Direct Observation

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Southeast Hub: Developing Faculty Competencies in Assessment

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Conflicts of Interest

- None to report

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- This presentation utilizes ACGME resources.
  - Developing Faculty Competencies in Assessment: A Course to Help Achieve the Goals of Competency-Based Medical Education (CBME), May 8-12, 2023
  - ACGME Faculty Development Toolkit: Improving Assessment Using Direct Observation
  - Holmboe ES, Durning SJ, Hawkins RE. Practical Guide to the Evaluation of Clinical Competence.

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Objectives

1. Define workplace-based assessment and the importance of direct observation in achieving competency-based medical educational outcomes.

2. Recognize and assess the barriers to frequent and high-quality direct observation.

3. Demonstrate an understanding of effective strategies to enhance the quality and frequency of direct observation in educational and professional settings.

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VARIABLE	EDUCATIONAL PROGRAM STRUCTURE/PROCESS-BASED	COMPETENCY-BASED
DRIVING FORCE FOR CURRICULUM	Content – knowledge acquisition	Outcome – knowledge application
DRIVING FORCE FOR PROCESS	Teacher	Learner
PATH OF LEARNING	Hierarchical (teacher → student)	Non-hierarchical (teacher ⇔student)
RESPONSIBILITY FOR CONTENT	Teacher	Student and teacher
GOAL OF EDUCATIONAL ENCOUNTER	Knowledge acquisition	Knowledge application
TYPICAL ASSESSMENT TOOL	Single subjective measure	Multiple objective measures ("evaluation portfolio")
ASSESSMENT TOOL	Proxy	Authentic (mimics real tasks of profession)
SETTING FOR EVALUATION	Removed (gestalt)	"In the trenches" (direct observation)
EVALUATION	Norm-referenced	Criterion-referenced
TIMING OF ASSESSMENT	Emphasis on summative	Emphasis on formative
PROGRAM COMPLETION	Fixed time	Variable time

Carraccio C, Wolfsthal SD, Englander R, Ferentz K, Martin C. Shifting paradigms: from Flexner to competencies. Acad Med. 2002;77(5):361-367.

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Assessments

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I TAUGHT STRIPE HOW TO WHISTLE

I DON'T HEAR HIM WHISTLING

I SAID I TAUGHT HIM. I DIDN'T SAY HE LEARNED IT

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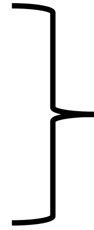
Assessments of Clinical Skills

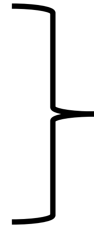
- Clinical reasoning
- Clinical judgment
- Reflective practice



Cognitive

Questions

- History
- Physical exam
- Counseling



Psychomotor

Observation

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Who watched you?

- Discuss:
- A time when you watched someone
  - How did it feel?
  - Was it useful? Why or why not?
- When someone watched you
  - How did it feel?
  - Was it useful? Why or why not?

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Mastery requires feedback and deliberate practice

“Learning is deeper and more durable when it’s effortful. Learning that’s easy is like writing in sand, here today and gone tomorrow.”

— Peter C. Brown, Make It Stick

make it stick

The Science of Successful Learning

Peter C. Brown
Henry L. Roediger III
Mark A. McDaniel

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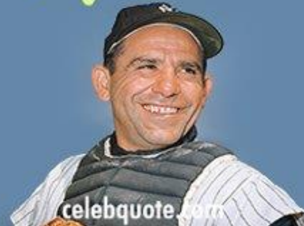
Why are observations so important?

YOU CAN
OBSERVE A LOT
BY JUST WATCHING
Yogi Berra



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Direct Observation = Workplace Based Assessment

Does

Shows How

Knows How

Knows

Workplace based assessment

SIM/Standardized patients

Problem based learning

Multiple choice exam

Adapted from Miller, G E. The assessment of clinical skills/competence/performance. Academic Medicine 65(9):p S63-7, September 1990

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Why are observations so important?

- Observation: The act of taking note of something that is occurring around you. It must involve your senses (touch, sight, hearing, etc)- Data gathering

- Inference involves drawing conclusions or making judgments based on observations (your own or someone else's).

