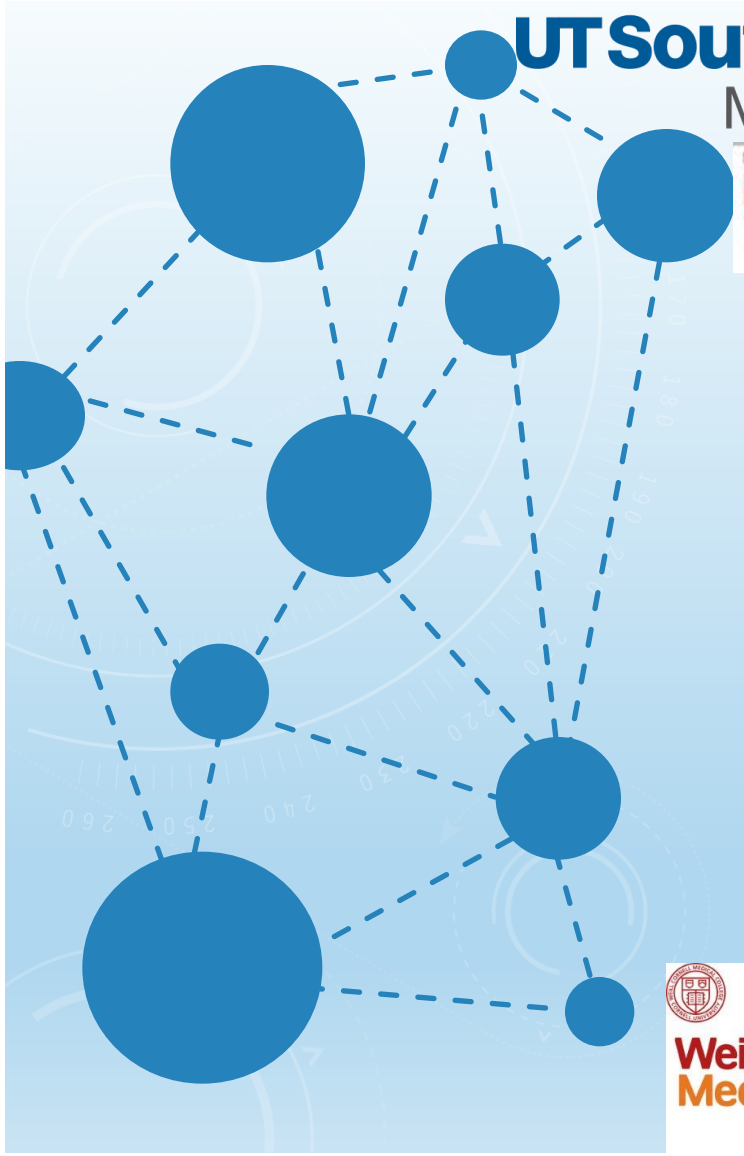


UT Southwestern Medical Center

University of Louisville School of Medicine

Lucile Packard Children's Hospital Stanford

Monroe Carell Jr. Children's Hospital at Vanderbilt

YOUR CLINICAL COMPETENCY COMMITTEES ARE BUSY, BUT WHAT DOES EVERYONE ELSE THINK?

Mark Vining, MD, University of Massachusetts; Jennifer DiPace, MD, New York Presbyterian Hospital; Geoffrey Fleming, MD, Vanderbilt University; Mackenzie Frost, MD, UT Southwestern; Sara Multerer, MD, University of Louisville; Charlene Larson Rotandi, AB and Carrie Rassbach, MD, Stanford University

Weill Cornell Medicine

New York-Presbyterian Phyllis and David Komansky Center for Children's Health
Weill Cornell Medical Center

UMASS University of Massachusetts Medical School

DISCLOSURES

The speakers have no financial or other conflicts of interest to report.

GETTING TO KNOW YOU

Please share：

- Your role in the program?
- Core program vs. fellowship?
- What do you hope to gain from this workshop?

OBJECTIVES

- Describe benefits and challenges of multi-source feedback
- Share successes and challenges in implementing multi-source feedback
- Disseminate tools for MSF

BENEFITS OF MULTI-SOURCE ASSESSMENT

- Captures behaviors that are difficult to assess
- Trainee can appreciate wide impact of her actions
- Data can be compared longitudinally
- Physicians are more likely to contemplate change when receiving feedback from multiple sources*

*Sergeant J, Mann K, Ferrier S. Exploring family physicians reactions to MSF: Perceptions of credibility and usefulness. Med Educ. 2005; 39(5): 497-504.

THE SELF EVALUATION

Mackenzie Frost, MD

UT Southwestern Medical Center

The Pediatrics Milestone Project

A Joint Initiative of
The Accreditation Council for Graduate Medical Education
and
The American Board of Pediatrics

Problem–Based Learning 3/4 (PBLI 3/4)

Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement

PBLI3. Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement					
Not yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Unable to gain insight from encounters due to a lack of reflection on practice; does not understand the principles of quality improvement methodology or change management; is defensive when faced with data on performance improvement opportunities within one's practice	Able to gain insight from reflection on individual patient encounters, but potential improvements are limited by a lack of systematic improvement strategies and team approach; is dependent upon external prompts to define improvement opportunities at the population level	Able to gain insight for improvement opportunities from reflection on both individual patients and populations; grasps improvement methodologies enough to apply to populations; is still reliant on external prompts to inform and prioritize improvement opportunities at the population level	Able to use both individual encounters and population data to drive improvement using improvement methodology; analyzes one's own data on a continuous basis, without reliance on external forces, to prioritize improvement efforts, and uses that analysis in an iterative process for improvement; is able to lead a team in improvement	In addition to demonstrating continuous improvement activities and appropriately utilizing quality improvement methodologies, thinks and acts systemically to try to use one's own successes to benefit other practices, systems, or populations; is open to analysis that at times requires course correction to optimize improvement
☐	☐	☐	☐	☐	☐
Comments:					

MERIT

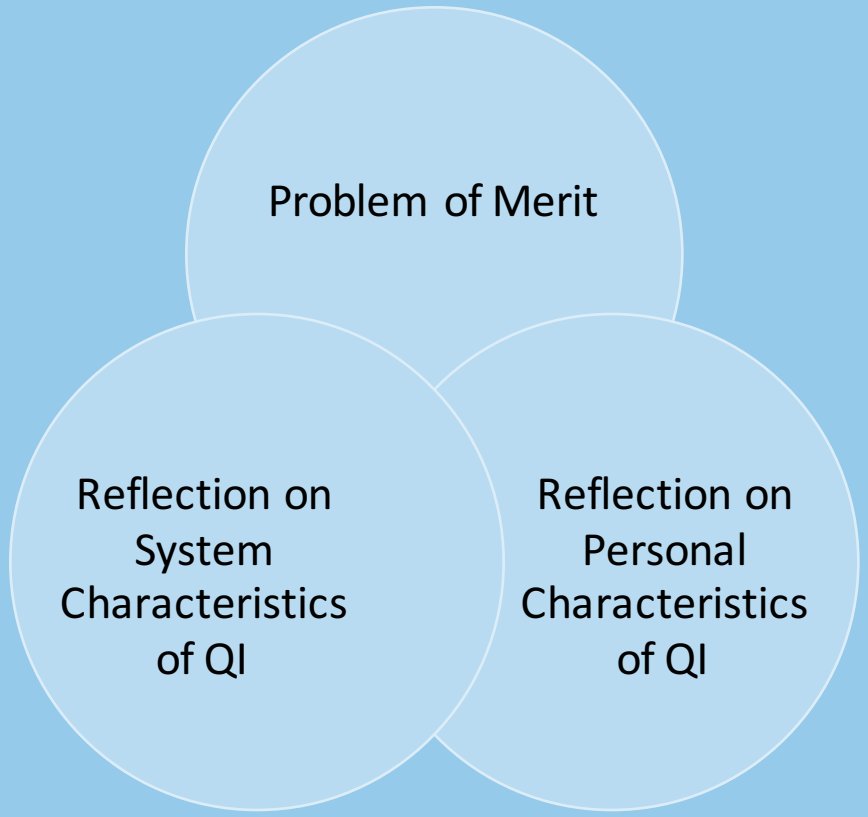
MERIT

Mayo Evaluation of Reflection on Improvement Tool

- Residents must be able to critically reflect on events in practice in order to develop meaningful QI interventions
- Residents kept improvement logs
  - Focused on clinical events
  - Evaluated with MERIT

Wittich, CM, et.al, Validation of a method to measure resident doctors' reflection on quality improvement. *Med Ed* 2010. 44:248–55.

MERIT



Wittich, CM, et.al, Validation of a method to measure resident doctors' reflection on quality improvement. *Med Ed* 2010. 44:248–55

MERIT

Problem of Merit

- Event was patient centered
- Potential for event to effect other patients
- Event could cause negative clinical impact
- Overall problem of merit
- Event was evidence based in its description
- Overall improvement opportunity

Wittich, CM, et.al, Validation of a method to measure resident doctors' reflection on quality improvement. *Med Ed* 2010. 44:248–55

MERIT

Reflection on Personal Characteristics of QI

- Resident questioned personal practice
- Quality of reflection
- Contributing personal factors identified
- Sufficient details to delineate contributing factors
- Multiple options for personal change considered
- Relevant new behaviors proposed
- Next steps towards personal change considered

Wittich, CM, et.al, Validation of a method to measure resident doctors' reflection on quality improvement. *Med Ed* 2010. 44:248–55

MERIT

Reflection on System Characteristics of QI

- Quality of reflection on institution/health care system
- Current institutional practice/system questioned
- Contributing system factors identified
- Multiple options for system change considered
- Relevant changes to system proposed
- Next steps towards system change identified

Wittich, CM, et.al, Validation of a method to measure resident doctors' reflection on quality improvement. *Med Ed* 2010. 44:248–55

MERIT Reflection on Improvement Evaluation Tool
Resident Name:_____ Evaluation Date:_____

Reflection on Personal Characteristics of Quality Improvement

	No	Somewhat	Almost	Yes
Relevant new behaviors were proposed				
Resident questioned personal practice				
Next steps towards personal change were considered				
Contributing personal factors were identified				
Multiple options for personal change were considered				
Sufficient details to delineate contributing factors				
	Bottom Quartile	Second Quartile	Third Quartile	Top Quartile
Quality of reflection				

