AMERICAN OSTEOPATHIC ACADEMY OF ORTHOPEDICS

21st ANNUAL OSTEOPATHIC
Educators’ Course

Thursday, May 2, 2013
Loews Miami Beach Hotel • Miami Beach, FL
Course Objectives
The goal of the Educators’ Course is to offer a diversified program of continuing education for the surgical specialty of orthopedics and to keep Osteopathic Orthopedic Surgical Residency Program Directors and Trainers informed regarding recent educational developments and techniques. These objectives will be achieved through panel discussions, symposia and lectures, as well as questions from participants and answers from presenters. At the completion of this meeting, orthopedic surgeons associated with training programs will:
• Be more aware of residency program training requirements and educational standards.

Based on participant comments from previous courses, concurrent sessions will be offered in a two-track format to meet the needs of both orthopedic residency program directors and trainers. Each session will offer opportunities for participant interaction in small group discussions.

AOA CME Credits
The AOA CME credits will be a benefit of the AOA Council on Continuing Medical Education. Participants will be required to sign in. Questions or concerns regarding credits can be directed to the AOA office at 804-565-6370. Certificates of attendance will be prepared for all attendees and an official roster of attendees and appropriate number of CME credits earned by each attendee will be provided to the American Osteopathic Association.

Credit for this program will only be given to those attendees who register, complete and return the program evaluation form with only the number of hours attended.

Disclaimer
The material presented at the Osteopathic Educators’ Course has been made available by the American Osteopathic Academy of Orthopedics for educational purposes only. This material is not intended to represent the only, nor necessarily best, methods or procedures appropriate for the medical situations discussed, but rather is intended to present an approach, view, statement or opinion of the faculty which may be helpful to others who face similar situations. The AOAO disclaims any and all liability for injury or other damages resulting to any individual attending a session and for all claims which may arise out of the use of the techniques demonstrated therein by such individuals whether these claims shall be asserted by a physician or any other person.

Speaker Listing

H. Brent Bamberger, DO, FAOAO
Program Co-Chair
Orthopedic Residency Program Director
Grandview Hospital and Medical Center
Dayton, OH

Franklin Medio, PhD – Program Co-Chair
President, Consulting Services for the Health Professions
Charleston, SC

Wade Faerber, DO, FAOAO
Chief of Staff
Orthopedic Residency Program Director
Riverside County Regional Medical Center
Riverside, CA

Catherine Henderson, DrPH, LFACHE
Consultant
Partners in Medical Education, Inc.
Irwin, PA

Joseph B. Koch
President, Innovative Consulting & Mediation, LLC
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Seth D. Krum, DO
Director, AOBOS Board
Orthopedic Surgeon
Pennsylvania Orthopedic Associates
Huntington Valley Surgical Center
Huntington Valley, PA

Carl Mogil, DO, FAOAO
Director of Medical Education
Orthopedic Residency Program Director
UMDNJ-SOM
Stratford, NJ

Lee Vander Lugt, DO, FAOAO
Executive Director
American Osteopathic Academy of Orthopedics
Chickasha, OK

21st Annual Osteopathic Educators’ Course
for Osteopathic Orthopedic Surgery Program Directors and Trainers
May 2, 2013 • Loews Miami Beach Hotel • Miami, FL

7:00 am-7:15 am
Registration and Welcome
H. Brent Bamberger, DO, FAOAO

7:15 am-8:15 am
The AOA-ACGME Accreditation System for GME: Implications for AOAO training programs (This lecture qualifies for 1.0 specialty credit)
Lee Vander Lugt, DO, FAOAO

8:15 am-9:00 am
A Comparison of Current AOAO and AAOS Residency Requirements
Carl Mogil, DO, FAOAO; Franklin Medio, PhD

9:00 am-9:15 am
Break

9:15 am-10:15 am
The ACGME’s Next Accreditation System (NAS): What’s it all about? (This lecture qualifies for .5 specialty credit)
Catherine Henderson, DrPH, LFACHE

10:15 am-11:00 am
Changes in the ACGME Site Surveys: The CLER visits
Catherine Henderson, DrPH, LFACHE

11:00 am-11:15 am
Break

11:15 am-12:00 pm
Performance Benchmarks (Milestones) to Document Resident Competence in Orthopedic Surgery (This lecture qualifies for .5 specialty credit)
Wade Faerber, DO, FAOAO

12:00 pm-12:30 pm
AOBOS Update
Seth D. Krum, DO

12:30 pm-2:00 pm
Lunch Session: Integrating Your Clinical Practice and Your Personal Life
Joseph B. Koch

2:00 pm-4:00 pm
CONCURRENT SESSIONS

2:00 pm-3:00 pm
Track A - Program Directors
Surgical Logs & Annual Program Evaluations
Lee Vander Lugt, DO, FAOAO

Track B - Faculty
Teaching the Millennial Learner
Franklin J. Medio, PhD; Joseph B. Koch

3:00 pm-4:00 pm
Track A - Program Directors
Effective Mentoring Programs
Joseph B. Koch

Track B - Faculty
Dealing with the Entitlement Mentality
Franklin J. Medio, PhD; Wade Faerber, DO, FAOAO

4:00 pm-4:30 pm
Track A - Program Directors
Question & Answer/Summary/Future Plans
H. Brent Bamberger, DO, FAOAO; Franklin Medio, PhD
Faculty Disclosures

Faculty Disclosure Key
In accordance with AOA accreditation requirements, Osteopathic Educators’ Course speakers are required to disclose any possible relationship which, in the context of their presentation, could be perceived by some as a real or apparent conflict of interest.

