Activating Learners to Solicit Feedback in 30 Minutes or Less

Authors: Deborah Simpson, PhD, Naomi Light, MD, **Jacob Bidwell, MD**, Colleen Nichols MD, Joseph Vogelgesang, DO, Will Lehmann, MD, W MacDonald, MD, S Neelati, MD, N Patel, MD, C Kelly, DO, MMM, R Battiola, MD, K Rivera, J Brill, MD, T La Fratta, MBA & AIAMC NI-VI Residents & Faculty

Feedback Puzzle?

Learners: No FB

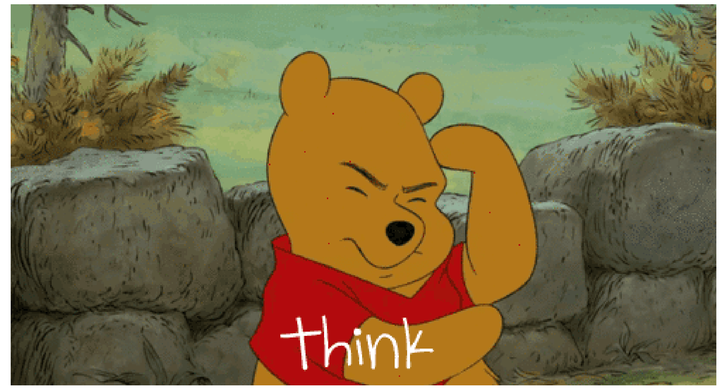
"DECADES"

Faculty Dev FB Workshops

Result: LITTLE/NO SUSTAINED IMPACT

Teachers: Give FB all time!

Steps: Literature



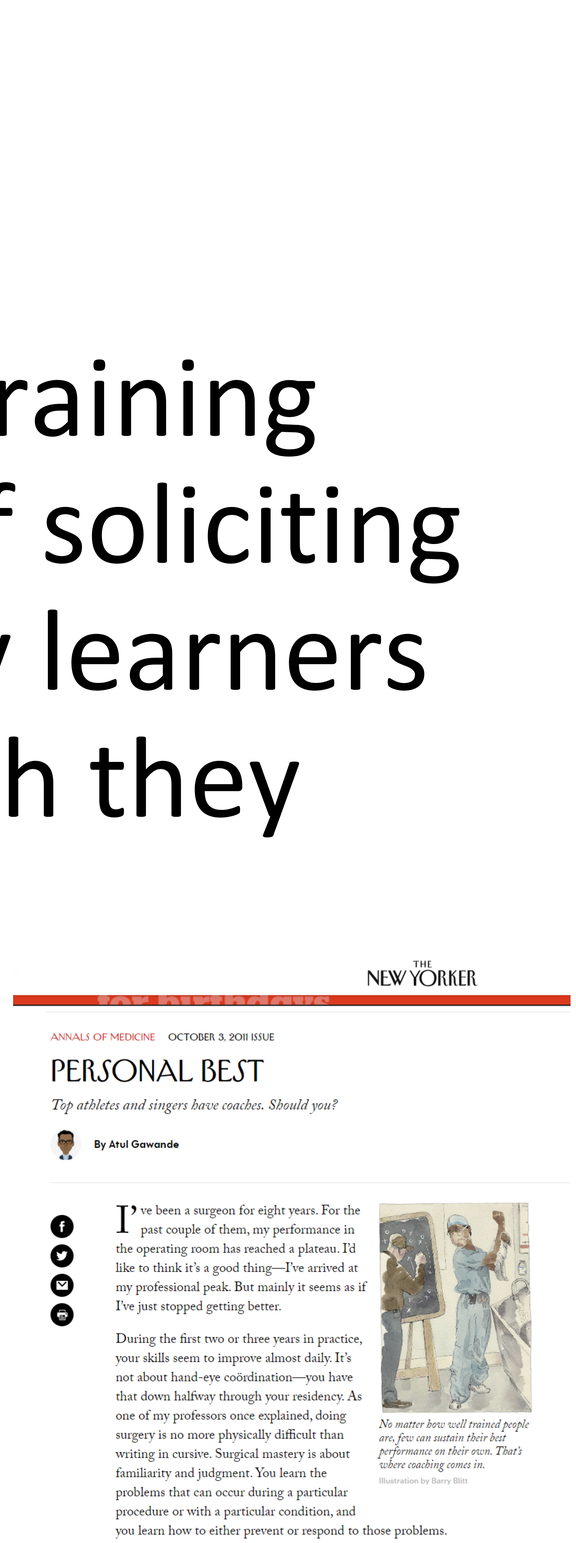
- **Medical Education**
  - May not be provided/perceived
  - If provided “low quality”
    - Not actionable – no goal performance and/or steps
    - No strategies / process for improvement / resources / practice opps
    - Not a “coproduction” = not interactive partnership
- **Org + Social Psych Research: Yes and**
  - Continue encourage teachers to give FB
  - Learners solicit **FB = AC2T**
    Ask, Clarity, Consider, Thanks

•Bing-You RG, Trowbridge RL. Why medical educators may be failing at feedback. JAMA. 2009;302:1330-1331.
•Bing-You R, Varaklis K, Hayes V, Trowbridge R, Kemp H, McKelvy D. The feedback tango: an integrative review and analysis of the content of the teacher–learner feedback exchange. Academic Medicine. 2018 Apr 1;93(4):657-63.
•Telio S, Ajjawi R, Regehr G. The ’educational alliance’ as a framework for conceptualizing feedback in medical education. Acad Med. 2015;90(5):609-14..
•Crommelinck M, Anseel F. Understanding and encouraging feedback seeking behavior: a literature review. Med Ed 2013:47:232-241. [Feedback Vacuum – Lit review 2013 ref 4]

Aim & Methods

- **Aim:** Does a brief, evidence-based training session highlighting the why/how of soliciting feedback result in a commitment by learners to increase the frequency with which they directly ask for feedback

- **Methods:** NI-6 Teams (Well Being)
  - Reviewed key findings literature
  - Who, what, when solicit feedback



THE NEW YORKER

ANNALS OF MEDICINE OCTOBER 3, 2011 ISSUE

PERSONAL BEST

Top athletes and singers have coaches. Should you?

By Atul Gawande

I've been a surgeon for eight years. For the past couple of them, my performance in the operating room has reached a plateau. I'd like to think it's a good thing—I've arrived at my professional peak. But mainly it seems as if I've just stopped getting better.

During the first two or three years in practice, your skills seem to improve almost daily. It's not about hand-eye coördination—you have that down halfway through your residency. As one of my professors once explained, doing surgery is no more physically difficult than writing in cursive. Surgical mastery is about familiarity and judgment. You learn the problems that can occur during a particular procedure or with a particular condition, and you learn how to either prevent or respond to those problems.

No matter how well trained people are, few can sustain their best performance on their own. That's where coaching comes in.