Reflection on System Characteristics of Quality Improvement

	No	Somewhat	Almost	Yes
Relevant changes to system were proposed				
Next steps towards system change were identified				
Current institutional practice or system was questioned				
Multiple options for system change were considered				
Contributing system factors were identified				
	Bottom Quartile	Second Quartile	Third Quartile	Top Quartile
Quality of reflection on institution or wider health care system				

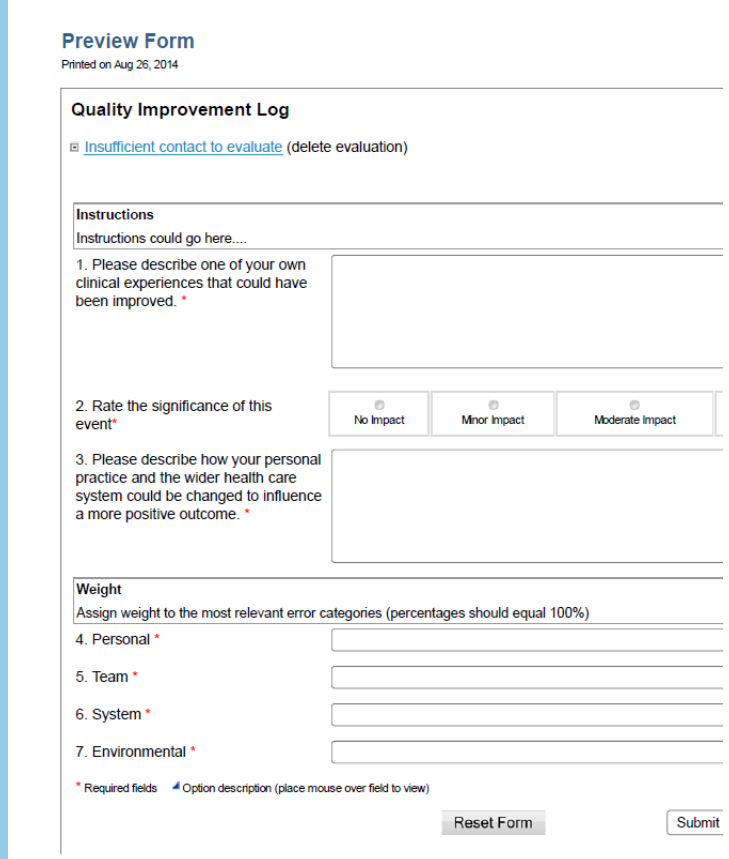
Problem of Merit

	No	Somewhat	Almost	Yes
Event was patient centered				
Potential for event to effect other patients				
Event could cause negative clinical impact				
Event was evidence based in its description				
	Bottom Quartile	Second Quartile	Third Quartile	Top Quartile
Overall problem of merit				
Overall improvement opportunity				

Adapted from Wittich, CM, et.al, Validation of a method to measure resident doctors' reflection on quality improvement. *Med Ed* 2010. 44:248-55

MERIT AT UTSW

- Added as evaluation during 2014–2015 academic year
  - Pediatric Residency
  - Neonatal Fellowship
- Took advantage of existing systems
  - Residency – MedHub
  - Fellowship – Biannual IDP



Preview Form

Printed on Aug 26, 2014

Quality Improvement Log

Insufficient contact to evaluate (delete evaluation)

Instructions

Instructions could go here....

1. Please describe one of your own clinical experiences that could have been improved. *

2. Rate the significance of this event* — No Impact | Minor Impact | Moderate Impact

3. Please describe how your personal practice and the wider health care system could be changed to influence a more positive outcome. *

Weight

Assign weight to the most relevant error categories (percentages should equal 100%)

4. Personal *

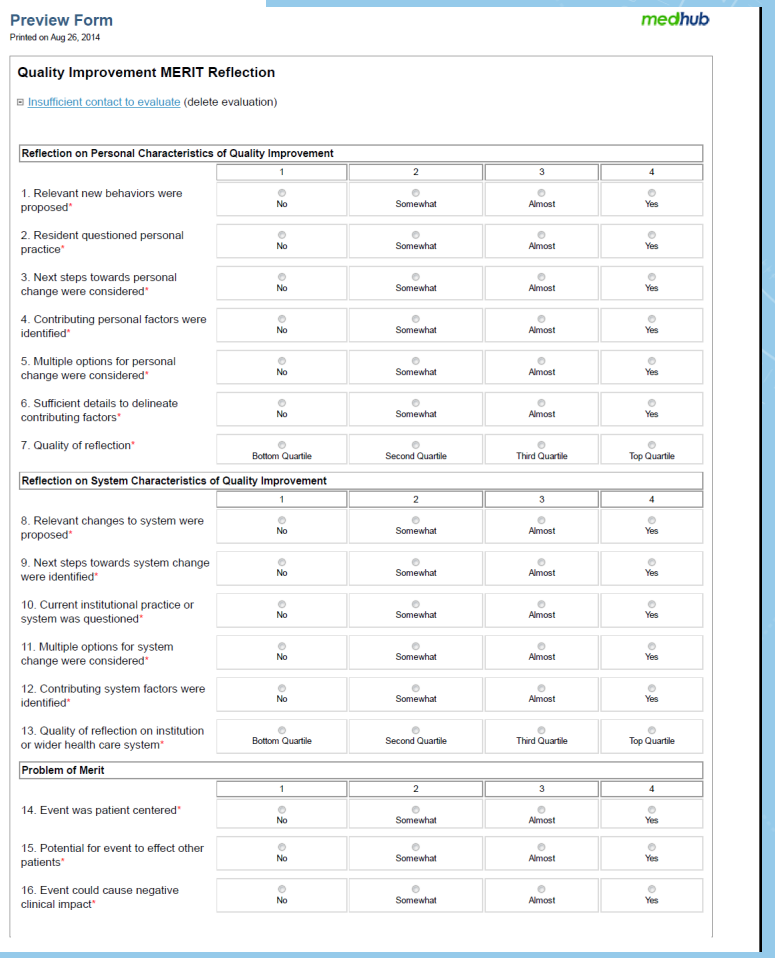
5. Team *

6. System *

7. Environmental *

* Required fields Option description (place mouse over field to view)

Reset Form Submit



Preview Form

Printed on Aug 26, 2014

medhub

Quality Improvement MERIT Reflection

Insufficient contact to evaluate (delete evaluation)

Reflection on Personal Characteristics of Quality Improvement	1	2	3	4
1. Relevant new behaviors were proposed*	No	Somewhat	Almost	Yes
2. Resident questioned personal practice*	No	Somewhat	Almost	Yes
3. Next steps towards personal change were considered*	No	Somewhat	Almost	Yes
4. Contributing personal factors were identified*	No	Somewhat	Almost	Yes
5. Multiple options for personal change were considered*	No	Somewhat	Almost	Yes
6. Sufficient details to delineate contributing factors*	No	Somewhat	Almost	Yes
7. Quality of reflection*	Bottom Quartile	Second Quartile	Third Quartile	Top Quartile

Reflection on System Characteristics of Quality Improvement	1	2	3	4
8. Relevant changes to system were proposed*	No	Somewhat	Almost	Yes
9. Next steps towards system change were identified*	No	Somewhat	Almost	Yes
10. Current institutional practice or system was questioned*	No	Somewhat	Almost	Yes
11. Multiple options for system change were considered*	No	Somewhat	Almost	Yes
12. Contributing system factors were identified*	No	Somewhat	Almost	Yes
13. Quality of reflection on institution or wider health care system*	Bottom Quartile	Second Quartile	Third Quartile	Top Quartile

Problem of Merit	1	2	3	4
14. Event was patient centered*	No	Somewhat	Almost	Yes
15. Potential for event to effect other patients*	No	Somewhat	Almost	Yes
16. Event could cause negative clinical impact*	No	Somewhat	Almost	Yes

Name: Date:___/___/_____
Fellowship Year (circle): 1 2 3 4 Page 1 of 8

Individual Development Plan
Fellowship in Neonatal-Perinatal Medicine
University of Texas Southwestern Medical Center at Dallas

Goals:

Name: Date:___/___/_____
Fellowship Year (circle): 1 2 3 4 Page 7 of 8

Self-As

NICU Fellow Improvement Log

Please briefly describe one of your own clinical experiences that could have been improved.

Area			ss
I. Patie			
Gather on pati			
Perforr exam c			
Orderir			
Counse			
Perforr intubat			
II. Med			
Unders diseas			
Up-to-c recomr			
Interpr ultraso			
III. Pra			
Unders benefit			
Evalua			
IV. Inte			
Perforr			
Leadin			
Ability			
V. Prof			
Unders			
Time m			
Integra			
Manag			
VI. Res			
Selecti			
Selecti			
Unders			
Acquiri			
Progress in completion of study	☐	☐	
Source of funding for research	☐	☐	

Rate the significance of the event: (circle the appropriate number/descriptor).
1 – no impact 2 - minor impact 3 – moderate impact 4 – significant impact 5- death

SMALL GROUP ACTIVITY

Use MERIT assessment tool to evaluate provided QI reflection

ASSIGN YOUR TRAINEE TO A MILESTONE LEVEL

PBLI3. Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement					
Not yet Assessable	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	Unable to gain insight from encounters due to a lack of reflection on practice; does not understand the principles of quality improvement methodology or change management; is defensive when faced with data on performance improvement opportunities within one's practice	Able to gain insight from reflection on individual patient encounters, but potential improvements are limited by a lack of systematic improvement strategies and team approach; is dependent upon external prompts to define improvement opportunities at the population level	Able to gain insight for improvement opportunities from reflection on both individual patients and populations; grasps improvement methodologies enough to apply to populations; is still reliant on external prompts to inform and prioritize improvement opportunities at the population level	Able to use both individual encounters and population data to drive improvement using improvement methodology; analyzes one's own data on a continuous basis, without reliance on external forces, to prioritize improvement efforts, and uses that analysis in an iterative process for improvement; is able to lead a team in improvement	In addition to demonstrating continuous improvement activities and appropriately utilizing quality improvement methodologies, thinks and acts systemically to try to use one's own successes to benefit other practices, systems, or populations; is open to analysis that at times requires course correction to optimize improvement
☐	☐	☐	☐	☐	☐
Comments:					

THE NURSING EVALUATION

Meaningful Assessment from our Trusted Allies

Sara Multerer, MD

University of Louisville

THE NURSING EVALUATION

- Previous evaluation – more items, made up
  - Poor response rate
  - Only filled out when there was a problem
- We attempted to create a Milestone-based Nursing eval… EPIC FAIL
  - Too long
  - Language didn't resonate
  - Several items that weren't applicable

WHAT DO NURSES WANT TO EVALUATE?

