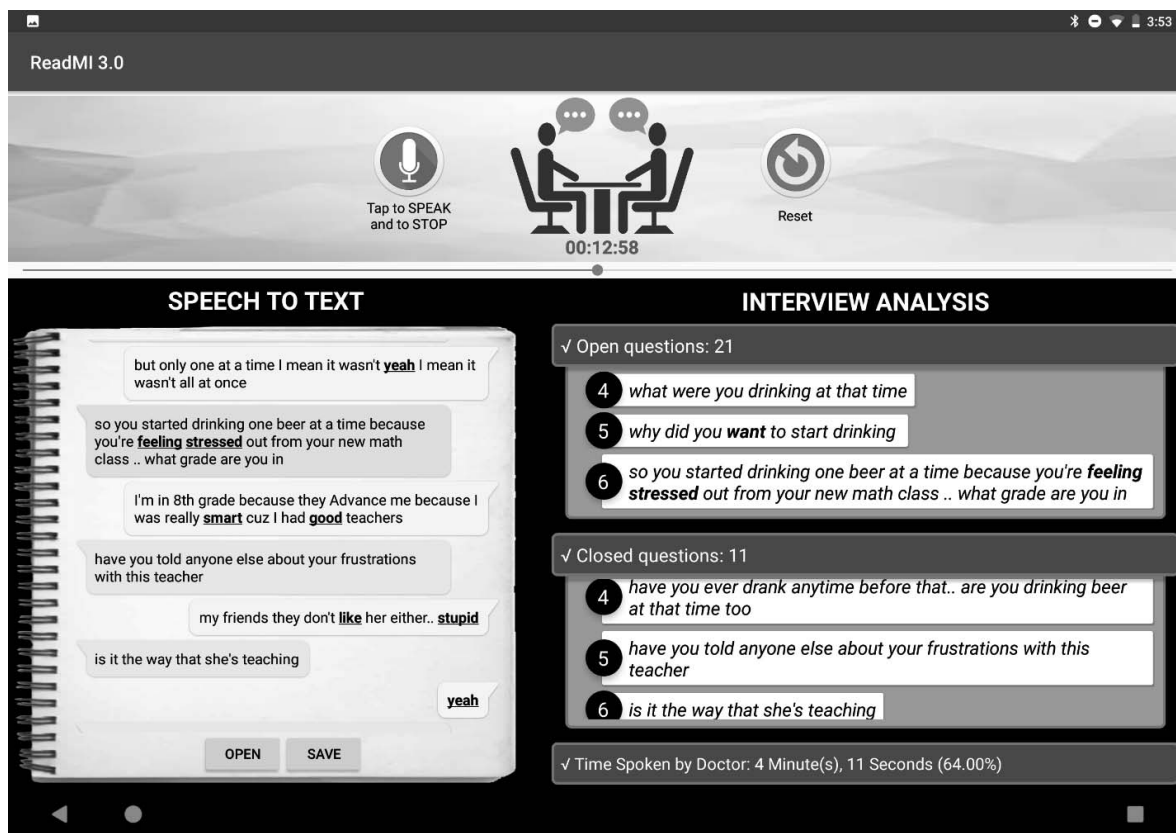


FIGURE
Screenshot of ReadMI Interface During Training With a Medical Resident

Intervention

Our research team has been developing and testing a training tool that uses natural language processing to provide Real-time Assessment of Dialogue in Motivational Interviewing (ReadMI). ReadMI is a low cost, ultraportable solution to enable instantaneous MI training assessment and analysis. It makes use of the latest advances in deep learning-based speech recognition and mobile and cloud computing technologies. In real time, ReadMI produces a spectrum of metrics for MI skills evaluation, including the number of open- and closed-ended questions asked, provider versus patient conversation time, use of emotion words, number of reflective statements, and use of a change ruler, which are all integral parts of MI. One of the innovative properties of ReadMI is that it will provide real-time feedback in the form of a buzzer and a light to trainees whenever they ask 3 consecutive closed-ended questions. ReadMI can facilitate resident skill development in MI as this software-based training solution analyzes their responses and provides immediate feedback. Our central hypothesis is that ReadMI will produce

significantly better MI performance than traditional MI training.

Outcomes to Date

The current version of ReadMI automatically produces the complete transcripts of the MI dialogue with over 92% accuracy and reports on provider versus patient conversation time (over 95% accuracy) and the number of open- and closed-ended questions (over 92% accuracy). The preliminary results demonstrate the significant benefit of making ReadMI results available in real time to the trainer and trainees. In role-play training sessions with a simulated patient (FIGURE), ReadMI produces specific metrics that a trainer can share with the resident for immediate feedback. This can be particularly effective for situations in which the resident is doing most of the talking, primarily asking closed-ended questions, or ignoring emotion words used by the patient. Given the time constraints on targeted skill development faced by most residency programs, ReadMI decreases the need to rely on subjective feedback and more time-consuming video review to illustrate important teaching points.

We plan to test ReadMI in a randomized controlled trial, comparing residents who receive MI training

with ReadMI technology with residents who receive the usual and customary MI training. ReadMI has the potential to transform MI training, because the prospective applications of ReadMI extend far beyond substance misuse detection and intervention to include chronic disease management. ReadMI will likely improve health care quality by better equipping physicians as decision support agents in their efforts to facilitate patients' health-related behavior change.

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“Clinical Teaching is Like Improv Because. . .” A Faculty Development Strategy

Setting and Problem

The opportunity to teach is often cited as an important reason physicians become involved in graduate medical education (GME). As of July 1, 2019, the Accreditation Council for Graduate Medical Education Common Program Requirements will require faculty members to pursue formal faculty development designed to enhance their skills, including those as teachers. Research has demonstrated that while expert teachers often appear to teach (or perform) without a lesson plan, it is not unplanned. Expert clinical teachers take cues from the patient, learners, setting, and time available to decide which educational path to pursue. It's an interactive process determined by the responses of the learners (audience)—adapting the content and strategies to best meet learners' needs—a skillset that is commonly associated with improv.

Intervention

Improv is increasingly used in medical education as an approach to improve communication skills. But it has had limited application as a faculty development strategy focused on clinical teaching. Applied Improv, like clinical teaching, has key principles and rules ranging from “Be present” and “Respect your Partner” to “Yes and . . .” When these skills are applied to a “teaching scene,” they yield faculty development exercises that are quick, practical, timely, and consistent with key principles of well-being (purpose and meaning as teacher, competence, relationship, autonomy). Our sessions begin, just as in improv, with at least one warm-up exercise. For example, participants shout out responses to an exercise called “Go with the possibility that clinical teaching is like improv because . . .” This exercise requires participants to warm up cognitively by identifying commonalities. The “Teacher's Pet Peeves” dyad warm-up exercise starts with one participant stating a teaching “peeve” (*Residents just don't read anything in depth—only what's on their app*). The

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