SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

2022 Annual Meeting Syllabus

November 11-12, 2022

Swissôtel Chicago · Chicago, Illinois

www.SAAAPM.org

Jointly Provided by the American Society of Anesthesiologists (ASA) and Society of Academic Associations of Anesthesiology and Perioperative Medicine (SAAAPM).

American Society of Anesthesiologists™

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Program Information

Target Audience

This meeting is designed for academic anesthesiologists in Chair, Core Residency Program Director, Subspecialty Fellowship Program Director and Residency Program Administrator positions. Members may invite physician and non-physician guests. The program is designed to present and discuss areas of topical interest to attendees in keeping with our collective attempt to improve academic anesthesiology departments' structure, function and the educational programs.

About This Meeting

Topics for this meeting were selected by various methods. Suggestions for topics were derived from evaluations of the 2021 and other previous Annual Meetings, Council members, the membership at large and reviews of the published literature with the highest impact on the anesthesia specialty. These suggestions were discussed by our authorities in the field of anesthesia education or previous meetings.

The purpose of this Annual Meeting is to educate and share information that will enable academic anesthesiology departments to improve management and care.

Registration

The registration fee for the SAAAPM 2022 Annual Meeting includes the course syllabus, all educational presentations, continental breakfasts, coffee breaks and Friday reception. There is a separate fee for lunches. Registrations that are either faxed, mailed, or made via the website to the SAAAPM office must be received by October 5, 2022. After October 5, 2022, late registration fees will be applied. Your registration fee is separate from the departmental membership dues that must be paid each year. Please include your ASA membership number with your registration to claim CME credits.

ACCME Accreditation and Designation Statements

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of American Society of Anesthesiologists and the Society of Academic Associations of Anesthesiology and Perioperative Medicine (SAAAPM). The American Society of Anesthesiologists is accredited by the ACCME to provide continuing medical education for physicians.

SAAAPM Presentations

The American Society of Anesthesiologists designates this live activity for a maximum of 5.25 *AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

AAAC Concurrent

The American Society of Anesthesiologists designates this live activity for a maximum of 6.50 *AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

AACPD Concurrent

The American Society of Anesthesiologists designates this live activity for a maximum of 6.50 *AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

AASPD Concurrent

The American Society of Anesthesiologists designates this live activity for a maximum of 7.50 *AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

AAPAE Concurrent

The American Society of Anesthesiologists designates this live activity for a maximum of 7.50 *AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Disclaimer

The information provided at this activity is for continuing medical education purposes only and is not meant to substitute for the independent medical judgment of a healthcare provider relative to diagnostic and treatment options of a specific patient's medical condition.

Disclosure Policy

The American Society of Anesthesiologists remains strongly committed to providing the best available evidence-based clinical information to participants of this educational activity and requires an open disclosure of any potential conflict of interest identified by our faculty members. It is not the intent of the American Society of Anesthesiologists to eliminate all situations of potential conflict of interest, but rather to enable those who are working with the American Society of Anesthesiologists to recognize situations that may be subject to question by others. All disclosed conflicts of interest are reviewed by the educational activity course director/chair to ensure that such situations are properly evaluated and, if necessary, resolved. The American Society of Anesthesiologists educational standards pertaining to conflict of interest are intended to maintain the professional autonomy of the clinical experts inherent in promoting a balanced presentation of science. Through our review process, all American Society of Anesthesiologists education activities are ensured of independent, objective, scientifically balanced presentations of information. Disclosure of any or no relationships will be made available for all educational activities.

Disclosures

This activity's content is not related to products or services of an ACCME-defined ineligible entity; therefore, no one in control of content has a relevant financial relationship to disclose, and there is no potential for conflicts of interest.

Special Needs

The Society of Academic Associations of Anesthesiology and Perioperative Medicine (SAAAPM) fully complies with the legal requirements of the Americans with Disabilities Act and the rules and regulations thereof. If any attendee in this educational activity is in need of accommodations, please contact the SAAAPM at (414) 389-8619.

Cancellation Policy

Cancellation of a meeting registration must be submitted in writing and will be accepted up until October 5, 2022. Your refund, less a $100 administrative fee will be sent after the conclusion of the meeting. Refunds will be determined by date written cancellation is received at the SAAAPM office in Milwaukee, Wisconsin.

Overall Learning Objectives

At the conclusion of this activity, participants should be able to:

- Describe the significance of hosting Global Health Initiatives in a Department of Anesthesiology.
- Initiate wellness initiative within departments of anesthesiology.
- Employ approaches to reengage faculty and students as academic departments of anesthesiology emerge from the COVID-19 pandemic.