- Professionalism
  - Responds to calls/pagers in a timely manner
  - Good attitude
  - Accepting of other team members' input
- Communication
  - Relationships with families
  - Relationships with nurses
  - Clear plans of care

AN ADDITIONAL AREA

- Transitions of Care
- Neonatal Nurse Practitioners
  - Provide all night coverage in our “small” NICU
  - Rotate into call schedule with seniors in our “big” NICU
  - Seen as a peer in many ways

USE IN THE CCC

- Nursing Evals
  - Monthly on inpatient wards – every resident
  - More sporadic on other rotations
  - For the CCC
    - Average numeric scores
    - Comments collated into one document
- NNP Transition of Care – document independent and part of portfolio

THE PEER EVALUATION

Geoffrey Fleming, MD

Vanderbilt University

PEER EVALUATION

- Peer group offers a valuable and insightful contributions to 360 Evaluations
- What is the appropriate focus and scope of assessment?
  - Medical Knowledge?
  - Patient Care?
  - Interpersonal Communication Skills?
- **Basic elements of professionalism the ability of the individual to contribute and foster the team dynamic**

EMOTIONAL INTELLIGENCE: AN APPROACH TO PEER ASSESSMENT

- Emotional Intelligence: Salovey and Mayer 1990
  - Monitor ones own emotions and the emotions of others.
  - Use this information to guide thinking and actions and approach to relationships.
- Emotional Intelligence: Goleman 1995
  - Self Motivate, Persist in the face of frustration
  - Control Impulses, Regulate self
  - Understand others to effectively communicate/connect

Emotional Intelligence: A Primer

Emotional intelligence – the ability to manage ourselves and our relationships effectively – consists of four fundamental capabilities: self-awareness, self-management, social awareness, and social skill. Each capability, in turn, is composed of specific sets of competencies. Below is a list of the capabilities and their corresponding traits.

Self-Awareness

- *Emotional self-awareness:* the ability to read and understand your emotions as well as recognize their impact on work performance, relationships, and the like.
- *Accurate self-assessment:* a realistic evaluation of your strengths and limitations.
- *Self-confidence:* a strong and positive sense of self-worth.

Self-Management

- *Self-control:* the ability to keep disruptive emotions and impulses under control.
- *Trustworthiness:* a consistent display of honesty and integrity.
- *Conscientiousness:* the ability to manage yourself and your responsibilities.
- *Adaptability:* skill at adjusting to changing situations and overcoming obstacles.
- *Achievement orientation:* the drive to meet an internal standard of excellence.
- *Initiative:* a readiness to seize opportunities.

Social Awareness

- *Empathy:* skill at sensing other people's emotions, understanding their perspective, and taking an active interest in their concerns.
- *Organizational awareness:* the ability to read the currents of organizational life, build decision networks, and navigate politics.
- *Service orientation:* the ability to recognize and meet customers' needs.

Social Skill

- *Visionary leadership:* the ability to take charge and inspire with a compelling vision.
- *Influence:* the ability to wield a range of persuasive tactics.
- *Developing others:* the propensity to bolster the abilities of others through feedback and guidance.
- *Communication:* skill at listening and at sending clear, convincing, and well-tuned messages.
- *Change catalyst:* proficiency in initiating new ideas and leading people in a new direction.
- *Conflict management:* the ability to de-escalate disagreements and orchestrate resolutions.
- *Building bonds:* proficiency at cultivating and maintaining a web of relationships.
- *Teamwork and collaboration:* competence at promoting cooperation and building teams.

Goleman, D. Leadership that gets results. HBR. 2000;March–April:78–90

EI IN PEER EVALUATION

- How is the individual perceived as a team member?
  - Are they always negative nelli and possibly bring the group down?
  - Are they the last to volunteer for a task on behalf of the group
  - Do they routinely embrace change and look at it as an opportunity to grow and learn?
  - Do they sense the emotions of others and hence display a great deal of empathy for their co-workers?
  - Are they trustworthy?
  - Do they take the initiative or require severe prodding?
  - Do they make others around them better?

EI IN SELF EVALUATION

- Physicians are not terribly accurate at self assessment.
  - This is likely true for leadership qualities or EI qualities.
  - But recognizing the gap between self-assessed abilities and peer assessed abilities is important for self awareness.

EI IN MEDICAL EDUCATION

Emotional intelligence in medical education: a critical review

M Gemma Cherry,[1] Ian Fletcher,[2] Helen O'Sullivan[3] & Tim Dornan[4]

Medical Education 2014: 48: 468–478
doi: 10.1111/medu.12406

CONCLUSIONS Emotional intelligence-based education may be able to contribute to the teaching of professionalism and communication skills in medicine, but further research is needed before its wholesale adoption in any curriculum can be recommended.

EI IN MEDICAL EDUCATION

The appeal of emotional intelligence

Jessica A Ogle & John A Bushnell

MEDICAL EDUCATION 2014; **48**: 456–465

Emotional intelligence: convinced or lulled?

Nancy McNaughton & Mohammad S Zubairi

MEDICAL EDUCATION 2014; **48**: 456–465

ARE THERE VALIDATED MEASURES OF EI?

Measuring Emotional Intelligence With the MSCEIT V2.0

Emotion
2003, Vol. 3, No. 1, 97–105

Exploring the Validity of the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) with Established Emotions Measures

Emotion
2006, Vol. 6, No. 4, 663–669

But these are expensive and complex to use. So….

FLEMING VERSION OF THE EI PEER EVAL

- 12 item list.
- Attempted to address areas included in EI that were observable by others/peers.
- Milestone type language used to create anchors
- No place for comments intentionally. Too much room for error in personal commentary
- NOT VALIDATED

Time Management: The fellow's tardiness-timeliness				
The fellow is frequently late for conference or appointments or duty, even if only a few minutes late.	The fellow is often late for conference or appointments or duty, even if only a few minutes late.	The fellow is occasionally late for conference or appointments or duty.	The fellow is rarely late for conference or appointments or duty.	The fellow is never late for conference or appointments or duty.
☐	☐	☐	☐	☐

Emotional Self Control: The fellow manages his/her emotions with regards to outward expressions.				
Always demonstrates/expresses frustration/anger regarding events/circumstances	Often demonstrates/expresses frustration/anger regarding events/circumstances	Occasionally demonstrates/expresses outward manifestation of emotions.	Rarely demonstrates/expresses outward manifestation of emotions.	Never demonstrates/expresses outward manifestation of emotions.
☐	☐	☐	☐	☐

Adaptability: The fellow's response to change				
Always resists change and always demonstrates difficulty accepting or enacting change	Often resists change and demonstrates difficulty accepting or enacting change	Occasionally resists change and but often is quick to accept or enact change	Highly adaptable to change, quick to modify behaviors and incorporate new strategy/guidelines.	Assists others with adapting to change.
☐	☐	☐	☐	☐

Motivation: The fellow's dedication to excellence				
Actions suggest the fellow is never motivated by pursuit of excellence or achievement.	Actions suggest pursuit of the minimum acceptable level of achievement.	Actions suggest the fellow is often in pursuit of improvement	Actions suggest a constant pursuit of the highest level of achievement	Actively motivates and assists others to excel
☐	☐	☐	☐	☐

Initiative: The fellow as a "self starter"				
Will begin a project or task only when punitive consequences imminent.	Will act only when prompted to do so by the system or others.	Occasionally takes the initiative of initiating a task or project before prompting but still relies heavily on external prompts.	Often takes the initiative of initiating a task or project before prompting in circumstances that require action, relies on external prompts infrequently.	Always takes the initiative of initiating a task or project before prompting in circumstances that require action.
☐	☐	☐	☐	☐

Optimism: The fellow's outlook				
The fellow continually focuses on the negative in people and situations even in the face of positive circumstances.	The fellow often focuses on the negative in people and situations.	The fellow is neutral regarding people and situations.	The fellow often focuses on the positive in people and situations.	The fellow continually focuses on the positive in people and situations, even in the face of negative circumstances.
☐	☐	☐	☐	☐

Empathy: The fellow's ability to empathize with others				
The fellow never perceives or takes interest in the feelings of others	The fellow rarely perceives or takes interest in the feelings of others	The fellow occasionally perceives or takes interest in the feelings of others	The fellow often perceives or takes interest in the feelings of others	The fellow continually perceives and considers the feelings of others
☐	☐	☐	☐	☐

Situational Awareness: The fellow's ability to anticipate and recognize ongoing issues.				
The fellow never anticipates or senses emerging situations or conflicts	The fellow rarely anticipates or senses emerging situations or conflicts	The fellow occasionally anticipates and senses emerging situations or conflicts	The fellow often anticipates and senses emerging situations or conflicts	The fellow always anticipates and assists others by alerting them to emerging situations or conflicts
☐	☐	☐	☐	☐

Developing Others: The fellow's ability to foster development among members of the team.				
The fellow never encourages the development of the skills/abilities of junior members of the team.	The fellow rarely encourages the development of the skills/abilities of junior members of the team.	The fellow occasionally encourages the development of the skills/abilities of junior members of the team.	The fellow often encourages the development of the skills/abilities of junior members of the team.	The fellow actively seeks opportunities for the development of the skills/abilities of junior members of the team.
☐	☐	☐	☐	☐

Leadership: The fellow's ability to lead the team in **non-crisis** situations. (Goleman Leadership Style)				
The fellow leads only through an authoritarian style. (Commanding)	The fellow leads by predominantly by a "top down" approach, dictating care with little input from the team. (Commanding)	The fellow relies heavily on a "top down" approach, but will obtain consensus occasionally. (Commanding, Democratic)	The fellow leads predominantly through consensus building and collaboration, with occasional coaching of juniors. (Democratic, Coaching)	The fellow leads predominantly by a "bottom up" approach, encouraging the team to identify or solve problems before the team. (Coaching)
☐	☐	☐	☐	☐

