

<p>"made their CC more personal. my patient was pregnant for the first time and had vaginal bleeding for the fourth time during this pregnancy. she kept apologizing (which didn't really bother me) but her card said she was most scared because it was her first pregnancy it gave her a much more vulnerable and human image, not just another patient with vaginal bleeding that required an uncomfortable exam."</p>	<p>"Reminded me that we are treating patients, not just diseases. The exercise really came as a humanizing reminder that we take care of human beings just like us, and taking a brief moment from worrying about ordering labs, documenting, requirements for billing, etc. and instead trying to understand my patient's concerns makes our job so much more real."</p>
<p>"I found this to be extremely helpful. I think it helped me to address the pts specific concern and discuss it with them. It also helped form a meaningful connection. Knowing someone's biggest worry is a big deal. I felt honored to discuss it with them and have a truly honest conversation."</p>	<p>"Made me think harder about treatment options I was considering - cost, ease of getting med and follow-up (transportation). Humbling to realize all the issues my patients are dealing with and how their health fits into or exacerbates those struggles"</p>
<p>"Psychiatric patient reflecting on being treated like a "human being". Very humbling and made me much more conscious of how I treat and respect my psychiatric patients"</p>	<p>"It made me think deeper about them as a being - This brings us back to the reasons we chose to work in this environment and reminds us that compassion and human connection are just as important as meds and clinical care"</p>

**Figure 2.** Example provider reflections displaying the theme of patient "humanization".

## 17 Critical Conversations: Using Simulation to Improve Comfort & Skill With Goals of Care Discussion.

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**Background:** Despite evidence that most Americans would prefer to die at home, the majority of them die in a health care institution. Goals of care conversations reduce the incidence of unwanted aggressive intervention, but physician discomfort with goals of care conversations leads to avoidance of such conversations. This suggests a need for a formal educational intervention to teach these critical communication skills, especially in the field Emergency Medicine which encompasses the care of both the critically and chronically ill.

**Educational Objectives:** To increase resident comfort and proficiency with goals of care conversations in an emergent setting.

**Curricular Design:** The educational intervention began with a didactic component covering both common terminology in end-of-life care, as well as a review of terminology to utilize and avoid during end-of-life conversations. Following this didactic session, learners participated in four different simulation cases that utilized high fidelity mannequins as patients and actors as family members. These cases addressed common goals of care scenarios in the emergency setting, including an advanced lung cancer patient unaware of his prognosis, a pair of conflicted family members with difficulty making decisions for an acutely ill and elderly mother, a hospice patient with progressive dyspnea, and a neurologically-devastated patient to be terminally extubated in the ED. Each case required residents to initiate direct but empathetic goals of care conversations with patient and/or family. Debriefing was performed by the standardized family

member(s) and an independent moderator. Feedback was given on bedside manner, terminology used and effectiveness of overall communication.

**Impact/Effectiveness:** Using a 5-point Likert scale format, emergency medicine resident physicians were surveyed before and after participation in the end of life simulation session. Post-participation, residents endorsed being significantly more comfortable initiating end of life conversations (3.7 vs. 3.3, p=0.009), contacting palliative care or hospice (3.7 vs. 2.4, p< 0.001), and initiating palliative, comfort or hospice care in the emergency department (3.5 vs. 2.3, p = 0.001).

## 18 Data-Driven Evaluation of Residents' Clinical Competence: Automating the Model of Clinical Practice of Emergency Medicine

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**Background:** Accurate, efficient tracking of procedures poses technical challenges that have been the subject of recent research and innovation. Procedural competency is only a portion of the knowledge and experience residents need to obtain through postgraduate training. The Model of Clinical Practice of Emergency Medicine ("EM Model") is a comprehensive list of everything the fully trained EM physician should have mastered. It is scientifically-derived, widely accepted, and details the breadth and depth of our field. First published in 2001 based on empiric data, it is reviewed and updated by panels of experts every 2 years. It serves as the basis for ABEM examinations, and is foundational to curricular planning by ACEP, CORD-EM, and residency programs across the US.

In 2011, Tintinalli et al published one of the only studies attempting to quantify the variation in clinical encounters among trainees in the same program. They found substantial variation among residents in the same cohort, 30% to 60%, with maximal variation corresponding to roughly 1 year of clinical training. There is currently no accepted method for tracking this wide variation, leaving learners and educators to guess at gaps in clinical experience, without data to inform educational plans.

**Educational Objectives:** To build a tool to automatically track resident clinical encounters by mapping all items of the EM Model to diagnostic and procedural codes already recorded in patient charts.

**Curricular Design:** We mapped each Model of EM item to 1 or more ICD-10 codes and SNOMED concepts, and each procedure to 1 or more CPT codes. These surrogates are nearly universal searchable constants in the EMR; each item and its matching code(s) can be queried in real time to