Point-of-Care Feedback: Preceptor Cosigning Workflow Promotes Milestone Assessment

Setting and Problem

In residency training, the Accreditation Council for Graduate Medical Education stipulates feedback from faculty should be frequent, exist in the context of routine clinical care, include multiple evaluators, emphasize competency and milestones, and be in writing so it can be shared with the Clinical Competency Committee.

Collecting frequent feedback in the context of ambulatory care is an ambitious ask. Supervision of residents in clinic can be busy, if not chaotic. Assessment surveys can be quick, and they can be web-based or smartphone application-based. Still, collection rates can be lower than is needed. Faculty reminders by email, signs in the supervision area, available program links on workplace computers, and prompts submitted by residents to supervising faculty have all been used to increase assessment completion by faculty.[1]

Oregon Health & Science University's Internal Medicine Clinic is the resident continuity clinic for 44 trainees, supervised by more than 30 part-time faculty preceptors. We tested a method to increase case-specific direct observation feedback by preceptors.

We looked to thought leaders in informatics for help in our tool design. The most frequently used clinical decision support tools are directly integrated with electronic medical record (EMR) systems. To design effective point-of-care support tools, our experts stick with these informatics rules of thumb: "Speed is everything," "Deliver in real-time," and "Fit into the user's workflow."[2]

Intervention

We designed a web-based rapid assessment tool. The evaluator selects content areas or processes to score and enters a narrative comment. Our innovation was to deliver this tool directly within the preceptor workflow: we embedded a link in the cosigning (preceptor attestation) template. The location of the survey link was a game changer for our collection rate.

Embedding the link into the cosigning template took some care. So that our survey hyperlink would never become part of the patient chart, we needed disappearing instructional text with automated removal from the chart when the preceptor note was signed. Many EMRs enable "prompts" in templates or text blocks. Our university utilizes EpicCare, and we were able to achieve disappearing text using the function "blank, optional SmartList." Our function displays as a single line of text at the bottom of the preceptor note in progress, with blue font that is recognized by the clinician as disappearing text. The text contains a hyperlink to our rapid assessment.

Within the attestation workflow, a preceptor has a visual reminder to provide the assessment and has the option to enter the assessment survey with a single click. The survey results can be collected at any interval by the clinic medical director, who has access to survey reports.

Outcomes to Date

Links to our rapid assessment tool were provided in several lower yield environments before we identified a way to embed a link into the cosigning workflow (FIGURE). Embedding the link within the existing preceptor workflow of chart attestation resulted in an immediate, meaningful, and sustained increase in the number of submitted assessments.

The feedback entered is exceptionally relevant—it is specific and contains colorful clinical performance anecdotes that inform resident competencies. This process has been popular with residents and faculty, and it has markedly enriched our resident feedback process.

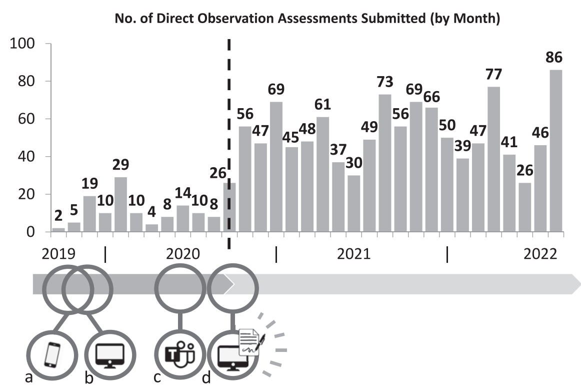

FIGURE
Direct Observation Assessments Submitted

Note: From 2019 through 2020, preceptors were instructed to access the evaluation through a smartphone app (a) or a link on their computer dashboard (b). A direct link from shared Microsoft Teams software (c) was added mid-2020. At the end of 2020, a URL link was embedded within the preceptor cosign-charts workflow (d). This last change resulted in an immediate, significant, and sustained increase in the number of submitted evaluations.

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NEW IDEAS

Establishment of a Fellowship in Street Medicine

Setting and Problem

The American Medical Association recognizes street homelessness as a significant barrier to the provision of high-quality care.[1] Traditional medical training provides inadequate preparation for physicians to manage persons experiencing unsheltered homelessness (PEUH). Street medicine is the direct provision of health care and social support to PEUH,[2] who experience high barriers to needed care and tend to use acute hospital-based care at high rates.[3]

We established a street medicine fellowship to enable physicians to acquire the requisite clinical and organizational skills to become leaders in improving outcomes in this vulnerable population.

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Intervention

The UPMC Mercy Street Medicine Fellowship is the first of its kind. This one-year, one fellow per year program was initiated in 2019 by UPMC Mercy, Pennsylvania. The fellowship accepts applications from physicians who have completed a residency in internal medicine, family medicine, emergency medicine, or psychiatry, and who seek to develop expertise in caring for PEUH while also participating in multidisciplinary care to enable them to serve as future leaders in this field. At the end of the fellowship training a survey is sent to learners.

Fellows are instructed in comprehensive management of PEUH. The program uses the "go-to people" approach to health care as promoted by the Street Medicine Institute. Fellows are challenged to set aside the mindset of the "office approach," which often does not embrace unique social determinants of health, and round 3 to 4 times per week on the streets, on the riverbanks, and in homeless encampments, including general rounds, targeted case management rounds, and specialty rounds (eg, psychiatric, harm reduction, intimate partner violence, etc). They participate in additional outpatient clinics, 3 half days per week, which have been established for PEUH and for those who have transitioned from street homelessness into housing. Fellows maintain this continuity group of patients throughout the fellowship year. Home visits are also conducted for newly placed patients.

Fellows apply the concept of "community united" so that changes initiated in one community are spread to others. They utilize multidisciplinary mentors and engage in productive communication with experts in street medicine. They conduct a formal comparative analysis of 2 communities in which street medicine is practiced to further develop insight into improvement opportunities as well as attend the annual International Street Medicine Symposium as a learning activity and for academic presentation as applicable.

Outcomes to Date

Fellows are assessed monthly according to the Accreditation Council for Graduate Medical Education's Core Competencies. Fellows also complete a monthly evaluation of their assigned experience. Lastly, fellows are surveyed at the completion of the year (FIGURE).

Our first fellow now carries a university faculty position in another city. She teaches in the outpatient setting and has integrated clinical street work with community initiatives, a street medicine interest group, and a peer outreach group. Our second fellow is practicing emergency medicine in another city and incorporating her skills to improve care in that setting for PEUH.