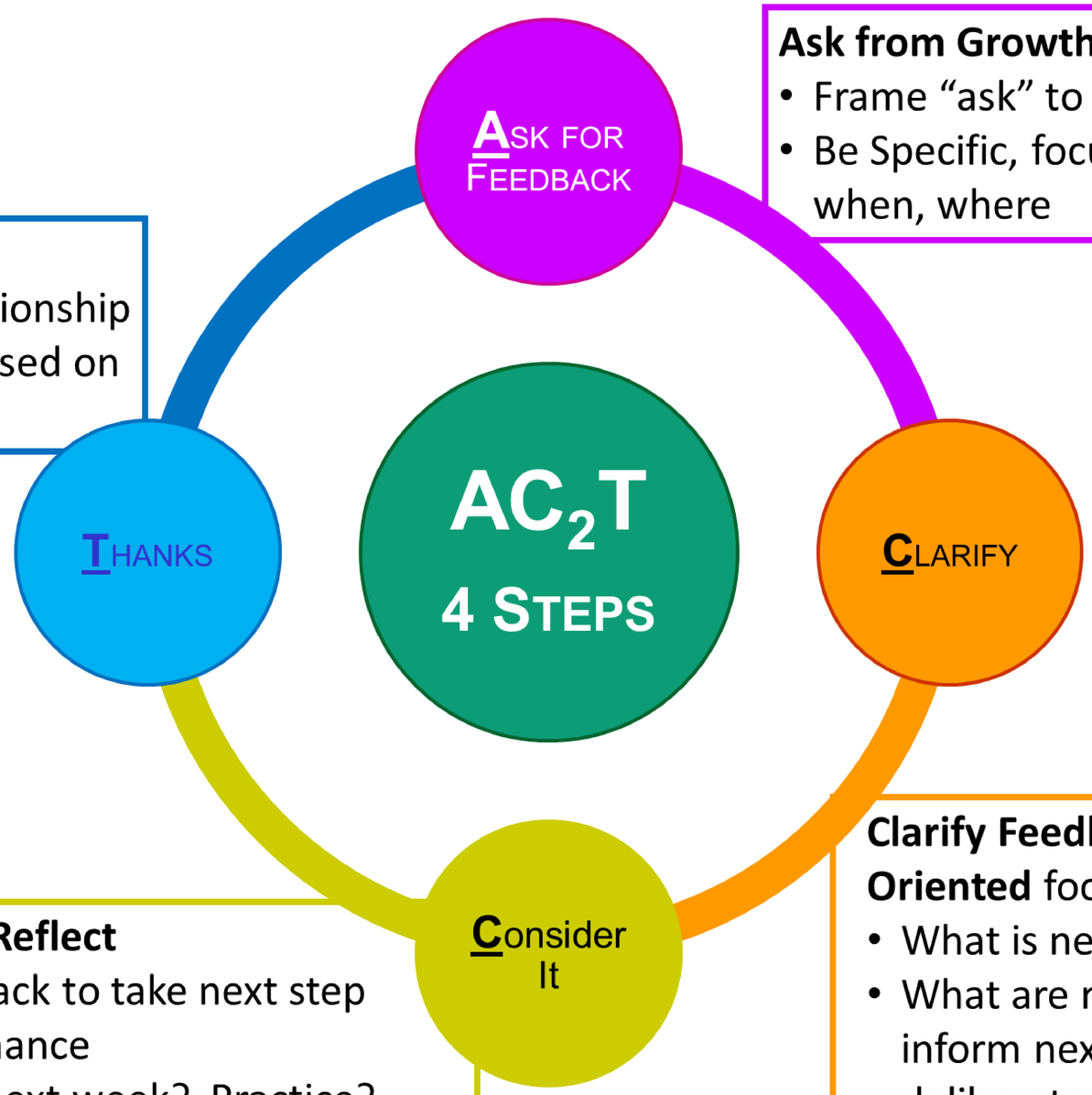
Illustration by Barry Blitt

Ask from Growth-Learning Mindset

- Frame "ask" to improve to next step
- Be Specific, focused, consider who, when, where

Say Thanks

- Recognize and respect the relationship
- It's an educational alliance focused on your growth



