GME UPDATES

Graduate Medical Education
June 8, 2017
# 2017 Orientations

## Orientation Dates

<table>
<thead>
<tr>
<th>Orientation Dates</th>
<th>Who:</th>
<th>When:</th>
<th>Where:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday, June 20, 2017</td>
<td>Fellows starting on July 7, 2017</td>
<td>Last Name A-M: Orientation starts promptly at 8:00 AM. Please arrive early.</td>
<td>Li Ka Shing, Paul Berg Hall - 2nd floor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Last Name N-Z: Orientation starts promptly at 10:00 AM. Please arrive early.</td>
<td></td>
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<tr>
<td></td>
<td>Interns from Ob/Gyn, General Surgery &amp; ALL Surgical Specialties, Emergency Medicine, and Psychiatry:</td>
<td>Interns from Internal Medicine and Pediatrics:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Orientation starts promptly at 10:00 AM. Please arrive early.</td>
<td>Orientation starts promptly at 9:00 AM. Please arrive early.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Who: Interns from Pathology, and ALL RESIDENTS/FELLOWS STARTING ON JULY 1, 2017.</td>
<td>When: Last Name A-C: Orientation starts promptly at 8:00 AM. Please arrive early.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Last Name A-D: Orientation starts promptly at 9:00 AM. Please arrive early.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Last Name K-M: Orientation starts promptly at 10:00 AM. Please arrive early.</td>
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<tr>
<td></td>
<td></td>
<td>Last Name N-R: Orientation starts promptly at 11:00 AM. Please arrive early.</td>
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<td></td>
<td></td>
<td>Last Name S-U: Orientation starts promptly at 12:00 PM. Please arrive early.</td>
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<tr>
<td></td>
<td></td>
<td>Last Name V-Z: Orientation starts promptly at 1:00 PM. Please arrive early.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Who: Interns from Pathology, and ALL RESIDENTS/FELLOWS STARTING ON JULY 1, 2017.</td>
<td>Where: Li Ka Shing, Paul Berg Hall - 2nd floor</td>
<td></td>
</tr>
</tbody>
</table>

## Orientation Conflicts

If you are leaving an outside internship/residency program and are unable to attend one of the orientations, please contact the Department of Graduate Medical Education at (650) 723-5848 no later than June 24th, 2016. You will NOT be able to start without attending orientation.

## What do I need to bring to Orientation?

1. Two forms of identification (passport, birth certificate or Social Security Card and a driver's license with picture).
2. Smartphone, if you own one, for SHC required encryption.
MBC Forms L3As & L4s – GME fills out the top and sends to you to complete
Summative Evaluation – Why?

- For **CURRENT** trainees, prior to completion of the program:
  - V.A.3.b) “The program director must provide a summative evaluation for each resident upon completion of the program. (Core)”

- For **TRANSFER-OUT** trainees:
  - III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who may leave the program prior to completion. (Detail)

- For **TRANSFER-IN** trainees:
  - III.C.1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident. (Detail)

