Millennials and Milestones

Training Our Future Physicians

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MILLENNIALS AND MILESTONES

TRAINING OUR FUTURE PHYSICIANS

WHO ARE THE MILLENNIALS?

The term "Millennial" applies to individuals who reached adulthood around the turn of the 21st Century

- Born between 1978 and 2000 (give or take a few years)
- Millennials are commonly referred to as Generation "Y" or the Net Generation because of the internet and technology based world they grew up in
- The largest generation to date with about 76 million in the United States - surpassing the 74.9 million Baby Boomers or Generation "X"

CHARACTERISTICS OF MILLENNIALS

- The most highly educated generation in history
- 72% will graduate with at least a high school certification
- 68% of those, will enroll in college
- 58% will graduate with a bachelor's degree within 6 years

CHARACTERISTICS CONT'D

- Most ethically diverse and tolerant generation to date
- 20% of Millennials have at least one immigrant parent
- Millennials were raised with parents including their input as part of the day to day decision making
- They know what they want
- They use social media as a forum to voice their opinions
- They demand work – life balance

MILLENNIALS AND THE MILESTONES

- How do we give feedback to a generation that is accustomed to giving feedback and not receiving feedback?

- How do we expect them to grow long-term when they are accustomed to immediate results from social media?

- How do we expect a millennial to respond to the high work demands during blocks of stressful rotations?

But first, let's briefly review the milestones . . .

WHAT ARE MILESTONES?

The ACGME defines Milestones as follows:

"… a milestone is a significant point in development. For accreditation purposes, the Milestones are competency-based developmental outcomes (e.g., knowledge, skills, attitudes, and performance) that can be demonstrated progressively by residents and fellows from the beginning of their education through graduation to the unsupervised practice of their specialties."

- ❖ Residents and fellows are required to demonstrate the skills, knowledge, and behaviors in the six clinical competency domains
- ❖ Milestones provide narrative descriptors of the competencies and sub competencies enabling residents and fellows to know the expectations of the program and determines individual trajectories of professional development as set forth by ACGME

GENERAL DESCRIPTION OF MILESTONE LEVELS

Milestone Description: Template				
Level 1	Level 2	Level 3	Level 4	Level 5
What are the expectations for a beginning resident?	What are the milestones for a resident who has advanced over entry, but is performing at a lower level than expected at mid-residency?	What are the key developmental milestones mid-residency? What should they be able to do well in the realm of the specialty at this point?	What does a graduating resident look like? What additional knowledge, skills & attitudes have they obtained? Are they ready for certification?	Stretch Goals – Exceeds expectations

Comments:

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WHY MILESTONES?

- Milestones are different from other assessments because there is an opportunity for the learner to demonstrate the attainment of aspirational levels of the sub competency and allows for a shared understanding of the expectations for the learner and the faculty

- Milestones provide a framework for all GME programs across the US that allows some assurance that all graduating residents and fellows have attained a high level of competency

WHAT ARE THE CORE COMPETENCIES?

The six ACGME Core Competencies evaluated are:

- Practice-Based Learning and Improvement
  learns from performance audit and learns from feedback
- Patient Care and Procedural Skills
  hunter & gatherer of patient data, procedural skills
- Systems-Based Practice
  cost effective care and effective transfer of patients
- Medical Knowledge
  clinical knowledge and interpretation of tests and procedures
- Interpersonal and Communication Skills
  health record compliance & effective communication skills
- Professionalism
  follows through on tasks, ethics, & respectful in interactions

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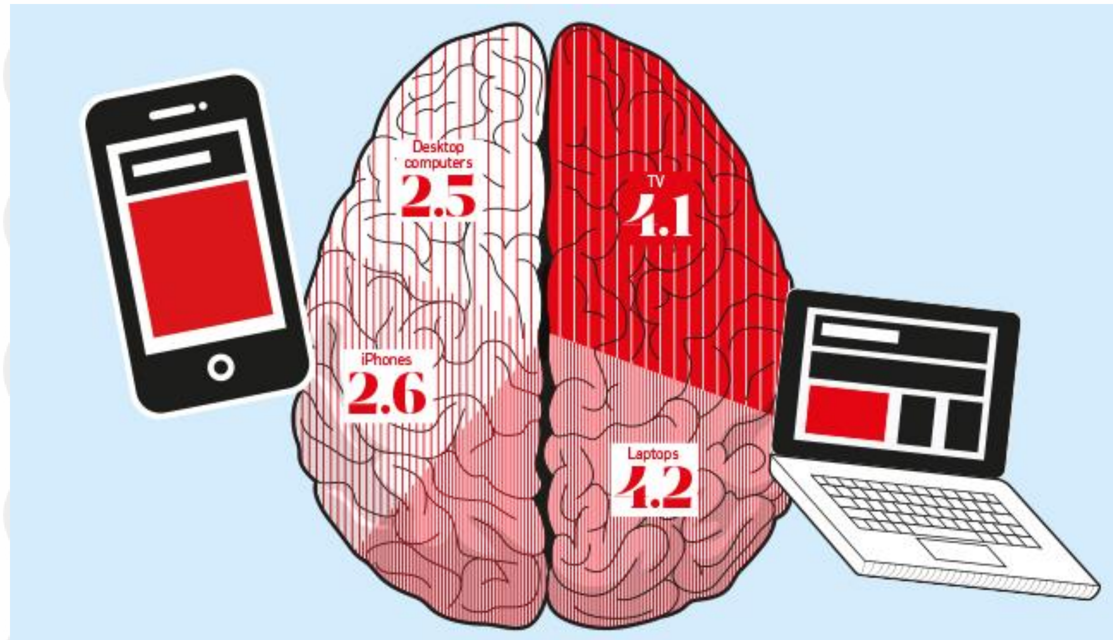
SO, THESE COMPETENCIES ARE USED TO EVALUATE THE MILLENNIALS.