Hotel & Transportation Information

Swissôtel Chicago

323 East Upper Wacker Drive
Chicago, IL 60601
http://www.swissotel.com/hotels/chicago/

Sleeping rooms are $259/night and the hotel is ready to take your reservations. The hotel is providing SAAAPM attendees with complimentary Internet in the guest rooms and access to the Penthouse Fitness Center. **You must make your reservation by October 20, 2022 to receive the discounted rate.**

Make your reservations online at https://book.passkey.com/e/50347981

Or call: 888-737-9477 and mention you are booking a room for the Society of Academic Associations of Anesthesiology and Perioperative Medicine Annual Meeting.

***Please Note:** if you are planning to extend your stay for the SEA Fall Meeting (November 10, 2022), you will need to book your hotel room for those nights with their room block link to receive the group rate. The hotel will assign you the same room.*

Local Airports

O'Hare International Airport (ORD), located 17 miles from downtown, is one of the largest airports in the world.

Midway International Airport (MDW) is located 10 miles from downtown Chicago is another convenient travel option.

Visit www.flychicago.com for details on parking, amenities, flight status, terminal maps and more for both O'Hare and Midway airports.

Both airports offer plentiful taxi service to downtown. Rates range from $40-50 from O'Hare, and $30-40 from Midway. Rates vary based on travel time and are subject to change.

The hotel does not provide shuttle service.

For more information on light rail, visit: www.transitchicago.com/airports

Parking

The Swissôtel Chicago offers 24-hour valet parking and will provide a 50% discount on the published valet pricing at time of check-in for SAAAPM attendees. **Please request your coupon for discounted valet parking at the meeting registration desk.** You do not need to stay at the hotel to receive discounted parking.

Discounted Bus Transportation from Hotel to Airport

SAAAPM is offering bus transportation to both O'Hare and Midway airports, immediately following the meeting.

Please RSVP yourself and any family/ friends on your registration form. The cost is only $10 per ticket.

The meeting ends at 2:30pm and buses would leave from the hotel by 2:45pm. This will allow for every member to catch a flight home on Saturday. PLEASE make your travel plans such that you do not leave from Chicago (O'Hare or Midway) before 6:00pm to allow ample travel time to the airport and to go through airport security.

The SAAAPM meeting is short, but the content is always outstanding.

Future Meeting Dates

2023 Annual Meeting
November 3-4, 2023
Swissôtel Chicago – Chicago, Illinois

2024 Annual Meeting
November 8-9, 2024
Swissôtel Chicago – Chicago, Illinois

2025 Annual Meeting
November 7-8, 2025
Swissôtel Chicago – Chicago, Illinois

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AAAC Concurrent Session

Friday, November 11

7:00 – 8:00am	**Continental Breakfast**
8:00 – 9:20am	**Mega-Mergers with Hospital Systems** *Moderator: B. Scott Segal, MD, MHCM*
8:00 – 8:20am	**Presentation 1** Roy G. Soto, MD
8:20 – 8:40am	**Presentation 2** James P. Rathmell, MD, MBA
8:40 – 9:00am	**Presentation 3** B. Scott Segal, MD, MHCM
9:00 – 9:20am	**Q&A**
9:20 – 9:40am	**RRC Update** **Aditee Ambardekar, MD, MSEd** **Cheryl Gross, MA, CAE**
9:40 – 10:00am	**Q&A**
10:00 – 10:30am	**Break**
10:30 – 11:45am	**Work-Life Integration** *Moderator: Stephanie B. Jones, MD, FASA*
10:30 – 11:00am	**Supporting Faculty: A Faculty Administration Perspective** Harriet W. Hopf, MD, FUHM, FASA
11:00 – 11:30am	**Work that Matters: Increasing Faculty Engagement by Cultivating a Sense of Meaning at Work** Martha Kenney, MD
11:30 – 11:45am	**Q&A/Panel Discussion**
11:45 – 1:15pm	**Box Lunch & Business Meeting** *(Ticket Required)*
11:45 – 12:45pm	**Box Lunch and Networking**
12:45 – 1:15pm	**AAAC Business Meeting & Introduction of All New and Interim Chairs** *Moderator: Michael C. Lewis, MD, FASA*
1:15 – 2:00pm	**Imperfect Storm: The Complexity of Anesthesiology Staffing and Compensation Metrics** TJ Gan, MD, MBA, MHS, FRCA, FFARCS (IRE), Lic Ac B. Scott Segal, MD, MHCM
2:00 – 2:15pm	**Q&A**
2:15 – 3:20pm	**Leaving a Legacy** *Moderator: Michael C. Lewis, MD, FASA*
2:15 – 2:30pm	**Presentation 1** Holly A. Muir, MD
2:30 – 2:50pm	**Presentation 2** Roberta Hines, MD
2:50 – 3:15pm	**Presentation 3** Douglas R. Bacon, MD, MA, FASA
3:15 – 3:20pm	**Q&A**
3:20 – 3:50pm	**Break**
3:50 – 5:00pm	**The Great Resignation** *Moderator: Cynthia A. Lien, MD*
3:50 – 4:10pm	**Presentation 1** Jill M. Mhyre, MD
4:10 – 4:30pm	**Presentation 2** Jeffrey Berger, MD, MBA
4:30 – 4:50am	**Presentation 3** Kenichi Tanaka, MD
4:50 – 5:00pm	**Q&A**
5:30 – 7:30pm	**SAAAPM Reception**