Write A Summative Evaluation

Collect A Summative Evaluation
<table>
<thead>
<tr>
<th>CLER Report 2017</th>
<th>CLER AREAS-Questions</th>
<th>Residents</th>
<th>Faculty</th>
<th>PDs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Safety</strong></td>
<td>Had personally reported a patient safety event at Stanford Medicine using the hospital’s reporting system</td>
<td>53%</td>
<td>25%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>Believe the hospital provides a supportive, non-punitive environment for reporting errors, near misses, and unsafe conditions</td>
<td>100%</td>
<td></td>
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<tr>
<td></td>
<td>Have received training on how to disclose medical errors to patients and families</td>
<td>51%</td>
<td></td>
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<tr>
<td><strong>Healthcare Quality</strong></td>
<td>Had participated in QI project of their own design or one designed by their program or department (PGY2s and above)</td>
<td>84%</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Knew the hospital’s priorities with regard to healthcare disparities</td>
<td>33%</td>
<td>57%</td>
<td>72%</td>
</tr>
<tr>
<td></td>
<td>Have participated in Cultural Competency Training while at Stanford Medicine</td>
<td>12%</td>
<td>25%</td>
<td></td>
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<tr>
<td><strong>Transitions in Care</strong></td>
<td>Used a standardized process for sign-off and transfer of patient care during change of duty</td>
<td>76%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Supervision</strong></td>
<td>Believe they are adequately supervised</td>
<td>63%</td>
<td>61%</td>
<td>65%</td>
</tr>
<tr>
<td><strong>Duty Hours, Fatigue Mgmnt &amp; Mitigation</strong></td>
<td>What would a resident do in this circumstance: you were or encountered a maximally fatigued resident two hours before the end of his/her shift.</td>
<td>71%</td>
<td>15%</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>…simply power through to sign-out</td>
<td>10%</td>
<td>58%</td>
<td>57%</td>
</tr>
<tr>
<td></td>
<td>…notify a supervisor and expect to be taken off duty</td>
<td>10%</td>
<td>58%</td>
<td>57%</td>
</tr>
<tr>
<td><strong>Professionalism</strong></td>
<td>51 Residents</td>
<td>56 Faculty Members</td>
<td>46 PDs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>51 Residents</td>
<td>56 Faculty Members</td>
<td>46 PDs</td>
<td></td>
</tr>
</tbody>
</table>
Mentorship Strategies Revisited & Local Implementation Results

Program Director Meeting ~ June 8, 2017
Introduction

Mentor is defined as a supporting person who provides career enhancement and psychosocial support:

- **Career Enhancement**: Provides sponsorship, protection, provision of challenging assignments, and transmission of ethics.

- **Psychosocial Support**: Enhance the mentee’s sense of competence, identity, and work-role effectiveness.

Considering the integral role a mentor plays in development and support of mentees, the identification of a mentor is a priority for young physicians in residencies and fellowships.
Traits of Successful Mentors

Not everyone should be a mentor.

Traits:
- Intelligent
- Caring
- Humorous
- Flexible
- Empathetic
- Supportive
- Patient

"MENTORS ARE NOT THERE TO MAKE US 'HAPPY.' THEY ARE THERE TO GUIDE US TO THE BEST OF THEIR KNOWLEDGE."
Benefits of Mentoring to Faculty

You get out what you put in:
- Accelerated research productivity
- Greater networking
- Enhanced professional recognition when protégés perform well
- Enhanced career satisfaction
- Rejuvenation of creative energy

Benefits of Mentoring to Trainees

The ability to change your trainees’ lives.

Mentors provide trainees with:
- Development of professional skills
- Enhancement of confidence and professional identity
- Scholarly productivity
- Enhanced networking
- Satisfaction with one’s program
- Stress reduction
- Faster time to first job
- Faster time to promotion
- Higher salary
Obstacles Explored

University

Although mentoring is one of the components of a typical CV, it is often overlooked and not taken seriously when promotions are considered.
- Research and publications are ‘currency’ to promotion

Part time faculty:
- 50% of college faculty nationwide
- Less engaged, less accessible

Obstacles Explored

Departmental

- Chairs overestimate the amount of mentoring that is ongoing.
- Few academic chairs explicitly reward effective mentorship.
- Senior members of the department may not represent the heterogeneous group of trainees.
Obstacles Explored

Individual

Discouraged by time cost of mentoring.

Poorly matched character traits:
- May lack key skills needed to be a successful mentor.
- May have mentees who do not match their personality.

Cloning:
- May desire to create ‘mini-me’ which often leads to a corrosive relationship.


Why do most mentoring programs fail before they start?

- Forced
- Lack of Trust
- Random assignment
- Non relationship based
Mentoring at Stanford

Trainees with mentors are more likely to report that faculty support their professional aspirations.

Trainees with mentors are more likely to be satisfied with their program.

Mentoring at Stanford

Trainees with mentors consider them effective in their roles.

- We should focus on establishing the relationships.

Overall, about 1 in 5 trainees do not identify a mentor.

- 40% of first year trainees did not identify a mentor compared to only 15% of remaining trainees without mentors.

This is an important point since first year trainees are more likely to develop depressive symptoms.

- Mentoring can help alleviate these symptoms.

Five Step Mentorship Plan

Step 1: Identify Program Rationale

Explain to the proposed mentor program leader the importance of mentoring for trainees.