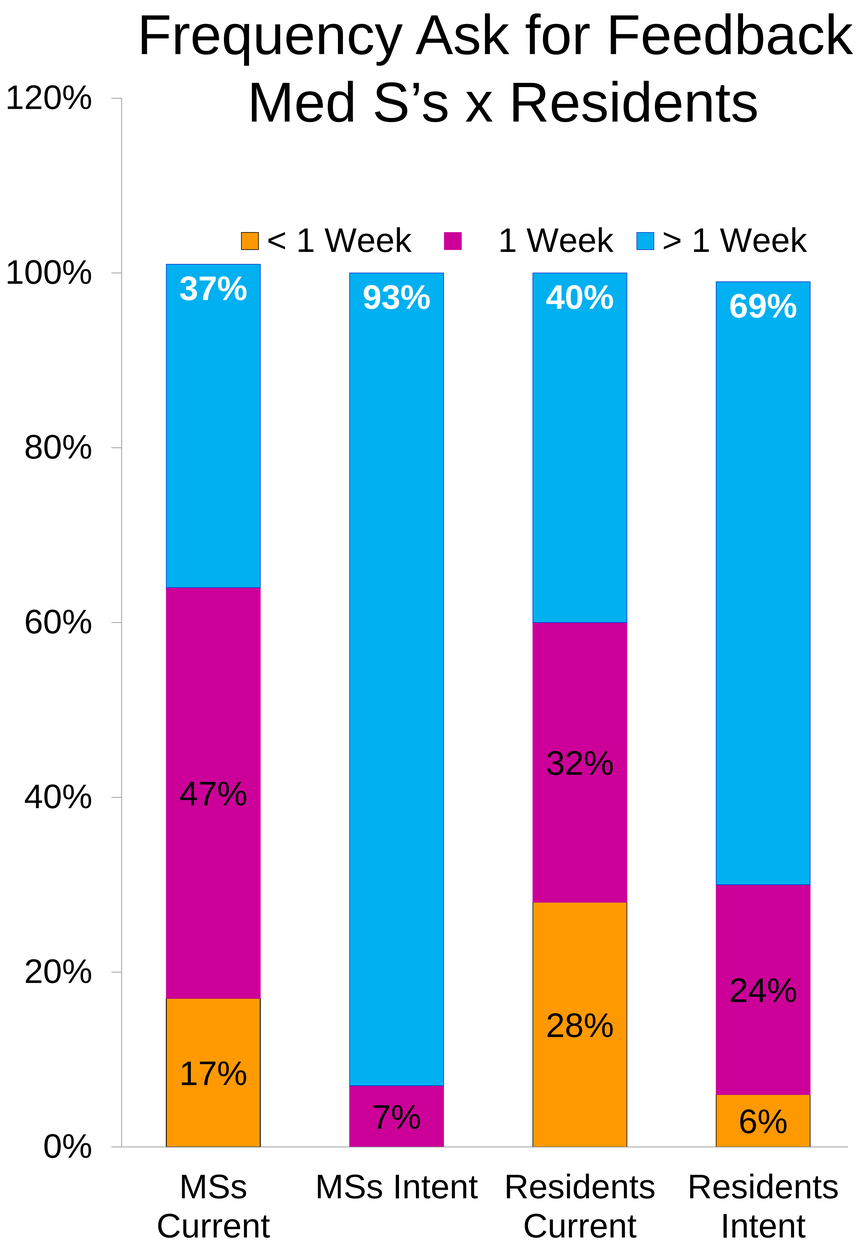
Consider the Feedback – Reflect

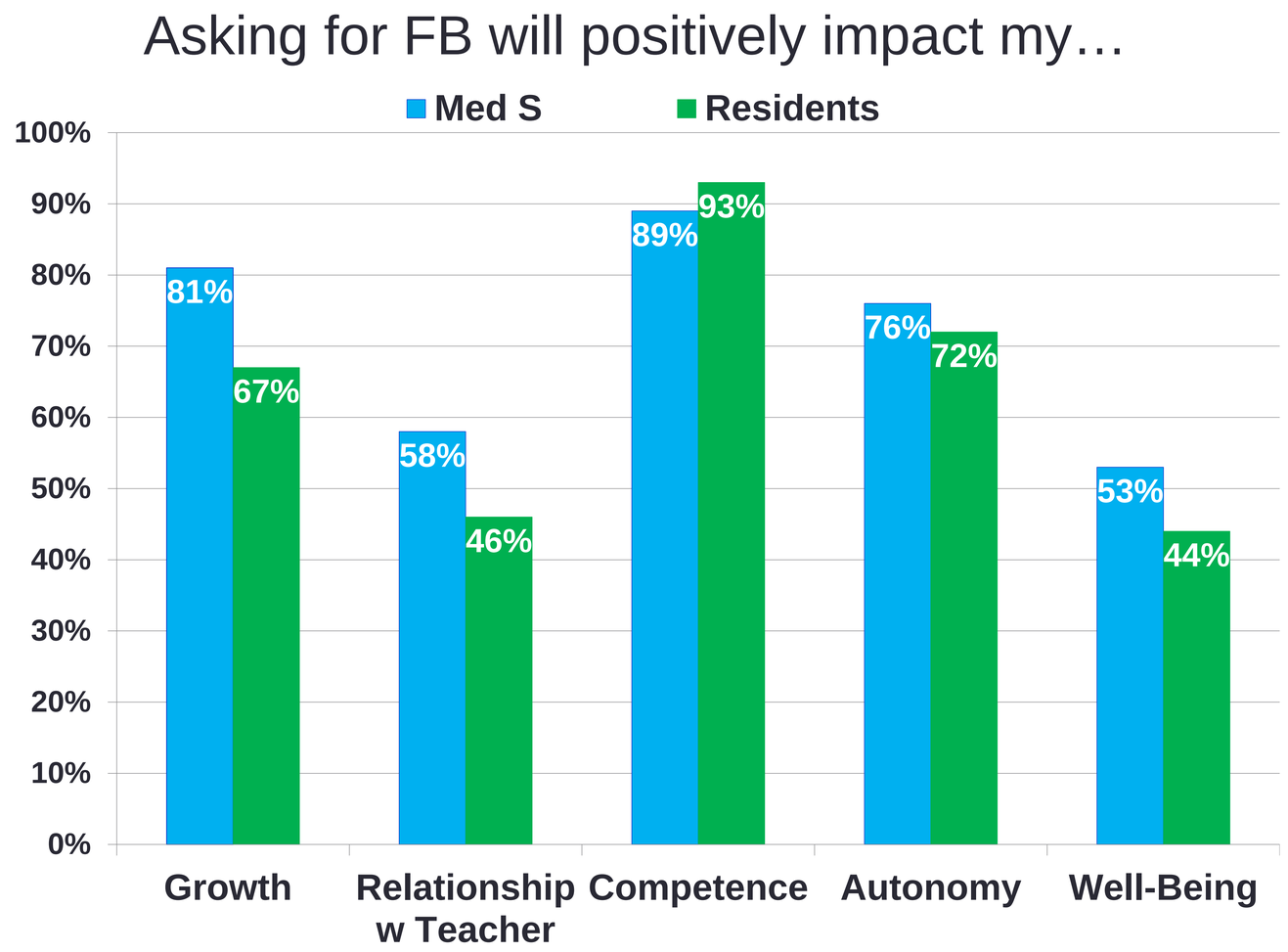
- How can I use this feedback to take next step towards my goal performance
- What actions take now, next week? Practice?
- Manage ego – it may hurt – reframe as progress towards your goal

Clarify Feedback to be Action Oriented focusing on "gap"

- What is next step (s) towards goal
- What are resources/strategies to inform next steps/facilitate deliberate practice

Results to Date & Next Steps





On-Going & Next Steps:

- (Re) Orient to Model & role plays → "scripts"
- Fac Dev focused on "actionable feedback"
- Data Collection + ACGME Annual Survey item re: feedback

Making GME Scholarly Activity Visible on Your Residency Program Website using a Cloud-Based Scholarly Tool

Authors: Deborah Simpson, PhD, Will Lehmann, MD, Brenda Fay, MLIS, William MacDonald, MD, Jennifer Deal, MA, MLIS, Carla Kelly, MMM, Esmeralda Santana, C-TAGME, **Tricia La Fratta, MBA**

AKA: *Does it count as scholarly work if it's not Visible? Endurable?*

Aim & Methods

- **Aim:** Showcase breadth & quantity of GME trainee & faculty scholarly activity linked to each program's website
- **Partnered:** Medical Libraries identified cloud based application *SelectedWorks™*
  - Individual Faculty Profiles
  - Group Profiles (FM Residents, Rad Faculty)
- Piloted FM Residency Program

