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Group Evaluations of Individual Faculty Hospitalists

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ABSTRACT

Introduction. Faculty evaluations are important tools for improving faculty-to-resident instruction, but residents in our pediatric and internal medicine/pediatric residency programs would seldom evaluate individual pediatric faculty hospitalists. Our objectives were to: (1) increase the percentage of completed evaluations of individual pediatric hospitalists to greater than 85%, (2) improve the quality of pediatric hospitalist feedback as measured by resident and faculty satisfaction surveys, and (3) to reduce the resident concern of lack of anonymity of evaluations.

Methods. Members of the resident inpatient team (pediatric and internal medicine/pediatric residents) completed group-based evaluations of individual pediatric hospitalists. A survey to evaluate this change in process was distributed to the pediatric hospitalists (n = 6) and another survey was distributed to residents, both based on a 5-point Likert-type scale. Surveys were completed before and four months after implementation of the changes. Pre- and post-survey data of resident and hospitalist responses were compared using the Mann-Whitney test and probability proportion test.

Results. The percent of completed evaluations increased from 0% to 86% in one month and to 100% in two months. Thereafter, the percent of completed evaluations remained at 100% through the end of the data collection period at seven months. Hospitalists reported (n = 6, 100% participation) their satisfaction regarding the feedback they received from residents significantly increased for all survey questions. Resident satisfaction (n = 24, 89% participation in post-intervention surveys) increased significantly with regards to the evaluation process.

Conclusions. For hospitalists, group-based resident evaluations of individual hospitalists led to an increased percentage of completed evaluations, improved the quality and quantity of feedback to hospitalists, and increased satisfaction with evaluations. For residents, these changes led to increased satisfaction with the evaluation process. ***Kans J Med 2019;12(3):62-64.***

INTRODUCTION

Resident evaluations of individual faculty are an Accreditation Council for Graduate Medical Education (ACGME) requirement[1] and an important tool used to improve faculty-to-learner instruction and faculty development.[2,3] Despite this requirement and the utility of the evaluations, our pediatric residency and the combined internal medicine/pediatric residency program previously struggled to obtain these evaluations from residents. The program is small and community-based with a university affiliation. It consists of five categorical pediatric residents and three internal medicine/pediatric residents per year. Residents routinely completed rotation evaluations for the inpatient pediatric service, but seldom would complete individual evaluations of the pediatric hospitalists. Despite the fact that faculty evaluations were anonymous, residents expressed concerns that faculty could identify which specific resident completed the evaluation. Faculty members were disappointed with the evaluation system and requested more individualized feedback from residents.

To address these concerns, the chief residents developed a plan for pediatric and internal medicine/pediatric residents who rotated together on the pediatric inpatient service to meet as a group to complete evaluations of individual pediatric hospitalists. The objectives were: 1) Increase the percentage of completed evaluations of individual hospitalist faculty to greater than 85% per block; 2) Improve the quality of feedback to faculty hospitalists from residents as measured by resident and faculty satisfaction surveys with a goal of 80% satisfaction; and 3) Reduce the resident concern over the lack of anonymity associated with individual evaluations of faculty. In this report, the method the residency program implemented to meet these objectives is described.

METHODS

The evaluation form was revised by the pediatric chief residents and approved by the pediatric hospitalist faculty to ensure the form addressed areas that the pediatric and internal medicine/pediatric residents and pediatric hospitalist faculty considered important. Revised evaluation questions were as follows:

1) Resident/faculty interaction was collegial. I was treated with respect and in a professional manner.
2) Faculty member provided sufficient instruction/teaching on rounds.
3) Faculty member provided sufficient instruction/teaching following rounds.
4) Faculty gave clear explanations/reasons for options, advice and actions.
5) Faculty member is interested in resident education.
6) Faculty member creates an environment of inquiry.
7) Faculty member provided sufficient supervision.
8) Faculty member started rounds on time at 8:45 am.
9) Rounds with faculty member were generally completed by 11:00 am.
10) Faculty member adhered to the rounding list.
11) Rounds with the faculty member were efficient.
12) Resident/faculty disagreements were properly handled.
13) My thoughts and ideas were considered and respected.
14) Faculty member was helpful and available to me when he/she was on-call for resident patients.
15) I was provided regular feedback on my performance during the rotation.
16) I was not asked to perform or to participate in morally objectionable situations.