The following key is provided to inform participants of any speakers who have disclosed a relationship with industry, but do not consider that it will influence their presentation.

1. Grant/Research Support
2. Consultant
3. Speaker’s Bureau
4. Major Stock Shareholder
5. Other Financial or Material Support
6. Will disclose prior to their presentation on-site
7. Nothing to disclose

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The AOA-ACGME Accreditation System for GME: Implications for AOAO training programs

Lee Vander Lugt, DO, FAOAO
A Comparison of Current AOAO and AAOS Residency Requirements

Carl Mogil, DO, FAOAO; Franklin Medio, PhD
Comparing the AOA/AOAO Standards in Orthopedic Surgery to the ACGME/AOBOS Standards

Carl Mogil, DO  
Program Director  
Orthopedic Surgery Residency  
UMDNJ-SOM

Overall assessment:

Both represent a detailed 5 year educational program in Orthopedic Surgery. The ACGME Standards have more detail. The AOA Standards reflect orthopedic training based in community medical centers, not large academic medical centers.

Major Differences
“The First Year”

• PGY 1 vs. OGME 1 year

ACGME: six months of structured education in surgery to include trauma, plastic surgery/burn care, intensive care and vascular surgery

The “first ACGME year” cont’d;

One month in three of the following areas:
• Emergency Medicine
• ICU
• Internal Medicine
• Neurology
• Neurosurgery
• Pediatrics or pediatric surgery
• Rheumatology
• Anesthesia
• Musculoskeletal Imaging
• Rehabilitation Medicine

AOA

• Traditional rotating osteopathic internship with three months Orthopedic Surgery.
• This has been an osteopathic tradition, explained as “making medical students into doctors”.

4/16/2013
ACGME

• programs divide orthopedic residencies into specialty "services" from years two thru five.
• This enables academic and clinical concentration over months, rather different than community orthopedic surgery.

AOA programs feature clinical community orthopedic rotations from years two thru five. These do include specific concentrated services in Trauma and Pediatric orthopedic surgery but, generally not "hand service", "joint service", "spine service", "sport service" or "foot/ankle service".

ACGME programs also include "rotation options" in services such as plastic surgery, PMR, hematology or neurologic surgery.
• This option is not available in AOA orthopedic programs.
Institutional Requirements

- ACGME defines primary site and Sponsoring Institution in specific forms and assigns responsibility for education and clinical experience. The ACGME specifically describes participating Institutions and their responsibilities, obligations.
- AOA lists sponsoring (Base) Institutions, but does not delineate responsibility or obligations of Base.

Program Personnel and Resources

- Both systems describe duties, responsibilities of Program Director as well as qualifications.

- ACGME requires narrative description of program with annual updating in ADS (automated data system).
- AOA does not use ADS.
- AOA does not require annual report for program, but does require annual report for each trainee.
• In ACGME Program Director must seek approval from RRC (Residency Review Committee) for changes in program of substantive nature; in AOA programs, the Program Director must petition the Evaluating Committee Specialty College then OPTI, then get approval from PTRC (Program and Trainee Review Committee) for program changes (AOA).

ACGME

• Each orthopedic program is required to have three faculty who each devote twenty (20) hours/week to the program.

AOA

• has a ratio of 3:1 trainee to trainers (spells out qualifications for each trainer).
• AOA does not define trainer qualification beyond certification by either the AOBOS or AAOS and years of experience after certification.

Faculty Scholarship
1. Is clearly defined by ACGME programs, not so in AOA Standards:
2. Discovery (original research and publication)
3. Dissemination (review articles and textbook chapter authoring)
4. Application case reports, presentations, participation in teaching, journal clubs, mentoring of residents.

Non Faculty Qualifications
1. Defined by ACGME, not specifically referenced in AOA Standards
2. "Must be provided" to support the program.
3. Resources (e.g. sufficient lab space and equipment, computer and statistical consultation services) must be available
ACGME Resident Appointment Process

1. Eligibility
2. Number of residents determined by RRC (ACGME), determined by PTRC (AOA)
3. Resident transfers – not discussed in AOA Standards
4. Appointment of fellows and students MUST NOT DILUTE OR DETRACT from educational opportunity of regularly appointed residents.

Program Curriculum

• Detailed in both AOA and ACGME Standards
  ▫ Clinical
  ▫ Educational

Clinical Components

1. Clinical resources
2. Continuity of care
3. Non operative outpatient experiences: at least ½ day outpatient office experience with direct supervision by faculty
4. Progressive responsibility
5. Basic motor skills training
Resident Scholarly Activities
• Emphasized in ACGME programs
  □ (see prior slide)

ACGME Core Competencies
• Emphasized by both AOA and ACGME Standards
• Evolving into NAS/CLER System in ACGME slide

Resident Duty hours and Supervision
1. Supervision of Residents
2. Duty Hours
3. On call activities
4. Moonlighting
5. Oversight
6. Evaluations - formative and final
   Same for AOA/ACGME
In the ACGME System:

- Evaluations of Faculty performance by trainees at least mid point in accreditation cycle.
- Annual assessment of program and trainers by resident submitted to RRC.
- Midcycle AOA Inspection Report does feature opinion of trainees about trainers and Program, sent to OPTI.