Provide blended didactic and interactive session for faculty members in the department.

- Having a high emotional intelligence is key to being an effective mentor.
- Highlight that all faculty may not be suitable mentors, which will help avoid apathetic mentors.

The mentees must have an **active role** in the mentorship relationship.

- Mentee apathy is often cited by mentors as a reason for losing interest in the relationship

Mentees should be

- Engaged
- Follow-up on assigned tasks
- Solicit feedback
Five Step Mentorship Plan

Trainees should prepare for their meetings
- Clarify values
- Identify productive and unproductive habits/skills
- Identify areas of improvements

Traits trainees should look for when choosing a mentor
- Availability
- Provide opportunities and encouragement

Manage the relationship
- Follow through on assigned tasks
- Actively listen
- Plan and set meeting agendas

Step 2: Provide Trainee Education

Five Step Mentorship Plan

Step 3: Design Structured Mentorship Program

Create a tailored mentor program that works for the department while adhering to fundamental foundations of effective mentor relationships

- Solicit volunteer faculty to avoid forced relations
- Avoid random assignment of mentors to mentees
- Build trustworthy relationships
Five Step Mentorship Plan

Step 3: Design Structured Mentorship Program

Additional resources for faculty seeking to improve their mentorship skills

- **I need a refresher:** Recommend paper on mentorship

- **I’m new to this:** Recommend web-based Interactive modules
  Consider University of Minnesota online mentorship training

- **I really am lost:** Recommend book on mentorship
  W.B. Johnson
Five Step Mentorship Plan

To avoid random assignment of mentors to mentees, volunteer mentor faculty developed profiles of personal and academic interests to facilitate early matching of mentors.

- Trainees provide ranked lists to mentorship program leader
Five Step Mentorship Plan

Step 5: Foster Mentor Relationships

Recommend **facilitated meetings** between mentors and mentees at least every 4 months

Use a structured discussion guide to highlight 6 key areas of mentorship

- Clinical skill development
- Post-training career planning
- Networking opportunities
- Sponsorship and advocacy during training
- Facilitation of research pursuits
- Mentoring on challenging or sensitive issues
Five Step Mentorship Plan

Step 5: Foster Mentor Relationships

Creative ways to facilitate mentor/mentee meetings

- Substitute a Journal Club
- Substitute a weekly lecture
- Split a grand rounds in half
- Fund lunch between mentor and mentee during work day
- Host a mixer at a faculty home or on campus conference room with dinner provided and then break into mentor/mentee pairs
- If your specialty lends itself – pair the mentor and mentee to work together throughout the day with a guided discussion at the end of the day
Termination or Continuation

Program directors should review mentee/mentor relationships annually.

Solicit new mentors annually.

Mandate that trainees resubmit their preference list based on profiles.
- Most mentorship program leaders quote that the trainee is always ‘allowed’ to terminate a relationship, but it is not realistic or proper to put this responsibility on the trainees.

All mentor relationships should have a set termination or review date by a non-vested faculty.

Implementation Results

We visited 16 programs between 2014-2016 and measured initial effectiveness and longitudinal effectiveness.

High variability was encountered:

- Some programs required little alteration of mentorship strategies while others adopted multiple new strategies.
- There is not 1 best fit for all programs. Because of variability in program characteristics, need to tailor mentor programs while maintaining adherence to best practice.
Implementation Results

Group 1: Programs from 2014-2015 Assessment of longitudinal gains (n=6 programs)

Group 2: Programs from 2015-2016 Assessment of initial gains (n = 10 programs)

Group 3: Control (n>100 programs)
We Can Help

- Explore different ways to incorporate mentorship into your program
- Compare different residency mentorship programs
- Lectures for faculty and trainees
- Online resources for mentorship training
- Reading recommendations
- Contact: tjcaruso@stanford.edu
Stanford Pediatric Residency
Coaching Program

GME Program Directors’ Meeting
June 8, 2017
Carrie Rassbach MD, Associate Program Director and Coaching Director
Becky Blankenburg MD, MPH, Associate Chair for Education and Program Director
Objectives

- Identify structure of mentorship in pediatric residency program
- Review purpose and benefits of coaching
- Introduce Coaching model from Stanford
- Review myths and misconceptions
Mentorship in the Stanford Pediatric Residency Program

- Scholarly Concentration Leader & Research Mentor
- Coach
- Core Clinical Skills
- Advisor
- Career Guidance & Wellness
- Humanism Leader(s)
- Scholarship
- Wellness
- Class/Track APD
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.”