A space for comments was added after each item on the evaluation.

A process change was implemented wherein individual pediatric hospitalist faculty members received a single, group-based evaluation completed by the resident inpatient team for each individual rotation block. The pediatric chief residents shared the responsibility of arranging a time for the completion of the evaluations with the resident group and facilitating the group discussion of each individual hospitalist. Prior to this intervention, faculty received their evaluations at the end of the academic year; in this new system, the evaluations were immediately accessible to faculty via New Innovations, our residency management system.

To evaluate the outcomes of this process change, several strategies were used. First, the number of evaluations completed was tracked through New Innovations. The calculation of percentage pediatric hospitalist completed was based on the number of hospitalists who were on service that block and had an individual evaluation completed by the residents. Second, two surveys were developed; one for the residents and one for the hospitalist faculty. Surveys were completed before and four months following the implementation of the process change. Each four-question survey was based on a 5-point Likert-type scale. Surveys were distributed to faculty and residents in paper format by a chief resident. The pediatric chief residents collected the completed forms and entered the data into a spreadsheet. The surveys were anonymous and were unmatched. A run chart was created to display the change in percentage of evaluations completed. Pre- and post-survey data of residents and faculty were compared using the Mann-Whitney test and probability proportion test. Third, the ACGME Resident Survey results were monitored. The ACGME Resident Survey is an annual, anonymous survey of residents' perceptions of their program's compliance with accreditation standards.[4] The ACGME Resident Survey questions related to the confidentiality of faculty evaluations and use of evaluations by the program to improve were assessed pre- and post-intervention.

RESULTS

Following the intervention, the percent of completed evaluations increased from 0% to 86% in one month and to 100% in two months. The change was maintained in the subsequent five months (Figure 1).

All six hospitalists completed the pre- and post-surveys. Hospitalist satisfaction increased above 80% for all survey questions (Figures 2 and 3). Ten pediatric residents (100% response rate) and nine medicine/pediatric residents (100% participation) completed the pre-intervention survey. First-year residents were not offered the pre-intervention survey, since they had just begun residency. Fifteen pediatric residents (100% participation) and nine medicine/pediatric residents (75% participation) completed the post-intervention survey. Resident satisfaction with the process of hospitalist evaluation increased. The resident perceptions that evaluations are anonymous and feedback reaches hospitalist faculty also increased. Resident perceptions that faculty use evaluations to improve nearly doubled, but did not reach the 80% threshold.

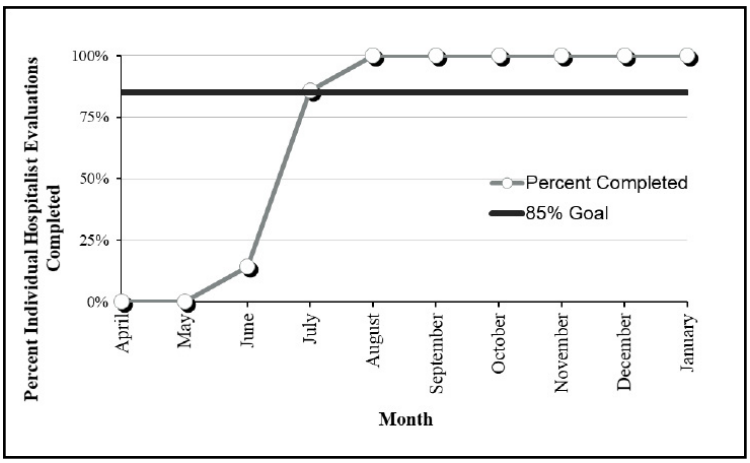

Figure 1. Run chart of percentage of completed individual hospitalist evaluations.