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LADDER OF INFERENCE

reinforce

Context
Beliefs
Values

Take
Action

Draw Conclusions
(evaluations, explanations, decisions)

Make Interpretations

influence

Select Data

Available Data

Senge, Peter M. (1990). The fifth discipline : the art and practice of the learning organization. New York :Doubleday/Currency

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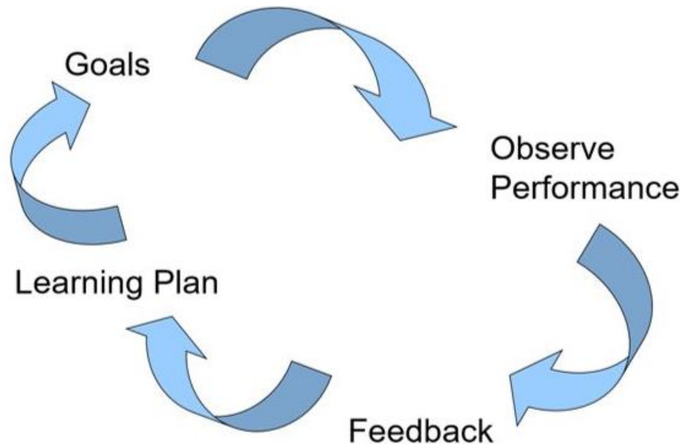
Why are observations so important?

- Foundational assessment strategy in CBME
- Assessment drives learning
- Essential component of the learning cycle



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Why are observations so important?

- Most importantly!
- Ensuring safe, effective, patient-centered care
  - Trainees
    - Wide variability in graduating students' clinical skills measured as MS4s or starting internship
  - Practicing physicians
    - Variability in physical exam skills
    - Missing elements of informed decision making

Stillman. Ann Intern Med.1990; Sachdeva. Arch Surg.1995; Lypson. Acad Med.2004; Mangione 1997; Braddock.1999

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Assumptions

- What assumptions do we make about trainees' skills?
- Why do we make them?
- When do we make them?
- What assumptions do we make on July 1st? Or June 30th?
- When is a resident ready to supervise?

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Direct Observation Tests Assumptions

Early

TIME/TASK

Late

Detect Outliers

Feedback/Development

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Entrustable Professional Activities (EPAs)

- EPAs represent the routine *professional*-life activities of physicians based on their specialty and subspecialty
- The concept of "entrustable" means…
- "… a practitioner has demonstrated the necessary knowledge, skills, and attitudes to be trusted to perform this activity *[unsupervised.]*"[1]

[1]Ten Cate O, Scheele F. Competency-based postgraduate training: can we bridge the gap between theory and clinical practice? Acad Med. 2007; 82(6):542–547.

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Entrustability Scales

Level	Descriptor
1	“I had to do” (i.e., requires complete hands on guidance, did not do, or was not given the opportunity to do)
2	“I had to talk them through” (i.e., able to perform tasks but requires constant direction)
3	“I had to prompt them from time to time” (i.e., demonstrates some independence, but requires intermittent direction)
4	“I needed to be there in the room just in case” (i.e., independence but unaware of risks and still requires supervision for safe practice)
5	“I did not need to be there” (i.e., complete independence, understands risks and performs safely, practice ready)

The Ottowa surgical competency operating room evaluation (O-SCORE): A tool to assess surgical comptence

Gofton W, et al. Acad Med. 2012;87:1401-407.

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Step 1. Resident sees patient and comes out to share their observations

Step 2.

We make a judgement on the reasonableness, completeness of their observations, and we infer

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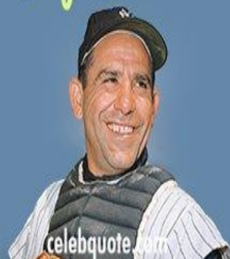
YOU CAN
OBSERVE A LOT
BY JUST WATCHING

Yogi Berra



swns
PARKING FAIL

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You're a fly on the wall…

Case:

- Second-year resident counseling a 54-year-old woman with hypertension, hyperlipidemia, obesity, and tobacco use who meets criteria to start lipid-lowering therapy

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You're a fly on the wall…

Case:

Second-year resident counseling a 54-year-old woman with hypertension, hyperlipidemia, obesity, and tobacco use who meets criteria to start lipid-lowering therapy

- Use your mini-CEX to document
- Areas performed well
- Errors/deficiencies
- How would you supervise the resident next time?
- Select a mini-CEX rating for counseling

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ACGME

7. Overall clinical competence

1 2 3	4 5 6	7 8 9
UNSATISFACTORY	SATISFACTORY	SUPERIOR

8. On what did you base your overall rating? (Check all that apply)

- ☐ On what a resident of that PGY level would be expected to do
- ☐ On what a practicing physician would be expected to do
- ☐ On how similar it was to what I would have done in that situation
- ☐ On guidelines for best practices
- ☐ It was a gestalt (i.e., a gut feeling)
- ☐ Other (Please explain)

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Audience discussion

- After directly observing the encounter, how did you rate the resident's overall competence on the mini-CEX form?
  - Why did you give this rating?
  - What influenced your decision?