Communication: The fellow's ability to communicate during conflict.				
The fellow never explores the concerns of others nor provides any option for "read-back" or questions.	The fellow rarely explores the concerns of others or provides any option for "read-back" or questions.	The fellow occasionally explores the concerns of others and provides an option for "read-back" or questions	The fellow often explores the concerns of others and provides an option for "read-back" or questions	The fellow continually explores the concerns of others and reframes the concerns/questions as they have been outlined.
☐	☐	☐	☐	☐

Conflict Management: The fellow's ability to communicate during and resolve conflict				
Problem solves in conflict only from a predetermined stance or position. Unable to cultivate open discussion and shared understanding of the issues.	Problem solves in conflict frequently from a predetermined stance or position. Will occasionally explore shared understanding of the issues.	Occasionally problem solves in conflict by exploring best outcome for the patient/situation and frequently negotiates/ communicates in a way that promotes shared decision making.	Often problem solves in conflict by exploring best outcome for the patient/situation and frequently negotiates/ communicates in a way that promotes shared decision making.	Problem solves in conflict by exploring best outcome for the patient/situation and negotiates/communicates in a way that promotes shared decision making.
☐	☐	☐	☐	☐

FLEMING VERSION OF THE EI PEER EVAL

- Each fellow fills out on each peer once per year.
- Then, the individual is asked to evaluate themselves on the same scale during the quarterly evaluation.
- We then compare the perception of peer vs self perception.
  - In my experience over the past few years, most under-rate themselves as compared to their peers.
  - I point out that this likely represents self management at some level (they don't feel like taking initiative, but their peers seem them doing this)

IMPORTANT POINTS

- Not Validated, so not appropriate for high stakes summative assessment.
- Anonymity is key and avoid comments as these are likely to be personal.
- Prep the fellows with a bit on Emotional Intelligence (reading, etc.)
- Use this is a method of talking about perceptions of one's behavior.
- THE TOOL IS UPLOADED TO **SHAREWAREHOUSE**

READING LIST

- Cherry, M. G., Fletcher, I., O'Sullivan, H., & Dornan, T. (2014). Emotional intelligence in medical education: a critical review. *Medical Education*, *48*(5), 468–478. http://doi.org/10.1111/medu.12406
- Mintz, L. J., & Stoller, J. K. (2014). A Systematic Review of Physician Leadership and Emotional Intelligence. *Journal of Graduate Medical Education*, *6*(1), 21–31. http://doi.org/10.4300/JGME-D-13-00012.1
- Goleman, D. (2006). What makes a leader? *Harvard Business Review*, *82*(1), 82–91.
- Goleman, D., Boyatzis, R. E., & McKee, A. (2004). Primal Leadership. Harvard Business Press.
- Goleman, D. (2000). Leadership that Gets Results. *Harvard Business Review*, *78*(2), 78–90.

STUDENTS AS DIRECT OBSERVERS OF RESIDENTS

MARK VINING, MD

UNIVERSITY OF MASSACHUSETTS

ICS1. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds

Not yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Uses standard medical interview template to prompt all questions; does not vary the approach based on a patient's unique physical, cultural, socioeconomic, or situational needs; may feel intimidated or uncomfortable asking personal questions of patients	Uses the medical interview to establish rapport and focus on information exchange relevant to a patient's or family's primary concerns; identifies physical, cultural, psychological, and social barriers to communication, but often has difficulty managing them; begins to use non-judgmental questioning scripts in response to sensitive situations	Uses the interview to effectively establish rapport; is able to mitigate physical, cultural, psychological, and social barriers in most situations; verbal and non-verbal communication skills promote trust, respect, and understanding; develops scripts to approach most difficult communication scenarios	Uses communication to establish and maintain a therapeutic alliance; sees beyond stereotypes and works to tailor communication to the individual; a wealth of experience has led to development of scripts for the gamut of difficult communication scenarios; is able to adjust scripts ad hoc for specific encounters	Connects with patients and families in an authentic manner that fosters a trusting and loyal relationship; effectively educates patients, families, and the public as part of all communication; intuitively handles the gamut of difficult communication scenarios with grace and humility
☐	☐	☐	☐	☐	☐

PROF1. Humanism, compassion, integrity, and respect for others; based on the characteristics of an empathetic practitioner

Not yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Sees the patients in a "we versus they" framework and is detached and not sensitive to the human needs of the patient and family	Demonstrates compassion for patients in selected situations (e.g., tragic circumstances, such as unexpected death), but has a pattern of conduct that demonstrates a lack of sensitivity to many of the needs of others	Demonstrates consistent understanding of patient and family expressed needs and a desire to meet those needs on a regular basis; is responsive in demonstrating kindness and compassion	Is altruistic and goes beyond responding to expressed needs of patients and families; anticipates the human needs of patients and families and works to meet those needs as part of his skills in daily practice	Is a proactive advocate on behalf of individual patients, families, and groups of children in need
☐	☐	☐	☐	☐	☐

PROF5. Trustworthiness that makes colleagues feel secure when one is responsible for the care of patients

Not yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Has significant knowledge gaps or is unaware of knowledge gaps and demonstrates lapses in data-gathering or in follow-through of assigned tasks; may misrepresent data (for a number of reasons) or omit important data, leaving others uncertain as to the nature of the learner's truthfulness or awareness of the importance of attention to detail and accuracy; overt lack of truth-telling is assessed in a professionalism competency	Has a solid foundation in knowledge and skill, but is not always aware of or seeks help when confronted with limitations; demonstrates lapses in follow-up or follow-through with tasks, despite awareness of the importance of these tasks; follow-through can be partial, but limited due to inconsistency or yielding to barriers; when such barriers are experienced, no escalation occurs (such as notifying others or pursuing alternative solutions)	Has a solid foundation in knowledge and skill with realistic insight into limits with responsive help seeking; data-gathering is complete with consideration of anticipated patient care needs, and careful consideration of high-risk conditions first and foremost; requires little prompting for follow-up	Has a broad scope of knowledge and skill and assumes full responsibility for all aspects of patient care, anticipating problems and demonstrating vigilance in all aspects of management; pursues answers to questions, and communications include open, transparent expression of uncertainty and limits of knowledge	Same as Level 4, but any uncertainty brings about rigorous search for answers and conscientious and ongoing review of information to address the evolution of change; may seek the help of a master in addition to primary source literature
☐	☐	☐	☐	☐	☐

ICS2. Demonstrate the insight and understanding into emotion and human response to emotion that allows one to appropriately develop and manage human interactions

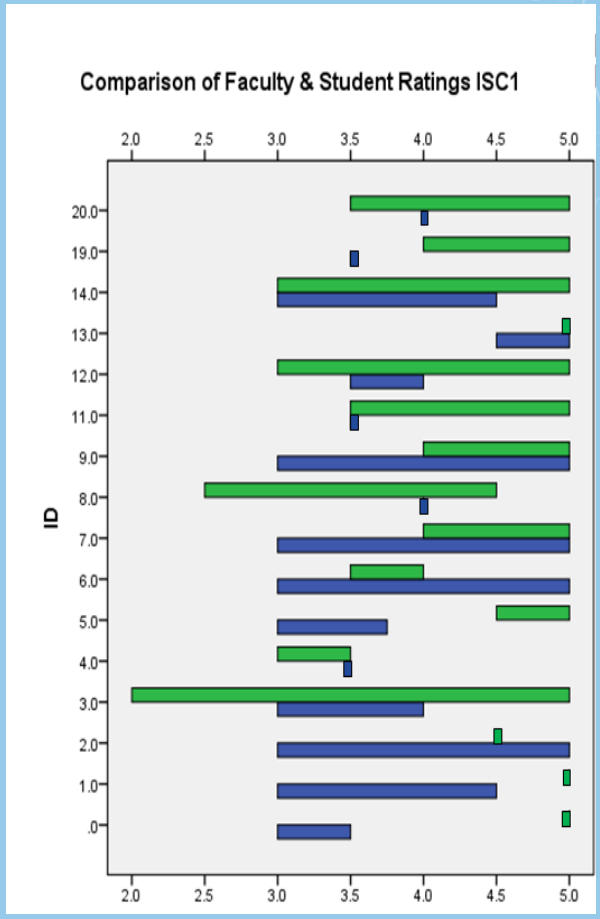
Not yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Does not accurately anticipate or read others' emotions in verbal and non-verbal communication; is unaware of one's own emotional and behavioral cues and may transmit emotions in communication (e.g., anxiety, exuberance, anger) that can precipitate unintended emotional responses in others; does not effectively manage strong emotions in oneself or others	Begins to use past experiences to anticipate and read (in real time) the emotional responses in himself and others across a limited range of medical communication scenarios, but does not yet have the ability or insight to moderate behavior to effectively manage the emotions; strong emotions in oneself and others may still become overwhelming	Anticipates, reads, and reacts to emotions in real time with appropriate and professional behavior in nearly all typical medical communication scenarios, including those evoking very strong emotions; uses these abilities to gain and maintain therapeutic alliances with others	Perceives, understands, uses, and manages emotions in a broad range of medical communication scenarios and learns from new or unexpected emotional experiences; effectively manages own emotions appropriately in all situations; effectively and consistently uses emotions to gain and maintain therapeutic alliances with others; is perceived as a humanistic provider	Intuitively perceives, understands, uses, and manages emotions to improve the health and well-being of others and to foster therapeutic relationships in any and all situations; is seen as an authentic role model of humanism in medicine
☐	☐	☐	☐	☐	☐

PROF3. Professional Conduct : High standards of ethical behavior which includes maintaining appropriate professional boundaries