Program Effectiveness:

1. Evaluation by representative personnel (Program Director, faculty, one resident) annually in ACGME programs.
2. Trainees in program “should have at least 75% 1st time board certification passage”. This is a written standard in ACGME programs.

• So, what’s the difference and what is there to do?
1. The AOA Programs feature “osteopathic identity”
2. The orthopedic difference is in detail and in measuring Core Competency Training.
3. If the AOA accepts the NAS System of measured core competency training in orthopedic surgery, then the AOAO should add the NAS System to our training along with the CLER method of implementing these measured competencies.

References:
• AOA Basic Standards in Orthopedic Surgery. July 2012
• ACGME Program Requirements for GME in Orthopaedic Surgery
• The Orthopaedic Surgery Milestone Project, The Accreditation Council for Graduate Medical Education and The American Board of Orthopaedic Surgery 2013
The ACGME’s Next Accreditation System (NAS): What’s it all about?

Changes in the ACGME Site Surveys: The CLER visits

Catherine Henderson, DrPH, LFACHE
ACGME’s Next Accreditation System
AOAO Educators’ Course
May 2, 2013

Presented by:
Catherine Henderson, DrPH, LFACHE
Consultant
Partners in Medical Education, Inc.

Catherine Henderson has no relevant financial disclosures

Objectives
At the conclusion of this presentation, participants will be able to:

- Describe changes in the way that programs will be accredited by ACGME in the Next Accreditation System (NAS)
- Identify the purpose and process of the ACGME CLER visits
ACGME's Next Accreditation System

**Introduction**

- ACGME’s accreditation process moves from “biopsy” to a continuous accreditation model in the Next Accreditation System (NAS)
- The “secret to success” always has been:
  - know the rules
  - follow the rules
  - document that you follow the rules
  - plus, now:
  - pay attention to the outcomes

**Goals of NAS**

- Free good programs to innovate
- Assist poor programs to improve
- Reduce the burden of accreditation
- Provide accountability for outcomes
- Develop national normative data

Presented by Partners in Medical Education, Inc. 2013
What Do We Know About NAS?

- Programs will be reviewed annually under a continuous accreditation model.
- The ACGME RRC will use data from a variety of sources to determine the continued accreditation status of the program.
- There will be no “accreditation cycles.” Status of existing programs will be:
  - Continued accreditation
  - Continued accreditation with warning
  - Probationary accreditation
  - Withdrawal of accreditation

NAS for Programs

Current Accreditation System
- Snapshot in time
- Teach to the test
- Based on rules
- Stagnant
- Standards revised every 5 years

Next Accreditation System
- Continuous accreditation
- Annual data update
- Based on outcomes
- Innovation
- Standards revised every 10 years

Current Accreditation System
- Information forms
- Scheduled site visits 1-5 years
- Internal Review at midpoint
- Competencies
- No categorization of requirements

Next Accreditation System
- Electronic annual data update
- Scheduled self-study (every 10 years); site visits if/as needed
- Internal Review as needed
- Milestones
- Categorization of requirements
NAS Timeline

- July 1, 2013:
  - Pediatrics
  - Internal Medicine
  - Diagnostic Radiology
  - Emergency Medicine
  - Orthopaedic Surgery
  - Neurological Surgery
  - Urological Surgery

- July 1, 2014: Everyone else!

Annual Data Review of Programs

In NAS, the RRC’s annual data review of the residency program will consider:

- Annual ADS Update
- Board pass rate
- TRENDS (3 year) in resident online survey responses
- Faculty online surveys
- Resident clinical experience (e.g., case logs, procedures)
- Milestone evaluations
- Scholarly activity (faculty and residents)
- Data from 10 year Self Study and CLER visits, when that information becomes available

Annual ADS Update

Annual update of program’s information maintained in WebADS

- Information collected has been expanded
- Includes faculty and resident scholarly activity from the last academic year
- Program structure: program director, core faculty, resident turnover
- Focus on resident participation in performance improvement projects and patient safety
Annual Review Component: ACGME
Online Resident Survey

- Theme emphasis – de-emphasize individual questions
- Domains
  - Duty hours
  - Faculty
  - Educational Content
  - Evaluations
  - Resources
  - Patient Safety (new)
  - Teamwork (new)

Annual Review Component: ACGME
Online Faculty Survey

- Completed by core faculty members
- Theme emphasis
- Domains include:
  - Educational Content
  - Resources
  - Patient Safety
  - Teamwork
- Have started for core programs in the first 7 RRCs to enter NAS

NAS: Annual Review Outcomes

- If the results of ACGME’s annual assessment of the program are good, program notified accreditation extended for another year
- If problems are identified, the RRC might:
  - Ask for an action plan and progress report
  - Schedule a focused site visit by a surveyor
  - Schedule a complete program survey
  - Request DIO/GMEC intervention
Milestones and the Next Accreditation System

- Milestone assessment of individual residents is a required feature of ACGME’s NAS
- One of the indicators used in ACGME’s annual evaluation of the residency program’s performance
- NAS transitions the general competencies to milestones

Overview

Milestones:
- Translate general competencies into specific competencies (still in the six domains)
- Track the progress of each resident individually along the trajectory of their development
- Move assessment from numbers to narratives
- Measure observable developmental steps

Clinical Competency Committees

- Clinical Competency Committee (CCC) developed within each program.
- Until ACGME issues guidelines for CCC composition:
  - Faculty who work directly with the residents
  - Minimum 3 members; consider 5 in core programs
  - Residents in final year training??
  - Not all CCC members must be physicians
- The CCC members need a common understanding of expectations and consensus about process.
How Do They Work??