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Frame of Reference?

1	2	3	4	5	6	7	8	9
Unsatisfactory			Satisfactory			Superior		

Adapted from Microlearning Understanding Issues of Reliability and Validity
ACGME – Direct Observation Toolkit

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Frame of Reference?

	1	2	3	4	5	6	7	8	9
	Unsatisfactory			Satisfactory			Superior		
Normative	Worse than expected for level			At expected level			Better than expected for level		
Self	Not what I do			Close to what I do			Better than what I do		

Adapted from Microlearning Understanding Issues of Reliability and Validity
ACGME – Direct Observation Toolkit

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Frame of Reference?

1	2	3	4	5	6	7	8	9

	1–3	4–6	7–9
Gestalt	???	???	???
Best Practice	Missing evidence-based elements	Most evidence-based elements	All evidence-based elements

Adapted from Microlearning Understanding Issues of Reliability and Validity
ACGME – Direct Observation Toolkit

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Tools to create an evidence-based frame of reference

Framework: History Taking

	Sets the Stage
1	Knocks on door before entering or asks permission to enter patient's space
2	Greets patient appropriately
3	Thanks patient for waiting; apologizes if late
4	Ensures patient readiness and privacy
5	Determines how patient would like to be addressed and calls patient by preferred name (new patient)
6	Introduces self (new patient)
7	Starts with social talk/small talk (first and return visit)
8	Removes barriers to communication (sits down before starting interview, makes eye contact, uses open body language)
9	Makes patient comfortable
	Elicits Chief Concerns/Sets the Agenda
10	Indicates time available (i.e. "in this visit" or "in the time we have today")
11	Obtains list of all issues patient wants to discuss; asks patient to prioritize list
12	Indicates physician's needs
13	Summarizes agenda and negotiates
	Begins with Non-Focusing Questions to Help Patient Express Self
14	Starts with open ended question (unless inappropriate)
15	Uses non-focusing open ended skills (uses open ended questions, uses silence, makes neutral utterances, doesn't interrupt)
16	Obtains information from nonverbal sources
	Uses Focusing Skills to Elicit Symptom Story, Personal and Emotional Content
17	Obtains description of symptom(s) (elicits physical symptom story in open ended way, reflecting, echoing, requesting (tell me more), summarizing)
18	Explores personal context (broader personal/psychological context of symptoms, beliefs, attributions, cultural, conceptual, social and spiritual)
19	Elicits emotional context directly (how did that make you feel) or indirectly (impact on life); Elicits beliefs about the problem, triggers for seeking care
20	Responds to patient's feelings/emotions using empathy by NURS (naming, understanding/legitimizing, respecting, supporting)
21	Expands the story by continuing to elicit personal and emotional context addressing feelings and emotions

Created by Jen Kogan and Eric Holmboe for the ACGME Course *Developing Faculty Competencies in Assessment: A Course to Help Achieve the Goals of Competency-based Medical Education (CBME).*
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ACGME FACULTY DEVELOPMENT TOOLKIT: IMPROVING ASSESSMENT USING DIRECT OBSERVATION

