Exploring Non-Physician Roles in Competency-Based Resident Education

AAFP Program Directors Workshop
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3:00 – 4:00 PM

Presenters

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Overview

The ACGME Outcomes and Milestones Projects emphasize the need for residency programs to invest new time and energy into curriculum development and resident assessment, but many of us face ongoing faculty shortages or high demand on physician-faculty time.

Poll: how many programs are actively seeking faculty?

We would like to encourage programs to consider ways that non-physician staff (professional staff) can be more directly involved in resident education. Developing new educational roles for professional staff can alleviate demands on physician-faculty time and increase the robustness of the training program. Though they involve predictable challenges, funding for an education-focused position or creating new responsibilities for existing staff are both avenues for programs to consider. We believe that working with existing staff on ways to more directly engage them in education can include the benefit of energizing them around their work as a whole.

Our presentation brings together a curriculum director, an education specialist, and a program manager to share case studies of educational work that they are involved in at their home-programs in Indiana, Montana, and Washington State. Each of us will share a different way she or he is involved in resident

education, including direction of a self-directed learning process, Milestones mapping, and oversight of a formal faculty development program. We will share materials related to our case studies for participants to review and adapt to their home programs.

It is important to note that our talk includes at least one big flaw: behavioral scientists have been a part of this work at programs for a long time, so the core of our message is nothing new. Given another iteration of the presentation, it would be great to have a behavioral scientist with us! We hope that we can illustrate how professional staff of different backgrounds can contribute in similarly meaningful ways.

Goal

Our goal is to encourage programs to consider ways to involve professional staff more directly in the educational process. For programs who already involve professional staff in education, we hope that our case studies contain useful elements for reflection or adaptation.

Objectives

At the end of our presentation and conversation, participants should be able to:

- draw on specific examples of curricular work led by professional staff to encourage brainstorming or pilot projects at their home program;
- utilize an expanded vocabulary for exploring the benefits and limitations of involving professional staff in curriculum development and management;
- connect with others interested in fostering the educational role of professional staff.

Defining Curricular Work

Core Tasks:

- Curriculum documentation - creating or updating detailed, competency-based curricular documents that define goals and objectives for every educational experience.
- Formative assessment - establishing evaluation forms and processes that flow from curricular documents.
- Summative assessment - developing an internally consistent framework by which evaluation processes inform Milestones assessment; creating and communicating semi-annual reviews of

resident progress.

- Program assessment - collecting feedback on the curriculum and implementing change.

Poll: describe the level of need for curricular work at your program

Given the pace and demands of residency, it is easy for these tasks to assume low priority year-to-year.

Hard-to-Wrangle: Challenging Facets of Curriculum Management

While the simple definition of curricular work outlined above seems fairly manageable at a glance, it includes myriad and sometimes time-consuming challenges. Examples include:

- Creating and managing opportunities for structured observation.
- Helping residents and faculty develop a shared understanding of curricular initiatives.
- Developing standards for resident assessment.
- Encouraging involvement in curricular goals.
- Developing feedback culture.
- Fostering resident involvement in self-directed learning.
- Developing strategies for making curricular information and evaluations meaningful to residents and faculty.
- Planning the curriculum review process and implementing action items.
- Aggregating data into meaningful pictures of resident progress and communicating it effectively.
- Managing communication about the curriculum between and among faculty and residents.

Managing Logistics vs. Contributing to Education

Feeling like you've helped a resident make progress is one of the great satisfactions of being part of a training program.

Involving professional staff in the hard-to-wrangle aspects of the curriculum is an obvious solution to the added curricular demands on programs. Our argument is that staff should not only be involved in the

logistical aspects of these challenges, but also find ways to do, for lack of a better term, *something extra* to have an impact on resident learning.

These distinctions are fine, but they are meant to illustrate that more direct involvement in education contributes to the richness of professional staff activities:

- Assigning and tracking evaluations vs. meeting with residents and faculty to gather and implement feedback on developing meaningful evaluations.

- Recording the CCC's Milestones assessments vs. managing communication with residents and faculty about how the Milestones integrate into the curriculum.

- Scheduling daily assignments vs. collecting information on the value of different educational experiences, integrating it into the APE, and working on action-items for improvement.

Are these distinctions fair? Are they useful? Other examples?

Poll: does your program involve professional staff in curricular work beyond managing logistics? Examples?

Our anecdotal experience is that many programs are starting to involve professional staff more directly in resident education, but there is lots of variety in the way they define these roles and positions.