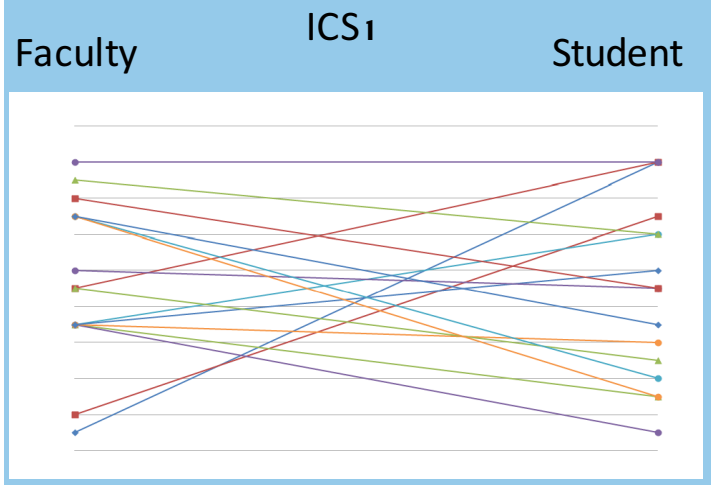
Not yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Has repeated lapses in professional conduct wherein responsibility to patients, peers, and/or the program are not met. These lapses may be due to an apparent lack of insight about the professional role and expected behaviors or other conditions or causes (e.g., depression, substance use, poor health)	Under conditions of stress or fatigue, has documented lapses in professional conduct that lead others to remind, enforce, and resolve conflicts; may have some insight into behavior, but an inability to modify behavior when placed in stressful situations	In nearly all circumstances, conducts interactions with a professional mindset, sense of duty, and accountability; has insight into his or her own behavior, as well as likely triggers for professionalism lapses, and is able to use this information to remain professional	Demonstrates an in-depth understanding of professionalism that allows her to help other team members and colleagues with issues of professionalism; is able to identify potential triggers, and uses this information to prevent lapses in conduct as part of her duty to help others	Others look to this person as a model of professional conduct; has smooth interactions with patients, families, and peers; maintains high ethical standards across settings and circumstances; has excellent emotional intelligence about human behavior and insight into self, and uses this information to promote and engage in professional behavior as well as to prevent lapses in others and self
☐	☐	☐	☐	☐	☐

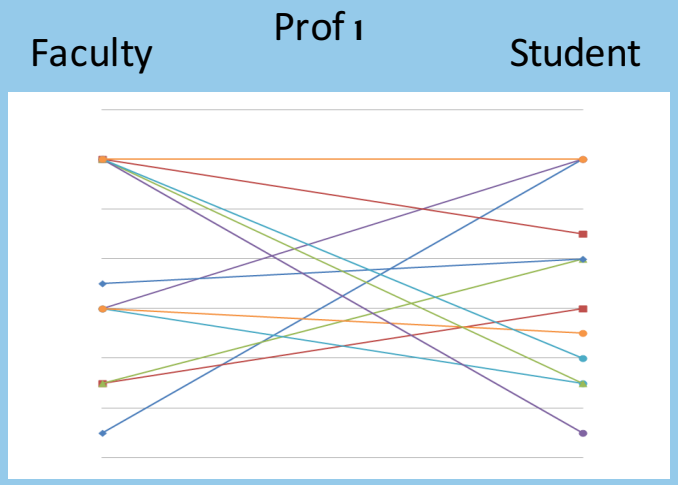
STUDENTS AS DIRECT OBSERVERS OF RESIDENTS

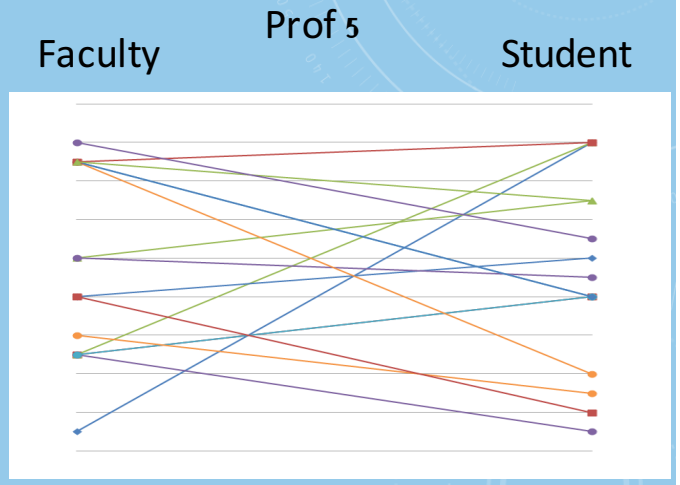
- 46 student evaluations were submitted.
- 20 residents had milestone assessments from at least one faculty and student evaluator in the same sub-competency which could be paired for analysis (N=62).



FACULTY VS. STUDENT *RANK* OF RESIDENTS







THE ROLE OF PATIENT FEEDBACK IN PEDIATRIC RESIDENT ASSESSMENT

CARRIE RASSBACH, MD

STANFORD SCHOOL OF MEDICINE

BACKGROUND

Effect of Multisource Feedback on Resident Communication Skills and Professionalism

A Randomized Controlled Trial

William B. Brinkman, MD, MEd; Sheela R. Geraghty, MD, MS; Bruce P. Lanphear, MD, MPH; Jane C. Khoury, PhD; Javier A. Gonzalez del Rey, MD; Thomas G. DeWitt, MD; Maria T. Britto, MD, MPH

Measuring patient views of physician communication skills: Development and testing of the Communication Assessment Tool

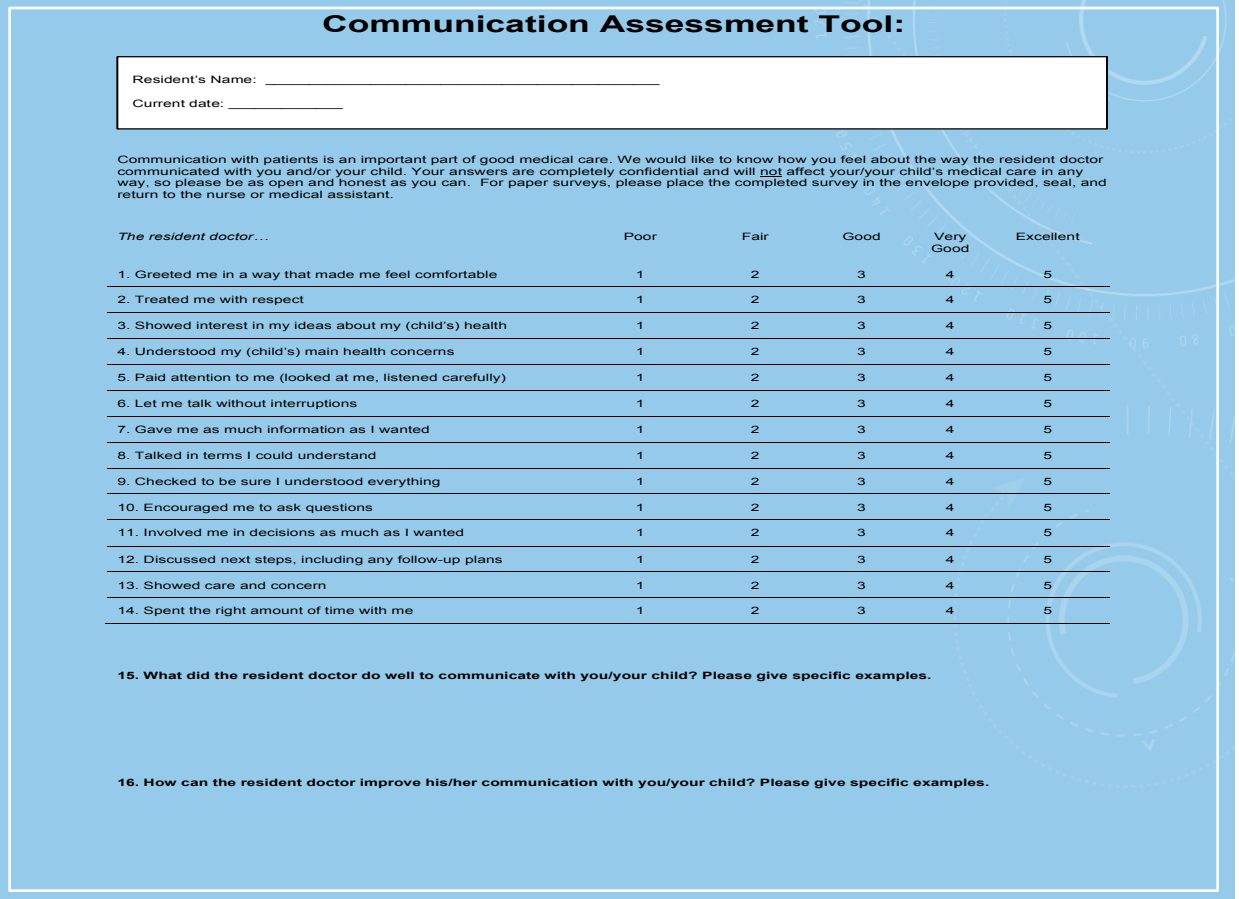
Gregory Makoul [a,*], Edward Krupat [b], Chih-Hung Chang [a]

[a] *Northwestern University Feinberg School of Medicine, Chicago, IL, USA*
[b] *Harvard Medical School, Boston, MA, USA*

Received 14 March 2007; received in revised form 1 May 2007; accepted 3 May 2007

COMMUNICATION ASSESSMENT TOOL (CAT)

- Validated
- English & Spanish
- 4th grade reading level
- In-person or by phone
- Ideal in office setting
- 2 minutes
- 12-30 CATs/physician
- Mean vs. % excellent



Communication Assessment Tool:

Resident's Name: _____

Current date: _____

Communication with patients is an important part of good medical care. We would like to know how you feel about the way the resident doctor communicated with you and/or your child. Your answers are completely confidential and will not affect your/your child's medical care in any way, so please be as open and honest as you can. For paper surveys, please place the completed survey in the envelope provided, seal, and return to the nurse or medical assistant.

The resident doctor…	Poor	Fair	Good	Very Good	Excellent
1. Greeted me in a way that made me feel comfortable	1	2	3	4	5
2. Treated me with respect	1	2	3	4	5
3. Showed interest in my ideas about my (child's) health	1	2	3	4	5
4. Understood my (child's) main health concerns	1	2	3	4	5
5. Paid attention to me (looked at me, listened carefully)	1	2	3	4	5
6. Let me talk without interruptions	1	2	3	4	5
7. Gave me as much information as I wanted	1	2	3	4	5
8. Talked in terms I could understand	1	2	3	4	5
9. Checked to be sure I understood everything	1	2	3	4	5
10. Encouraged me to ask questions	1	2	3	4	5
11. Involved me in decisions as much as I wanted	1	2	3	4	5
12. Discussed next steps, including any follow-up plans	1	2	3	4	5
13. Showed care and concern	1	2	3	4	5
14. Spent the right amount of time with me	1	2	3	4	5

15. What did the resident doctor do well to communicate with you/your child? Please give specific examples.

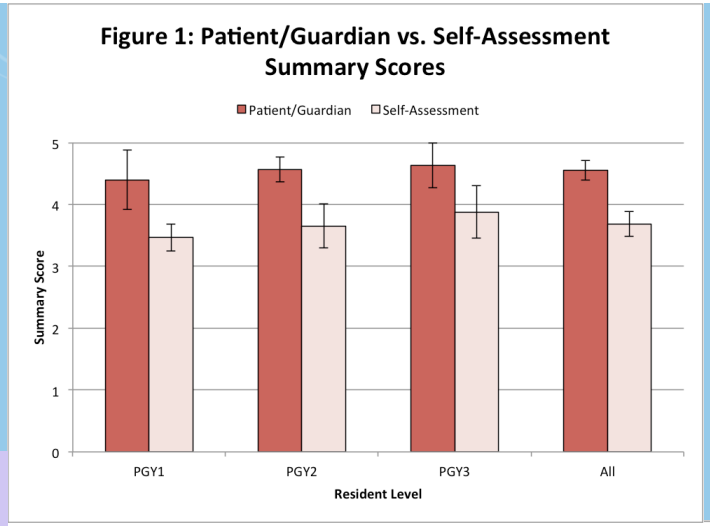
16. How can the resident doctor improve his/her communication with you/your child? Please give specific examples.