Framework: Counseling/Shared Decision Making

	Setting the Stage and Getting Started
1	Begins by orienting patient to the end of interview (e.g., "We will be discussing assessment and plan")
2	Asks if patient would like someone else present
3	Assesses what patient knows (patient understanding) before telling
	Discussing the Clinical Issue/Diagnosis/Nature of Decision
4	Explains diagnosis/prognosis, incorporating patient's informational needs. Connects language of symptom description to diagnosis.
5	Assesses patient readiness to address topic, invoke change
	Shared Decision Making
6	Discusses patient role in decision-making (explicit discussion there is a decision to make)
7	Discusses clinical issue or nature of the decision
8	Discusses alternatives
9	Discusses pros and cons of alternatives
10	Discusses uncertainties with decision (complex decision only)
11	Assesses patient understanding
12	Explores patient preference/willingness to follow recommendation
	Content of Plan
13	Provides medically accurate and complete plan
14	Identifies SMART (specific, measurable, actionable, realistic, and time-based) goal acceptable to patient
15	Discusses medication name, number of pills per day, how to take, side effects, etc.
16	Presents plan in an organized manner
	Wrapping Up
17	Addresses patient's barriers to recommendation (financial, social, cultural)
18	Summarizes decisions; provides written plans/instructions appropriate to patient's level of health literacy
19	Discusses patient's ability and confidence to follow agreed-upon plan
20	Uses teach back
21	Arranges follow-up
22	Indicates reasons for sooner follow-up

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Rater Errors

- <u>Correlation Errors</u>
  - Halo vs Horn effect

- <u>Distributional Errors</u>
  - Doves vs Hawks

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“Think something that nobody has thought yet, while looking at something that everyone has seen”

Arthur Schopenhauer- “Philosopher of Pessimism”

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Increasing reliability

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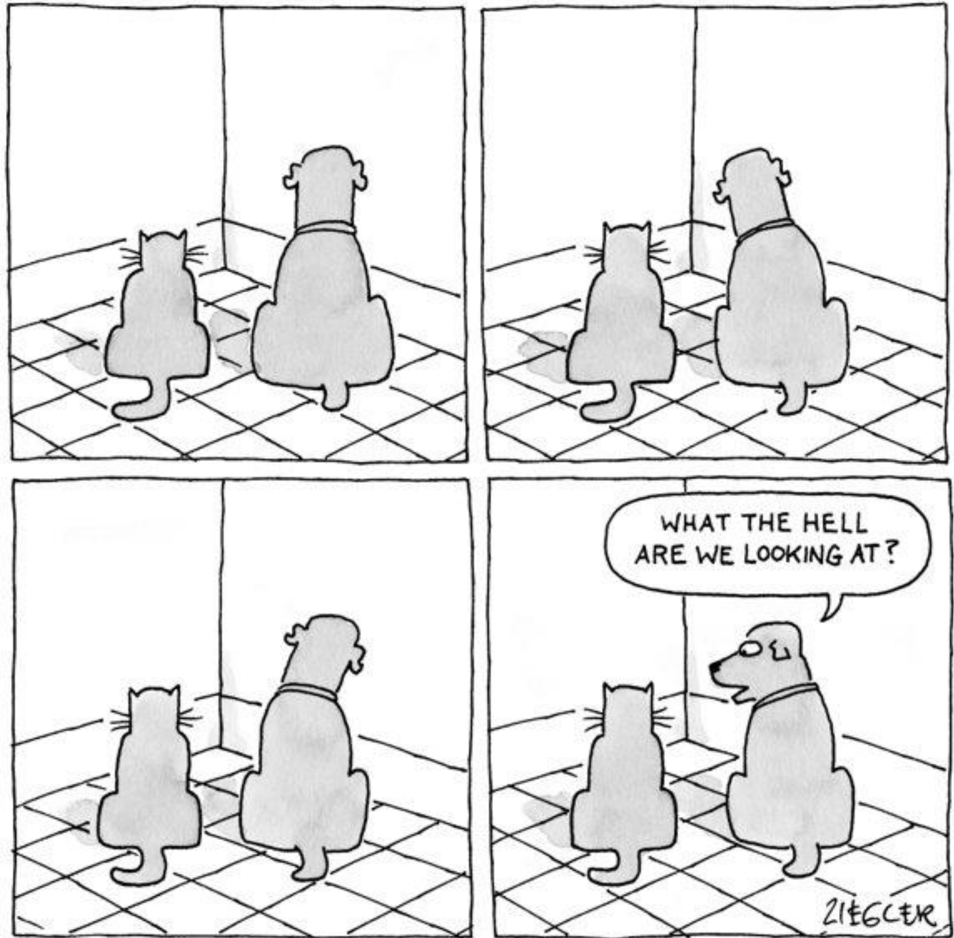
It helps to know what you are looking for!



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Performance Dimension Training

Identify specific dimensions of a competency in behavioral terms

Discuss the criteria and qualifications required for each dimension of that competency

Compare with an evidenced-based framework

Develop a SHARED MENTAL MODEL

Holmboe et al. 2010

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Creating a shared mental model

Lets Practice!