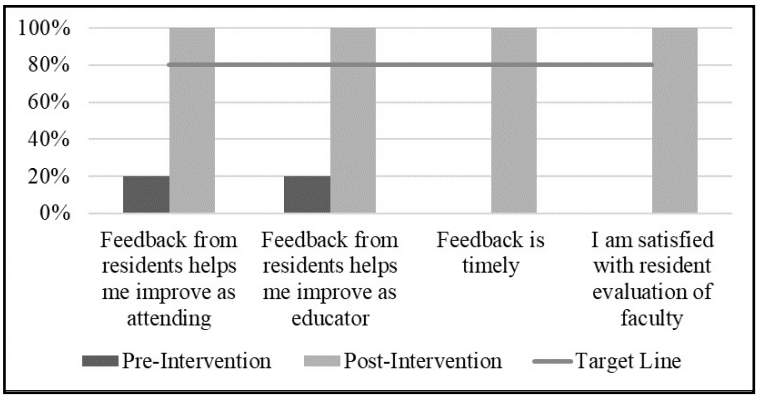

Figure 2. Percent of faculty who agreed or strongly agreed to each item.

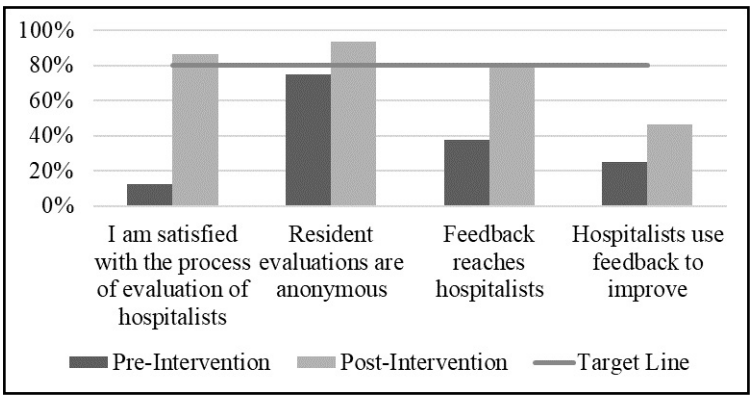

Figure 3. Percent of residents who agreed or strongly agreed to each item.

Change was noted in the ACGME resident survey results. The year prior to implementation of group evaluations, the ACGME survey reported resident satisfaction that evaluations of faculty are confidential was 75% (program mean of 3.6), but increased to 100% (program mean of 4.7) the following year. Additionally, resident satisfaction that the program uses evaluations to improve increased from 25% (program mean 2.9) before the intervention to 92% (program mean 4.3) the year following the intervention.

DISCUSSION

Group-based resident evaluations of individual pediatric hospitalist faculty members led to an increased percentage of completed evaluations and increased satisfaction with evaluations among faculty. Just as individual evaluations can improve faculty to learner instruction,[3] the results showed that group-based evaluations of individual hospitalist faculty by residents led to increased resident satisfaction with the evaluation process, perception of anonymity, perception feedback reaches faculty, and contributed to improved overall resident satisfaction that the program uses feedback to improve. The benefit of group-based evaluations on enhancement of faculty teaching remains unclear.

While this change in the evaluation system showed movement toward the goals in all areas, it did not lead to the 80% goal of residents agreeing or strongly agreeing that "hospitalists use feedback to improve". This result may indicate it takes longer than four months for hospitalists to seek out any additional training, implement changes, and for residents to identify those improvements. A limitation of the study is that residents were not specifically asked why their satisfaction with the process increased. Further assessment of the utility of this approach to evaluating faculty on other rotations is necessary to determine generalizability. This project was limited further by the fact that not every resident had the opportunity to participate in the new evaluation process as some joined the residency after implementation of the intervention.

CONCLUSION

Group-based resident evaluations of individual pediatric hospitalists improved the quality and quantity of feedback to hospitalists and improved the residents' confidence that evaluations of faculty were anonymous. The ACGME survey result concerning using evaluations to improve the program also improved following the change in the evaluation process. This method of evaluation could be a model for hospitalist services in other pediatric and non-pediatric residency programs. Further studies are needed to determine if this is an effective method of evaluation in other areas of resident education.

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