AACPD Concurrent Session

AACPD
ASSOCIATION OF ANESTHESIOLOGY CORE PROGRAM DIRECTORS

Friday, November 11

7:00 – 8:00am	**Continental Breakfast**
8:00 – 8:05am	**Introduction / Welcome** Timothy Long, MD
8:05 – 9:15am	**Novel Practices** *Moderator: Kristina Sullivan, MD*
8:05 – 8:20am	**Holistic Review of Residency Applicants** Jack Buckley, MD
8:20 – 8:35am	**A Novel Community Engagement Curriculum** Stacy Fairbanks, MD
8:35 – 8:50am	**Efficiently Changing Program Culture** Mada F. Helou, MD
8:50 – 9:05am	**The Board Runner Rotation** Timothy W. Martin, MD, MBA
9:05 – 9:15am	**Q&A**
9:15 – 10:00am	**Competency-Based Medical Education and Time-Variable Training in Anesthesiology** *Moderator: Daniel Saddawi-Konefka, MD, MBA*
9:15 – 9:45am	**Competency-Based Medical Education and Time-Variable Training in Anesthesiology** Glenn Woodworth, MD
9:45 – 10:00am	**Q&A**
10:00 – 10:30am	**Break**
10:30 – 11:30am	**Mistakes Made/Lessons Learned** *Moderator: Susan M. Martinelli, MD*
10:30 – 10:40am	Bryan Mahoney, MD
10:40 – 10:50am	Kate McCartney, MD, FASA
10:50 – 11:00am	Lee Chang, MD
11:00 – 11:10am	Tanaya Sparkle, M.B.B.S., D.ABA
11:10 – 11:30am	**Q&A**
11:30 – 11:45am	**Business Meeting** *Moderator: Timothy Long, MD*
11:45am – 1:00pm	**Box Lunch and Networking**
11:45am – 12:00pm	**Grab Lunch (Ticket Required)**
12:00 – 1:00pm	**AACPD Meet & Greet** *Moderators: Julie L. Huffmyer, MD & Charles A. Napolitano, MD, PhD*
1:00 – 3:00pm	**Annual Updates** *Moderator: Andrea Dutoit, MD*
1:00 – 1:40pm	**ABA/ITE Update** Mark Keegan, MB, BCh, BAO, MRCPI, DABA, MSc, FCCM Alex Macario, MD
1:40 – 2:10pm	**ACGME Update** Aditee Ambardekar, MD MSEd Cheryl Gross, MA, CAE
2:10 – 2:40pm	**ERAS Supplemental Application** Andrea Dutoit, MD Emily G. Teeter, MD, FASE, FASA
2:40 – 3:00pm	**Q&A**
3:00 – 3:30pm	**Break**
3:30 – 5:00pm	**Everything You Wanted to Know** *Moderator: Jed T. Wolpaw, MD, MEd*
5:30 – 7:30pm	**SAAAPM Reception**