How do you make a Peanut Butter and Jelly sandwich?

- Place two pieces of bread on plate
- Spread peanut butter on one piece
- Spread jam on other piece
- Put together
- Cut in half (optional)
  - Wash hands

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Creating a shared mental model

How do you make a Peanut Butter and Jelly sandwich?

- Place two pieces of bread on plate
- Spread peanut butter on one piece
- Spread jam on the other piece
- Put together
- Cut in half (optional)
- Wash hands

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Shared Mental Model

- Notion that the team will perform better if they have a shared understanding of the task to be performed and the role of the team member.

Jonker, C.M., van Riemsdijk, M.B., Vermeulen, B. (2011). Shared Mental Models. In: De Vos, M., Fornara, N., Pitt, J.V., Vouros, G. (eds) Coordination, Organizations, Institutions, and Norms in Agent Systems VI. COIN 2010. Lecture Notes in Computer Science(), vol 6541. Springer, Berlin, Heidelberg. https://doi.org/10.1007/978-3-642-21268-0

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How to Create a Shared Mental Model

1. Set aside Faculty Development time
2. Have the group make a list of observations they would like to make
3. Choose one
4. Then have group make a list of steps they expect to see to complete the skill
5. (Share with group a validated tool- if one available)
6. Compare your list to the validated tool- tweaking it as needed (streamline or add)
7. Pilot it (perhaps on a standardized video as a group)
8. Discuss time to implement
9. Discuss tracking of resident progress

GYN exam/Pelvic exam	GYN exam
Osteopathic Structural Exam	Osteopathic Exam
Shared Decision Making	
New Medication	shared decision making
Pain Management	shared decision making
Goals of Care	shared decision making
Contraception Counseling	shared decision making
Informed Consent	informed consent
Other	shared decision making
Difficult Conversations	
Bad News	SPIKES model
End of Life	SPIKES model

Kogan JR, Holmboe ES, Hauer KE. Tools for direct observation and assessment of clinical skills of medical trainees: a systematic review. JAMA. 2009 Sep 23;302(12):1316-26. doi: 10.1001/jama.2009.1365. PMID: 19773567.

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Lets give it a try… SMM for agenda setting

	Elicits Chief Concerns/Sets the Agenda
10	Indicates time available (i.e. “in this visit” or “in the time we have today”)
11	Obtains list of all issues patient wants to discuss; asks patient to prioritize list
12	Indicates physician's needs
13	Summarizes agenda and negotiates

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Lets see how the Framework works

	Elicits Chief Concerns/Sets the Agenda
10	Indicates time available (i.e. "in this visit" or "in the time we have today")
11	Obtains list of all issues patient wants to discuss; asks patient to prioritize list
12	Indicates physician's needs
13	Summarizes agenda and negotiates

https://www.youtube.com/watch?v=Xy80LzVYGG0- Mayo Clinic video

ACGME Direct Observation Tool Kit

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Synthesizing observations

Did well

- Assessed patient knowledge at start of visit
- Medically accurate
- Discussed medication
- Organized plan

ACGME FACULTY DEVELOPMENT TOOLKIT: IMPROVING ASSESSMENT USING DIRECT OBSERVATION
Rater Assessment Form

Instructions
Thinking about the encounter that you just watched, please answer the following questions.

1. What, if anything, did you observe the resident do well (i.e., behavior that enables safe, effective, patient-centered care) and what deficiencies/errors did the resident commit (i.e., behavior that impedes or hinders safe, effective, patient-centered care)? Be as complete as possible.

Did Well	Errors/Deficiencies

Deficiencies

- Missed discussing pt role in decision
- Did not explore patient preference
- No SMART goal
- Poor side effect discussion

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Prioritize observations

<u>Did well</u>

- Assessed patient knowledge at start of visit
- Medically accurate
- Discussed medication
- Organized plan

ACGME FACULTY DEVELOPMENT TOOLKIT: IMPROVING ASSESSMENT USING DIRECT OBSERVATION
Rater Assessment Form

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Did Well	Errors/Deficiencies

<u>Deficiencies</u>

- Missed discussing pt role in decision
- Did not explore patient preference
- No SMART goal
- Poor side effect discussion

