Coaching Strategies to Help Trainees’ Clinical Skills Development

Association of Pediatric Program Directors’ Meeting
April 6, 2017
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Objectives

• Review purpose and benefits of coaching
• Discuss skills and tools for successful coaching
• Practice coaching with scenarios
• Introduce Coaching models from Stanford and Seattle Children’s Residency Programs
• Review myths and misconceptions
What is Good Coaching?

- Think: Individual reflection—positive and negative Coach behaviors
- Pair-share
What is Coaching?

“Coaching philosophy adheres to the notion that learning is never finished and to reach one’s maximum potential requires an external viewpoint to correct or enhance performance.”

Three types of Coaching relevant to coaching in medicine:

1. Coaching for skill enhancement
2. Coaching for increased performance
3. Coaching for development

Schwellnus H, Carnahan H. Peer-coaching with health care professionals: What is the current status of the literature and what are the key components necessary for peer-coaching? A scoping review. *Med Teach.* 2014
What are the benefits of Coaching?

• Improves clinicians’:
  – Confidence in their clinical and communication skills
  – Communication skills (ie. Motivational interviewing)
  – Self-reported burnout scores
  – Patient satisfaction scores

• Improves residents’:
  – Perceptions of feedback
  – Reflective skills
  – Goal-setting skills
Introduction to Coaching

• When should Coaching be used?
• How do you assess what the learner needs?
• How do you become an effective Coach?
Role Play
6 Essential skills for effective coaching

1) Recognizing the big picture of Coaching
2) Establishing a safe learning climate
3) Observing
4) Facilitating reflection
5) Giving feedback
6) Helping learners set goals
Skill 1: Recognizing the big picture of Coaching

Resident identifies goals, communicates with coach/attending

Observation

Learner Reflection

Feedback

Further goal-setting

Internalization and application
Skill 2: Establishing a safe learning climate

- Clarify role of coach
- Grow relationship over time
- Emphasize non-evaluative feedback
- Be approachable and available
- Help, not judge
- Give feedback privately
- Facilitate goal-setting
- Serve as support
- Cultivate trust
- Ask/learn strengths and insecurities
- Focus on skills
- Improve confidence
Skill 3: Observing

• Direct observation is:
  (1) first-hand observation of a learner
  (2) coupled with feedback
  (3) in a real-life setting

• It can provide:
  (1) reinforcing and/or formative feedback
  (2) increased credibility for the observer
Direct observation: Miller’s Pyramid

- **Knows**: Possesses knowledge
  - Example assessment method: Multiple choice test

- **Knows How**: Applies knowledge
  - Example assessment method: Case-based examination

- **Shows How**: Demonstrates ability in a structured environment
  - Example Assessment Method: OSCE

- **Does**: Performs in a real-life clinical scenario
  - Example assessment method: Direct observation

- **Impact on Patient**
Tools to enhance direct observation

• Standardized tools
  – Systematize the process
  – Increase objectivity
  – Serve as a mental prompt, like a checklist, especially for less experienced observers

• Ideally, tools are flexible and allow user autonomy, expertise
Date: ___/___/____
Resident’s Name: __________________________ Circle one: R1  R2  R3
Observer’s Name: __________________________
Location (circle one): Continuity Clinic Other Clinic Nursery Ward ICU E.D.
Patient age: _______ yrs.
Patient complexity (circle one): Low Moderate High

*Indicate the type of patient encounter that was observed.*
*Examples: admission H&P, daily follow-up, discharge day, well child check, acute care visit*

**Key Feedback Points from Observation:**

(1) Describe something that the resident identified they did well, and why it worked.

(2) Describe something that you as the observer identified was done well, and why it worked.

(3) Describe something you and the resident identified that s/he could continue to work on. What would be 1-2 ways to specifically hone this skill or ability?
Skill 4: Facilitating reflection

<table>
<thead>
<tr>
<th>Technique</th>
<th>Example</th>
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</table>
| **Ask**   | “How did you feel that went?”  
|           | “What went well?”  
|           | “What was challenging?”  
|           | “What, if anything, surprised you?” |
| **Tell**  | Provide feedback |
| **Ask**   | “Does this resonate with you?”  
|           | “Is this something you’ve heard before?”  
|           | “What goals can we work on together?” |
Skill 5: Giving feedback

Technique ("Tell")
- Related to learner’s goals/reflections
- Specific, focused on task or behavior
- Timely
- Nonjudgmental
- Provided in small pieces
- Mindful to how learner processes feedback

Example
- “I noticed that when you were speaking with your patient’s family you used ‘febrile’ and ‘tachycardic.’ Some families may not understand what these terms mean...
- “In the future, you may want to consider…”
- “I would have said…”
- “You could have said…”
Skill 6: Helping learners set goals

• Adult Learning Theory:
  – Adults learn best when they are actively engaged and self-direct their own learning goals and activities
  – Adults must reflect on their experiences
  – The role of the teacher (aka coach) is to engage the learner’s needs

• In addition to helping set goals, the coach can help the learner refine them to ensure they are appropriate for the learner’s individual needs and actionable
I-SMART goals

Important (to the learner)
Specific
Measurable
Accountable
Realistic
Timeline
Skills Practice Scenarios

6 Essential Skills for Effective Coaching

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Two models of residency Coaching Programs