OPPORTUNITIES & CHALLENGES

- Opportunities:
  - Perhaps no better assessment of how physicians communicate than by patients/families
- Challenges:
  - Who obtains?
  - Time
  - Language & literacy
  - Integrating patient feedback with milestone assessment

STANFORD CHILDREN'S EXPERIENCE

- Pilot study 2014-15
  - 75/82 (91%) residents completed pre- and post-self-assessments
  - 27 of these residents also received CATs
  - 14 discussed their patient feedback with a faculty coach (intervention group)
  - 13 received their patient feedback electronically (control group)
  - Intervention group residents showed improved self-assessment scores on post-intervention; control group did not



$p > 0.0001$

Treating patients with respect

Spending the right amount of time with patients

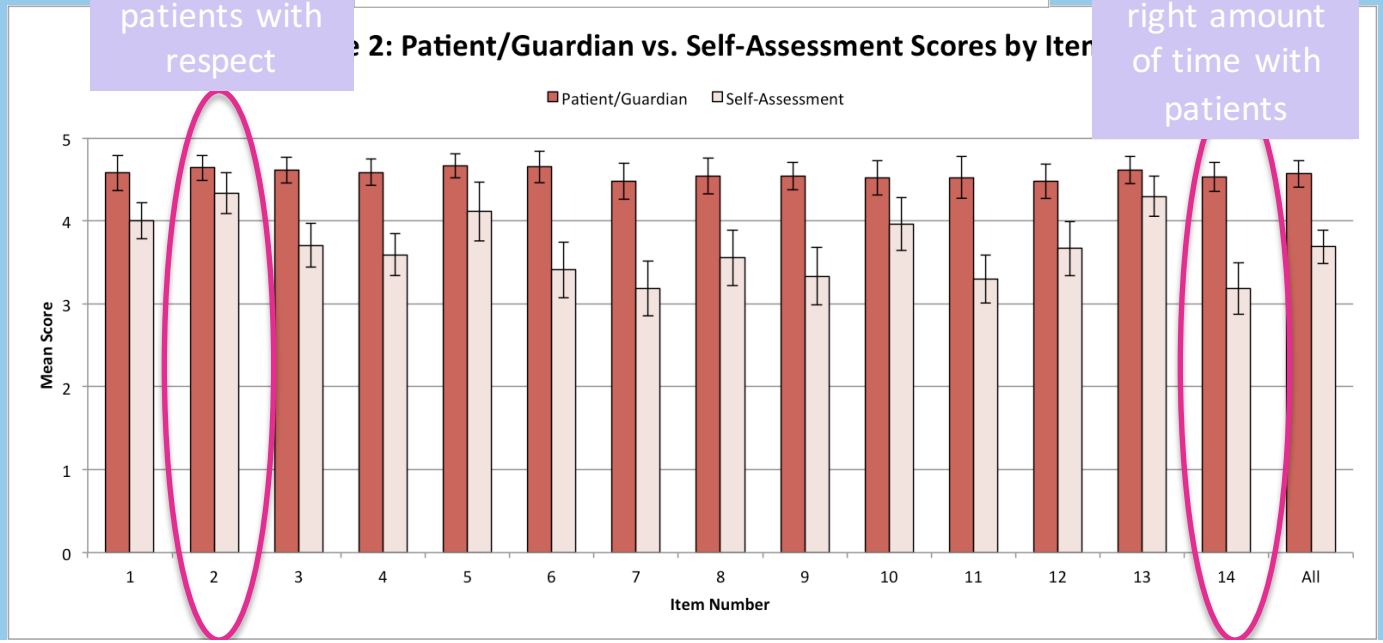


Figure 1: Resident Self-Assessment with COACHING Intervention

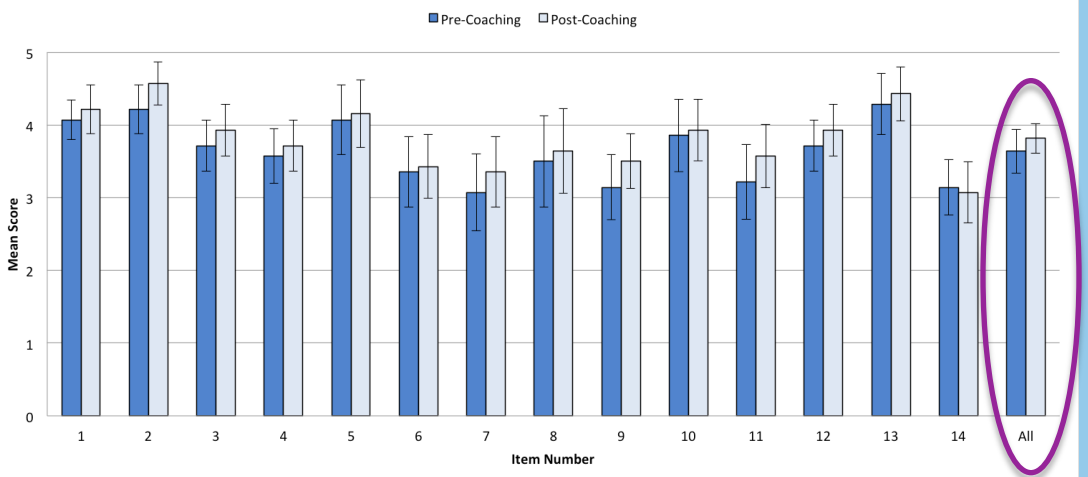
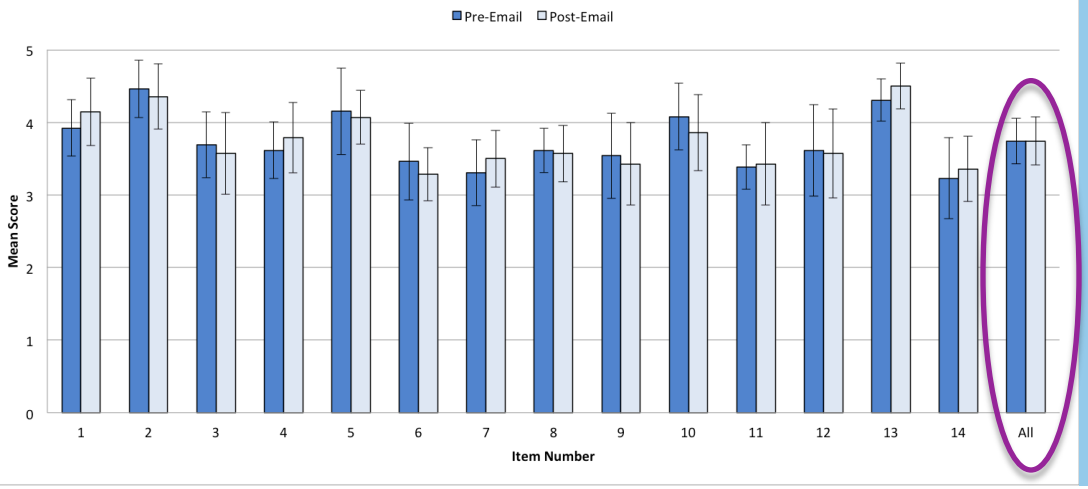


Figure 2: Resident Self-Assessment with EMAIL Intervention



CURRENT STUDY

- Funded by APPD Special Projects Grant
- Randomized controlled trial at: Stanford, University of Chicago, Phoenix Children's
- Pre- and post-intervention:
  - Resident self-assessments
  - Patient CATs
- Coaching intervention vs. control
- Feasibility
- Resident attitudes
- Qualitative data

NEXT STEPS

- Validity of CAT in pediatrics
- Translation to milestones/CCCs
- Value for residents
- Curricular interventions