- Framework of the six general competencies
- Milestone sub-competencies may be organized around a clinical area or more widely applicable observations of behavior
- Milestone sets
- Milestones
- Levels of training = observed level of behavior, not PGY

In This Example . . .

- Level 1 is what is expected of an incoming resident
- Level 4 describes graduation target (not requirement)
- Level 5 describes performance expected by physician in practice several years. Few residents will achieve this level
What Happens to the Milestone Assessments?

- Submitted online through WebADS
- ACGME creates individual resident reports (plotting trajectory)
- Individual resident reports are returned to program to become part of resident’s file
- Aggregate program report shared with program, and becomes part of the program’s NAS data portfolio

Program Requirement Categorization

Specialty-specific program requirements are/will be “categorized” for NAS.

Core
Outcome
Structure
Detail

Site Visit Process in NAS

- Types
  - Focused: Limited to review of one or more problematic areas based on the RRC’s review of the annual data
  - Diagnostic: Used to identify what is causing deterioration in annual data parameters
  - Self-Study Visit
- Other changes (focused & diagnostic visits)
  - “PIFless”: reviewers will use program’s management data on-site; emphasis on the interviews
  - Shorter notice; 30 – 45 days expected
Self-Study Visits

- Every 10 years
- Self-assessment of program strengths and plans for improvement
- Built on the results of the program’s Annual Program Evaluations
- One year advance notice
- Survey team
- Begin late 2015

ACGME CLER Visits

What is “CLER” ?

- “Clinical Learning Environment Review”
- Focus on educational environment, not accreditation requirements
- Purpose: promote safe quality patient care
- Survey conducted where the residents receive clinical training
CLER Foundation

- Why is CLER being added?
  - The IOM's call for unannounced, annual ACGME program visits to monitor duty hours is logistically impossible.
  - Supervision, and teaching patient safety and quality improvement, as important as duty hours.

- CLER Components
  - Regular site visits (every 18 months)
  - ACGME Evaluation Committee

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CLER's Six Areas of Focus

- Patient safety
- Quality improvement
- Transitions of care
- Supervision
- Duty hours, fatigue mitigation
- Professionalism

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Think about your own residency program…

How many examples can you provide?
Assessment Examples

Patient Safety
- Do residents report patient safety issues? (errors, unsafe conditions, near misses)
- Do residents participate on inter-professional teams to promote patient safety?

Quality Improvement
- Are GME leadership, faculty, and residents integrated into the hospital’s quality improvement activity?
- Do residents learn how to identify opportunities for reducing healthcare disparities?
- Do residents use data to improve systems of care?

Assessment Examples (2)

Transitions of Care
- Is there “effective” standardization and oversight?
- Does the Institution facilitate professional development for residents and faculty about transitions of care?

Supervision
- Does the Institution establish and monitor policies for effective supervision of residents?
- Do all residents have a protected mechanism to report inadequate supervision? Do/would they use it?

Assessment Examples (3)

Duty hours, fatigue mitigation
- Are faculty and residents educated about fatigue?
- Is there Institutional oversight and monitoring of duty hours across all programs?

Professionalism
- Do you educate/monitor behavior of residents and faculty?
- Is there “veracity in scholarly pursuits”?
- Accurate reporting of program information (to ACGME)?
- Are duty hours reported accurately?
**CLER Implementation**

September 2012 - February 2014

- All Sponsoring Institutions (SI) with more than one ACGME-accredited program (except, possibly, VA & military)
- 400 clinical sites
- Beta testing and establish baseline information
- SIs will receive “formative evaluation” report, but results will not be used in making accreditation decisions

As of July 1, 2014, CLER visit results “count”

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**How a CLER Visit is Conducted**

**Notification**
- DIO is contacted
- 10 days to 3 weeks notice

**Who are the surveyors?**
- Team of 2 – 6 “visitors”
- Includes one “peer visitor” – a volunteer from a Sponsoring Institution in a different State
- Includes 1 or more ACGME professionals (not current Site Visit staff)
- Size and membership of team based on size and complexity of the Sponsoring Institution

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**ACGME’S Evaluation Committee**

- New “non-accreditation” ACGME committee
- Established to
  - Review draft CLER reports
  - Make recommendations to the Institutional Review Committee (IRC) about the learning environment
  - Inform the IRC about how well the Sponsoring Institution is “teaching” patient safety and quality improvement
  - Evaluate how well the Sponsoring Institution engages residents in the patient safety and quality improvement functions of the learning environment (e.g., the primary teaching hospital)
Evaluation Committee Members

- Physicians and non-physicians
- At least 2 residents
- Individuals with expertise in
  - Patient safety
  - Quality improvement
  - Graduate medical education
  - Hospital administration
- Representatives of the public
- Representative from the Agency for Health Care Research and Quality (AHCRQ)

The CLER visit format may change after data from the Beta testing phase is reviewed.

Experiences from the initial CLER visits, and information published by ACGME, may give us a glimpse into the future.

