
PRACTICAL TIPS ON IMPLEMENTING A PROGRAM OF DIRECT OBSERVATION:

Lessons Learned from a
Multi-Institutional Pilot Project

Thanks to...

- The APPD for support from the Special Projects Fund
 - Children's National Medical Center Research Advisory Council
 - The Ambulatory Pediatrics Association Region 4 Start-up Funding
-

Our Project Team

- Dale Coddington, Sandra Cuzzi, Ellie Hamburger
 - Children's National Medical Center
 - Angela Allevi and Lindsey Lane
 - Jefferson Medical College
 - Joseph Lopreiato and Clifton Yu
 - Uniformed Services University of Health Sciences
-

Today's Plan

- Introductions and Overview
 - Steps in Implementing Direct Observation
 - Purpose
 - Tools
 - Settings
 - Orientation of residents and faculty
 - Panel Discussion of Lessons Learned
 - Moving forward in your program
-

Getting to Know You-

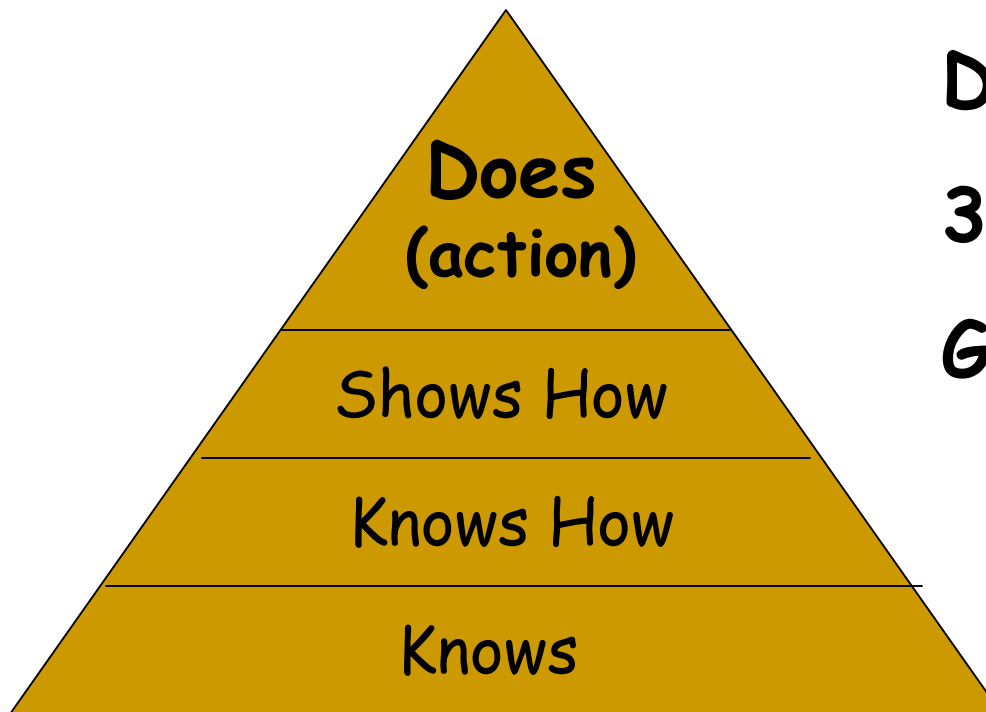
- Do you currently have a program of direct observation?
 - Do you use a tool to record observations and feedback?
 - In what setting are your residents observed?
 - What do you hope to get out of this workshop?
-

Realistically, how can it be done?

- Series of brief (3-5 minute) observations over time
 - Set up observation plan with the resident beforehand
 - Provide timely focused feedback right after observing
-

Why Do Direct Observation?

Hierarchy of Clinical Assessment



Direct Observation
360° Evaluation
Global Ratings

How does direct observation relate to ACGME competencies?

- Hearing a resident present a case gives you information about:
 - Medical Knowledge and Patient Care
 - Seeing a resident interact with a patient gives you that plus a window into their:
 - Interpersonal & Communication Skills and Professionalism
-

Step 1- What is your purpose for direct observation?

- Documentation of competencies
 - Formative evaluation
 - Summative evaluation
-

Step 2- Choosing Your Tool

- What is the primary purpose of the observation?
 - How are you going to document the observation?
 - Where are you observing/documenting currently?
-

Modified SCO

(Structured Clinical Observation)

- Adapted from a tool developed by Lane and Gottlieb at Jefferson Medical College for use with medical students
 - Incorporated ACGME competencies
 - Developed a checklist of behaviors
 - Currently being studied for reliability, validity, feasibility
-

Why use a tool at all?