PUTTING IT ALL TOGETHER AND GETTING IT DONE

Charlene Larson Rotandi, AB

Stanford School of Medicine

EVOLVING ROLE FOR COORDINATORS IN EVALUATIONS

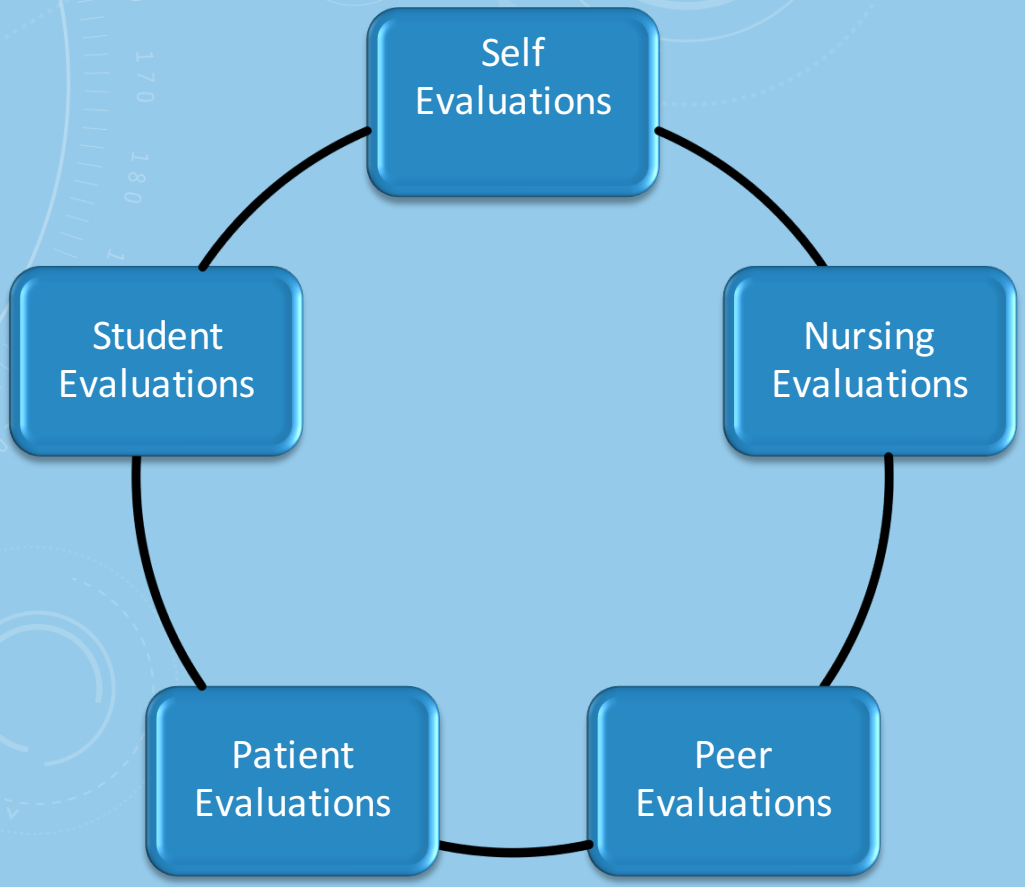
- Deliver evaluations
- Develop evaluation forms for PDs to approve
- Schedule semi annual evaluations
- Ensure summative evaluations completed and filed

+

- Constructing new milestone evaluations to pilot/deliver
- Reviewing evaluation completion data for accuracy
- Aggregating data for the CCC from multiple sources and forms
- Milestone data to ACGME

Walker K, Dohn A, Piro N. 2014 ACGME Annual Educational Conference. *Coordinators and Clinical Competency Committees: How to Streamline and Support the Work of your Program's CCC.*

Multi-source Evaluations…putting it all together!



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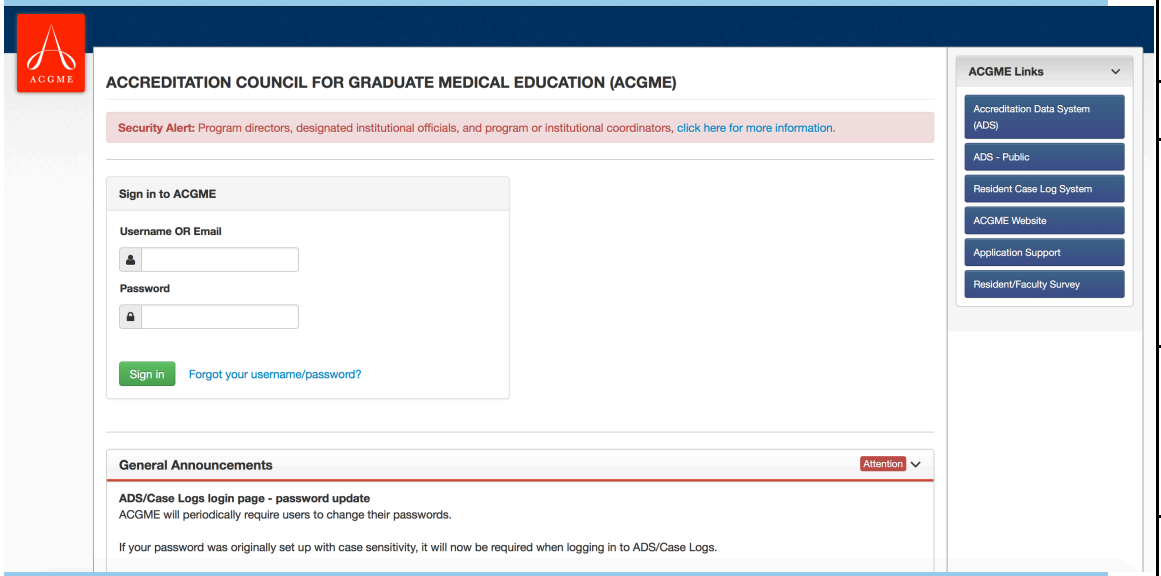
MILESTONES REPORTING



Subcompetencies for Reporting of Milestones to ACGME: Pediatric Subspecialties*

COMPETENCY DOMAIN	SUBCOMPETENCY NUMBER	PAGE IN PEDIATRIC MILESTONES PROJECT BOOKLET	SUBCOMPETENCY
Patient Care (PC)	3	11	Provide transfer of care that insures seamless transitions
	6	18	Make informed diagnostic and therapeutic decisions that result in optimal clinical judgment
	7	21	Develop and carry out management plans
	12	32	Provide appropriate role modeling
Medical Knowledge (MK)	2	40 & 53	Locate, appraise and assimilate evidence from scientific studies related to their patients' health problems
Systems-Based Practice (SBP)	1	85	Work effectively in various health care delivery settings and systems relevant to their clinical specialty
	2	87	Coordinate patient care within the health care system relevant to their clinical specialty
	3	90	Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate
	5	94	Work in inter-professional teams to enhance patient safety and improve patient care quality
	6	96	Participate in identifying system errors and implementing potential systems solutions
Practice- Based Learning and Improvement (PBLI)	1	40	Identify strengths, deficiencies, and limits in one's knowledge and expertise
	4	49	Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement
	7	56	Use information technology to optimize learning and care delivery
	9	61	Participate in the education of patients, families, students, residents, and other health professionals
Professionalism (PROF)	2	80	Professional Conduct: High standards of ethical behavior which includes maintaining appropriate professional boundaries
	5 (PPD**)	111	Trustworthiness that makes colleagues feel secure when one is responsible for the care of patients
	6 (PPD)	116	Provide leadership skills that enhance team function, the learning environment, and/or the health care delivery system/ environment with the ultimate intent of improving care of patients
	8 (PPD)	119	The capacity to accept that ambiguity is part of clinical medicine and to recognize the need for and to utilize appropriate resources in dealing with uncertainty
Interpersonal and Communication Skills (ICS)	3	69	Communicate effectively with physicians, other health professionals, and health related agencies
	4	71	Work effectively as a member or leader of a health care team or other professional group
	5	74	Act in a consultative role to other physicians and health professionals

*GRAY shaded competencies indicate milestones also to be reported by General Pediatrics Residency Programs
**Personal and Professional Development

STRATEGIES – MAPPING MILESTONES

Milestone	Description	Inpatient A	Inpatient B	Outpatient/ Consult	Biannual A	Biannual B	Team A Pre-Attending A	Team A Pre-Attending B	Team B Pre-Attending	360 Patient/ Family	360 Nurses/Staff	Peer (Resident)	Peer (Fellow)	Peer (Fellow Pre-Attending)	Presentation	Fellow Self	Faculty Self
C3	transfer of care	X					X									X	X
PC6	informed management/judgment		X	X		X		X	X				X	X		X	X
PC7	management plans	X				X	X									X	X
PC8	procedures		X					X	X							X	X
PC12	role modeling		X											X		X	X
PC13	supervision						X					X		X		X	X
MK2	applied knowledge				X		X						X		X	X	X
PBLI1	self identify strengths and deficiencies		X			X		X							X	X	X
PBLI4	QI, practice improvement					X										X	X
PBLI7	information technology for learning and care		X	X				X	X						X	X	X
PBLI9	educate patients, families, and other learners	X			X		X			X		X		X		X	X
ICS1	communicate w/ patients and families	X			X		X			X	X	X		X		X	X
ICS3	communicate w/ health professionals				X						X		X		X	X	X
ICS4	member or lead health care team		X			X		X				X		X		X	X
ICS5	consultive role			X			X		X							X	X
P1	humanism			X	X			X	X	X		X	X			X	X
P2	professional conduct			X	X		X		X			X	X			X	X
SBP1	health care setting										X			X		X	X
SBP2	coordinate care				X				X	X						X	X
SBP3	cost/risk-benefit analysis					X										X	X
SBP5	team patient safety/QI										X					X	X
SBP6	system errors/solutions										X					X	X
PROF2	coping mechanisms			X					X		X		X			X	X
PPD5	trustworthiness					X					X					X	X

Milestones - Subcompetencies

Subcompetencies | EPAs | Milestone Elements | Milestones Summary | Progress Reports | Milestone Settings

Pediatric Hem/Onc Subcompetencies

Competency:	ID:	Subcompetency:	Status:	Linked EPAs:	Linked Elements:	Tagged Questions:	Actions:
Patient Care	PC-1	Provide transfer of care that ensures seamless transitions	Active		1	6	Modify
	PC-2	Make informed diagnostic and therapeutic decisions that result in optimal clinical judgment	Active		1	11	Modify
	PC-3	Develop and carry out management plans	Active	0	1	7	Modify
	PC-4	Provide appropriate role modeling	Active	0	1	7	Modify
	PC8	procedures (ASPHO)	Active	0	1	7	Modify
	PC13	supervision (ASPHO)	Active	0	1	6	Modify
Medical Knowledge	MK-1	Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems	Active	0	3	10	Modify
Systems-based Practice	SBP-1	Work effectively in various health care delivery settings and systems relevant to their clinical specialty	Active	0	1	5	Modify
	SBP-2	Coordinate patient care within the health care system relevant to their clinical specialty	Active	0	1	7	Modify
	SBP-3	Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate	Active	0	1	4	Modify
	SBP-4	Work in inter-professional teams to enhance patient safety and improve patient care quality	Active	0	1	4	Modify
	SBP-5	Participate in identifying system errors and implementing potential systems solutions	Active	0	1	4	Modify
Practice-based Learning and Improvement	PBLI-1	Identify strengths,deficiencies,and limits in one's knowledge and expertise	Active	0	1	10	Modify
	PBLI-2	Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement	Active	0	1	4	Modify
	PBLI-3	Use information technology to optimize learning and care delivery	Active	0	1	11	Modify
	PBLI-4	Participate in the education of patients, families, students, residents, and other health professionals	Active	0	1	13	Modify
Professionalism	P1	humanism (ASPHO)	Active	0	1	10	Modify
	PPD2	coping mechanism (ASPHO)	Active	0	1	5	Modify
	PROF-1	Professional Conduct : High standards of ethical behavior which includes maintaining appropriate professional boundaries	Active	0	4	17	Modify
	PROF-2	Trustworthiness that makes colleagues feel secure when one is responsible for the care of patients	Active		1	5	Modify
	PROF-3	Provide leadership skills that enhance team functioning, the learning environment, and/or the health care delivery system/environment with the ultimate intent of improving care of patients	Active		1	9	Modify
	PROF-4	The capacity to accept that ambiguity is part of clinical medicine and to recognize the need for and to utilize appropriate resources in dealing with uncertainty	Active	0	1	5	Modify
Interpersonal Communication Skills (ICS)	ICS-1	Communicate effectively with physicians, other health professionals, and health-related agencies	Active	0	1	17	Modify
	ICS-2	Work effectively as a member or leader of a health care team or other professional group	Active	0	1	8	Modify
	ICS-3	Act in a consultative role to other physicians and health professionals	Active	0	1	7	Modify
	ICS1	patients and families (ASPHO)	Active	0	1	11	Modify

STRATEGIES – NARRATIVES, OPEN-ENDED QUESTIONS, ETC.