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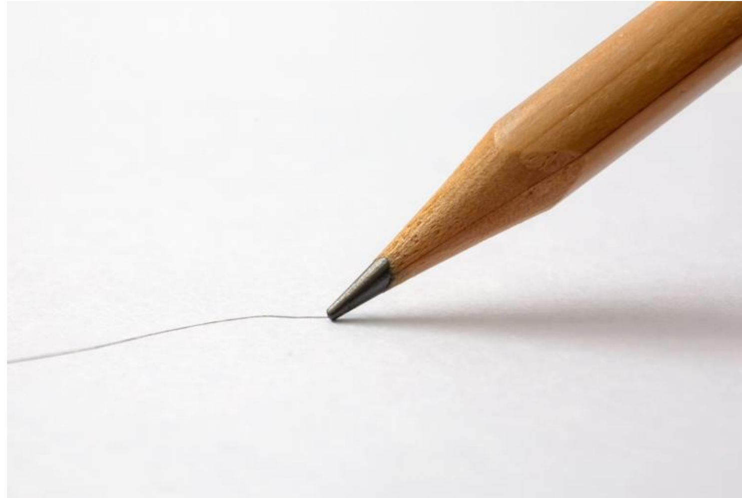
Summary Statement

3. In a few words or phrases, how would you summarize/synthesize the big picture of this resident's skills in this scenario?



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Summary of Steps of Observation

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Top Tips for Direct Observation

- Start with clear objectives – maybe begin with 5 key history of shared decision making skills
- Make sure folks know it will be frequent and formative
- Identify existing tools/frameworks
- Take time to reflect on what you are learning along the way
- Make sure to train faculty and orient residents
- Do it frequent enough it becomes part of your culture

Karen E. Hauer, Eric S. Holmboe & Jennifer R. Kogan (2011) Twelve tips for implementing tools for direct observation of medical trainees' clinical skills during patient encounters, Medical Teacher, 33:1, 27-33, DOI: 10.3109/0142159X.2010.507710

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What are the barriers?

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Faculty	Learners
Lack of time	Lack of faculty time
Lack of buy-in	Lack of trust
Fear of undermining learner/pt relationship	Anxiety provoking
Low self-efficacy	Threatens autonomy
	Fear of high stakes assessment

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Addressing the time barrier

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Observe One Skill at a Time

Try to think about "holes" in your assessment systems.

What are the things you need to see more of or see better?

How can you structure your observations around those?

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Observe One Skill at a Time

History

- Agenda setting
- Part of admission history
- Pre-rounds

Exam

- Part of exam
- Pre-rounds
- One maneuver

Counseling

- Post-rounds
- Discharge
- Starting medication
- Behavioral change
- Family meeting
- Code status
- Pre-rounds
- Anticipatory guidance

Procedures

- Consent
- Procedure
- Post-check

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Observe One Skill at a Time

History

- Agenda
- Part of admission history
- Pre-rounds

3 things

...ng

- ...cation
- ...hange
- ...eting
- ...tatus
- ...e-rounds
- Anticipatory guidance

Procedures

- Consent
- Procedure
- Post-check

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Challenges to Overcome

- Time Constraints
- Resource Limitations
- Resistance to Change
- Lack of Training and Development
- Balancing Multiple Roles
- Assessment Design Complexity
- Engagement and Motivation
- Assessment Fatigue
- Standardization Challenges

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Strategies for Overcoming Challenges

- Gradual Implementation
- Resource Allocation
- Addressing Resistance
- Faculty Training and Development
- Customize Assessment Tools
- Utilize Technology
- Integration into Curriculum
- Transparent Evaluation Criteria
- Feedback Mechanisms
- Peer Collaboration
- Clear Communication and Buy-in

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Faculty Development Toolkit

Improving Assessment Using Direct Observation

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Our Direct Observation Toolkit

- Spreadsheet of skills- and which framework to use
- History (ACGME)
- Physical (Stanford 25)
- Shared decision making (ACGME)
- Difficult conversations (SPIKES)
- Counseling for Behavior Change (Univ. MN- Change that Matters framework)
- Frameworks available (paper/clipboard or online teams)
- Evaluation (quick and easy)
- Tracking tool on Teams so all preceptors can see what needs to be observed

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Making tracking and Assessment easier

How to track your Direct Observations

How to use Milestone Elements (behavioral markers) in your Evals to help your CCCs