Who is Interviewed?

So far...

- CEO
  Participation by the CEO in the opening and closing conferences (at minimum) is essential!
- Hospital Leadership ("C Suite")
  CMO; CNO; Chief Patient Safety and Chief Quality
- GME Leadership
  DIO, GME office staff, GMEC Chair, GMEC resident reps
- GME Programs
  Program Directors, core faculty, peer-selected residents from all core programs and “larger” fellowships
How Is the CLER Visit Conducted?

- 1 – 5 days on-site, for 2 or 3 days
- Open by asking hospital leadership to describe their performance in the six focal areas
- Walking tours of clinical areas, conducted by chief residents
  - Talk with nurses
  - Talk with other residents and physicians on units
  - Possible patient contact
  - May ask people encountered about their perspective of residents related to the six focus topics
- Team members have returned in the evening
- Team provides exit conference to hospital and GME leaders

Assess for Yourself

Some walking tour questions:
- How many residents know how to report an “event” or potential safety concern?
- Do your residents file reports of safety concerns – or do they leave it for the nurses to do?
- If a resident reports a concern, does he/she get feedback about what action was taken?
- How many residents know the hospital’s quality goals?
- Do residents know how their individual PI and patient safety projects relate to the hospital’s overall plan? Do the faculty members?

After the Visit

- About 4 weeks after visit, written report sent to institution – response invited
- CLER site visit report goes to ACGME Evaluation Committee
- About 6 months after visit, final report to Sponsoring Institution and ACGME IRC
- Data from CLER visits become part of “institution’s portfolio” that the IRC will monitor over time
ACGME’s Next Steps

- Refine the CLER protocol
- Increase CLER site visit staff
- Align with CLER Evaluation Expectations
  - Due April 2013 for comment
  - Final Oct 2013
- Test new sub-protocols
  - Patient encounter
  - Contact with governance
  - Visits to multiple participating sites

The Future

- Phase 1 programs:
  - enter NAS & annual assessments 7/1/2013
  - milestones & categorized requirements are posted
  - first milestone assessments 12/2013 – 1/2014
- Phase 2 programs:
  - draft categorized requirements are posted
  - milestones to be posted summer 2013
  - enter NAS & annual assessments 7/1/2014
  - first milestone assessments 12/2014 - 1/2015
- Process for subspecialties (fellowships)
  - development starts fall 2013
- Self-study visits begin fall 2015

Thank you!

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Performance Benchmarks (Milestones) to Document Resident Competence in Orthopedic Surgery

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OBJECTIVES
At the conclusion of the program, participants should be able to:

1. Describe characteristics of the millennial learner and the relationship to the core competencies.

2. Describe signs of impairment from an entitlement mentality that can create problems for residents, faculty and patients.

3. Describe four strategies that program directors and faculty can use to help residents overcome the impaired judgment resulting from an entitlement mentality, including a strategy to deal with the splitting process.

4. Describe a Five-Stage Process to effectively give crucial instructive feedback and strategies for managing the resident's reactions at each step.

TOPICS
Do Generational Differences Really Make a Difference?
Establishing Academic Standards and Expectations for the Millennial Learner

Signs of Impairment Caused by an Entitlement Mentality:
How to Recognize Them and Use Them as Teachable Moments

Teaching Residents to Be Responsible, Self-Directed, Lifelong Learners:
How to Handle the Entitlement Mentality and Break the Spoon-Feed-Me Habit

Giving Crucial Instructive Feedback:
If the Interaction Went Smoothly, then It Did NOT Go Well!
Characteristics of the Millennial Learner

1. Prefers structured environment with clear expectations, goals and objectives

2. Seeks leadership and guidance from supervisors but expects that you draw out and respect their ideas

3. Enjoys working in teams and collaborating on projects

4. Has a positive, confident attitude and sense of self-assuredness

5. Possesses high electronic literacy with computers and other media which results in instant contact with others and a preference for networking

6. Wants a variety of tasks and challenges on a regular basis to avoid boredom

7. Engages in several activities at one time but also seeks flexibility to balance personal life with academic or work demands
INTEGRATING TEACHING & PATIENT CARE: 
GUIDELINES FOR ORIENTING YOUR LEARNERS

Franklin J. Medio, PhD
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Conducting an orientation at the start of a clinical rotation establishes your role as the TEAM LEADER. The orientation gives each member of your team a clear understanding of what you expect from him/her and what he/she can expect from you. This meeting is especially critical in our era of “duty hours” because it will avoid problems and make things run smoothly by explaining how the clinical service will function. To conduct a well-organized, effective orientation, the TEAM LEADER should:

1. PROMOTE A POSITIVE ATTITUDE AND PROPER MOTIVATION
Remind everyone that each rotation is part of their established curriculum. While learners may not find every rotation equally interesting and exciting, remind them that EACH ROTATION IS IMPORTANT. Emphasize that each learner must meet the requirements in order to successfully complete the rotation. Be sure to make everyone feel welcomed as integral members of the team.

2. DISCUSS OBJECTIVES, STANDARDS, AND EXPECTATIONS
Review the specific learning goals and objectives for each of the learners in the group as well as the standards for professional conduct. Explain the clinical duties and responsibilities to be assigned to each team member commensurate with his/her abilities. Review the didactic schedule (e.g., lectures, etc.) to be sure each team member knows his/her role in these sessions. Discuss the Seven Elements of Professionalism.

