**Facilitators Guide**

**Description**: This workshop is intended to assist Program Directors, Associate Program Directors, and Clinical Competency (CCC) members utilize a Shift card to assess residents’ performance in the outpatient clinic setting. The card has been derived from Emergency Medicine (Bandiera 2008). In that specialty, residents typically work defined shifts with supervising physicians in close proximity. In the Internal Medicine outpatient setting, the situation is very similar. Residents are in the clinic for a half day per week or perhaps more or less depending on their schedule. The card can be useful in helping catalogue a resident’s performance over time.

For this workshop, the participants will learn about a Shift card and how it can be used in resident observation in the outpatient clinic. They will watch several videos of residents presenting an acute problem and a more chronic one. One is a resident to patient interaction and the other a resident to attending interaction. A shift card will then be completed for each video. The group will discuss the use of the Shift card as an EPA and how it includes reporting milestones. Finally, a discussion of newer technologies as they may relate to the Shift card will be carried out. For example, the Shift card presented utilizes paper. However, a smart phone or laptop are more portable and could potentially link a shift card completed on line to the resident’s portfolio. This information is vital when the CCC meets to discuss individual residents and their progress through training.

**Learning Objectives**:

* Describe the difficulty of obtaining resident observations in the outpatient clinic and ways in which residents receive feedback
* Describe how the Shift card can be used by the outpatient faculty to provide real time feedback
* Demonstrate how the Shift card can provide helpful information for CCC members
* Analyze how a Shift card can be an EPA with associated milestones
* Examine advantages of the Shift card from faculty, resident, and CCC perspective

**Audience and Setting:** The intended audience are CCC members, core Internal Medicine faculty (Associate Program Directors), and outpatient faculty. A large group setting with some time and space for small group work within the session is ideal.

**Equipment Required:** A computer with projector for PowerPoint presentation, and speakers. A white board of flipchart as needed. Access to the Internet is needed to access the videos.

**Preparation for the Session:**

No specific preparation is needed. Participants should be ready to work in both large and small group settings as they view a video of residents in an outpatient setting and complete the Shift card.

**Workshop Introduction:**

* Divide into groups of 2-4, depending on the number of participants
* Show the videos-one is a resident to patient interaction-acute problem one is a resident to attending-chronic problem

<https://www.youtube.com/watch?v=1N3muSELSeE&feature=player_detailpage#t=73>

<https://www.youtube.com/watch?v=NAHJRdKY4dI>

* Have the participants use the Shift card to evaluate the resident by circling the appropriate box on the card. Not all the boxes need to be circled. It is up to the individual completing the card to determine how they will complete the card based on their observations
* Allow each group time to discuss their observations and why they completed their cards based on their observations
* Debrief with the large group to discuss what worked and what didn’t work.

**Workshop Steps:**

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| **Step** | **Description** | **Estimated TIme** |
| 1 | Welcome participants, introdue the topic, and review the learning objectives | 5 min |
| 2 | Mini-lecture: This will be done in a large group. Present the slides. This will help participants understand what a Shift card is all about what led to its creation, how it can be utilized by various group: * outpatient faculty-feedback is given in real time which can impact future performance on the path to competence
* Program Director-cards completed over time can be used to

 follow resident progress and can aid in feedback for residentimprovement* core program faculty-as above
* CCC members-information is provided about outpatient milestones and growth and development-can assist the CCC in providing feedback for those doing well and those struggling
 | 10 min |
| 3 | Show the videos—this can either be done in a large group setting prior to breaking up the group or after the group has been divided into groups of anywhere from 2-4 participants. The videos demonstrate acute and chronic problems-one is a resident to patient interaction and the other a resident to attending interaction. Instead of videos, you may choose to use a Simulation center if one is available or role play with standardized patient or even members of your teaching staff. | 5 min |
| 4 | Have the participants individually complete 2 Shift cards—one for each video—one for the Acute problem and one for the Chronic problem. Not all the boxes on the card need to be completed. | 5 min |
| 5 | Large group discussion-allow time for the groups to discuss any concerns or problems they may have had in completing the cards. Discuss how/why they completed the cards in the manner they did | 10 min |
| 6 | Discuss the use of the Shift cards going forward: * ways to have as many cards as possible completed per resident
* the importance of providing immediate feedback to the residents—this can be done quickly, especially if the resident is running behind. It may be helpful if there is time to show the resident prior cards and how they have progressed over time…a semiannual evaluation may be a good time to review performance this way
* the importance of how the card provides useful information for those in #2 above
 | 10 min |
| 7 | Action Plan1. Discuss how newer technologies may be used to make the Shift card easier to use (ex., smartphone app, laptop). In this way, paper can be avoided and potentially a direct link to the resident’s portfolio could occur.
2. Develop other observational tools for training in the use of the Shift card: standardized patients, create your own videos, create a written scenario(s)
3. Determine who will be responsible for summarizing the Shift card information for the CCC-this may vary from program to program but may include an outpatient firm chief (supervising faculty member for a group of residents), subgroups of the CCC, Chair of the CCC.
4. It is important to emphasize that the Shift card is a useful modality for obtaining observational resident data. It can be resident or attending-driven. Residents need to obtain a Shift card for a faculty member to complete if that individual has not already planned to complete a card. The goal is at least one shift card completed/shift.
5. The ultimate beneficiary is the CCC which will utilize the data to help determine a resident’s competence through training for the milestones on the card. You may decide other milestone would be more appropriate for your program-in which case the card can be reconfigured
 | 10 min |
| 8 | Summary and Q & A | 5 min |