- Standardizes what faculty watch for
 - Clarifies expectations for both faculty and residents
 - Guides feedback to make it more specific
 - Facilitates sharing of information to address programmatic gaps
 - Fulfills documentation requirements
-

Step 3 -Choosing Your Setting

- Where are faculty already doing observation (but maybe not documenting it)?
 - Which faculty members will be enthusiastic about doing this?
-

Project Settings

- Continuity Clinic
 - Newborn Nursery
 - Inpatient (family-centered rounds)
 - Out-patient Block Month
-

Step 4- Orient Your Faculty

- Assess your faculty members current knowledge, attitudes and experience about observation AND feedback
 - What faculty development is needed and how do you know if it's effective?
-

Faculty Attitudes & Experience

(data obtained prior to our D.O. program)

21% had training in direct observation

36% familiar with one or more tools

35% routinely observe in continuity clinic

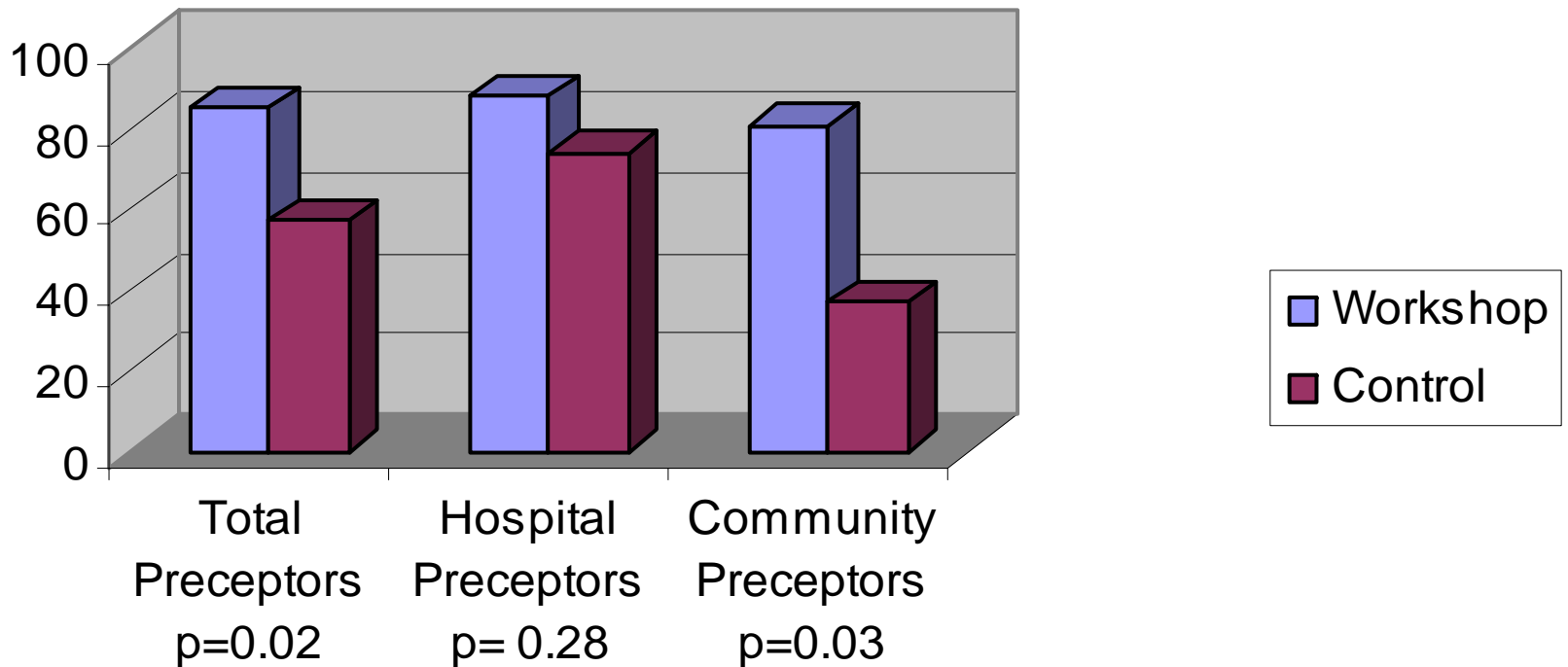
13% give feedback after obs. >80% of time

61 % comfortable with process of observing

80% thought direct observation was valuable

Impact of Faculty Development: 12-Month Follow-up

Percent of Preceptors doing Direct Observation at 12 months



Step 5- Orient the residents

- What are resident attitudes and experiences with direct observation?
 - Who will do the orientation?
-

Resident Attitudes & Experience

(data obtained prior to our D.O. program)

89% report observed during residency

23% said a formal instrument was used

37% routinely got feedback after D.O.

