

UC Irvine

Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health

Title

Faculty Evaluations: Using MyEvaluations to Increase Response Rates

Permalink

<https://escholarship.org/uc/item/2rd739r4>

Journal

Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health, 17(4.1)

ISSN

1936-900X

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Publication Date

2016

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Results: 18 of 24 core faculty (75%) and 23 of 26 (88%) residents completed the survey. Residents rated their initial competence higher in every category than did the faculty (mean difference 20.9%, 95% CI 4.6-43.3%). The greatest discrepancy was for Observation and Reassessment (PC6) with 90.5% of residents rating themselves competent compared to faculty estimating that only 47.2% are competent at the start of internship. (P<0.0001). The most concordant results occurred for milestones where both faculty and residents gave lower overall ratings (PC3, PC5, PC9, PC11, PC12, PC14), which included predominantly procedural and pharmacology-based milestones.

Conclusions: EM Residents rate high self-perceived mastery of level 1 EM milestones at the start of residency, and significant discrepancies were identified between residents and faculty in perceived milestone competency. These discrepancies in perceived mastery are likely multifactorial, but may guide future development of educational interventions for incoming EM residents.

31 Faculty and Resident Perception of Mastery of Level One Emergency Medicine Milestones

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Background: Residency programs are in an era of accreditation that pressures them to evaluate their curricula and faculty with metrics that demonstrate their effectiveness. This demand can overwhelm residents with surveys, forms, and checklists, and the validity of such evaluations should be suspect, given the high volumes that are being requested. While the reliability of performance evaluation reports has been studied in the literature, the effect of when and how these evaluations are administered on the quality of data gathered is not well understood.

Objectives: The aim of this study was to evaluate

Table 1. Intern competency in level 1 milestones as assessed by faculty and residents.