FIRST, WE MUST LOOK AT HOW THE MILLENNIALS LEARN…DIFFERENT FROM THE BOOK LEARNING FROM PRIOR GENERATIONS.

HOW DO MILLENNIALS LEARN BEST?



BARRIERS FOR EACH RESIDENT

LEARNING PREFERENCES

A Millennial's Desired Learning Environment should have:

- Structure and Direction

  They want to know what is expected of them in explicit terms

- Feedback

  Millennials are in need of explicit feedback on a regular basis.
  In order to achieve the goals they set for themselves, consistent encouragement is needed and necessary to keep the motivation.
  Their goals remain as aspirational as prior generations

LEARNING PREFERENCES CONT'D

- Technology

  Integrating technology into the daily educational routine is a necessity. There are many web based learning modules like Johns Hopkins that allows for certain topics to be completed and graded within a timeframe

  or

  PollEverywhere.com can change the dynamics of an ordinary lecture or PowerPoint presentation by incorporating the cellphone or I pad into an interesting and interactive way to learn

LEARNING PREFERENCES CONT'D

- Collaboration / Team Based Learning / Problem Based Learning
  Working in teams or groups is a preference to Millennials. They feel more comfortable in a collaborative multidisciplinary learning experience rather than independent. A form of Socratic learning without the one on one pressure atmosphere.

- Mentorship
  Millennials want to have close relationships with the authority figures just as they did with their parents. They want to feel that their supervisors care about them personally. They welcome personalized learning plans with a mentor whom they can go to for guidance, feedback, and assistance. They are not ashamed of asking for help.

- Life Work Balance
  The Emotional Competence and stability of the resident is very important. Resident burnout is a real concern.

MERGING THE TWO:

APPLYING THE MILESTONES TO THE LEARNING NEEDS OF THE MILLENNIAL

FIRST STEPS:

- Provide education based on a model that reaches the maximum number of residents/fellows

- Provide a forum by which they can voice their concerns openly
  -frequent (monthly) program limited meetings with chiefs

- Have faculty members on the Clinical Competency Committee (CCC) who the residents respect

- These steps allow for constructive criticism to be received with greater confidence in the process

ENTRUSTABLE PROFESSIONAL ACTIVITIES (EPA)

Concrete clinical activities or "entrustable behaviors" linked to core competencies/milestones (or roadblocks. . .)

1. Establish an EPA for each rotation
2. Give to residents/fellows prior to each rotation
3. Establishes 5 or 6 observable behaviors "entrustable activities" for each rotation
4. Must reflect the milestones
5. Assessment is a process, can be changed based on feedback from the residents/fellows after an observable behavior is evaluated

Next Steps…

- Refinement of Rotational Goals and Objectives
- Incorporate Milestones in the rotation
- Identify EPA's and observable behaviors for each rotation
- Map EPA's to Milestones and Competencies
- Create New Assessment based on EPA's

CLINICAL COMPETENCY COMMITTEE MEMBERS

A CCC is the Accreditation Council for Graduate Medical Education (ACGME)'s "required body comprising three or more members of the active teaching faculty who is advisory to the program director and reviews the progress of all residents in the program."

The CCC "reviews all resident evaluations semi-annually, prepares and ensures the reporting of Milestone evaluations… and advises the program director regarding resident progress, including promotion, remediation, and dismissal."

Note*

The role of the program director regarding the Milestones. The ACGME's intent is that the program director has the final decision on milestones, as he/she has the authority for summative decisions relative to resident/fellow promotion and graduation. However, if the CCC functions effectively, it is expected that it would be a rare occurrence for a program director to overrule its Milestone judgments, especially since the Milestones are primarily for formative purposes. In summary, the program director has final responsibility for the program's evaluation and promotion decisions.

