



American Board  
of Internal Medicine

---

# Teaching and Assessing PBL&I and SBP “On the Fly”

Wisconsin Hospital Visit

July 2009

# Objectives

- Demonstrate how to embed the teaching and assessment of PBLI and SBP into daily activity
  - “Simple tools”
  - Benefits for both patients and trainees

# Assessment: A Definition

- *A process with a specific purpose that uses methods or tools that leads to a meaningful and interpretable result and when required, judgment. The foundation for sound assessment should be laid out from the beginning to best serve the assessment purpose.*

*(Williamson et al, 2004)*

# Observation: Faculty's Most Potent Process

- Almost all evaluation tools used by faculty start with the premise they have actually observed the competency of interest:
  - Monthly evaluation forms
  - MiniCEX
  - Procedure checklist
  - Others

# Observation: The Reality

- Observation of core clinical and communication skills rarely performed
- Poor reliability and accuracy among faculty when skills are observed
  - Lack of shared mental models
    - Specific criteria and frameworks
    - Discrimination of levels of performance

# Mnemonic for SBP

- **T**eamwork
- **A**dvocacy
- **C**oordination
- **T**echnology use in practice
- **I**mprovement tools/skills
- **C**ost
- **S**afety

*Mark, Gruppen, Simpson, AAMC 2003*

# Working in Teams

- Multi-disciplinary
  - Each discipline contributes its particular expertise independently to an individual patient's care
  - Physician responsible for determining contribution of other disciplines and coordination of services
  - Parallel structure

*Hall and Weaver, 2001*

# Working in Teams

- Inter-disciplinary
  - Team members work closely together and communicate frequently to optimize patient care
  - Team organized around solving common set of problems
  - Frequent consultation
  - Matrix structure

*Hall and Weaver, 2001*



# Interdisciplinary Education

## Important principles:

- Idea dominance
  - Clear and recognizable idea must serve as focus for teamwork
  - Patient center of that focus
  - Team must also be able to recognize success and achievements

*Petrie, 1976*



American Board  
of Internal Medicine

1.800.441.ABIM | [www.abim.org](http://www.abim.org)

# Interdisciplinary Education

- Professional role versus role blurring
  - Most of us learn our roles through process of professional socialization within our discipline
    - Petrie’s individual “cognitive map”
    - Preconceived “maps” of roles based on learned culture, beliefs, and cognitive approaches learned in discipline

*Hall and Weaver, 2001*

# Teamwork Competencies

- Baker (AHRQ, 2005)
  - Systematic review of literature on teamwork competencies
    - Most evidence from other fields
      - Crew resource management (aviation)
  - Surprisingly little information from medicine

# Teamwork Competencies

- Team leadership
- Mutual performance monitoring
- Back-up behavior
- Adaptability
- Team/Collective orientation
- Shared mental models
- Mutual trust
- Closed-loop communication

# Mutual Performance Monitoring

- Ability to ...apply appropriate task strategies in order to accurately monitor teammate performance
  - Identifying mistakes and lapses in other team member actions
  - Providing feedback regarding team member actions in order to facilitate self-correction

# Back-up Behavior

- Ability to anticipate other team member's needs to shift workload among members to achieve balance during high periods of workload
  - Recognition by potential back-up providers there is a workload distribution problem
  - Shifting of work responsibilities to under-utilized team members

# Closed-loop Communication

- The exchange of information between a sender and a receiver irrespective of the medium
  - Following up with the team members to ensure message was received
  - Acknowledging that a message was received
  - Clarifying with the sender of the message that the message received is the same as the intended message sent.

# Small Group Exercise

- Using the AHRQ teamwork competencies, create a BARS evaluation form a member of an interdisciplinary team could use to evaluate a resident on “teamwork”
  - Create anchors for unsatisfactory, satisfactory, and superior performance
  - Which members of the team would be able to rate the resident on each specific domain?