Our Challenge…

Professional staff will never have the same insight into residency training as physicians, let alone their medical knowledge, so it is easy to assume that there is little educational or curricular work that is appropriate for them. While professional staff will never supervise a toenail removal or round in the hospital, they can bring expertise in communication, professionalism, data management, humanism, and other crucial areas to bear on residents' progress to practicing physicians. The Milestones give us a rationale for the importance of these areas.

The three of us have found great satisfaction in being part of the educational mission of family medicine residency programs. That is really what is at the heart of this talk and what has motivated us to share a little bit of our background and examples of what we do.

We will each briefly describe our program and role there, our directors' perspectives on involving us in curricular work, and a case study from our work that includes the "*something extra*" that makes us feel like we are having an impact on resident learning.

Case Study #1: Program Manager and Milestones Mapping

Program Requirement V.A.2.a) The faculty must evaluate resident performance in a timely manner during each rotation…

Program Requirement V.A.2.b) The program must provide objective assessment of competence… based on the specialty specific Milestones…

Program Information

The Family Medicine Residency of Western Montana is a three-year-old, 10-10-10 residency program split into two community-based sites in Western Montana. Missoula is the 'parent' program where all residents start their training. Three residents in each class move to Kalispell, a more rural community, for their R2 and R3 years.

Background

Jenny Wilson has been with the program since its development phase – one year before starting its inaugural class. She was a key figure in getting the new program on its feet and maintains a unique dyad relationship with her program director, which was the subject of a PDW presentation in 2015. Consequently, she is involved in all aspects of curriculum and logistical planning.

Director's Perspective

"Jenny, in her role as program manager, has been crucial in the development of our young program. She is highly integrated into our organizational structure and essentially functions as a faculty member regarding management of our annual calendar, resident schedules, resident duty hours and other New Innovations reporting, applicant interviewing and ranking, and many other aspects of program management and development. She is also a key sounding board for me as program director. It has been very important to us to have her engaged as a non-physician member of our core team."

Case Study: Milestones Data Integration

Like many programs, we were worried about how to effectively collect feedback that would allow our CCC to accurately portray resident progress along the Milestones. Our original evaluations would have been very cumbersome to integrate into Milestones and we realized that not all attendings in all areas would be able to give useful Milestones data.

To solve these problems, I worked with my program director to create a Milestones 'Map' (see supplemental materials). The map allows us to document when and where Milestones are addressed during the residents' three-years. Our primary focus was on core rotations (Adult Medicine, Pediatrics, Gynecology, OB) where attendings spend the most time with residents and would be able to accurately evaluate their progress.

I then structured our evaluations so that they would address the relevant Milestones for each rotation. Since faculty members are often overwhelmed by the format and quantity of the evaluation information we collect, I use my knowledge of the curriculum and how it addresses the Milestones, along with New Innovations, to prepare tailored feedback reports and recommendations for the CCC to use in assessing the residents.

Similarly, since residents often express confusion as to the utility of the Milestones, how they fit into their training, and where there rankings are coming from, I plan to begin leading sessions with the faculty where they discuss their reasoning behind assessment.

The opportunity that I have to help the Milestones make sense to both the residents and faculty is the "something extra" that I find in this work. By mapping the curriculum with my director, I have a birds-eye-view of our program. Many of our faculty members do not have this perspective since they are focused more narrowly on different curricular areas. Similarly, residents are often too focused on getting through a given block to have a good sense of their overall program of education. Through mapping, collecting evaluation data, and tailoring reports, I am able to foster better feedback for our residents and help drive the evolution of our competency-based curriculum.

Case Study #2: an Education Specialist and a Formal Faculty Development Series

Program Requirement II.B11) There must be a structured program of faculty development that involves regularly scheduled faculty development activities designed to enhance the effectiveness of teaching…

Program Information

Union Hospital Family Medicine Residency is a 7-7-7 residency program in Terre Haute, Indiana.

Background

Nicole has a doctorate of health sciences, as well as a bachelor and master's degree in adult learning. She is also a registered respiratory therapist and has certificates in human resource development and nonprofit management. She has done data management and analysis for the U.S. Army, Medicare, and Medicaid. In addition to her role as an educator at the residency program, she teaches epidemiology and public health at Indiana State University.

Director's Perspective

Faculty development is Nicole's primary strength. It is a major asset for our program.

Case Study: a Formal Faculty Development Series

I plan and lead a thirty-minute faculty development sessions on the second Tuesday of each month. These sessions take place at the end of a regularly scheduled weekly faculty meeting. All core faculty and non-physician faculty are in attendance.

Based on an assessment of faculty skills and needs, I plan these topics six months in advance (topic list included in supplemental materials). We often make adjustments as the academic year progresses, other needs emerge, or other topics are requested. These sessions work best when they are interactive and involve faculty in discussion. Lectures typically receive poor responses.