AASPD Concurrent Session

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Friday, November 11

7:00 – 8:00am	**Continental Breakfast**
8:00 – 8:05am	**Welcome and Announcements** *Moderator: Magdalena Anitescu, MD, PhD*
8:05 – 9:00am	**How to Develop Your Reputation** *Moderators: Magdalena Anitescu, MD, PhD & Edward R. Mariano, MD, MAS, FASA*
8:05 – 8:15am	**Administrative Service** Daryl Oakes, MD
8:15 – 8:25am	**Education** Lynn R. Kohan, MD
8:25 – 8:35am	**Publications** Holly Ende, MD
8:35 – 8:45am	**Social Media and Online Platforms** Emily E. Sharpe, MD
8:45 – 9:00am	**Q&A**
9:00 – 10:00am	**Combined Fellowships Demystified: Lessons Learned and Road Ahead** *Moderators: Ammeka Pannu, MD & Andi Traynor, MD*
9:00 – 9:20am	**OB Anesthesia/Regional** Naida M. Cole, MD, MM
9:20 – 9:40am	**Cardiac/CC** Shahzad Shaefi, MD, MPH
9:40 – 10:00am	**Q&A**
10:00 – 10:30am	**Break**
10:30 – 12:40pm	**Breakouts**
10:30 – 11:30am	**Breakout Block 1 (Select 1)**
	Breakout 1: How Do You Choose a Fellow to Interview: Tips on Evaluation of Applicants Lynn R. Kohan, MD & Jody Leng, MD, MS
	Breakout 2: Building Up the Future: From Med Student to Attending, How to Identify, Guide, Mentor and Promote Fellows to Continue in Academia Dalia Elmofty, MD & Michele Sumler, MD, MA, FASE
	Breakout 3: The Tripartite Missions: The Research Component Magdalena Anitescu, MD, PhD & Brandi Bottiger, MD
	Breakout 4: Fellowship Matches: How Common and What are the Challenges? Franklyn P. Cladis, MD, MBA, FAAP; Chandrika Garner, MD; Mark Stafford-Smith, MD, MBA
11:30 – 11:40am	**Move to Breakout Block 2 Room**
11:40 – 12:40pm	**Breakout Block 2 (Select 1)** ***Repeat of Block 1***
12:40 – 1:30pm	**Box Lunch & Business Meeting** *(Ticket Required)*
12:40 – 1:10pm	**Lunch**
1:10 – 1:30pm	**AASPD Business Meeting** *Moderator: Magdalena Anitescu, MD, PhD*
1:30 – 2:15pm	**Updates from the Subspecialties** *Moderator: Magdalena Anitescu, MD, PhD*
	Regional Anesthesiology and Acute Pain Medicine Edward R. Mariano, MD, MAS, FASA
	Critical Care Medicine Erin Hennessey, MD, MEHP
	Pain Medicine Magdalena Anitescu, MD, PhD
	Pediatric Anesthesiology Concetta Lupa, MD
	ACTA Douglas C. Shook, MD, FASE
	OB Anesthesia Andrea Traynor, MD
	Pediatric Cardiac Anesthesiology Stephanie N. Grant, MD
2:15 – 2:45pm	**Break**
2:45 – 5:30pm	**Subspecialty Breakout Sessions**
	Adult Cardiothoracic Douglas C. Shook, MD, FASE
	Critical Care Medicine Erin Hennessey, MD, MEHP
	Obstetric Andrea Traynor, MD
	Pain Medicine Magdalena Anitescu, MD, PhD Lynn R. Kohan, MD
	Pediatric Concetta Lupa, MD
	Regional Anesthesia Christina Jeng, MD, FASA
5:30 – 7:30pm	**SAAAPM Reception**

AAPAE Concurrent Session

Friday, November 11

7:00 – 8:00am	**Continental Breakfast**
8:00 – 8:15am	**Introduction / Welcome / Business Meeting** *Moderator: Faye Haggar, EdD*
8:15 – 9:00am	**Keynote Speaker** Amy Miller Juve, MEd, EdD
9:00 – 10:00am	**Snap Talks** *Moderators: Fei Chen, PhD, MEd & Amy N. DiLorenzo, MA, PhD*
9:00 – 9:15am	**Are Our Trainees Checked Out? Let's Check-In! A Low Stakes, Systematic Approach to Checking In On Trainees' Progression** Rachel Moquin, MA, EdD
9:15 – 9:30am	**Resident Wellness Development: A Coordinator's Perspective** Megan Souter, BA, C-TAGME
9:30 – 9:45am	**Institutional Racism – What Is This? And How Does It Affect Your Trainees?** Rena Gresh, C-TAGME, GC-MedEd
9:45 – 10:00am	**GroundHog Day: A Yearly Cycle of Graduate Medical Education Administrative Work** Jannot Ross
10:00 – 10:15am	**Break**
10:15 – 11:15am	**AAPAE Community of Practice** *Moderators: Lara Zisblatt, EdD, MA, PMME & Faye Haggar, EdD*
11:15 – 11:45am	**Justice, Equity, Diversity & Inclusion (JEDI) Panel** *Moderator: Lucine Torosian, BS*
11:15 – 11:25am	**Why Diversity, Equity and Inclusion Matters: Living Our Values** Kimberly J. Ward, MBA
11:25 – 11:35am	**Challenges and Solutions to Safe Reporting** Erin Wood, MS, C-TAGME
11:35 – 11:45am	**Strategies for Increasing Diversity and Supporting URM Trainees** Marisa E. Hernandez-Morgan, MD, MPP
11:45am – 12:20pm	**Box Lunch (Ticket Required)**
12:20pm – 1:00pm	**AAPAE Lunch Round Tables** **(20 minutes x2)** **Table 1: Managing Multiple Programs** Lucine Torosian, BS **Table 2: Work – Life Balance During COVID** Lara Zisblatt, EdD, MA, PMME **Table 3: How to Get Started with Ed Research** Ashley Grantham, MA, PhD **Table 4: Step-By-Step How to Write an Abstract/Poster** Fei Chen, PhD, MEd **Table 5: Dealing with Difficult Personalities at Work** Amy N. DiLorenzo, MA, PhD & Rossela Martinez
1:00 – 5:00pm	**Join AACPD**
1:00 – 3:00pm	**Annual Updates** *Moderator: Andrea Dutoit, MD*
1:00 – 1:40pm	**ABA/ITE Update** Mark Keegan, MB, BCh, BAO, MRCPI, DABA, MSc, FCCM & Alex Macario, MD
1:40 – 2:10pm	**ACGME Update** Aditee Ambardekar, MD MSEd Cheryl Gross, MA, CAE
2:10 – 2:40pm	**ERAS Supplemental Application** Andrea Dutoit, MD Emily G. Teeter, MD, FASE, FASA
2:40 – 3:00pm	**Q&A**
3:00 – 3:30pm	**Break**
3:30 – 5:00pm	**Everything You Wanted to Know** *Moderator: Jed T. Wolpaw, MD, MEd*
5:30 – 7:30pm	**SAAAPM Reception**