3. DESCRIBE PATIENT CARE ACTIVITIES
Delineate the daily schedule of clinical activities and assignments for each team member. Include a review of the format for case presentations and medical records (i.e., EMR). An outline of a model format for the case presentation would be useful. If applicable, discuss how to handle the handoffs of patients and patient information (e.g., post-call, end of day, etc.). Introduce other key personnel who are part of the team (e.g., nurses, pharmacists, physician assistants, technicians, clerical staff, etc.), and conduct a brief tour to familiarize everyone with the facility and/or equipment.

4. REVIEW EVALUATION AND DISCIPLINARY PROCEDURES
Review HOW, WHEN, and WHO will evaluate each team member and specifically remind residents of the 360° evaluations! Include a review of the forms and/or tests that will be used and the procedure for determining successful completion of the rotation. Take time to review the policies and procedures for excused absences, and for handling problems that may arise within the team.

5. EMPHASIZE ADULT LEARNING SKILLS
Discuss the importance of developing good professional work habits and self-directed learning skills. Review the Adult Learner Model and the adult learning skills that enable individuals to maximize learning and accomplish the required learning objectives. Emphasize examples of the active learner approach. Point out bad learning habits (e.g., being late, not following-up on patient care questions, not being prepared to perform or assist with procedures, being absent without prior approval, etc.) and negative attitudes that can create problems for everyone (i.e., patients, faculty, learners, staff).

6. GET TO KNOW YOUR TEAM MEMBERS
Take time to learn about each team member’s prior clinical rotations and their personal situations. Some learners have prior clinical experiences; entering healthcare as a second or third career. Ask each person what s/he wants to get out of the rotation (and getting out of the rotation is NOT an option!). Identify possible conflicts between clinical education requirements and personal life obligations (proactively). Develop patient cases and/or clinical scenarios based upon common problems to be seen during the rotation, to assess their knowledge and problem-solving skills. Review any procedures to be learned during the rotation and find out who has performed them. Create an email group for use with a “Clinical Case/Question of the Week” exercise.
The Five-Stage Process
for giving
Crucial Instructive Feedback
Franklin Medio, PhD
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If the interaction went smoothly, then it did NOT go well

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are concerned about some aspect of his/her performance. You want to help him/her.

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will happen if the mistake is NOT corrected.

Monitor your frustration level. It will rise if the person continues to deny the mistake or problem.
If you don’t seem to get through, restate Steps 1-2-3. If you fail to break through the denial, call a
“time-out” for a brief period, or stop and schedule another meeting.

Stage 2  ANGER/UPSET (Acknowledge the feeling not the comments)
When the denial wall (i.e., excuses) comes tumbling down, the person will likely become
angry or upset. These feelings are INNER-FOCUSED but OUTER-DIRECTED.

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1. Stay focused on the mistake or problem. Do not get distracted by the “lashing out”
   comments, insults or other statements---don’t “bite the bait.”
2. Allow the person to be angry or upset, but remind him/her the goal is to recognize
   and correct the mistake or problem.
3. Resist the tendency to feel that you have to justify your position or your actions
   repeat Steps 1-2-3 in Stage 1.
4. Watch the person’s reactions. Call a “time-out” if the person becomes too upset or
   appears threatening. Give the person time to regain composure or cool off.
5. If the person becomes unable to continue the conversation or you are feeling too
   frustrated, stop and set a date for a follow-up meeting. If necessary, consult a mental
   health specialist to determine if the person should undergo a more formal evaluation.

NOTE: With some individuals, you may not progress through Stage 1 or Stage 2!
Stage 3  **UNDERSTANDING** (Hear it directly from the learner)

The key to correcting the mistake or resolving the problem is getting the person to “own up” and take responsibility for his/her learning, behavior and actions!

*Strategy:*
1. Watch for verbal and nonverbal signs that the person understands the nature of the mistake/problem and the necessary corrective steps.
2. Ask the person to **TELL YOU IN HIS/HER OWN WORDS** what s/he did wrong, what s/he must do to correct it, and what will happen if s/he does or does not correct the mistake or problem (i.e., “I did X, I need to do Y to correct it, ...”).

**PLEASE DO NOT ASK:**

1. “Do you know what the mistake/problem is?”
2. “Do you know what you have to do to correct it?

*The person simply has to nod his/her head----which is basically meaningless!*

3. Take notes as the person states the problem, the corrective steps and the consequences. This will serve as a record of the interaction. Writing notes is also a useful technique to calm things down, if the interaction gets heated.

Be careful------when the person states what s/he did wrong, s/he may revert back to Stage 1 by denying the problem or minimizing its seriousness. If the person does this, **repeat Steps 1-2-3 from Stage 1** and reiterate that your goal is to HELP him/her correct the mistake or resolve the problem. If the person tries to negotiate different corrective steps, move into Stage 4.

Stage 4  **BARGAINING** (Know what is within your authority or control)

The goal is to correct the mistake or solve the problem, not to minimize it.

*Strategy:*
1. Remind the person (and yourself) that your goal is to help him/her correct the mistake or solve the problem.
2. Repeat the corrective action(s) described in Stage 1. Some individuals will try to negotiate different corrective steps or consequences.
3. Decide whether there is room for negotiation. If so, decide what YOU are willing to negotiate. Remember to negotiate only those changes within your authority.
4. Don’t hesitate to say, “Sorry, this is NOT NEGOTIABLE.”