Residency Programs

Fellowship Programs

FAMILY MEDICINE

the People

GME VIDEO

MEET THE RESIDENTS

RESIDENT CAM

MILWAUKEE

COFFEE WITH THE RESIDENTS

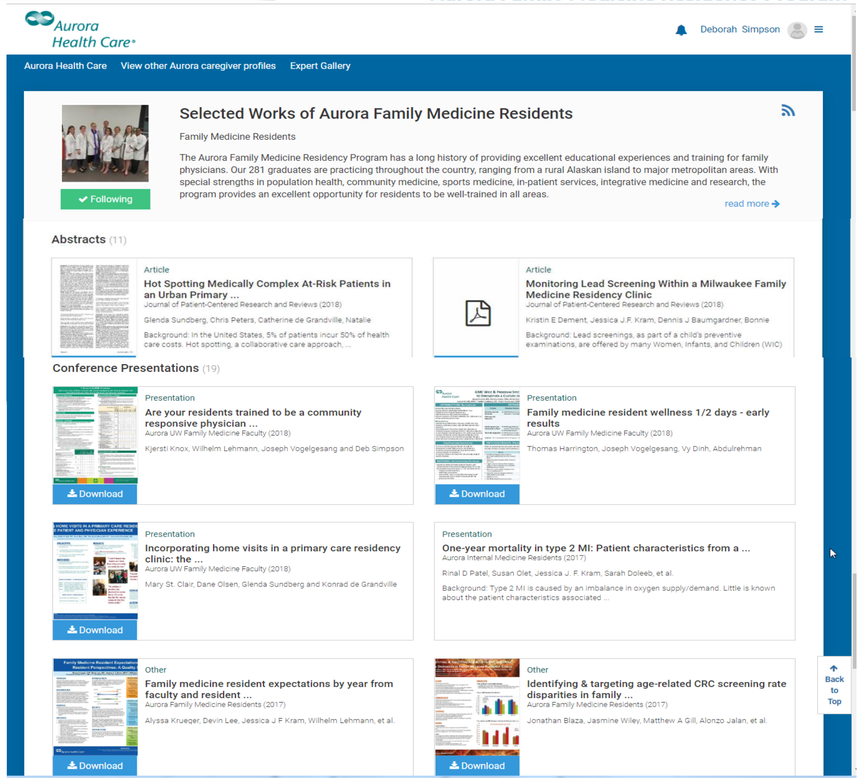
FACULTY

CURRENT RESIDENTS

RESIDENCY SCHOLARSHIP

WELCOME TO WISCONSIN

Aurora Family Medicine Residency Program



PROGRAM FACTS

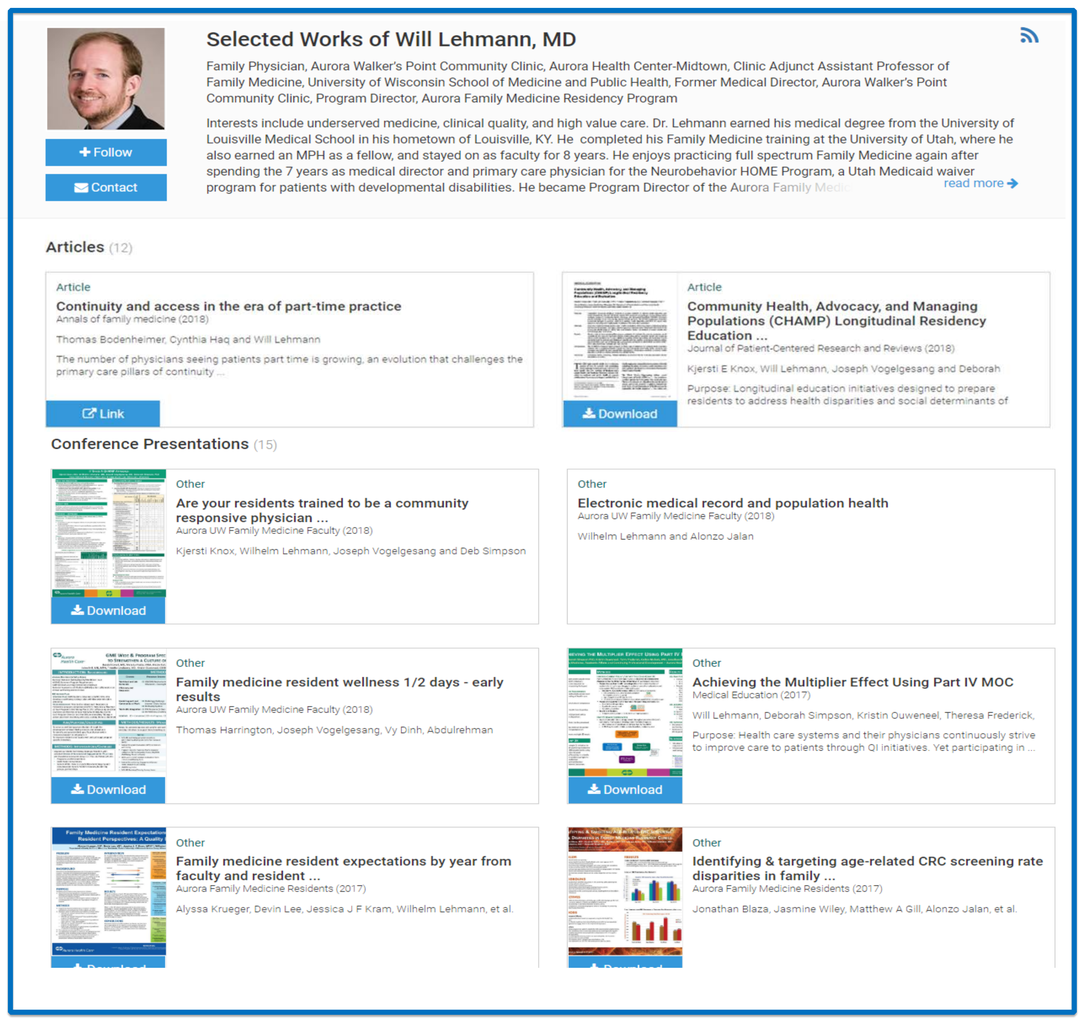
LEADERSHIP TEAM/FACULTY

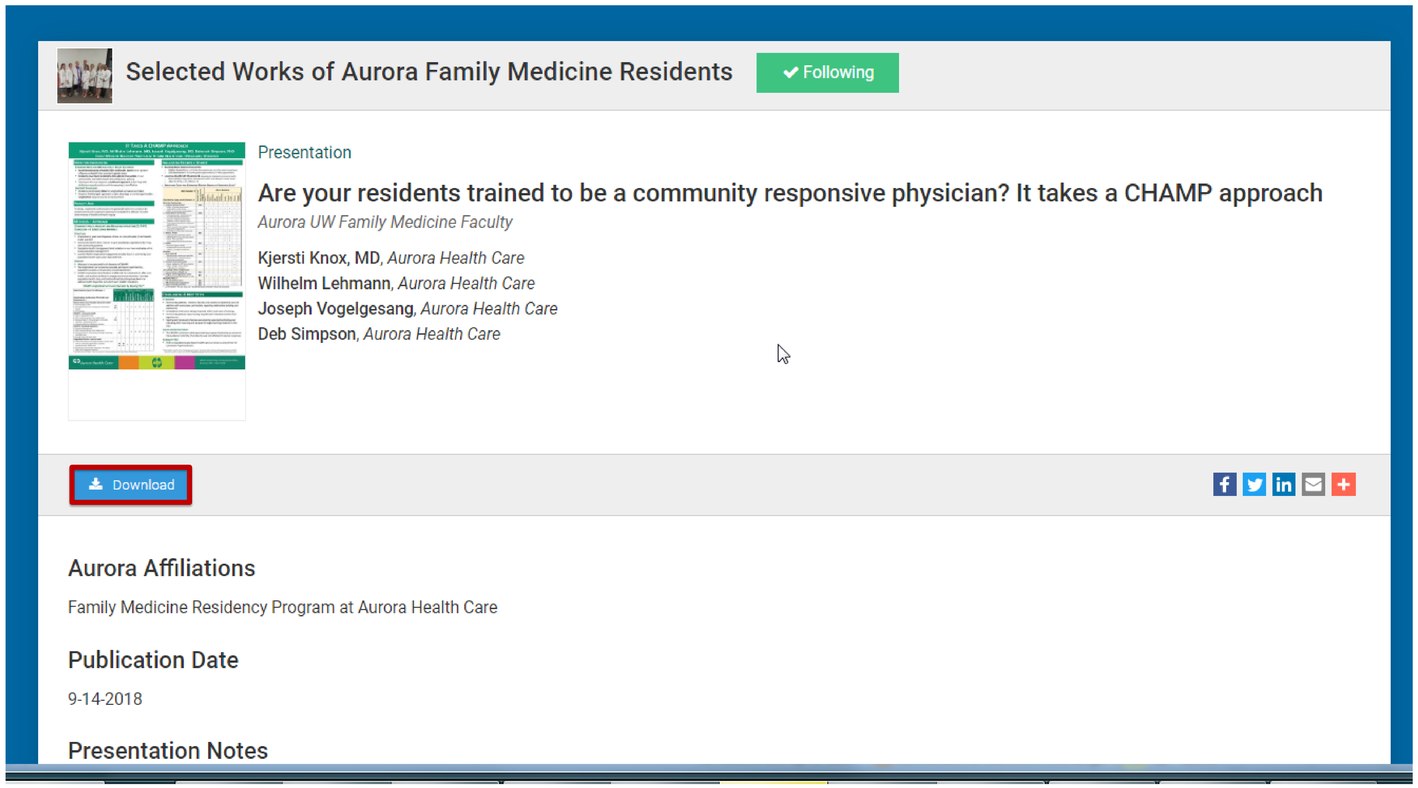
Physician Faculty | Non-Physician Faculty

PHYSICIAN FACULTY

Learning to be a family physician requires two key ingredients, a motivated learner and a motivated teacher. Our faculty, with diverse backgrounds in Family Medicine, are excellent role models and teachers for you during your training. Supporting this work, the campus and department leaders all have a background in and deep understanding of Family Medicine.