SAAAPM Presentations

SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Saturday, November 12

7:00 – 7:30am	**Continental Breakfast**
7:30 – 8:00am	**SAAAPM Business Meeting**
8:00 – 8:10am	**Introduction / Welcome** Michael C. Lewis, MD, FASA
8:10 – 8:30am	**ASA Update** Ronald L. Harter, MD
8:30 – 8:40am	**FAER Update** James Eisenach, MS, MD
8:40 – 8:55am	**Q&A**
8:55 – 10:15am	**Global Health** *Moderator: Warren S. Sandberg, MD, PhD*
8:55 – 9:00am	**Introduction** Warren S. Sandberg, MD, PhD
9:00 – 9:20am	**Presentation 1 – Role of Global Health in Your Department: Vice-Chair of Education Perspective** Dawn Dillman, MD
9:20 – 9:40am	**Presentation 2 – Role of Global Health in Your Department: Program Director Perspective** Brian J. Gelfand, MD
9:40 – 10:00am	**Presentation 3 – Role of Global Health in Your Department: Chair's Perspective** Daniel Talmor, MD, MPH
10:00 – 10:15am	**Q&A**
10:15 – 10:45am	**Break**
10:45 – 11:45am	**Re-Engagement with Residents and Faculty** *Moderator: Lara Zisblatt, EdD, MA, PMME*
10:45 – 10:50am	**Introduction** Lara Zisblatt, EdD, MA, PMME
10:50 – 11:20am	**Presentation 1** Shelley Brickson, MA, PhD
11:20 – 11:40am	**Presentation 2** John D. Mitchell, MD & Nick Yeldo, MD
11:40 – 11:45am	**Q&A**
11:45 am – 12:15pm	**Box Lunch (Ticket Required)**
12:15 – 1:15pm	**The Wellbeing of an Anesthesia Department** *Moderator: Amy E. Vinson, MD, FAAP*
12:15 – 12:20pm	**Introduction** Amy E. Vinson, MD, FAAP
12:20 – 12:35pm	**Establishing Psychological Safety** Elizabeth W. Duggan, MD, MA
12:35 – 12:50pm	**Organizational of a Wellbeing initiative** Carol Ann Diachun, MD, MSEd
12:50 – 1:05pm	**Peer Support in Action** Bridget Pulos, MD
1:05 – 1:15pm	**Q&A**
1:15 – 2:30pm	**Perioperative Medicine. What is Now and What is Next** *Moderator: TJ Gan, MD, MBA, MHS, FRCA, FFARCS (IRE), Lic Ac*
1:15 – 1:20pm	**Introduction** TJ Gan, MD, MBA, MHS, FRCA, FFARCS (IRE), Lic Ac
1:20 – 1:40pm	**The Vision and Value of Perioperative Medicine** Angela F. Edwards, MD, FASA
1:40 – 1:50pm	**Where Are We Now?: Opportunities and Barriers for Advancing Perioperative Medicine at the National and Institutional Level** *Matthew D. McEvoy, MD*
1:50 – 2:20pm	**Training the Next Generation of Perioperative Physicians: A Close Up Look at Fellowship Training** *Jenna D. Blitz, MDD, FASA, DFPM*
2:20 – 2:30pm	**Q&A**
2:30pm	**Event Ends**
2:45pm	**SAAAPM Hosted Buses Depart for Airports**