**NOTE:** If you are unsure whether something is within your authority, be candid and say, “Let me check with ..... and I will get back to you.”

Stage 5  **ACCEPTANCE/AGREEMENT** (Make it written or oral)

The goal is to reaffirm the person’s responsibility to correct the mistake or problem and your willingness to help.

*Strategy:*
1. Restate the corrective steps to be taken and the consequences for achieving (or failing to achieve) them.
2. Conclude by emphasizing the importance of the meeting, recognizing the effort involved to reach this final stage, and providing encouraging comments.

**GENERAL GUIDELINE:** If repeated conversations occur or the “seriousness” of the problem increases, there should be a written record of the interactions (i.e., documentation). If the problem is not corrected, develop a formal remediation plan signed by both parties.
Guidelines for Giving

**INSTRUCTIVE FEEDBACK**

1. Base Your Comments on Direct Observation (as much as possible)
2. Give It Immediately After Performance
3. Choose an Appropriate Setting
4. Focus on Specific Behaviors, Skills or Words
5. Link to Stated Expectations, Goals and Objectives
6. Use *Specific, Descriptive Words* to:
   - Reinforce Problem-Solving Skills
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7. Provide *Specific Instructions* to:
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8. Limit the Amount of Information
9. Check for Comprehension and Understanding
Effective Mentoring Programs

Joseph B. Koch
Effective Mentoring and Mentorship Programs: Principles, Practices and Strategies for Success

Joseph B. Koch, Innovative Consulting & Mediation, LLC

OBJECTIVES

At the conclusion of the program, participants should be able to:

1) Understand the traditional meanings associated with “mentoring” --- what it is, what it is not, and how mentoring differs from the traditional Supervisor--Resident relationship.

2) Initiate thought and discussion on what ingredients might be critical to designing and implementing a successful mentorship program, and attributes associated with successful mentors and mentorship programs.

3) Identify and discuss the three R’s: Recruitment, Readiness, and Remediation, and their relevance to effective mentoring of residents throughout their training. Review these in terms of strategies which might be appropriate and achievable for implementation in a particular residency program.

4) Utilize the information of at least one residency program’s experience in establishing a mentorship program, as a basis for deciding if and how to develop one at their own institution.
Dealing with the Entitlement Mentality

Franklin Medio, PhD; Wade Faerber, DO, FAOAO
Entitlement Mentality

Signs of Impairment

Franklin Medio, PhD

1. “I want a structured educational environment, as long as I structure it.”
   
   I want (or to do) X…therefore I get (or to do) X…
   I do not want (or to do) Y…therefore I don’t get (or have to do) Y…
   If you do not concede to my request, I will:
   • Plead my case, kill you with kindness, or badger you until you relent
   • Get upset or cry to create an uncomfortable situation for you
   • Become demanding or aggressive until you back down
   • Call you names to embarrass you into granting my request

2. “I have the right & authority to make decisions about my educational environment.”
   • curriculum content, expectations, and learning goals and objectives
   • patient care duties and assignments
   • standards of personal and professional conduct
   • criteria and/or methods to evaluate my performance
   • recourse when I disagree with a judgment my performance or a decision affecting me

3. “I think teams are great because if I don’t want to do something, I will:”
   • Let someone else pick up the slack—lacks sense of obligation or commitment to others
   • Find someone to cover-up for me—uses splitting to achieve self-interests
   • Wait till the last minute and begs off—catches others off-guard or asks for forgiveness

4. “I am excellent and have a strong sense of self-confidence.”
   • Has not developed skills to handle mistakes or failures—strong denial mechanisms
   • Does not worry about mistakes or failures—they are attributed to external forces
   • Develops an exaggerated sense of skills, abilities and competence
   • Does not fear dismissal (i.e., failing out) due to unsatisfactory academic performance
   • May develop the Kevlar Syndrome (i.e., I’m untouchable) to deal with serious infractions

5. “I don’t have to recognize these arbitrary standards or boundaries.”
   • Expects instant responses to any and all communication
   • Fails to differentiate between personal and professional communication in a wide variety of situations (i.e., “I do this in my personal life, so what is the problem now?”)
   • Justifies disrespectful or rude behavior by claiming to be multi-tasking
   • Has difficulty putting the concepts of privacy and confidentiality into practice

6. “I will fit my clinical practice into my personal life and not the other way around.”
   • Decides to give priority to personal interests or non-emergent personal events over patient care duties and responsibilities and feels an explanation justifies the decision
   • Makes last-minute requests—asking others to cover professional obligations
   • Does not demonstrate altruistic behavior toward patients or colleagues
Four Strategies to Overcome Entitlement Mentality Impairment
Franklin Medio, PhD
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1. Communicate explicitly the institutional, programmatic, and personal expectations and standards to spell out what is acceptable and unacceptable.
   a) Learn to just say NO to a learner’s request in a firm, polite voice
   b) Be comfortable denying a request; be sure to add a one or two sentence explanation
   c) Be careful not to get into a debate or prolonged discussion defending your decision

2. Develop and implement, consistently, institutional and departmental rules, policies, procedures and requirements for GME that:
   a) describe the Core Competencies and related concepts (e.g., professional conduct, confidentiality, responsibility, integrity, etc.) in concrete terms, with specific examples of what is appropriate/inappropriate or acceptable/unacceptable.
   b) explain the accreditation requirements, academic standards, educational expectations and activities, evaluation methods and processes, etc.
   c) designate who is responsible for implementing and enforcing each policy and procedure as well as who has the authority to make changes or grant exemptions.
   Be sure to include the specific consequences for failure to follow (by omission or commission) a rule, policy, procedure or requirement!