Man-to-Man

Zone
The Stanford Pediatric Residency Coaching Program
2013-present
Stanford Pediatric Residency Coaching Program Goals

• To improve residents’ clinical skills in:
  • Critical Thinking (including asking questions and seeking evidence to drive decision-making)
  • Physical examination
  • Communication
  • Professionalism
Stanford Coaching Program

- 10 Faculty Coaches
- 10-11 residents/Coach
- Longitudinal direct observations in multiple settings: inpatient, outpatient, through training years
- Review ILPs
- Serve on CCC
• Focus on core clinical skills
• Coaching sessions:
  – Goal-directed observation
  – Reflection
  – Feedback
  – Goal-setting
Direct Observations

• PGY1s:
  – History-taking
  – Physical exam
  – Presentations
  – Clinical Reasoning
  – Communication
  – Handoffs
  – Documentation

• PGY2s and PGY3s:
  – Teaching
  – Precepting
  – Care Conferences
  – Giving bad news
Faculty Development
Feasibility

- Coaching sessions by Resident Year (N = 82 residents)

<table>
<thead>
<tr>
<th>Resident year</th>
<th>Median</th>
<th>Interquartile range</th>
<th>Goal</th>
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<tbody>
<tr>
<td>PGY1</td>
<td>11</td>
<td>8-12</td>
<td>10</td>
</tr>
<tr>
<td>PGY2</td>
<td>7</td>
<td>6-9</td>
<td>7</td>
</tr>
<tr>
<td>PGY3</td>
<td>5.5</td>
<td>4.75-7</td>
<td>5-7</td>
</tr>
</tbody>
</table>

- 82/82 residents had at least 3 coaching sessions
- 659 sessions; average = 82/Coach (range 57-108)
Coach vs. Other Faculty's Skill and Use of Reflection and Goal-Setting in Giving Feedback

- **Skill**
  - Resident: eval of coach
  - Coach: self-eval
  - Resident: eval of non-Coach
  - Non-Coach: self-eval

- **Reflection**
  - Resident: eval of coach
  - Coach: self-eval
  - Resident: eval of non-Coach
  - Non-Coach: self-eval

- **Goal-setting**
  - Resident: eval of coach
  - Coach: self-eval
  - Resident: eval of non-Coach
  - Non-Coach: self-eval
Effect of Coaching Program on Coach and Non-Coach Core Faculty

Confidence in Giving Feedback in the Following Domains

- **COACH: PE**
  - 2013: 3.5
  - 2014: 3.7
  - *p<0.01*

- **Non-COACH: PE**
  - 2013: 3.4
  - 2014: 3.7
  - *p<0.01*

- **COACH: Assessment**
  - 2013: 3.3
  - 2014: 3.8
  - *p<0.01*

- **Non-COACH: Assessment**
  - 2013: 3.2
  - 2014: 3.6
  - *p<0.01*

- **COACH: Communication**
  - 2013: 3.1
  - 2014: 3.5
  - *p=0.062*

- **Non-COACH: Communication**
  - 2013: 3.0
  - 2014: 3.4
  - *p<0.01*

- **COACH: Goal-setting**
  - 2013: 2.9
  - 2014: 3.3
  - *p<0.01*

- **Non-COACH: Goal-setting**
  - 2013: 2.8
  - 2014: 3.2

*Level of Confidence (1-4 scale)*
UW/Seattle Children’s Pediatric Residency Coaching Program
Model

• 18 coaches
• 6-7 residents/coach – all in one class
• Combined into coach teams with a PD/APD: all residency levels (R1, R2, R3) represented
• Meet at least twice per year with each resident
• Serve on the CCC
Roles

• Observe their assigned mentees and other residents in their clinical domain ("zone")
• Review evaluations and give summative clinical feedback
• Help residents develop and track ILP goals
• Use faculty evaluations to map milestones
• Bonus: wellness, career mentoring
Coach Feedback

• Brief survey of coaches, 50% response rate
• All respondents (n=9) liked the DOT form, found it helpful & perceived residents did too
• Biggest barriers to completion were time, coordination with residents
• Areas for improvement: more integrated time to meet with residents, more structure for each meeting
Future Plans: CCC PODS

Pod = 5 CCC coaches and their 6-7 residents (R1s, R2s, R3s) in addition to an APD and chief resident.

Credit: Lilian Ho R3 and Wei-Jen Hsieh R3
Pod Proposal: new features

- Include a chief resident with each pod
- Focus on peer mentoring through more social events with pods integrated across classes
- Utilize Intern, R2, R3 retreats as strategic touchpoints with coaches/pods
- Incorporate structured approach to learning skills: “milestone of the month”
Touch points throughout the year:

- **summer**
  - CCC pod R1, R2, R3 (August)
  - R1 orientation (June)

- **fall**
  - R2 retreat (Oct)
  - R1 retreat (Sept)
  - R3 retreat (Nov)

- **winter**
  - CCC pod R1, R2, R3 (January)

- **spring**
  - CCC pod R1, R2, R3 (April)
  - R1 transition (June)
Myths, Misconceptions, and Quandaries

- Cost
- Time
- Feedback in person
- Formative Feedback vs. Evaluation vs. Both
Coaching in Medicine Toolkit
Summary: 6 Essential skills for effective coaching

1) Recognizing the big picture of Coaching
2) Establishing a safe learning climate
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Thank you!

And

Questions?