HANDOUT

Mega-Mergers with Hospital Systems

Moderator: B. Scott Segal, MD, MHCM

Friday, November 11
8:00 AM - 9:20 AM

HANDOUT

Mega-Mergers with Hospital Systems: Presentation 1

Roy G. Soto, MD

Friday, November 11
8:00 AM – 8:20 AM


Mega-Mergers with Hospital Systems
The Beaumont Perspective
Roy Soto, MD
Residency Program Director
Beaumont Hospital

1


Mega-Mergers with Hospital Systems
The Beaumont Perspective
Roy Soto, MD
Residency Program Director
Oakland University William Beaumont Hospital

2


Mega-Mergers with Hospital Systems
The Beaumont Perspective
Roy Soto, MD
Residency Program Director
Beaumont Health

3


Mega-Mergers with Hospital Systems
The Beaumont Perspective
Roy Soto, MD
Residency Program Director
Corewell Health

4


Mega-Mergers with Hospital Systems
The Beaumont Perspective
Roy Soto, MD
Residency Program Director
Corewell Health - East

5


Mega-Mergers with Hospital Systems
The Beaumont Perspective
Roy Soto, MD
Residency Program Director
Corewell Health William Beaumont University Hospital

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Mega-Mergers with Hospital Systems

The Beaumont Perspective

Roy Soto, MD
Residency Program Director
Corewell Health William Beaumont University Hospital

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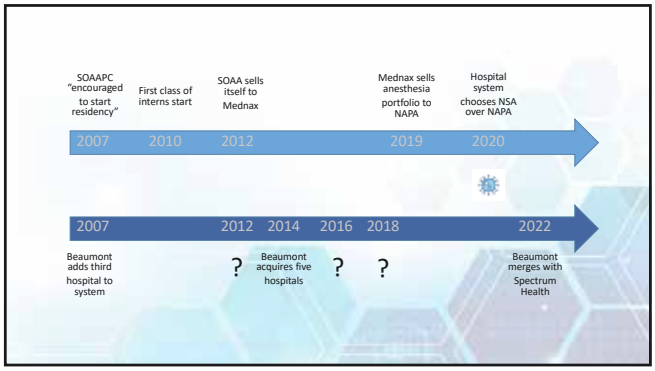

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My Conundrum

- Separating the anesthesia group changes from the hospital mergers
- We're still here, so everything must be fine

11

Effects of Group Mergers

Money	Accounting changes
Personnel	Change in/consolidation of Program Coordinator for some residencies • Smaller lost, larger gained
Supplies	No change in drugs/equipment/offices
Residency as a whole	Consolidation of Family Practice, orthopedics, pulmonary programs • Quality of residents vs. elitism

12

Effects of Change

- Threat of merger with HFH drove us to sell practice
- Anticipation of merger with Spectrum drove hospital to consolidate anesthesia groups

13

The NAPA → NSA Change

- Lost 50% of clinical faculty
  - Chair/PD/APD stayed same
  - 80% of rotation directors left
  - 50% of prior "teacher of the year" left
  - Bad press
- Created anxiety in residents/remaining faculty
- Created anxiety for surgeons
- Made interview season challenging

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Residency Threats

- Other PDs badmouthing us
- Instability
  - Existential angst among residents
  - Interview season
- Name recognition
  - Residency candidates
  - Fellowship interviews
  - Job candidates

15

Residency Opportunities

- We gained 50% new faculty
  - New ideas/techniques/tips
  - Revitalized simulation, POCUS, CCM
- New vision includes enhanced academic footprint
  - "the Cleveland Clinic or Mayo of Michigan"
- Real world for our residents
- Job opportunities for our graduates
- Leadership opportunities for our attendings

16

Change is the only constant in life

-Heraclitus, 6th century BCE

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HANDOUT

Mega-Mergers with Hospital Systems: Presentation 2

James P. Rathmell, MD, MBA

Friday, November 11
8:20 AM – 8:40 AM

Mega-Mergers with Hospital Systems

The Emerging Mass General Brigham Healthcare System

James P. Rathmell, M.D., M.B.A.
Chief, Enterprise Anesthesiology, Mass General Brigham
HARVARD MEDICAL SCHOOL