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
Benefits of Coaching

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

• Improves residents’:
  – Perceptions of feedback
  – Reflective skills
  – Goal-setting skills
Stanford Pediatric Residency Coaching Program

2013 - present
Coaching Program Goals

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

• 10 Faculty Coaches
• 10-11 residents/Coach
• Longitudinal direct observations in multiple settings: inpatient, outpatient, through training years
• Review ILPs
• Serve on CCC
• Dedicated time
• 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
Stanford Pediatric Residency Coaching Model

- Resident identifies goals, communicates with coach
- Coach observes the learner in real-time
- Learner reflects
- Coach provides feedback
- Coach helps learner set goals
- Learner internalizes and applies feedback from coaching

Models of Residency Coaching Programs

Man-to-Man
(Stanford)

Zone
Faculty Development
Feasibility, 2013 - 2014

• 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>
</tr>
</thead>
<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)
Skill Reflection and Goal-Setting in Giving Feedback

- **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 vs. Non-COACH: PE, p < 0.01
- COACH: Assessment vs. Non-COACH: Assessment, p < 0.01
- COACH: Communication vs. Non-COACH: Communication, p = 0.062
- COACH: Goal-setting vs. Non-COACH: Goal-setting, p < 0.01

Level of Confidence (1-4 scale)

2013 vs. 2014
Feedback from Residents

• “The coaching program is FANTASTIC and one of the things I emphasize to prospective applicants as a strength of our program. I love our approach to transparent feedback and the wide-ranging support from multiple perspectives for different aspects of our work. Thank you for all the time you put into setting up the coaching program and to Dr. ______ for being so awesome.”

• “[My coach has helped me with] how to give efficient sign out, how to engage challenging patients, how to develop a succinct but useful discharge summary.”

• “[My coach] makes an effort to see me in a variety of settings, and identifies strengths and areas to work on that apply to all those areas. Provides good reflective listening regarding my experiences on each rotation, helps me to think through career decisions. Focuses on specific challenges for each stage of training-e.g. this year she is focusing more on supervisory skills.”

• “Gives very direct and helpful, real-time feedback. Always comes up with 1-2 things to work on. Helps me to come up with my own goals for things to work on for each rotation. Extremely approachable, the kind of mentor/coach that you WANT to give you feedback and that you WANT to go to for help or advice.”
Patient Feedback Study
2015 - 2016

• Randomized controlled trial at 3 institutions
• Compared the effect of coaching around patient feedback versus no coaching on:
  – Resident **attitudes** towards patient feedback/patient communication
  – Resident **confidence** in communication skills
  – **Patient ratings** of resident communication skills
• Funded by the Association of Pediatric Program Directors
Patient Feedback Study

• Findings:
  – Residents in Coaching group more likely to ask for patient feedback than control group residents
  – Residents in Coaching group more likely to accept and learn from patient feedback
  – No measurable difference in confidence ratings or patient ratings between groups

• Bogetz A, Orlov N, Blankenburg R, Bhavaraju V, McQueen A, Rassbach C. How Can Faculty Help Residents Learn From Patient Feedback? A Multi-Institutional Qualitative Study of Pediatric Residents’ Perspectives. (Submitted).
• Rassbach C, Bogetz A, Orlov N, McQueen L, Bhavaraju V, Mahoney D, Leibold C, Blankenburg R. The effect of faculty Coaching on Resident Attitudes, Confidence, and Patient-rated Communication. (In development)
Next Steps

• Dissemination of tools & resources for other programs/institutions
• Development of additional best-practice tips and scripts for coaches
• Delivery of faculty development to other faculty in the department
Myths, Misconceptions and Quandaries

• Cost
• Time
• Small programs
• Feedback in person
• Formative Feedback vs. Evaluation vs. Both
Thank you and Questions?