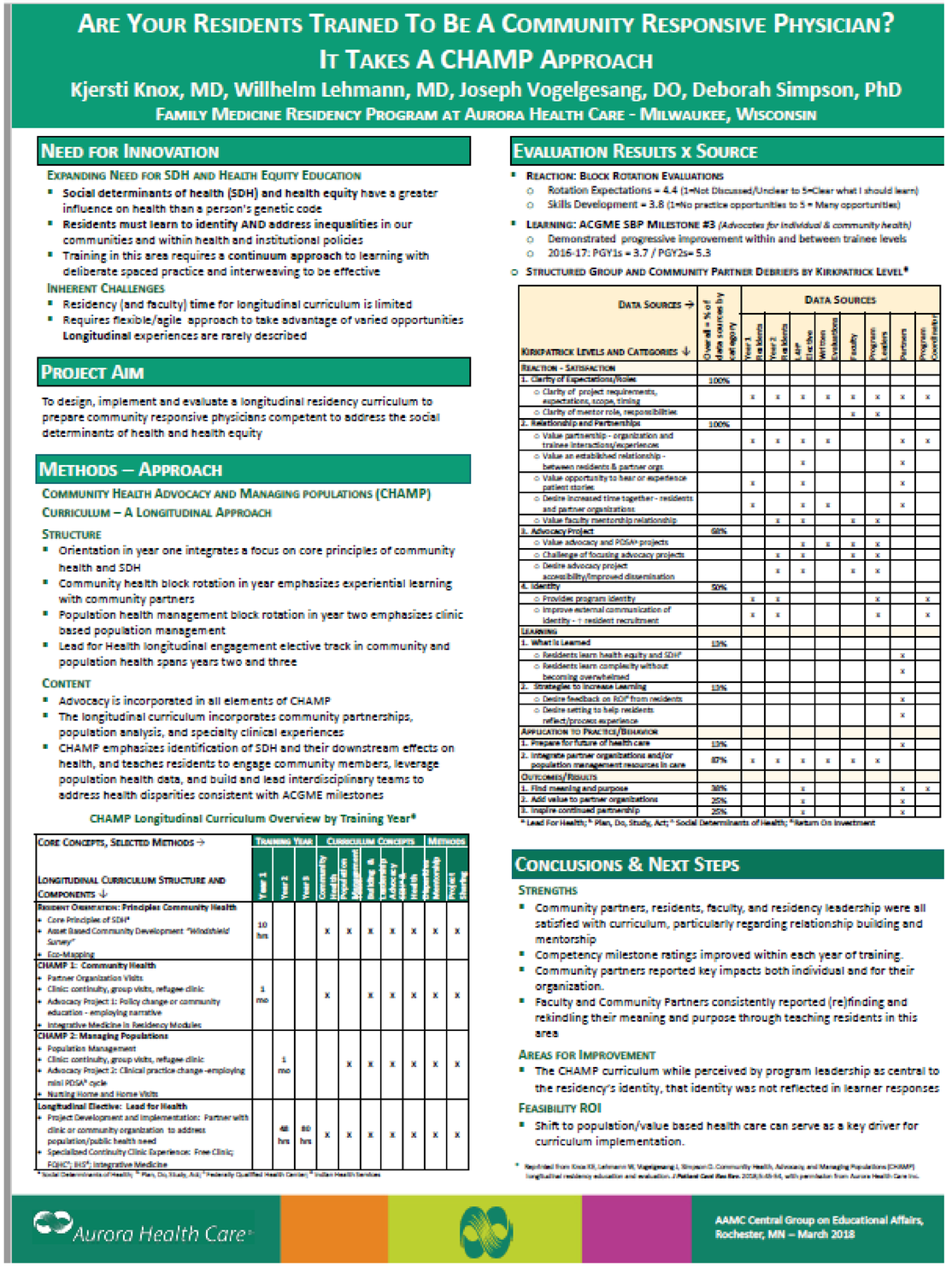
A B C D E F G H I J K L M N O P Q R S T U V W X Y Z





Results

- Reports on downloads +
- Exportable results to facilitate data entry into ACGME's ADS



ARE YOUR RESIDENTS TRAINED TO BE A COMMUNITY RESPONSIVE PHYSICIAN? IT TAKES A CHAMP APPROACH

Kjersti Knox, MD, Willhelm Lehmann, MD, Joseph Vogelgesang, DO, Deborah Simpson, PhD
FAMILY MEDICINE RESIDENCY PROGRAM AT AURORA HEALTH CARE - MILWAUKEE, WISCONSIN

NEED FOR INNOVATION

EXPANDING NEED FOR SDH AND HEALTH EQUITY EDUCATION

- **Social determinants of health (SDH) and health equity** have a greater influence on health than a person's genetic code
- **Residents must learn to identify AND address inequalities** in our communities and within health and institutional policies
- Training in this area requires a **continuum approach** to learning with deliberate spaced practice and interweaving to be effective

INHERENT CHALLENGES

- Residency (and faculty) time for longitudinal curriculum is limited
- Requires flexible/agile approach to take advantage of varied opportunities
- **Longitudinal** experiences are rarely described

PROJECT AIM

To design, implement and evaluate a longitudinal residency curriculum to prepare community responsive physicians competent to address the social determinants of health and health equity

METHODS – APPROACH

COMMUNITY HEALTH ADVOCACY AND MANAGING POPULATIONS (CHAMP) CURRICULUM – A LONGITUDINAL APPROACH

STRUCTURE

- Orientation in year one integrates a focus on core principles of community health and SDH
- Community health block rotation in year emphasizes experiential learning with community partners
- Population health management block rotation in year two emphasizes clinic based population management
- Lead for Health longitudinal engagement elective track in community and population health spans years two and three

CONTENT

- Advocacy is incorporated in all elements of CHAMP
- The longitudinal curriculum incorporates community partnerships, population analysis, and specialty clinical experiences
- CHAMP emphasizes identification of SDH and their downstream effects on health, and teaches residents to engage community members, leverage population health data, and build and lead interdisciplinary teams to address health disparities consistent with ACGME milestones

CHAMP Longitudinal Curriculum Overview by Training Year*

CORE CONCEPTS, SELECTED METHODS → / LONGITUDINAL CURRICULUM STRUCTURE AND COMPONENTS ↓	TRAINING YEAR: Year 1	Year 2	Year 3	CURRICULUM CONCEPTS: Community Health	Population Management	Building & Sustaining Advocacy around Health	Population Relationships	METHODS: Project Sharing
RESIDENT ORIENTATION: Principles Community Health								
• Core Principles of SDH*	10 hrs			X	X	X	X	X	X
• Asset Based Community Development "Windshield Survey"*									
• Eco-Mapping									
CHAMP 1: Community Health								
• Partner Organization Visits									
• Clinic: continuity, group visits, refugee clinic	1 mo			X		X	X	X	X
• Advocacy Project 1: Policy change or community education – employing narrative									
• Integrative Medicine in Residency Modules									
CHAMP 2: Managing Populations								
• Population Management									
• Clinic: continuity, group visits, refugee clinic		1 mo			X	X	X	X	X
• Advocacy Project 2: Clinical practice change -employing mini PDSA* cycle									
• Nursing Home and Home Visits									
Longitudinal Elective: Lead for Health								
• Project Development and Implementation: Partner with clinic or community organization to address population/public health need		48 hrs	80 hrs	X	X	X	X	X	X
• Specialized Continuity Clinic Experience: Free Clinic; FQHC*; IHS*; Integrative Medicine									

* Social Determinants of Health; * Plan, Do, Study, Act; * Federally Qualified Health Center; * Indian Health Services

EVALUATION RESULTS X SOURCE

- REACTION: BLOCK ROTATION EVALUATIONS
  - Rotation Expectations = 4.4 (1=Not Discussed/Unclear to 5=Clear what I should learn)
  - Skills Development = 3.8 (1=No practice opportunities to 5 = Many opportunities)
- LEARNING: ACGME SBP MILESTONE #3 *(Advocates for individual & community health)*
  - Demonstrated progressive improvement within and between trainee levels
  - 2016-17: PGY1s = 3.7 / PGY2s= 5.3
- STRUCTURED GROUP AND COMMUNITY PARTNER DEBRIEFS BY KIRKPATRICK LEVEL*