1

2

Mass General Brigham

The Case for Change

SECURING OUR MISSION

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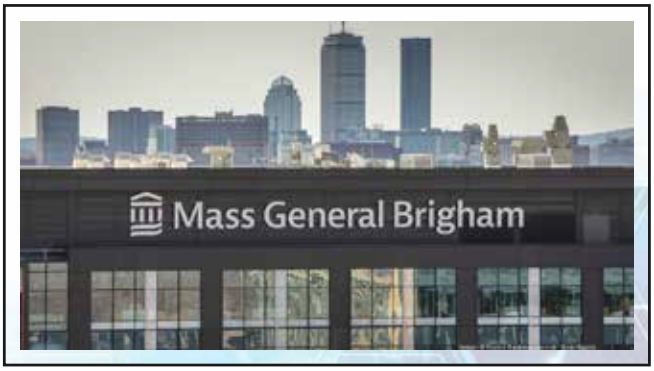

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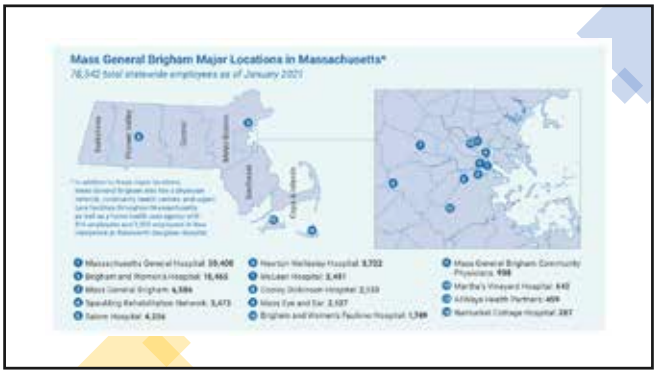

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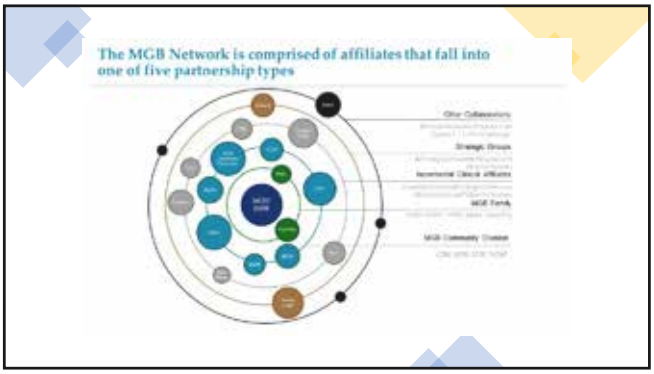

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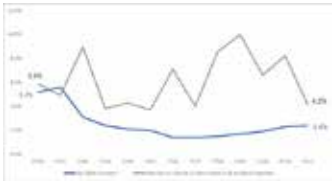
Revenue growth has not kept pace with expense growth for the past decade

Trended Revenue (per unit) and Expense Run Rate Growth[1]



- Prior to 2012, reimbursement rate growth closely matched expense growth
- Since then, expense growth has exceeded revenue growth by 1-2% annually
- Each 1% of expense growth over revenue growth creates a $160M financial gap for the next year
- From 2012-2020, the gap was closed through a combination of levers no longer available:
  - One-time cost reduction (voluntary retirement options [VROs], Partners 2.0 initiatives, etc.)
  - Organic hospital-based outpatient volume growth, which has now peaked
  - Most recent inorganic growth (Wentworth Douglass and Mass Eye and Ear)
  - Natural growth in 340B pharmacy revenue, which has recently plateaued

[1] Run Rate excludes impacts of significant one-time items, e.g., Partners eCare "at the elbow" support and BWH & MAH (Voluntary Retirement Offer (VRO), Royalty). Wentworth-Douglass (WD) and Mass Eye and Ear (MEE) are included beginning with their first full year of operations (WD FY18 and MEE FY19).

7

7

Continued and new headwinds are having significant financial impact

- Structural financial challenges in the healthcare industry:
  - Clinical revenue growth cannot keep pace with expense growth, given needs to curb growth in total medical expenditures and improve affordability
  - New entrants seeking to cherry-pick the areas where we are most profitable (e.g. ambulatory operators focused only on commercial patients, investor-owned single-specialty groups)
  - Prior strategies to close the trend gap are no longer available or adequate
- Continued need for infrastructure investment
- Additional, more recent headwinds include:
  - Recent and ongoing COVID disruptions to care
  - Further barriers from the State to organic growth
  - Tightening labor market dynamics
  - Highest inflation pressures in over 40 years placing unprecedented pressure on labor and non-labor costs