3. Have a clear process for granting exemptions from established rules, policies, procedures and requirements. Before granting one, answer these five questions:
   1. Who is authorized to grant this exemption?
   2. What is the unusual circumstance for granting this exemption?
   3. What is the lesson for the learner who is getting the exemption?
   4. What is the lesson for all the other learners?
   5. What is the impact on the specific rule, policy, procedure, or requirement?

   Avoid problems created by the Splitting Process
   • Designate the individual(s) who has (have) the authority to make a change or grant an exemption to an established policy or procedure (see #2c)
   • Do not accept information second or third-hand, require verification
   • Speak directly with the designated individual regarding the decision to make a change

4. Use the Five-Stage Instructive Feedback Process
   a) Conduct the interaction in a private setting; managing it to ensure a positive, interaction to teach learners to acknowledge and deal with mistakes and failures
   b) Provide support, guidance, and specific instructions to help the learner correct mistakes, solve problems and/or change behaviors
   c) State clearly the consequences if the mistake, problem or behavior occurs again
   d) Be sure to have the learner tell you in his/her own words----using “I” statements: 1) the mistake/problem; 2) what s/he must do to correct it; and 3) what the consequences will be if the mistake/problem is corrected and if it occurs again.
Conducting an orientation at the start of a clinical rotation establishes your role as the TEAM LEADER. The orientation gives each member of your team a clear understanding of what you expect from him/her and what he/she can expect from you. This meeting is especially critical in our era of “duty hours” because it will avoid problems and make things run smoothly by explaining how the clinical service will function. To conduct a well-organized, effective orientation, the TEAM LEADER should:

1. **PROMOTE A POSITIVE ATTITUDE AND PROPER MOTIVATION**
   Remind everyone that each rotation is part of their established curriculum. While learners may not find every rotation equally interesting and exciting, remind them that EACH ROTATION IS IMPORTANT. Emphasize that each learner must meet the requirements in order to successfully complete the rotation. Be sure to make everyone feel welcomed as integral members of the team.

2. **DISCUSS OBJECTIVES, STANDARDS, AND EXPECTATIONS**
   Review the specific learning goals and objectives for each of the learners in the group as well as the standards for professional conduct. Explain the clinical duties and responsibilities to be assigned to each team member commensurate with his/her abilities. Review the didactic schedule (e.g., lectures, etc.) to be sure each team member knows his/her role in these sessions. Discuss the Seven Elements of Professionalism.

3. **DESCRIBE PATIENT CARE ACTIVITIES**
   Delineate the daily schedule of clinical activities and assignments for each team member. Include a review of the format for case presentations and medical records (i.e., EMR). An outline of a model format for the case presentation would be useful. If applicable, discuss how to handle the handoffs of patients and patient information (e.g., post-call, end of day, etc.). Introduce other key personnel who are part of the team (e.g., nurses, pharmacists, physician assistants, technicians, clerical staff, etc.), and conduct a brief tour to familiarize everyone with the facility and/or equipment.

4. **REVIEW EVALUATION AND DISCIPLINARY PROCEDURES**
   Review HOW, WHEN, and WHO will evaluate each team member and specifically remind residents of the 360° evaluations! Include a review of the forms and/or tests that will be used and the procedure for determining successful completion of the rotation. Take time to review the policies and procedures for excused absences, and for handling problems that may arise within the team.

5. **EMPHASIZE ADULT LEARNING SKILLS**
   Discuss the importance of developing good professional work habits and self-directed learning skills. Review the Adult Learner Model and the adult learning skills that enable individuals to maximize learning and accomplish the required learning objectives. Emphasize examples of the active learner approach. Point out bad learning habits (e.g., being late, not following-up on patient care questions, not being prepared to perform or assist with procedures, being absent without prior approval, etc.) and negative attitudes that can create problems for everyone (i.e., patients, faculty, learners, staff).

6. **GET TO KNOW YOUR TEAM MEMBERS**
   Take time to learn about each team member’s prior clinical rotations and their personal situations. Some learners have prior clinical experiences; entering healthcare as a second or third career. Ask each person what s/he wants to get out of the rotation (and getting out of the rotation is NOT an option!). Identify possible conflicts between clinical education requirements and personal life obligations (proactively). Develop patient cases and/or clinical scenarios based upon common problems to be seen during the rotation, to assess their knowledge and problem-solving skills. Review any procedures to be learned during the rotation and find out who has performed them. Create an email group for use with a “Clinical Case/Question of the Week” exercise.
The Five-Stage Process
for giving
Crucial Instructive Feedback
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SAVE THE DATES
for AOAO’s upcoming meetings!

2013 Annual Meeting
October 17-19, 2013
Sheraton San Diego Hotel and Marina • San Diego, CA

54th Postgraduate Seminar
May 2-4, 2014
Omni Dallas Hotel • Dallas, TX

2014 Annual Meeting
October 23-26, 2014
Terranea Oceanfront Resort • Rancho Palos Verdes, CA