I utilize a transfer of training matrix according to adult learning principles in implementing:

- Learners are included in planning the education
- Strategies for transfer are built into the educational design
- Supportive work environment is fostered to enable transfer
- Send out materials to faculty after the session
- Follow up discussions/direct observation & feedback of faculty performance after one month

I feel uniquely positioned to participate in resident education due to my role as an educator, but there is definitely a “something extra” in planning and leading faculty development. While I am not working directly with residents, I am excited at the opportunity to make sure that faculty have a structured approach and shared understanding for issues that they collectively deem important for our residency. This helps to insure that the messages residents receive from faculty are consistent and that our program as a whole feels like it is moving in a unified direction.

Case Study #3: a Curriculum Director and Resident Self-Directed Learning

Program Requirement IV.A.5.c) Residents must demonstrate the ability to investigate and evaluate their care of patients… and to continuously improve patient care based on constant self-evaluation…

Program Information

The Group Health Family Medicine residency is a 6-6-6 program with clinical training sites in Seattle (4) and Burien (2) Washington. We operate under a longitudinal schedule instead of the block model and make resident immersion in their outpatient clinic our top priority.

Background

Paul taught software, managed databases and helped plan educational events for the University of Washington's Family Medicine Residency Network prior to joining at Group Health. He is still a regional educator and support person for the Network affiliates who use New Innovations as their residency management software (around 20 programs in five states). At Group Health, he directs the curriculum, which involves coordinating faculty work on their curricular areas, conducting curriculum reviews and improvement, managing the evaluation system, tracking the impact of the program's longitudinal schedule, and working to provide meaningful assessment of progress to residents and faculty.

Director's Perspective

"Having a professional, non-physician staff member oversee our program's curriculum allows us to make faster, more reliable progress on accomplishing our educational goals. It frees individual faculty to focus their sometimes-scarce administrative time on the content of their curricular areas and increases the overall physician-faculty FTE available to the program."

Case Study: Resident Self-Directed Learning

When I arrived at my program, resident participation in documented self-directed learning (SDL) was very low due to cumbersome forms and a lack of feedback on those that were completed. Encouraging documented SDL was a very high priority for a few faculty members, but many did not perceive it as useful. As a program, we decided it was a priority not only because of the ACGME requirements, but also because of its potential usefulness to advisors in the semi-annual review process.

I took a presentation by Dr. Melissa Nothnagle from last year's RPS innovation panel as inspiration for the first phase of implementing SDL at our program. The key point I took away from Dr. Nothnagle's talk

is that it takes regular, personal involvement with residents to encourage their participation in SDL. In her example, those regular check-ins were the responsibility of a physician-faculty member.

I did away with detailed, frequent forms, and instead encouraged residents to simply write in advance of their semi-annual review meetings (two examples are included in our supplemental materials). Participation rose from nearly zero to sixteen of our eighteen residents. I attribute this to a lot of personal encouragement from me to complete the task and a strong, positive response from the residents' advisors, who utilized the learning plans as central pieces of the review process. It was particularly satisfying to see a resident who had struggled early in residency and been strongly opposed to self-directed learning tasks sincerely participate in the new process. Her writing, one of our examples, energized the discussion of her progress at her review meeting.

The "something extra" that I find in this process is the opportunity to become more intimately involved in how residents feel that they are doing. Having a sense of how residents perceive their progress allows me to be another informed voice at faculty meetings. By promptly reading and responding to what the residents offer in their learning plans, I can help them have confidence that their participation in the process will have an impact. As we develop a better culture for self-directed learning at our program, I hope to improve the structure and frequency of resident participation.

Wrap-Up and Discussion

Summary

The ACGME requirements and their conversations around curriculum encourage programs to engage in constant review and development of what is taught, how it is taught, and how it is evaluated. There is a spectrum of tasks related to this work that require skills in communication, data management, organizational change, planning, evaluation, and other non-medical areas. As programs continue to face a scarcity of physician-faculty time, our hope is that they will consider new ways to involve professional staff in this work. In our experience, professional staff can derive unique and valuable satisfaction by feeling that they are having a direct impact on aspects of resident learning.

While programs can certainly consider new staff roles focused on education, we hope that they will also consider the small steps that staff can take to be involved in curricular work. Each of our case studies illustrates a piece of work that contains logistical, administrative elements that are easy to attribute to professional staff, as well as “something extra” that puts us in more regular, meaningful contact with how residents learn and are evaluated.

Discussion

More information on our individual case studies or roles?

Questions, concerns, or opinions about the overall message of the talk?

Examples to share?