KIRKPATRICK LEVELS AND CATEGORIES ↓ / DATA SOURCES →	Overall = % of data sources by category	DATA SOURCES: Year 1 Residents	Year 2 Residents	Year 3 Residents	L&P Electives	Written Evaluations	Faculty	Program Leaders	Partners	Program Coordinator
REACTION - SATISFACTION										
1. Clarity of Expectations/Roles	100%									
○ Clarity of project requirements, expectations, scope, timing		x	x	x	x	x	x	x	x	x
○ Clarity of mentor role, responsibilities							x	x		
2. Relationship and Partnerships	100%									
○ Value partnership - organization and trainee interactions/experiences		x	x	x	x				x	x
○ Value an established relationship - between residents & partner orgs					x				x	
○ Value opportunity to hear or experience patient stories			x		x				x	
○ Desire increased time together - residents and partner organizations			x		x	x			x	
○ Value faculty mentorship relationship				x	x		x	x		
3. Advocacy Project	88%									
○ Value advocacy and PDSA* projects					x	x	x	x		
○ Challenge of focusing advocacy projects				x	x		x	x		
○ Desire advocacy project accessibility/improved dissemination				x	x		x	x		
4. Identity	50%									
○ Provides program identity		x	x					x		x
○ Improve external communication of identity - ↑ resident recruitment		x	x					x		x
LEARNING										
1. What is Learned	13%									
○ Residents learn health equity and SDH*									x	
○ Residents learn complexity without becoming overwhelmed									x	
2. Strategies to Increase Learning	13%									
○ Desire feedback on ROI* from residents									x	
○ Desire setting to help residents reflect/process experience									x	
APPLICATION TO PRACTICE/BEHAVIOR										
1. Prepare for future of health care	13%								x	
2. Integrate partner organizations and/or population management resources in care	87%	x	x	x	x	x	x			
OUTCOMES/RESULTS										
1. Find meaning and purpose	38%			x					x	x
2. Add value to partner organizations	25%			x					x	
3. Inspire continued partnership	25%			x					x	

* Lead For Health; * Plan, Do, Study, Act; * Social Determinants of Health; * Return On Investment

CONCLUSIONS & NEXT STEPS

STRENGTHS

- Community partners, residents, faculty, and residency leadership were all satisfied with curriculum, particularly regarding relationship building and mentorship
- Competency milestone ratings improved within each year of training.
- Community partners reported key impacts both individual and for their organization.
- Faculty and Community Partners consistently reported (re)finding and rekindling their meaning and purpose through teaching residents in this area

AREAS FOR IMPROVEMENT

- The CHAMP curriculum while perceived by program leadership as central to the residency's identity, that identity was not reflected in learner responses

FEASIBILITY ROI

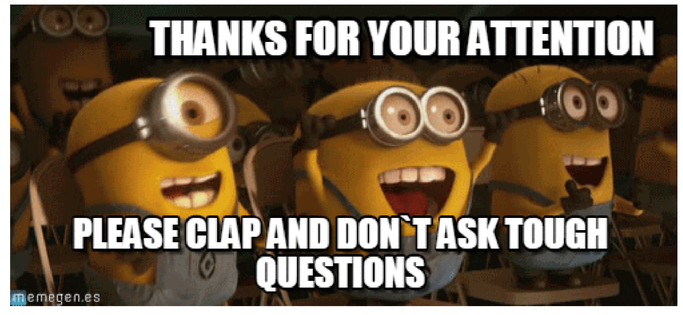
- Shift to population/value based health care can serve as a key driver for curriculum implementation.

* Reprinted from Knox KK, Lehmann W, Vogelgesang J, Simpson D. Community Health, Advocacy, and Managing Populations (CHAMP) longitudinal residency education and evaluation. J Patient Cent Res Rev. 2018;5:59-64, with permission from Aurora Health Care Inc.

Aurora Health Care

AAMC Central Group on Educational Affairs, Rochester, MN – March 2018

Results & Lessons



- 14 GME Group + > 75 Faculty Profiles
- All profiles linked to program websites
  - Biggest Hits Res/Fellow Grp Profiles – **Nov-Jan**

# Users	# New Users	# Sessions	Bounce Rate	Page Views
191	164	226	79%	1.4

- Using cloud-based application (avoids firewalls)
  - Visible, Trackable (Google Analytics), Endurable
  - Provides 1 stop - Centralized Repository

Billings Clinic
Internal Medicine Residency

Studies on Physician Resiliency and Well-Being in Rural Montana

James Jackson MD, Kylie Ebner DO; Robert Renjel MBBS, JD, PGY-3; Virginia Mohl MD, PhD; Ashley Dennis, PhD; Keith Davis MD; Sarah Peila MD; Joseph Peila MD; Mark Lee MD FACP

Study 1 - Decreasing Burnout in Medical Residency: Implementing a Balance Coaching Program

- Examined whether Internal Medicine residents who participate in a program designed to improve resident coping and communication (“Balance Groups”) experience an improvement in their well-being scores and a decline in their burnout scores.
  - Baseline, four month, and eight month well-being and burnout scores.
  - Do residents who participate in “Balance Groups” experience an improvement in their well-being scores over the study time period?

Study 1

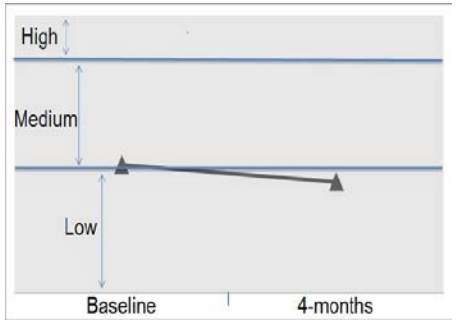


Figure 2. **ProQOL- burnout**: This figure demonstrates a decrease in mean resident burnout scores from baseline to four months, from a medium to a low score, respectively.

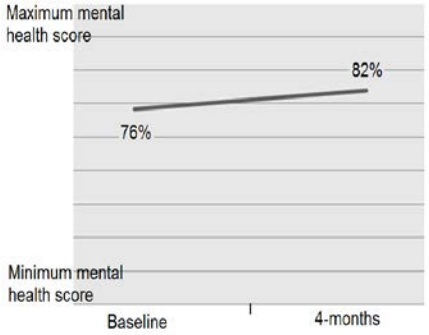
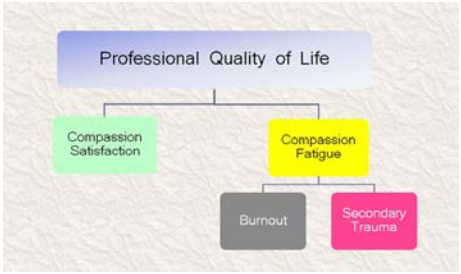


Figure 3. **Mental Health Inventory**: This figure demonstrates an increase in resident mean mental health scores from baseline to four months.

	Sessions		
	0 sessions	1-2 sessions	3-4 sessions
Professional Quality of Life (ProQOL)			
Burnout	16.8	31.2	17.7
Compassion Satisfaction	44.0	36.6	42.3
Secondary Trauma	16.5	20.8	16.7
Mental Health Inventory (MHI)	92.0	73.4	85.7

Figure 4. This figure displays resident mean data from the ProQOL and MHI according to the number of balance groups attended. Higher numbers are desired in the MHI and compassion satisfaction surveys; whereas, lower numbers indicate less burnout and secondary trauma.



- Residents at Billings Clinic experienced a medium level of burnout at study onset.
- Early data shows no correlation between outcome measures and balance group attendance.
- Qualitative data suggests residents who attended balance groups enjoyed the opportunity for confidential, small group discussions with their peers.
- Data analysis of 8 month follow up
- Connected with Mayo Physician Well Being initiative

Study 2 - Qualitative Analysis of Internal Medicine Physician Recruitment and Retention in Rural Montana

- The purpose of this study is to examine the common factors, which impact resiliency and well-being, that exist among Internal Medicine physicians practicing in rural MT/WY.
  - This study uses the grounded theory research methodology to conduct data gathering and analysis.

Study 2

Retention Factors

Continued attraction to practicing in rural MT?

- Good relationship with administration (support, receptive to feedback)
- Flexibility/autonomy to shape practice (ex hybrid model of practice)
- Lifestyle (outdoor, small town, commute)
- Scope of practice

What makes you want to leave current practice?

- Isolation
- Too much administrative work (clerical)

Suggestions for other IM physicians considering IM practice in rural MT?