ICS1. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds

Not yet Assessable					
	Uses st… interv… all ques… approa… unique… socioec… needs; … uncomf… questio…				
	26. Comm… range of s…				
	Uses stan… medical interview… template. uncomfortable asking personal questions.	but cannot manage barriers to communication.	scenarios. Is able to mitigate barriers.	**approach to the individual. Handles majority of difficult situations.**	and families. Intuitively handles difficult situations.

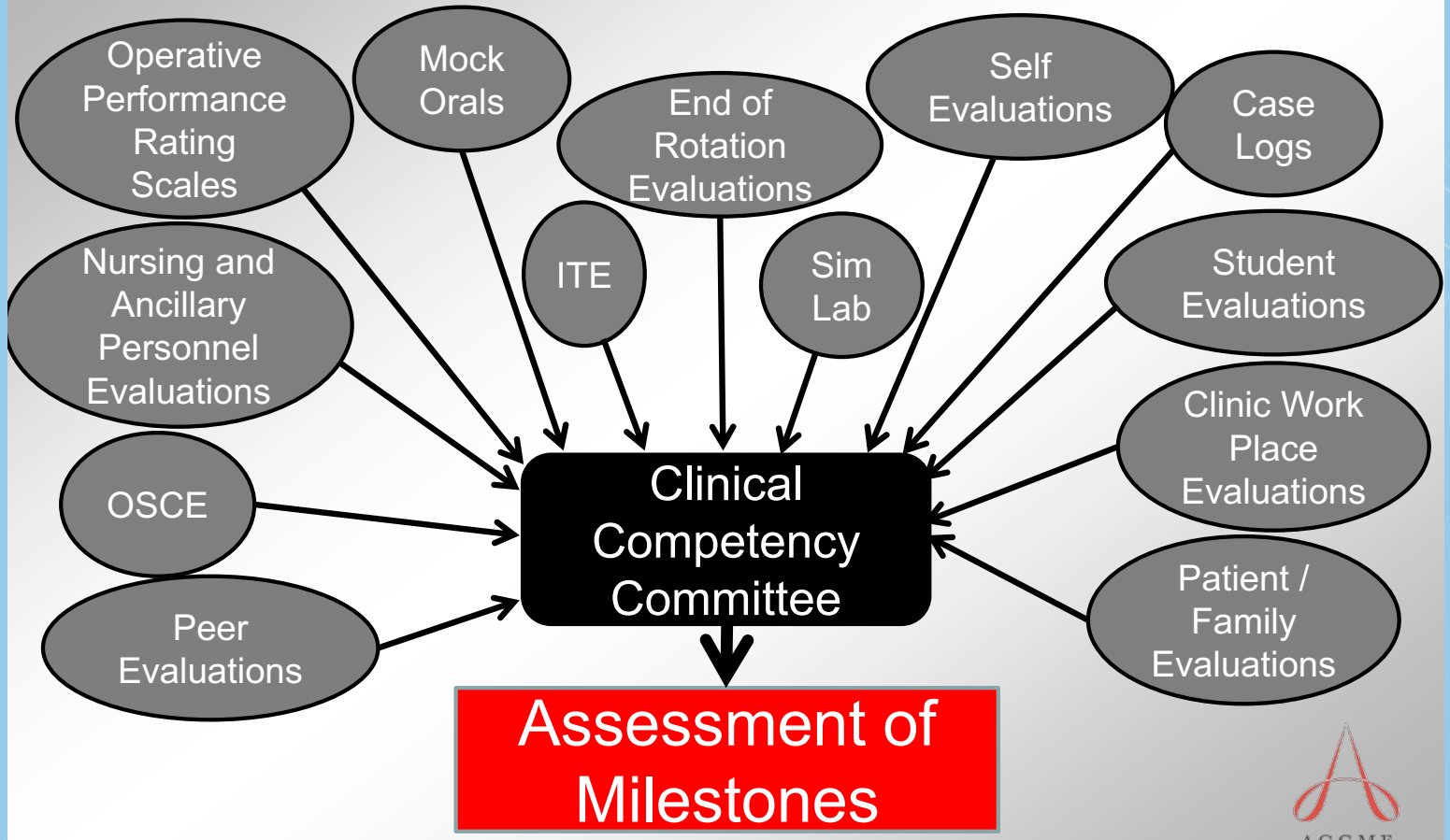
ICS1. How well does the resident communicate effectively with patients and families across a broad range of socioeconomic and cultural backgrounds? Consider:

- Use of non-judgmental language and body language to develop trust and respect
- How well the resident addresses any physical, cultural, psychological and social barriers to communication
- How well the resident addresses the patient/families' primary concern
- How well the resident manages difficult conversations

Subcompetency Achievements (0 / 26)

Competency:		Subcompetency:	LAST 6 MONTH STATISTICS Average:	Range:	# Questions:
Patient Care	PC-1	Provide transfer of care that ensures seamless transitions	2.8	2.5 - 3.5	
	PC-2	Make informed diagnostic and therapeutic decisions that result in optimal clinical judgment	3.0	2.5 - 4.0	2
	PC-3	Develop and carry out management plans	3.0	2.0 - 4.0	11
	PC-4	Provide appropriate role modeling	3.2	1.5 - 4.5	16
	PC8	procedures (ASPHO)	3.2	2.5 - 4.0	14
	PC13	supervision (ASPHO)	3.1	2.0 - 4.5	19
Medical Knowledge	MK-1	Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems	3.0	2.0 - 4.0	12
Systems-based Practice	SBP-1	Work effectively in various health care delivery settings and systems relevant to their clinical specialty	3.5	3.0 - 4.0	4
	SBP-2	Coordinate patient care within the health care system relevant to their clinical specialty	3.6	3.0 - 4.5	4
	SBP-3	Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate	3.0	2.5 - 4.0	3
	SBP-4	Work in inter-professional teams to enhance patient safety and improve patient care quality	2.9	2.5 - 3.0	4
	SBP-5	Participate in identifying system errors and implementing potential systems solutions	3.4	3.0 - 4.0	4
Practice-based Learning and Improvement	PBLI-1	Identify strengths,deficiencies,and limits in one's knowledge and expertise	3.3	2.5 - 4.0	8
	PBLI-2	Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement	2.5	2.0 - 3.0	2
	PBLI-3	Use information technology to optimize learning and care delivery	3.1	2.5 - 4.0	18
	PBLI-4	Participate in the education of patients, families, students, residents, and other health professionals	3.5	1.5 - 5.0	22
Professionalism	P1	humanism (ASPHO)	3.7	2.5 - 5.0	28
	PPD2	coping mechanism (ASPHO)	3.3	2.5 - 5.0	18
	PROF-1	Professional Conduct : High standards of ethical behavior which includes maintaining appropriate professional boundaries	3.5	2.0 - 5.0	38
	PROF-2	Trustworthiness that makes colleagues feel secure when one is responsible for the care of patients	3.1	2.5 - 4.0	8
	PROF-3	Provide leadership skills that enhance team functioning, the learning environment, and/or the health care delivery system/environment with the ultimate intent of improving care of patients	3.3	1.5 - 5.0	24
	PROF-4	The capacity to accept that ambiguity is part of clinical medicine and to recognize the need for and to utilize appropriate resources in dealing with uncertainty	3.4	2.5 - 4.0	8
Interpersonal Communication Skills (ICS)	ICS-1	Communicate effectively with physicians, other health professionals, and health-related agencies	3.4	2.5 - 4.5	
		Work effectively as a member or leader of a health care team or other professional group	3.2	2.0 - 4.5	20
	ICS-3	consultative role to other physicians and health professionals	2.8	2.0 - 3.5	14
	ICS1	patients and fami (ASPHO)	3.4	2.5 - 5.0	25

Clinical Competency Committee



ACGME

HOW DO YOU GET IT ALL DONE?

WHEN A CCC MEETING…

Doesn't go well

- Data
  - not complete
  - not organized
  - not accurate
- PD or faculty member dominates meeting
- Prolonged inefficient decision making with inability to gain consensus
- Unsubstantiated/unreliable conclusions

Does go well

- Data
  - complete
  - organized
  - accurate
- Cooperative, collaborative decision making
- Efficient use of time
- Sound valid conclusions aligned with data

Walker K, Dohn A, Piro N. 2014 ACGME Annual Educational Conference. *Coordinators and Clinical Competency Committees: How to Streamline and Support the Work of your Program's CCC.*

HOW DO YOU GET IT ALL DONE?

- Collaborate and strategize with your program director and the Chair of the CCC to create systems that are most effective
- Stay organized, make timelines
- Break down large tasks into smaller tasks to keep it manageable
- Learn how to effectively use you Residency Management Software and/or external databases
- Think outside the box, i.e., sometimes you will need to go low-tech to get evaluations back
- Share best practices across programs and institutions
- Graduate medical education is cyclical, reassess tools and systems annually and make adjustments to improve

DISCUSSION

Share a barrier you have met in your own program with MSF.

CHALLENGES OF MULTI-SOURCE ASSESSMENT

- Minimum # for generalizability
  - 6-11 peers
  - 22-25 patients
- Confidentiality and anonymity
- Collating responses can be labor intensive, time-consuming

*Lockyer J. MSF in the assessment of physician competencies. J Contin Educ Health Prof. 2003(1): 4-12.


ANY
QUESTIONS
?

EVALUATIONS