the clinic team felt the interns were integrated into the care team much more smoothly and rapidly when compared to previous years. Due to the overwhelmingly positive feedback, we plan to incorporate this rotation for the upcoming academic year. The main adjustment will be to improve the integration of the patient care into the lecture days to avoid the potential for "educational overload" from multiple content sessions.

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New Ideas

The Resident Audio Recording Project: A 3-Step Process to Improve Clinical Communication Skills

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Setting and Problem

Communication is a crucial skill that an internist must master to improve patient outcomes and limit liability. Accreditation Council for Graduate Medical Education Internal Medicine Reporting Milestone No. 20 evaluates residents on their ability to communicate with patients and their caregivers, but the concept presents innumerable challenges of interpretation and scoring because of its fluidity and nuanced nature. There is no consistent platform to evaluate residents and provide feedback for outpatient encounters. Recognizing the importance of communication competency in resident education, Southern Illinois University Department of Internal Medicine developed the Resident Audio Recording Project (RAP).

Intervention

RAP is a collaborative and longitudinal evaluation project of residents' communication skills during outpatient encounters using audio recordings. The project was initiated in 2008, choosing audio recordings as a cost-effective method to track residents' clinical communication skills. Reviews are provided by 3 to 5 person review panels that include faculty and university staff with multidisciplinary backgrounds, representing medicine, education, communication, and conversational analysis. The group's composition ensures representation of multiple perspectives to measure the success of the interview. Three review panels follow a stable group of residents over the 3 years of residency.

Each RAP review consists of 3 steps:

1. A resident records a consented patient encounter in the outpatient clinic.
2. The interview is transcribed and provided to the respective group panelists along with the original audio recording. At a group meeting the transcript is reviewed while the audio encounter is played back. Each member evaluates the communication independently. A final group discussion produces a consensus evaluation of the interviewer's effectiveness.
3. Following the review, the resident meets with a panel mentor for feedback. The resident is provided a transcript and listens to his or her recording to self-evaluate during the hour prior to the meeting. During this mentor session, positive and negative feedback are provided on various aspects of the resident's communication skills.

Each resident completes 1 RAP session per year. Total time involved for the recording is around 4 to 6 hours of

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TABLE **Numbers of Residents with 1 Recording per Year for 3 Years and the Number of Recordings Used for Comparison, As Well As Recordings Including Teachback**

	Residency Year			
Table 1a: Cohort	**R1**	**R2**	**R3**	**Total Recordings**
1	6	6	6	18
2	10	10	10	30
3	13	13	13	39
Total recordings for residents with 1 recording per year	29	29	29	87
Mean RAP score[a]	1.6	2	2.3	
Table 1b: Teachback vs No Teachback	**R1**	**R2**	**R3**	**Total Recordings Compared for Teachback**
Teachback	8	16	12	36
No teachback	50	35	24	109
Total recordings for residents who made a recording[b]	58	51	36	145
Percentage teachback	16%	45.7%	50%	

For a copy of the evaluation form, contact M. Papireddy, MD, at mpapireddy@siumed.edu.

[a] Kruskal-Wallis H = 36.97; df = 20; $P = .01$.
[b] Chi-square = 6.3; df = 2; $P < .05$.
Abbreviation: RAP, Resident Audio Recording Project.

faculty and panelist time, including 90 minutes of resident time and 90 minutes of attending physician time.

Outcomes to Date

Since 2008, we evaluated and gave feedback for 145 recordings. Residents' acceptance of feedback is positive, and over the 5-year period we have observed a steady improvement in the communications competency from the intern to the final year. RAP scores range from 0 to 4 for each of 23 categories of communication (0, unsatisfactory; 4, exemplary). Data for the first 3 cohorts of residents (academic years 2009–2012), with 1 recording per year each, indicate that there are significant increases in mean RAP scores by resident year: postgraduate year (PGY)–1 = 1.6, PGY-2 = 2.0, PGY-3 = 2.3 (Kruskal-Wallis H = 36.97; df = 20; $P = .01$; TABLE 1A). One drawback is that while an audio recording can capture nonverbal audio cues, including voice tones and speed of speech, it cannot capture body language or bedside manners as well as video. However, the transcript has proven to be a respected tool from both sides of the table.

An added benefit of the review process is that it continually evolves as our panelists debate what constitutes best communication practices. Since the project began we have seen changes in resident communication skills, not only in the outpatient clinics, but also in the inpatient setting. One major gain in communication occurred in the area of teachback, a technique to assess patient understanding. Only 16% of PGY-1 residents used teachback, whereas there is a significant increase of its use among PGY-2 residents (45.7%) and PGY-3 residents (50% [Chi-square = 6.3; df = 2; $P < .05$; TABLE 1B]).

Conclusions

As a result of our RAP project, communication skills have become a visible entity within our program. For the residents, this means they see their communication with patients as inspectable and potentially improvable. But it has done more—the project has engendered a conversation within the department about what counts as competence in clinical communication.

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New Ideas

Meeting of the Minds: A Novel Longitudinal Ambulatory Mental Health Rotation for Internal Medicine Residents

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Setting and Problem

Primary care physicians often are the first providers to encounter patients with undiagnosed or undertreated psychiatric illness, but they are rarely trained to competently evaluate and treat these patients. In addition, mental health resources are difficult for patients to access. Providing internal medicine (IM) residents with education and training in ambulatory mental health will better equip them with the competencies to address the needs of this complex patient population.

Intervention

We adopted a "2 + 4" immersion schedule for our primary care IM residency at Cambridge Health Alliance to provide more meaningful ambulatory training experiences. Residents rotate for 2 weeks in the ambulatory setting, alternating with 4 weeks in other inpatient settings and electives for all 3 years of training. This structure emphasizes longitudinal relationships with patients, a meaningful participation in our transformation to a patient-centered medical home and our focus on teamwork and community health.

Residents participate in a primary care continuity clinic at 1 of 3 busy, urban community health centers affiliated with our institution. Psychiatric comorbidity is common in our patient population. In an integrated model of care, staff psychiatrists, psychologists, and counselors work with primary care providers at each site to care for patients with comorbid psychiatric illness and addictions.

We developed a novel longitudinal mental health rotation for our first-year primary care residents which addresses the gap in mental health knowledge and skills for primary care IM residents. We worked closely with psychiatry leaders to align faculty resources and goals for the rotation. This work was facilitated by an existing structure of psychiatry providers who already practiced in the ambulatory sites where IM residents see their patients. Core goals and objectives for the rotation were developed collaboratively by IM and psychiatry faculty.

Outcomes to Date

For a full year, first-year residents work with a staff psychiatrist once a week at the resident's continuity clinic site. During this 4-hour session, IM residents participate in the care of patients referred to a consult liaison psychiatrist, and comanage each patient with the consultant. Time is set aside for case-based teaching that builds longitudinally throughout the year. The rotation enables trainees to refer their own patients to sessions with the psychiatrist. Importantly, IM residents are present for the mental health evaluation and contribute the medical perspective, as diagnostic and treatment strategies for each patient are evolving. Rather than seeing patients once in an acute phase of mental illness, as is the case in inpatient psychiatry rotations for IM residents, this

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