- Obtain sufficient career/education/practical training before starting
- Obtain good referral base (for sub-specialities)
- Create attractive practice model Realistic expectations (good understanding of rural practices)

Recruitment Factors

Original attraction to rural practice?

- Friend/family living or practicing in region
- Lifestyle (location, no commute, outdoor activities)
- Local origin or rural upbringing

What opportunities does practicing in rural MT offer your career?

- Scope of practice (managing complex patients)
- Established in community, get to know patients
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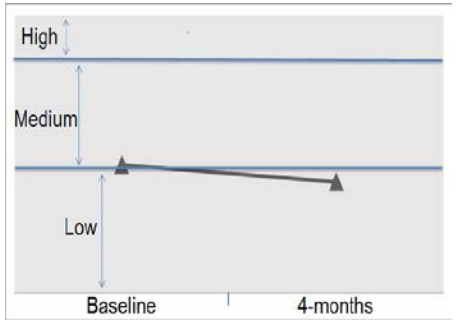

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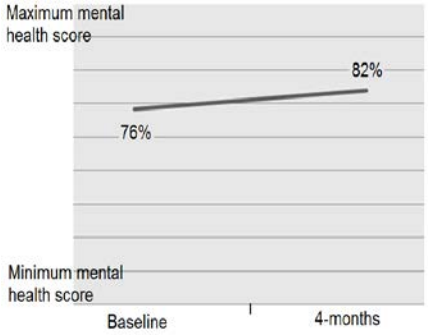

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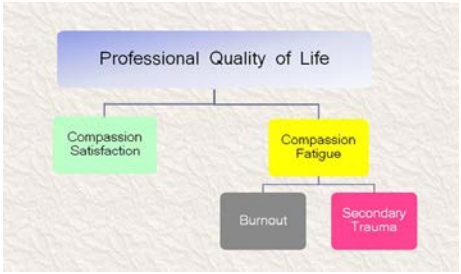

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GME Enterprise as Influencer, Hospital Leadership as Driver: A Story of I-PASS Implementation

Richard J. Vath MAEd

Sr Director & Dean of Education

Our Lady of the Lake Regional Medical Center

AIAMC Annual Meeting 2019

Creating a Shared Need & Execution Plan

AIM: Prior to July 1, 2017, we set a GME-wide goal for increasing the measurable occurrence of I-PASS hand-offs on all acute care patients on teaching services (via EHR "biopsy") from an unmeasured baseline to 80% by the end of AY18 (June 30, 2018)

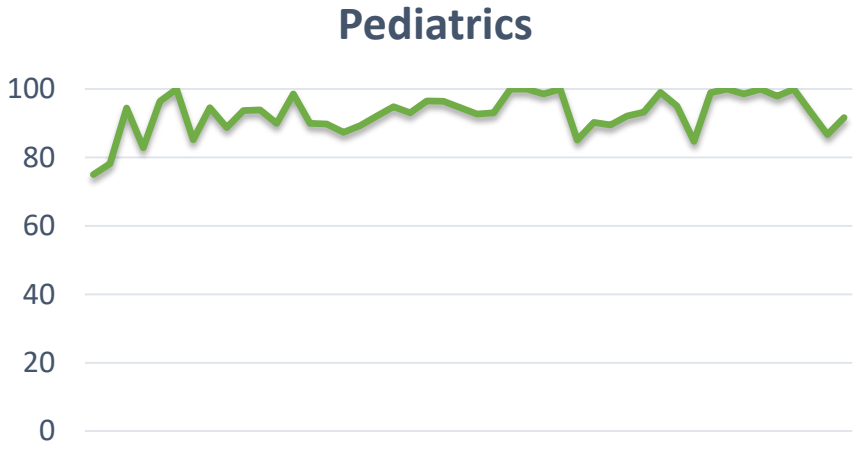
GME and Quality leadership partnered to drive rapid change:

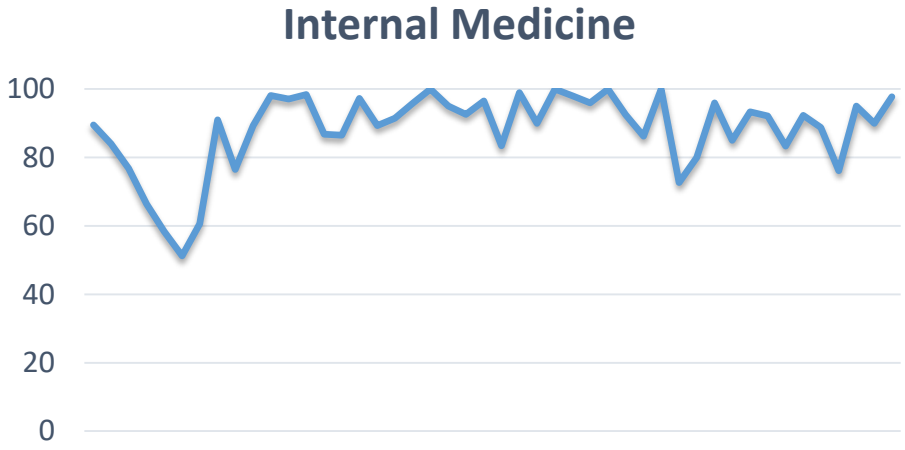
(1) Hospital Quality set timeline for go-live and an expectation of surveillance

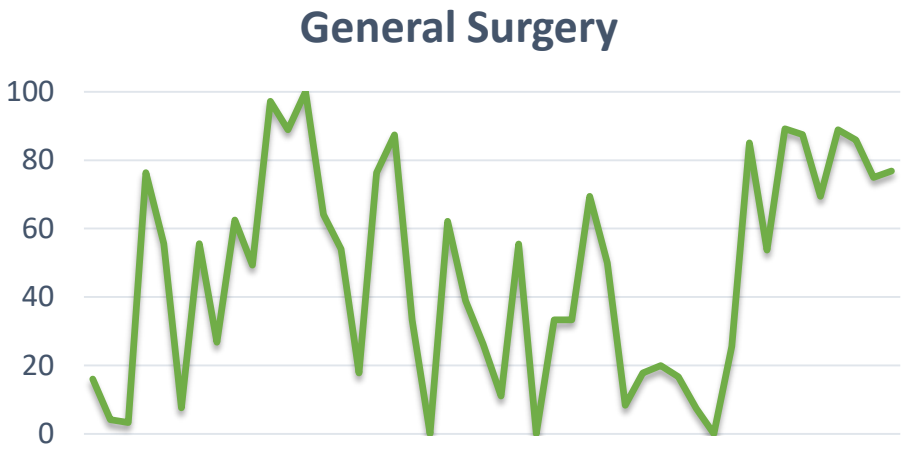
(2) GME supported EHR hand-off template optimization and developed a process for surveillance

(3) GME shared surveillance data across programs; Hospital Quality reported data up through hospital leadership