Patient care is the ACGME competency
most commonly addressed

Orienting the Residents

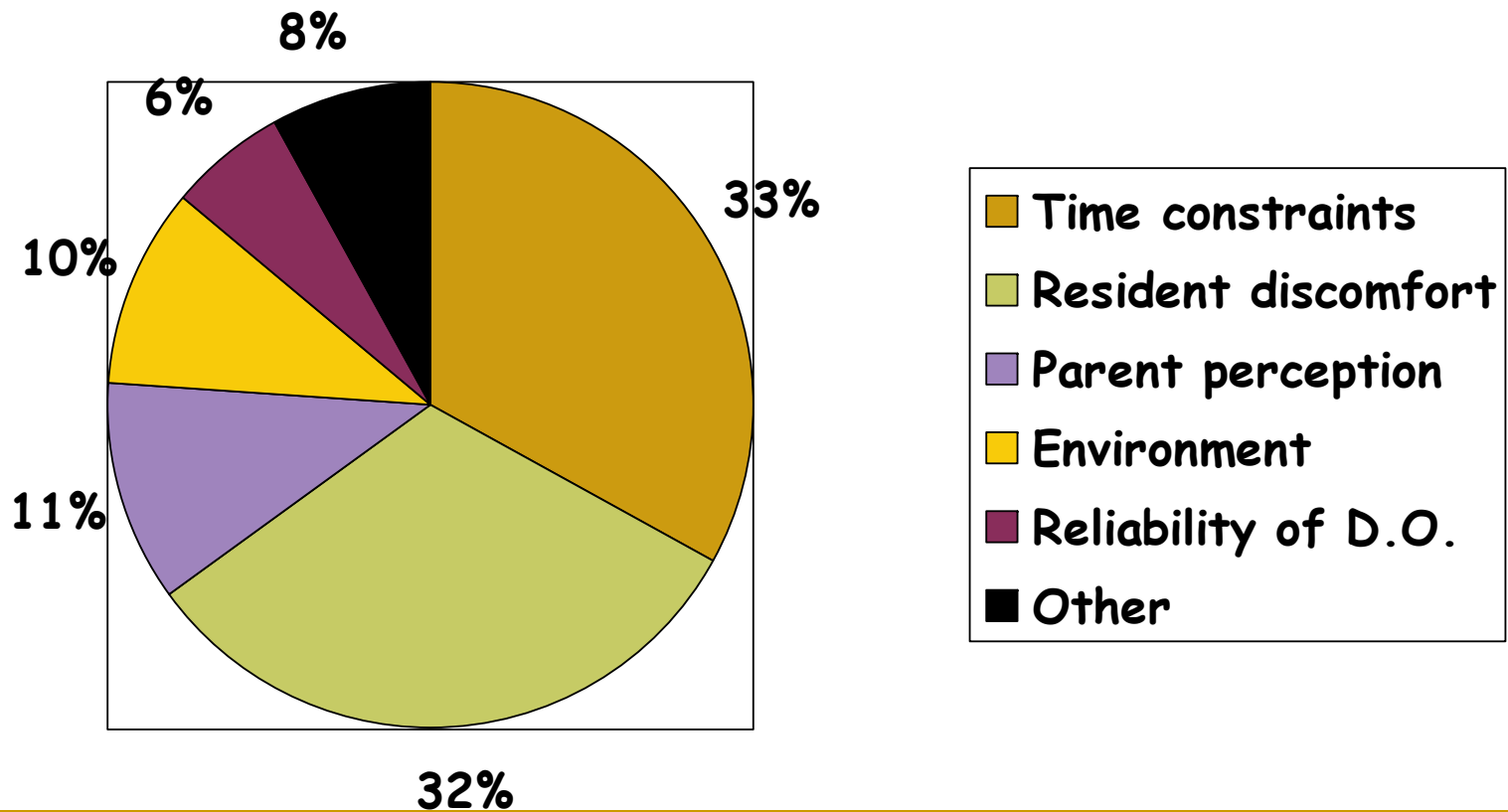
- Intern orientation
 - Noon conference
 - Letter to all residents
 - Review of SCO & observation set-up by all cc preceptors
-

Step 6- Overcoming Barriers and Creating the Culture

- What barriers do you anticipate?
 - Time
 - Space
 - Discomfort
 - Family perceptions
 - Ways to create a culture of observation
-

Perceived barriers to D.O.

(data obtained prior to our D.O. program)



Panel Discussion

- What worked well in implementation?
 - What was the biggest challenge?
 - What are key lessons learned?
 - What have you decided to do about direct observation in your program?
-

Children's National Medical Center

- 48 continuity preceptors for 90 residents
 - 16 hospital-based (2 hospitals)
 - 32 community-based preceptors
 - % of preceptors who sent in ≥1 SCO= 54%
 - Mean # SCO/ preceptor= 4.1
 - % residents observed= 48%
 - Mean # observation/resident observed= 2
-

Thomas Jefferson University/duPont Hospital for Children

- 9 Hospital-based continuity preceptors for 27 residents
 - % of preceptors who sent in ≥1 SCO= 100%
 - Mean # SCO/ preceptor= 9.2
 - % residents observed= 93%
 - Mean # observation/resident observed= 3.9
-

National Capital Consortium Pediatric Residency

- 14 Hospital-based continuity preceptors(2 hospitals) for 24 residents
 - % of preceptors who sent in ≥1 SCO= 86%
 - Mean # SCO/ preceptor= 2.7
 - % residents observed= 75%
 - Mean # observation/resident observed= 1.8
-

Moving Forward with Implementation in Your Program

1. Consider your purpose
 2. Choose a tool
 3. Decide on setting and scope
 4. Conduct faculty development
 5. Orient the residents
 6. Overcome barriers & create a culture
-