**References:**

1. Bandiera G, Lendrum D. Daily encounter cards facilitate competency-based feedback while leniency bias persists. *CJEM* 2008 Jan Vol 10 (1):44-50
2. SBIRT: HTN Case-average medical resident example (May 21, 2013) retrieved from <https://www.youtube.com/watch?v=NAHJRdKY4dI>
3. The Value of Non Physician Observations in Resident Assessment: Outpatient Case (Sept. 28, 2014) retrieved from <https://www.youtube.com/watch?v=1N3muSELSeE>

Name of Resident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Shift Care:\_\_\_\_\_\_\_\_\_\_\_\_\_Preceptor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Milestones for new problem/acute illness

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| **Sub Competency** | **Critical Deficiency** | **Requires Direct Supervision** | **Requires Indirect Supervision** | **Ready for Unsupervised Practice** | **Aspirational** |
| *PC1- Gathers and Synthesizes essential and accurate information* | Inaccurate history and physical | Incomplete history and physical skills or limited differential diagnosis | Can use history, physical and other data to identify central clinical problems | Hypothesis driven history and physical or appropriately prioritized differential diagnosis | Obtains subtleties and recognizes unusual clinical presentations |
| *PC2/PC3-Develops and achieves comprehensive management plans/ Manages patients with progressive responsibility* | Inappropriate care plans ordoes not assume responsibility for patient management decisions | Has difficulty developing care plan without assistance | Develops appropriate care plans and/or recognizes urgent/emergent issues without preceptor assistance | Can independently manage unusual acute problems or can modify plans based on changing clinical scenario | Able to develop complete care plan even when faced with diagnostic uncertainty and uses cost conscious principles |
| *MK1/MK2 – Clinical knowledge/knowledge of diagnostic tests* | Does not have knowledge to care for patients | Incomplete knowledge of common medical conditions or treatments | Demonstrates knowledge of common medical conditions  | Demonstrates and applies knowledge of complex medical problems | Demonstrates and applies knowledge of treatment or diagnosis of unusual medical problems |
| *PROF3 – responds to each patient’s unique characteristics (culture, gender, race, ethnicity, etc…)* | Unwilling to modify care plan for patient unique needs | Requires assistance to modify care for patients unique needs | Aware of patients unique needs and can modify care plan with minimal assistance | Independently and appropriately modifies care plans to accommodate patients unique needs | Role model s and teaches others (colleagues, care team) on unique needs for patients |
| *ICS1 – communicates effectively with patients and caregivers* | Makes no attempt to share decision making | Needs help to develop a shared decision making with a patient even for straight forward concerns | Can engage shared decision making for uncomplicated discussions, but might needs help for complicated problems | Independently engages patients in shared decision making for complicated problems, including caregivers when appropriate. | Role model of engaging patients in shared decision making, including caregivers, even in complicated and changing clinical situations. |

Comments/specific cases/illustrations:

Name of Resident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Shift Care:\_\_\_\_\_\_\_\_\_\_\_\_\_Preceptor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Milestones for chronic disease management and preventative care

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| **Sub Competency** | **Critical Deficiency** | **Requires Direct Supervision** | **Requires Indirect Supervision** | **Ready for Unsupervised Practice** | **Aspirational** |
| *PC1- Gathers and Synthesizes essential and accurate information* | Inaccurate history, physical or data review | Incomplete history and physical skills or does not review prior notes to understand purpose of visit | Uses history, physical and chart review to make complete and prioritized problem list | Efficiently uses history, physical and data review to appropriately prioritized problem list and minimize need for further testing | Obtains subtleties and recognizes unusual clinical presentations |
| *PC2/PC3-Develops and achieves comprehensive management plans/ Manages patients with progressive responsibility* | Inappropriate or inaccurate care plans ordoes not assume responsibility for patient management decisions | Has difficulty developing care plan without assistance | Develops appropriate care plans for controlled problems without preceptor assistance | Can independently manage complex patients with multiple uncontrolled chronic problems  | Able to independently develop complete care plan and coordinate care even when faced with complex social barriers to good care  |
| *MK1/MK2 – Clinical knowledge/knowledge of diagnostic tests* | Does not have knowledge to care for patients | Lacks knowledge of common clinical guidelines | Demonstrates knowledge of common clinical guidelines  | Demonstrates and applies clinical guidelines and understands appropriate times to deviate from guidelines | Demonstrates knowledge of latest literature that may not be yet included in guidelines but could influence care of the patient |
| *SBP1 – Works effectively with an interprofessional team(Nursing, social work, pharmacy, diabetes educators)* | Frustrates team members | Does not know what team members are available or how they can help patients | May need prompting from preceptor to utilize skills of other team members | Independently engages team to maximize and efficiently deliver best care to patients | Viewed as a leader of team care. Effectively and efficiently coordinates care even when away from the office. |
| *ICS1 – communicates effectively with patients and caregivers* | Makes no attempt to share decision making | Needs help to develop a shared decision making with a patient even for straight forward concerns | Can engage shared decision making for uncomplicated discussions, but might needs help for complicated problems | Independently engages patients in shared decision making for complicated problems, including caregivers when appropriate. | Role model of engaging patients in shared decision making, including caregivers, even in complicated and changing clinical situations. |

Comments/specific cases/illustrations: