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

Title

Inter-Rater Reliability of Select Emergency Medicine Milestones in Simulation

Permalink

<https://escholarship.org/uc/item/6bm7d9g8>

Journal

Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health, 18(5.1)

ISSN

1936-900X

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Publication Date

2017

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Otorhinolaryngology (ENT), Pediatrics, Psychiatry, Toxicology, Trauma, Urgent Care/Fast Track, and Research.

Impact/Effectiveness: Based on the feedback from our alumni and current residents, the PEC has made adjustments to our curriculum including the elimination of our inpatient medicine rotation, the inclusion of ENT and Orthopedic morning report didactic sessions, and evidence-based medicine lectures. We will continue this work longitudinally to ensure that our curricular changes make a difference in our graduates' assessment of their preparedness. We will continue to dynamically adapt our curriculum based on current resident and alumni feedback in an attempt to meet their needs in their future Emergency Medicine careers.

55 We are Being Interviewed too: Faculty Development on How to Find and Attract The Best Resident for Your Program

Choudhri T, Roche C /The George Washington University, Washington DC

Background: With the field of Emergency Medicine growing increasingly more competitive and the numbers of applicants on the rise, our recruitment efforts need to be tailored specifically toward those students who we feel will be a good 'fit' for our programs. As we attempt to find that ideal candidate, the candidates themselves are looking for the program that passes the 'gut' check. Whereas interviews have traditionally been viewed as where applicants need to impress, changing the rhetoric to understand that the applicants are interviewing us as well is important to recruiting those best suited for our individualized programs. We found that the style and approach our faculty had toward interviewing varied greatly among the various members of our department, thus sending differing messages among applicants. Educating faculty and designing a structured and polished interview process for your faculty to follow is integral in creating a marketable interview day.

Educational Objectives: 1. Conduct a survey of the faculty and the residents to determine the key tenants and mission of our program that makes our program unique 2. Design an interview day that highlights those ideals of our individual program 3. Conduct a formal faculty development session to educate the faculty on the residency program and the interview process 4. Conduct repeat informal faculty development sessions throughout the interview season to ensure quality and standardization of the interview process.

Curricular Design: Months prior to the start of interview season, residency leadership conducted a survey of faculty and residents to determine what our department held as the important ideals and tenants of our program; namely, what makes our program unique. Utilizing that information, residency leadership designed an interview day that

highlighted those key components and created documents to assist faculty in the interview process. Understanding that not all members of the faculty are abreast of the day-to-day operations and details of the program, a series of information sheets and FAQs were created in order to assist faculty with their interviews. A formal faculty development session was held to educate the faculty and give tips on how to interview, what types of applicants to look for, and how to answer questions. Finally, throughout the interview season informal education was given through both written and verbal modalities to keep all faculty up-to-date and sharp with their interview skills.

Impact/Effectiveness: After this new interview process was implemented, faculty were polled to ascertain the effectiveness of this process. Qualitatively, faculty were satisfied with the additional development sessions and felt more prepared for their interviews. Residency leadership also noted a distinct change in the faculty's ability to critically assess an applicant. Each of our programs are unique in their own right, and tailoring a day to highlight those individualized aims helps us attract residents who will be the most successful in our programs. Understanding that the interview day is just as important for the department as it is for the applicant, guides us to identify those residents who are the best fit for our program, and in turn which programs are the best fit for them.

Best of the Best Oral Presentations

1 Inter-Rater Reliability of Select Emergency Medicine Milestones in Simulation

Wittels K, Abboud M, Chang Y, Sheng A, Takayesu J/ Brigham and Women's Hospital/Massachusetts General Hospital, Boston, MA

Background: In 2012, the ACGME established the Milestones in emergency medicine (EM) training to provide competency-based benchmarks for residency training. Small observational studies have shown variable correlation between faculty assessment and resident self-assessment.

Objectives: Using a simulation clinical scenario, we sought to determine (1) the correlation between resident self-assessment and faculty assessment of clinical competency using selected Milestones; and (2) the inter-rater reliability between EM faculty using both Milestone scoring and a critical actions checklist.

Methods: This is an observational study in which second-year EM residents at an urban academic medical center were assessed with two simulation cases focusing on management of cardiogenic shock and sepsis. Twenty-three residents completed both cases; they were assessed by two EM faculty in eight select Milestones (scored 1-5, increments of 0.5) and with a checklist of critical actions to

perform (scored 0 or 1). Intra-class correlation coefficients (ICC) were used to compare Milestone scoring between faculty and to assess correlation between resident self-assessment and faculty scoring. Faculty checklist inter-observer agreement was assessed using kappa statistics. Correlation between Milestone achievement and checklist performance were assessed using Spearman and Pearson correlation coefficients.

Results: The ICCs for inter-rater agreement between faculty for Milestone level were 0.12 and 0.15 for the cardiogenic shock and sepsis cases, respectively. The ICC comparing resident self-assessment with the average of faculty Milestone level scoring for each case was 0.00. The inter-rater agreement on checklist items for the cardiogenic shock and sepsis cases had kappa coefficients of 0.83 and 0.78, respectively. Pearson and Spearman correlation coefficients comparing Milestone scoring and checklist items in the cardiogenic shock case were 0.27 and 0.29; in the sepsis case, 0.085 and -0.021.

Conclusions: When compared to critical action checklists, use of Milestones lacks consistency between faculty raters for simulation-based competency assessment. Resident self-assessment shows no correlation with faculty assessments.

2 Proceedings from the CDEM Consensus Conference on Clinical Assessment of Medical Students in the ED: Introducing the NCAT-EM

Hiller K, Franzen D, Jung J, Lawson L /University of Arizona, Tucson, AZ; University of Washington, Seattle, WA; Johns Hopkins University, Baltimore, MD; East Carolina University, Greenville, NC,

Background: Clinical assessment of medical students in the Emergency Department (ED) is a highly variable process with unique challenges. Currently, clerkship directors use institution-specific tools with unproven validity and reliability. Standardization of assessment practices and development of a common tool would benefit EM educators, students and patients.

Educational Objectives: The objective of the consensus conference was to derive guidelines and a common tool for clinical assessment of students in the ED.

Curricular Design: The conference was held in the CDEM track of the 2016 Council of Residency Directors in Emergency Medicine (CORD) Academic Assembly in Nashville, TN. All stakeholders in the clinical assessment process were invited. A total of 140 participants registered; approximately 60 participated in the first day and 70 in the second day of the conference. Themes underlying assessment, domains to include, and the structure of a national tool were discussed and voted

on. These were (1) criterion- vs norm-referenced assessment, (2) learners at different levels, (3) translation of clinical assessment data into other products, (4) implementation and use of a national form, and (5) ensuring post-implementation reliability and validity. The second day of the conference determined consensus on domains of assessment to include on a national assessment form. For all questions not reaching consensus, a modified Delphi process was initiated after the conference to reconcile differences. The first day of the consensus conference was dedicated to developing consensus on high stakes themes. The second day of the conference and subsequent Delphi determined consensus on domains of assessment to include on a national assessment form. Once the domains were finalized, Delphi participants were invited to participate in three conference calls during which wording for the tool was finalized. (Figures 1 and 2).

Impact/Effectiveness: This consensus conference was the first of its kind for CDEM, or any clinical educator group of which we are aware. By standardizing assessment, educators can move toward more valid and reliable practices that facilitate high quality feedback and permit accurate assessment across multiple institutions. Future plans include pilot testing and further refinement of the new tool, research regarding its feasibility, reliability across users and institutions, and validity.

Clerkship Directors in Emergency Medicine National Clinical Assessment Tool

| Student Name: | | Date: | | |
|---|---|--|---|---|
| Assessor Name: | | Shift/Unit: | | |
| | Pre-Entrustable | Mostly Entrustable | Fully Entrustable/ Milestone 1 | Outstanding/ Milestone 2 |
| Focused history and physical exam skills | Extraneous or insufficient information. May miss key physical findings or examine incorrectly. | Generally adequate information. Exam mostly adequate and correct. May not differentiate important from extraneous detail. | Appropriate information for clinical context. Exam complete and appropriately tailored. May include excess detail, but thorough and accurate. | Exceptional focused H&P, exams all relevant information. Addresses chief complaint and urgent issues. Differentiates important from extraneous detail. |
| <input type="checkbox"/> Unable to assess | | | | |
| Ability to generate a prioritized differential diagnosis | Limited ability to filter, prioritize, and connect information to generate a basic differential based on clinical data and medical knowledge. | Generally able to filter and connect information to generate a basic differential based on clinical data and medical knowledge. Beginning to incorporate data and prioritize. | Reliably synthesizes data into a complete differential. Incorporates data. Prioritizes differential by likelihood. | Demonstrates exceptional differential diagnosis and data interpretation. Uses all available information to develop a prioritized differential focusing on life/threats. |
| <input type="checkbox"/> Unable to assess | | | | |
| Ability to formulate plan (diagnostic, therapeutic, disposition) | Difficulty applying knowledge to formulate plans, or does not offer plan. | Usually able to apply knowledge to formulate plans, though plans may be incomplete/incorrect in some details. | Reliably able to apply knowledge to formulate plans that are complete, appropriate, and tailored to patient needs/wishes. | Exceptional ability to apply knowledge to formulate outstanding patient-centered plans. |
| <input type="checkbox"/> Unable to assess | | | | |
| Observation, monitoring and follow-up | May not re-evaluate patients or follow up results in a timely fashion. | Usually re-evaluates patients and follows up results, though may need prompting. Beginning to integrate new data into ongoing plan. | Reliably re-evaluates patients and follows up results in a timely manner without prompting. Integrates basic data into ongoing plan, though may need help. Completes tasks despite distraction. | Exceptional re-evaluation and follow up skills. Proactive. Integrates complex results into ongoing plan. Able to handle multiple patients simultaneously. |
| <input type="checkbox"/> Unable to assess | | | | |
| Emergency recognition and management | May not recognize or respond to abnormal vital signs or patient deterioration. Delays or fails to seek help. Unable to recommend stabilization interventions. | Recognizes and responds to most abnormal vital signs and trends, but may miss subtle changes. Promptly seeks help. Recommends and/or initiates some basic stabilization interventions. | Reliably recognizes and responds to all vital sign abnormalities and trends. Promptly seeks help. Recommends and/or initiates all basic and some advanced stabilization interventions. | Exceptionally attentive to vital sign abnormalities and patient deterioration. Promptly seeks help. Recommends and/or initiates basic and advanced interventions appropriately. |
| <input type="checkbox"/> Unable to assess | | | | |