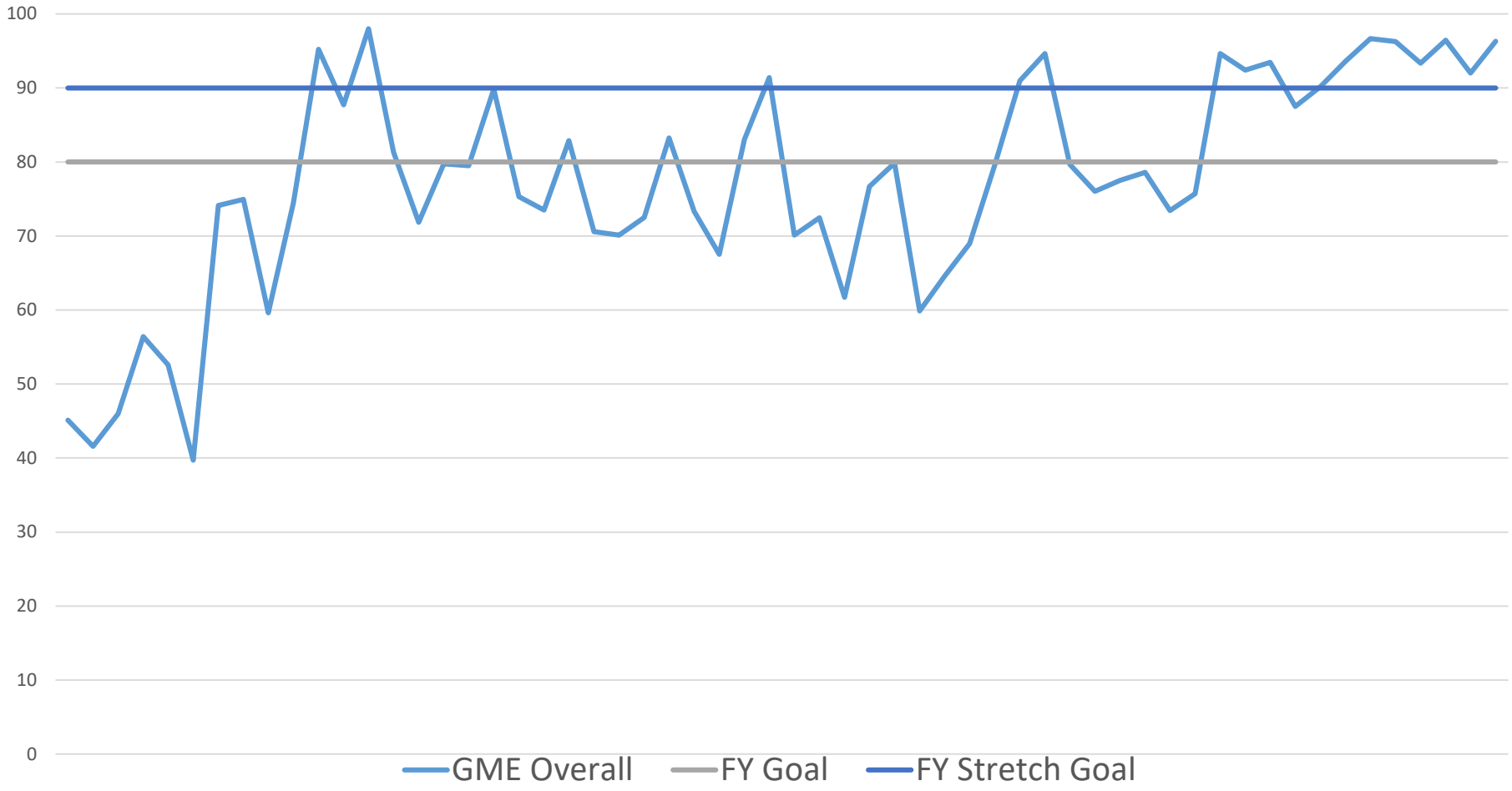
3 Stories of IPASS Compliance in EPIC across AY18





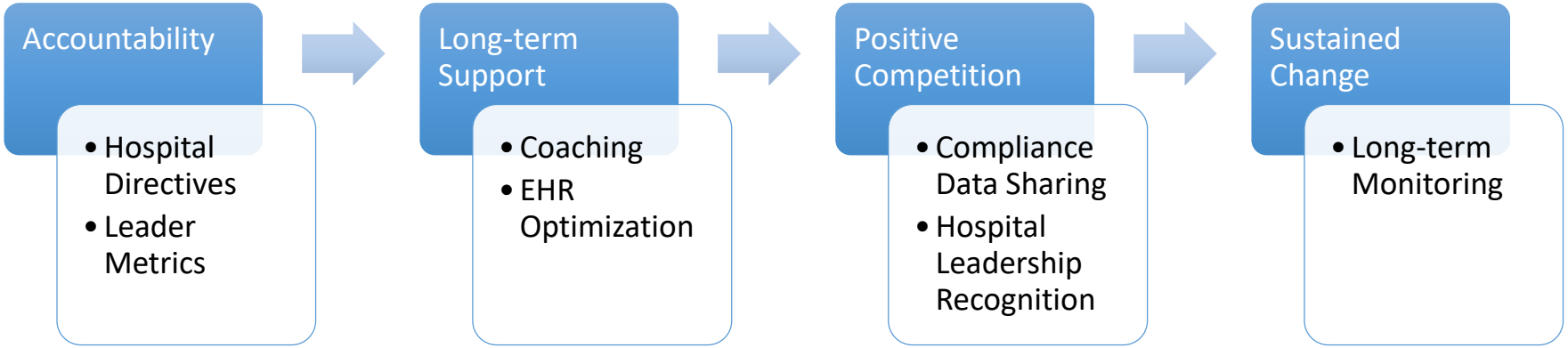


OVERALL GME IPASS Compliance in EPIC *(7/17-9-18)*



Impact & Lessons Learned

- Sustained data sharing and hospital recognition drove average compliance to above the 90% stretch goal by the end of AY18.
- I-PASS compliance is now shared with hospital medical executive committee and hospital board as part of Quality Reporting
- Follow-up initiatives are underway to develop family-centered and team-based I-PASS processes in GME areas



Thank you to the OLOL Academic Clinical Integration Team

Engaging Quality Improvement Education Through In-Depth Resident Experiential Learning

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Quality Improvement Education through Experiential Learning

BACKGROUND

- MRSA is an important cause of infections in the ICU.
- The CDC lists MRSA as a threat in the US due to antibiotic resistance.
- Residents are expected to participate in QI activities during training.
- Integration of residents into hospital QI activities provides an opportunity to align QI projects with institutional goals.
- Resident participation in QI activities can improve resident skills and contribute toward a culture of safety and improvement.

Quality Improvement Education through Experiential Learning

METHODS

- 2017-2018 Academic Year: Internal Medicine Resident QI Team addressed MRSA screening in ICU
- Project Goal: Decrease vancomycin usage in ICU
- Curriculum Goal: Involve residents in all aspects of QI project implementation
- Intervention: Change MRSA screening from culture to PCR testing, so clinicians can know negative results sooner and d/c vancomycin

Quality Improvement Education through Experiential Learning

RESULTS: Resident Action Steps

- Resident QI Team met with: ICU Nurses, Pharmacy Leaders, ID and Critical Care Specialists, Research Faculty, Hospital Informatics, Billing and Laboratory Staff.

- Residents submitted IRB application, reviewed historic data (2 months) to confirm issue, and presented their screening change plan to Hospital Critical Care and Policy committees.

- Residents educated nurses on change in screening, implemented intervention, and collected post-intervention data (2 months).

- Residents disseminated results at local Medical Education conference and discussed next cycles of change.

Quality Improvement Education via Experiential Learning

RESULTS: Project Intervention

- Culture Results reported ~48 hours vs. PCR results ~2 hours
- Cost [patient charge]: Culture $8 [$71]; PCR $14[$137]
- Pre-Intervention MRSA screenings (n=356): 94% culture, 6% PCR testing
- Post-Intervention MRSA screenings (n=321): 3% culture, 97% PCR testing
- Vancomycin use results have **not** shown improvement across study periods (i.e., % initiation or crude duration).

Quality Improvement Education through Experiential Learning

CONCLUSIONS / LESSONS LEARNED

- Residents can be involved in all key steps in hospital-approved QI initiatives.
- A successful change in the MRSA screening method occurred.
- PCR results not yet consistently used in antibiotic deceleration.
- Opportunities for additional resident participation in cycles of change
  - 2018-2019 (Education of ICU nurses, pharmacists and providers)
  - 2019-2020 (Number screened, timing of screening, and antibiotic selection)

Thank You!