COMMON PROGRAM REQUIREMENTS FOR A CCC

- The program director must appoint CCC but cannot be an active member
- Minimum of three program faculty members

  Three is considered the smallest number essential for a good discussion. The literature suggests that a group size of five to seven is probably ideal, and no more than eight to ten is recommended for optimal committee functioning
- Must have a written description of responsibilities of the CCC
- Review all resident evaluations semi-annually
- Should advise the program director regarding resident/fellow progress, including promotion, remediation, dismissal

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THE COORDINATOR ROLE IN THE CCC:

- ❖ Program coordinators are extremely valuable in the CCC process through their involvement with many, if not all, aspects of the program, and their knowledge of the residents/fellows. Program coordinators frequently distribute and collect assessment tools.

- ❖ They may also participate by gathering all of the feedback assessments into understandable language to the committee members. This offers valuable and often unique perceptions of an individual resident/fellow's abilities in interpersonal and communication skills, teamwork, and professionalism

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THE COORDINATOR ROLE IN THE CCC:

- Program coordinators may administratively attend CCC meetings at the discretion of the program director

- They can assist in the collection, preparation, organization, and distribution of assessment data; take minutes; and capture key aspects of the discussion. They can also serve as observers of group process using some of the tools and frameworks, and provide feedback to the CCC as part of a continuous quality improvement (CQI) process

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LIMITATIONS OF THE CCC

1. Time
   -limited time allocated on average per resident
   -more difficult residents encroach on discussion of other residents
2. Data
   -completed evaluations
   -outpatient vs inpatient data
3. Most recent rotation bias
4. CCC members being absent: wisdom of many is better than the wisdom of few
5. Evaluator type should reflect into the final evaluation: Hawk vs Dove
6. Most recent experience bias
   -poor quality morning report, afternoon conference overshadows multiple prior successful presentations

COMPETENCE

FEEDBACK GUIDELINES

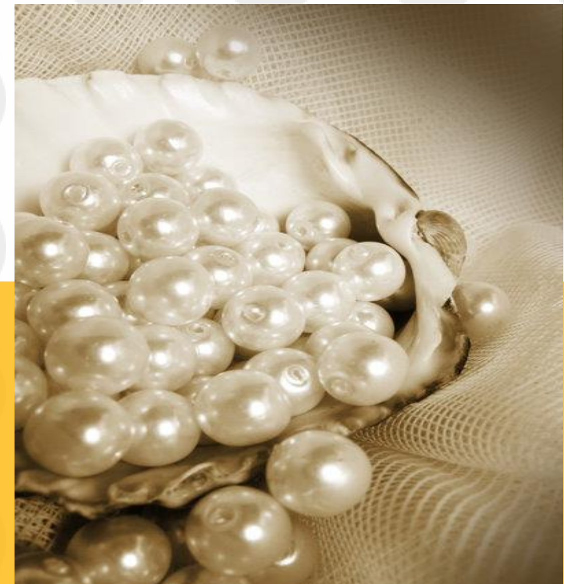
1. Each performance is for the individual and not meant to compare one resident to the others. Although this tool is available.
2. Each performance is not a <u>complete</u> reflection of the resident, rather a telescopic view given the limitations of the CCC.
3. It is mostly a consensus evaluation by the CCC.
4. An action plan must be laid out.

GUIDELINES CONT'D

5. As in all evaluations, the positives should be brought to light.
6. The resident should have an opportunity to respond to the PD or APD.
7. Closed loop communication: resident reports back what they have learned about their evaluation.
8. Secondary causes does not excuse poor performance.
9. Be ready to establish an improvement coach, but need resident buy-in and protect their confidentiality. But delineate consequences of failure.

PEARLS FOR PERSON GIVING FEEDBACK

1. Must be structured
2. Must be a consistent approach with each resident/fellow
3. Documentation
4. Focus on pattern of behavior
5. Require significant improvement



DO THE MILESTONES DO ENOUGH?

1. They are an improvement.
2. Attempts to ascertain a resident's competence but their true competence may not be brought out because of a small sampling or inappropriate sampling.
3. Milestone evaluations are not on a straight line, due to the imperfect human aspect to the evaluations. It can vary up and down quite a bit.
4. Level 4 is the goal for graduation, but ACGME does not require that for a resident to graduate.
5. Use of EPAs highly encouraged for each rotation for increasing quantifiable and observable behaviors.
6. Still uses numbers, but greater movement towards language descriptors.

CONCLUSION

The ACGME has intentionally moved away from the a PROCESS-driven system and moved towards an OUTCOME-driven accreditation system that is more aligned with the learning needs and expectations of the Millennials.

Competency Based Medical Education, including the Milestones and EPA’s is an ideal fit, a perfect pairing of sorts.

It is an **evolving** process that we must adapt and personalize to each individual resident. Always keeping in mind that these various forms of evaluations are simply multi layers to assist in evaluating the resident as a WHOLE. The ACGME also continues to re-evaluate the competencies with these goals in mind.

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ANY QUESTIONS???

THE END……

THANK YOU TO THE ACOI FOR ALLOWING ME TO PRESENT AND THANK YOU FOR YOUR TIME!