Milestone	Level 1 Description	Faculty Mean	Resident Mean	Mean Difference (95% CI)	P-value
PC1 Emergency Stabilization	Recognizes abnormal vital signs.	73.6	95.2	21.7 (7.1-36.3)	0.0048
PC2 Focused H&P	Performs a reliable, comprehensive history and physical exam.	56.9	90.5	33.6 (15.8-51.4)	0.0005
	Communicates a reliable, comprehensive history and physical exam	50.4	85.7	35.3 (14.0-56.5)	0.0018
PC3 Diagnostic Studies	Determines the necessity of diagnostic studies.	43.4	52.4	8.9 (-19.4 – 37.3)	0.5256
PC4 Diagnosis	Constructs a list of potential diagnoses based on chief complaint and initial assessment.	52.2	85.7	33.5 (13.1-53.8)	0.002
PC5 Pharmacotherapy	Knows the different classifications of pharmacologic agents and their mechanism of action.	46	52.4	6.4 (-21-34.4)	0.647
	Consistently asks patient for drug allergies.	47.7	57.1	9.5 (-18.6-37.6)	0.4985
PC6 Observation and Reassessment	Recognizes the need for patient re-evaluation.	47.2	90.5	43.3 (24.8-61.8)	0.0001
PC7 Disposition	Describes basic resources available for care of the emergency department patient.	55.1	66.7	11.6 (-15.0-38.2)	0.3821
PC8 Task-switching	Manages a single patient amidst distractions	65.8	85.7	19.9 (-1.7-41.5)	0.0703
PC9 General Approach to Procedures	Identifies pertinent anatomy and physiology for a specific procedure	60.9	66.7	5.8 (-19.9-31.5)	0.6517
	Uses appropriate Universal Precautions.	66.3	85.7	19.4 (-3.2-42.0)	0.0906
PC10 Airway Management	Describes upper airway anatomy	56.9	81	24.1 (1.0-47.1)	0.0414
	Performs basic airway maneuvers or adjuncts (jaw thrust/chin lift, oral airway/nasopharyngeal airway) and ventilates/oxygenates patient using BVM.	58.3	90.5	32.2 (12.2-52.2)	0.0024
PC11 Anesthesia, Pain Management	Discusses with the patient indications, contraindications and possible complications of local anesthesia.	43.3	52.4	9.1 (-18.2-36.4)	0.5031
	Performs local anesthesia using appropriate doses of local anesthetic and appropriate technique to provide skin to sub-dermal anesthesia for procedures.	56.9	81	24.1 (0.2-48.0)	0.0482
PC12 Ultrasound	Describes the indications for emergency ultrasound.	52.5	57.1	4.6 (-21.8-31.1)	0.724
PC13 Wound Management	Prepares a simple wound for suturing (identifying appropriate sutures material, anesthetizing wound and irrigate)	65.1	90.5	25.4 (5.9-44.9)	0.0122
	Demonstrates sterile technique.	66.2	90.5	24.3 (4.9-43.8)	0.0157
	Places simple interrupted suture.	74.1	95.2	21.1 (6.2-36.1)	0.0069
PC14 Vascular Access	Performs a venipuncture.	43.9	61.9	18.0 (-9.2-45.2)	0.1874
	Places a peripheral intravenous line.	33.5	61.9	28.4 (1.6-55.2)	0.0386
	Performs an arterial puncture.	35.4	47.6	12.2 (-15.0-39.4)	0.3682
SBP1 Patient Safety	Adheres to standards for maintenance of safe working environment.	64.1	90.5	26.4 (5.7-47.1)	0.0139
	Describes medical errors and adverse events.	52.8	80	27.2 (3.5-51.0)	0.0258
SBP2 Systems-based Management	Describes members of ED team (nurses, technicians, security)	70.8	81	10.1 (-13.1-33.4)	0.3833
SBP3 Technology	Uses the Electronic Health Record (EHR) to order tests, medications and document notes and responds to alerts.	68.1	85.7	17.6 (-3.8-39.0)	0.1033
	Reviews medication for patients.	41.7	66.7	24.9 (-1.2-51.1)	0.0607
PBL1 Practice-based Performance Improvement	Describes basic principles of evidence-based medicine	51.8	71.4	19.7 (-5.6-44.9)	0.1238
PROF1 Professional Values	Demonstrates behavior that conveys caring, honesty, genuine interest and tolerance when interacting with a diverse population of patients and families.	74.4	100	25.6 (14.6-36.7)	0.0001
PROF2 Accountability	Demonstrates basic professional responsibilities such as timely reporting for duty, appropriate dress/grooming, rested and ready to work, delivery of patient care as a functional physician.	83.1	95.2	12.2 (-0.5-24.8)	0.0584
	Maintains patient confidentiality.	84.1	100	15.9 (10.0-21.9)	0.0001
	Uses social media ethically and responsibly.	77.1	100	22.9 (15.7-30.0)	0.0001
ICS1 Patient Centered Communication	Establishes rapport with and demonstrates empathy toward patients and their families.	74.3	100	25.7 (19.6-31.8)	0.0001
	Listens effectively to patients and their families.	67.2	95.2	32.8 (25.3-40.3)	0.0001
ICS2 Team Management	Participates as a member of the patient care team.	77.8	95.2	17.5 (4.0-30.9)	0.0125

the timeliness of completion and variation of response by residents being asked to provide mid-year evaluations for EM faculty members.

Methods: 33 EM residents were randomized into 2 groups and asked to complete voluntary anonymous evaluations that assessed faculty members' interpersonal and communication skills, medical knowledge, practice based learning, and systems based practice on a scale from 1(unsatisfactory) to 5 (Superior). Group A received all 27 faculty evaluations at one time while Group B received 5 faculty evaluations each week on the day of conference for a period of 6 weeks.

Results: The response rate for the Group A was 19.7% and 47.8% for Group B at 90 days with an overall response rate at only 33% for all faculty evaluations. The time to completion at the 90 day mark was 34.6 days for Group A and 19.6 days for Group B. The overall faculty evaluation mean score was 4.5 (Excellent {4}/Superior {5}) with 4.6 for Group A and 4.4 for the Group B.

Conclusions: Understanding the effect of the timing of requests for evaluation may allow programs to increase the number and quality of faculty evaluations.