# Care Coordination

- Major problem in U.S. Healthcare system
- Transitions of care often high risk and require substantial coordination
- Trainees often have major responsibilities in care transitions:
  - Intra-hospital transfers
  - Hospital discharge

# Discharge: Opportunity for Teaching and Assessment

- Direct Observation:
  - Watch a trainee perform a discharge counseling and planning session with patient and/or family
    - Document via miniCEX or simply provide text on monthly evaluation form
  - Areas of assessment:
    - Quality and completeness of counseling and information
    - Clear follow-up plans
    - Appropriate feed forward of information

# CTM Tool: Patients and Discharge

- Care Transition Measure
  - Developed and validated by Eric Coleman and colleagues at University of Colorado
  - Two versions: CTM-3 and CTM-15
    - 4 point scale (strongly agree – strongly disagree)
  - Only care coordination measure currently endorsed by the National Quality Forum (NQF)

# CTM as MSF: Patients and Discharge

- Care Transition Measure (CTM-3)
  - *The hospital staff took my preferences and those of my family or caregiver into account in deciding **what** my health care needs would be when I left the hospital*
  - *When I left the hospital, I had a good understanding of the things I was responsible for in managing my health*
  - *When I left the hospital, I clearly understood the purpose for taking each of my medications*



# Small Group Exercise

*How could you potentially use the CTM-3 tool in your residency program?*

# System Performance and Coordination

- Output of a system dependent on the quality of the *interactions* between the parts.
- Interactions are “white space”:
  - Space not owned or claimed by anyone or any party
  - Often ignored or unnoticed

# System Performance and Coordination

- White space creates gaps
  - Errors in care
  - Transitions and coordination are often the white spaces in healthcare
  - Hand-offs example of white space
- Hand-off?
  - How to coordinate a continuing role and responsibility between parties?
    - Ward team and the night float

# Transitions in Hospital: System Problems

- No standardization of process
  - Significant heterogeneity, even within *same* institution
- Hand-offs often associated with high tension levels
- Frequent interruptions and distractions
  - Lack of recognition or acknowledgement of how this affects others

*Solet, Acad Med, 2005; Volpe, NEJM, 2003*



# Key Lessons to Improve Hand-offs

- Face-to-face verbal update(s) with interactive questions
  - Needs to be an *active* process
- Present data in same sequence every time
  - Standardization reduces error
- Limited interruptions and distractions
  - “Protected” space
- Read back techniques
- Explicit acknowledgement of responsibility

# Management of Transitions: Principles

- Joint accountability
- Avoidance of mitigated communication
- Timely feed-forward and feedback of information
- Involvement of patient and/or family member
- Respect hub of coordination of care
  - Especially important in outpatient setting

*Kilo, SUTTP, ABIMF, 2007*

# Small Group Exercise

- Discuss how you could evaluate the various “handoffs” that occur between residents, and between residents and other members of the microsystem

# Hand-off Models

- SBAR (from Military):
  - Situation, Background, Assessment, Recommendation
- ANTICipate:
  - **A**dministrative data (eg, patient's name, medical record number, and location) must be accurate.
  - **N**ew clinical information must be updated.
  - **T**asks to be performed by the covering provider must be clearly explained.
  - **I**llness severity must be communicated.
  - **C**ontingency plans for changes in clinical status must be outlined, to assist cross-coverage in managing the patient overnight.



# Patient Safety

- Number of safety measures that can be built into daily teaching and care:
  - Medication reconciliation
    - Was this done at admission and at discharge?
  - Fall risk assessment
    - Did the resident assess or at least discuss with ward staff?
    - How does the resident use the safety assessment performed by nursing?
  - Urinary catheters
    - Length of insertion

# Small Group Exercise

- What systems-based practice knowledge and skills do residents need for:
  - Effective medication reconciliation
  - Fall risk reduction
  - High risk care interventions:
    - Urinary catheters
    - Central venous and arterial lines

# Questions