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Competency-Based Education - | Modify Form - MedHub | Preview Form - MedHub

https://ngmcgme.medhub.com/u/a/evaluations_forms_preview.mh?evaluationID=801

Preview Form
Printed on Jan 25, 2024

medhub

Direct Observation Evaluation form

Insufficient contact to evaluate (delete evaluation)

This is an on demand evaluation to be used for direct observation- can be used in hospital or clinic or simulation

1. Where did the observation take place? *
- [ ] Clinic
- [ ] Hospital
- [ ] Simulation

2. Did you observe history taking? No

4. Did you observe a physical exam? No

6. Did you observe counseling for behavioral change? No

8. Did you observe a difficult conversation? Yes

9. If observing a difficult conversation, which type? Bad news

10. Did you observe shared decision making? No

12. What did you observe that went well? *

13. What did you observe that could be improved upon? *

Only as an Observer	With Direct Supervision	With Indirect Supervision	Independently	As an instructor of Junior Colleagues	N/A
I prefer to show you again	I'd prefer to see you do this again to demonstrate competence/confidence with skill	I am comfortable being available if you need me	I am comfortable with you doing this on your own	You are good to teach junior colleagues	

▾ Expand ▾

14. What entrustability scale would you apply to this observation?* ○ ○ ○ ○ ○ ○

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

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Direct Observation Worksheet

Skills to Observe	Framework (SMM) to use	Dr. Feelgood	Dr. Strange	Dr. Love	Dr. Frasier Crane	Dr. Evil
History						
New Patient	History	11/23 (3) MN				
Sexual History	History					
Medication Reconciliation	Medication Reconciliation					
Preventive/Wellness Visit	History		1/24 (4) MN			
Agenda Setting	History					
Other	History					
Physical Exam						
Neuro	Cranial Nerves Sheet					
Cardio	Cardiac					
Resp	Pulmonary					
MSK	Knee, Shoulder, Foot, LBP					
Abd	Abdomen					
Skin	Skin lesion					
GYN exam/Pelvic exam/Breast	Pelvic/Breast					
Osteopathic Structural Exam	Osteopathic					
General Wellness	Wellness					

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Faculty: Bray Brown Hill Songara Bringhurst Hubbard

Name	on ambulatory?	topic	Date	Observed	History exam plan
Ghani		PAD	5/6/24	4/16/24	MDM
Kao		Carpel tunnel Tx, Dx	5/6/24	4/17/24	MDM
McGeagh		Types of skin biopsies	3/26/24	4/12/24	History
Pidakala		CKD Management	4/8/24	4/08/24	History
Lassiter				4/12/24	History
Page		Peronial neuropathy	4/24/24		
Rhyne		diabetes workup (Type 1 + beyond) labs	5/6/24	4/17/24	MDM
Woods		MODY	3/21/24		
Bailey		Management of nasal dryness	4/15/24		
Balan		Dementia screening in PC	4/19/24	4/9/24	making
Burgos Rossy		Painful conditions of the forearm	05/06/24	4/08/24	MDM
Flageolle		Medical Management GERD	4/16/24	4/9/24	shared pt dec. making
rotator - Tripp		Anemia of chronic complaints	4/2/24		
rotator -					
rotator					

running tally

		Jan	Feb	Mar
Gold	14	3	5	6
purple	10	5	3	2
Blue	15	7		

gold	purple	blue	green
~~IIII~~	III		~~IIII~~ II

Didactic Topic Ideas

Multi-Cultural Discussion

QI Project

Program Director's Role

- **Vision and Strategic Planning**
  Establish a clear vision for competency-based education
- **Advocacy and Communication**
- **Curriculum Integration**
  Actively lead the integration of competencies into the curriculum
- **Faculty Training and Development**
  Organize and facilitate faculty development related to competency-based assessments

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Success is a moving target

- We started Direct Observation in October 2023
- The plan is to have 750 done by end of September 2024
- As of January 2024, we have done nearly 200 direct observations
- This is fine since we are ramping up and getting more comfortable. We plan to use direct observation in our simulation lab, POCUS and orientation with new interns.
- As of August 2024, we have done 775 Direct Observations

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Conclusion

- Direct observation is a crucial assessment in competency-based medical education
- It is important to address inter-rater variability with your faculty – attempt to use an evidence-based frame of reference → Faculty Development is key
- Address Resistance and Concerns
- Use snapshots of observations to help address time barriers

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