

specifically about giving feedback..I was able to implement frequent ‘nuggets’ of feedback...,” “...taught great techniques,” “great idea and a wonderful tool in the midst of COVID,” “...one particular skill was the focus each week. . . gave me time to practice that skill and incorporate the next.”

Faculty were very receptive to this teaching strategy as it was designed to be easily accessible, eliminated the need to “go to a training,” was time efficient, and used simple strategies to practice. Currently, investigators are qualitatively evaluating comments from faculty and future direction should include behavioral effect on faculty skills and impact on learners. Tuesday’s Teaching Tips has broad applicability across all specialties and institutions.

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An Intervention to Preserve the Collaborative Educational Mission in Virtual Psychiatric Teaching Clinics

Setting and Problem

The Department of Psychiatry at the University of North Carolina offers outpatient services in a series of half-day subspecialty clinics. Each clinic operates out of a shared conference room and is staffed by faculty, resident psychiatrists, social workers, and medical students. Half-day clinics emphasize education through formal preclinic didactics and throughout the half-day by feedback and teaching during patient care and staffing in the shared workspace. This model fosters collaborative learning wherein learners who are not directly involved in a case may participate in discussions around medical decision-making and clinical care. The implementation of this model has demonstrated effectiveness through resident and medical student evaluations of their outpatient experiences.

In March 2020, the COVID-19 pandemic compelled the department of psychiatry to mobilize a rapid telehealth conversion to preserve the outpatient clinical care mission and to maintain patient and provider safety. This conversion necessitated a parallel effort to rebuild educational infrastructure and workflows to preserve the educational experience through virtual solutions.

Intervention

Several virtual solutions were piloted to support the education mission. Through iterative, plan-do-study-act cycles within a single half-day module, a team-based software solution and accompanying in-application workflow was developed. Following each cycle, surveys were used to gauge solution usability, and participants’ educational and clinical experience.

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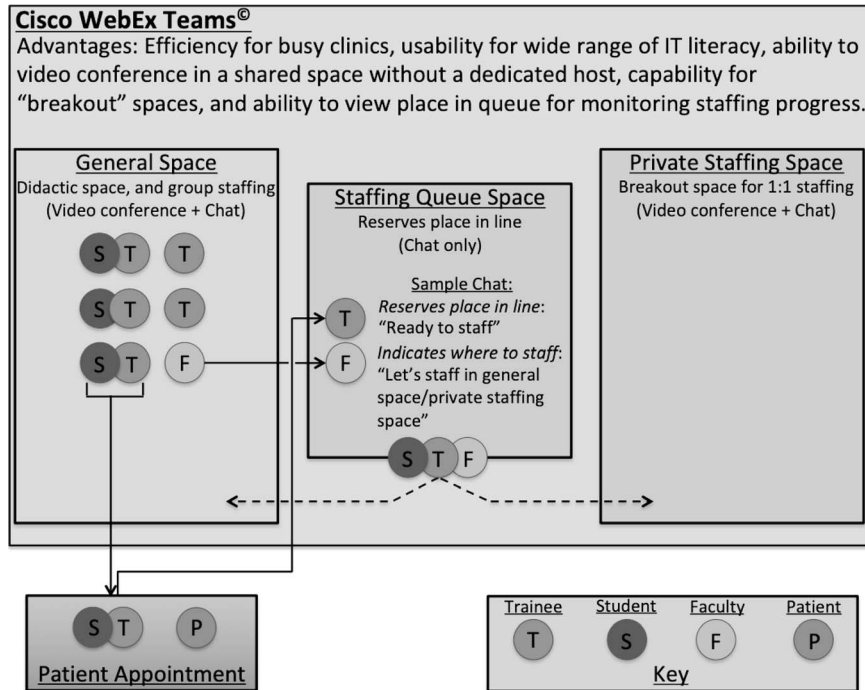


FIGURE
 Virtual Solution, Advantages, and Accompanying Workflow Diagram

Note: The general design of virtual clinic experience is as follows. The clinical team meets in the general space for discussion, didactics, and group staffing. Residents and students leave to complete patient visits and then indicate readiness to discuss patients with the attending in the “staffing queue.” If the attending prefers to staff the case individually, they can join the trainees in the separate “staffing space.” Otherwise, they can discuss the case in the general space for all team members to hear to facilitate group learning.

Ultimately, a solution (FIGURE) was developed that supported the conditions necessary to recreate the educational experience and showed high satisfaction rates from faculty and trainees (6 of 7 respondents in the trial either strongly agreed or somewhat agreed that the solution was both a good fit and better than previous alternatives). This solution was reviewed and endorsed by key stakeholders in department leadership.

The new virtual remote educational model was operationalized and scaled through an educational campaign. Educational materials included a walk-through video and live video demonstration, along with an accompanying “tip sheet.” The educational materials were designed to be viewed as part of a department-wide town hall and were hosted on a secure server for future use. Participants in the town hall were surveyed on their perceptions of the proposed solution. Peer support was provided to faculty through informal office hours and screen-sharing walkthroughs as they set-up their virtual clinic modules. In the first week of “go-live,” didactic time was extended to give clinic teams a chance to watch the video, orient to the software, participate in virtual walkthroughs, and practice the workflow.

Outcomes to Date

The team-based software solution and accompanying workflow went live across multiple half-day clinics as of the new academic year (July 2020) and remains the preferred method for preserving the core tenets of the shared educational model across the department of psychiatry. Surveys related to the teaching materials and teaching session suggested faculty were optimistic they could operationalize this solution and workflow. To date, end-user perceptions of the team-based software solution and workflow have been favorable. Surveys sent 3 months after “go-live” yielded responses from 21 faculty members and 21 trainees. In general, survey responses and comments suggested faculty and trainees were satisfied with the solution described. Comments from faculty and trainees cited the ability to listen and learn from peers’ cases as an advantage of the solution described. Respondents appreciated its efficiency for patient care, and most did not feel it contributed to delays in clinic. This virtual solution and workflow, its subsequent educational campaign, and deployment have preserved the key aspects that have historically defined the strong educational experience in the department’s outpatient clinics. This “new idea” is a feasible model for how other programs could support remote telehealth

clinical care while preserving the collaborative educational mission that is the cornerstone of residency and fellowship training.

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