Our findings suggest that it is beneficial to offer fewer surveys over a longer period of time to increase voluntary response rates. Trends of greater score variation were noted in Group B, but none with statistical significance.

This study has provided evidence that decreasing the number of evaluations requested at one time is will likely improve response rates and decrease form fatigue. Further investigation into the timing of requests is warranted, including number of requests, deadline for completion and length of individual evaluations.

Figure 1.

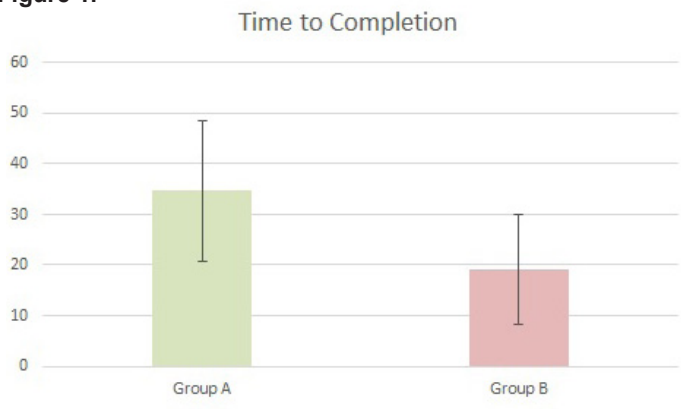
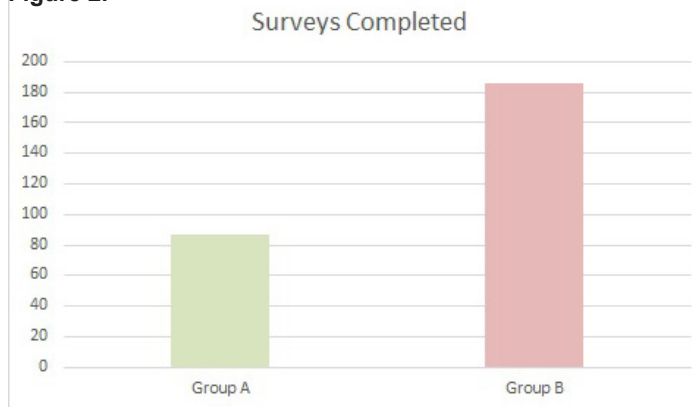


Figure 2.



32 Going with the ED Flow: Teaching and Learning Rapid Task Prioritization

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Background: Rapid task prioritization is a critical skill in the emergency department. Regularly, emergency physicians are asked to concurrently manage multiple patients at once at any given point in their shifts, and often have to make time-sensitive decisions around the priorities across multiple patients. The art and science of teaching the critical skill of task prioritization is not well described in the literature.

Objectives: In this study we sought to identify the strategies used and barriers faced by faculty members when teaching of task prioritization in the Emergency Department.

Methods: DESIGN - We conducted a qualitative study with semi-structured, critical incident interviews aimed at better what teaching and learning strategies that are employed by faculty and residents to facilitate the acquisition of emergency department (ED) management and prioritization skills. SETTING - We conducted this study at multiple teaching hospitals associated with a major Canadian academic institution. PARTICIPANTS - Both experienced physicians (nominated via a peer-nomination technique) and junior residents (postgraduate year 1 or 2) were interviewed in an effort to triangulate the experiences around teaching and learning the skill of task prioritization.

Results: Twenty physicians (10 faculty members, 10 junior residents) participated in this study. There were three main themes that emerged from our interviews in our participant's descriptions of how they taught or learned the skill of task prioritization: 1) Formal didactic teaching; 2) Observation; 3) In Situ instruction (i.e. on-the-job teaching, informal coaching in the ED). Only one teaching strategy was named by a single participant (i.e. formal teaching around the Canadian Triage Acuity Score). The bulk of teaching and learning strategies were more akin to coaching. They tended to be found within the In Situ category (Collaborative Problem Solving; Information Conversation with Staff [i.e. Think Aloud, "running the board", walk-around rounds]). A