*Initial budget gap for FY23 was **double** what it had been in recent years in every part of the health system; FY24-FY28 forecast is similarly challenged*

8

8

The growing gap threatens our mission

Patient Care
~$600M subsidy for Medicaid
(costs net of reimbursement)

Research and Discovery
~$250M of support
(costs net of indirect cost recovery)

Teaching
~$200M of support
(costs net of GME/IME payments)

Community
~$100M charity care
~$100M of direct investment

9

9

Our margin improvement plan includes growth, integration, and efficiency components to continue supporting our mission

Establishing a culture of and model for continuously improving effectiveness and efficiency

Comprehensive approach to expense management
- Continued process improvement in key functional areas (supply chain, revenue cycle, etc.)
- Increased emphasis on intelligent automation
- Labor productivity benchmarking and management
- Systemwide approaches to managing large non-labor spend areas (IT, pharmacy, real estate, etc.)

Clinical integration to care for patients better and more efficiently
- Enterprise Clinical Services to deliver a clinically integrated, consistent patient experience
- Enterprise and Local Asset Management to improve cross-system resource and capacity management
- Service lines to improve integration and impact across the system
- Access integration to promote easy access and reduce leakage

Pursuing diversified businesses to improve our margin
- New scientific businesses (e.g., expansion of innovation funds, gene & cell therapy)
- New clinical businesses (e.g., specialty pharmacy, global advisory, destination patient, home care, sports medicine)
- New partnerships focused on new revenue/extending marketing reach
- Health insurance (Mass General Brigham Health Plan) expansion into additional lines of business
- Possible investments in or acquisitions of targeted companies in key growth areas

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Reported & Adjusted Income from Operations – YTD Jun 2022

($ in millions)	Q1	Q2	Q3	June Year to Date
Income (loss) from ops, as reported	$ 10	$ (193)	$ (120)	$ (303)
Item excluded from budget:				
Rural floor rate benefit	(37)	(36)	(40)	(113)
Quality of Earnings total	(37)	(36)	(40)	(113)
Income (loss) from ops, as adjusted	$ (27)	$ (229)	$ (160)	$ (416)
Income (loss) from ops, budgeted	(12)	(32)	62	18
Budget variance, as adjusted	$ (15)	$ (197)	$ (222)	$ (434)
Reported margin %	0.2%	-4.8%	-2.8%	-2.4%

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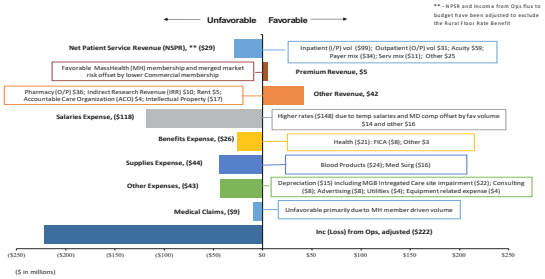
Adjusted Budget Variance Drivers – Q3 Jun 2022



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12

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1872 The Boston Globe 2022

Serving our community for 150 years

At Mass General Brigham, a sweeping effort to unify hospitals and shed old rivalries

Executives say greater cooperation is necessary to stay relevant in a dynamic and competitive health care industry. But the aggressive push to integrate is stirring tensions and sowing discontent among doctors and hospital leaders.

By Priyanka Dayal McCluskey and Larry Edelman, Globe Columnist, Updated March 27, 2023, 6:15 p.m.

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Emerging Trends

LEADERSHIP IN TURBULENT TIMES

15

Emerging Trends in Anesthesiology Practice

Workforce

Practice Consolidation

Paul Pomerantz, CEO, American Society of Anesthesiologists, March 2022

16

Workforce Trends

Practices of all types are reporting recruiting challenges

Anesthesiology is among the most popular of specialties for medical school graduates but cannot keep up with growing demand

- Demand for anesthesiology likely to increase in coming years
- Ability to impact supply is limited due to funding limitations and lengthy timelines to impact training

ASA convened a Workforce Summit on June 9-10, 2022, focusing on means to address demand, rather than supply

- Stimulate discussion among U.S. Health systems and anesthesiology leadership
- Create next steps to address the supply/demand imbalance

17

17

Anesthesiologist Supply v. Demand

Factors affecting Supply

Residency Match results signal strong demand for anesthesiology residency programs
-Growth in the number of applicants
-Growth in positions offered
-Increase in percentage of positions filled

Greater emphasis on shift work/lifestyle/ locum tenens among new graduates

Aging of the anesthesiologist workforce

Factors affecting Demand

Aging of the population

Growth of ambulatory surgery

Growth of non OR anesthesia services

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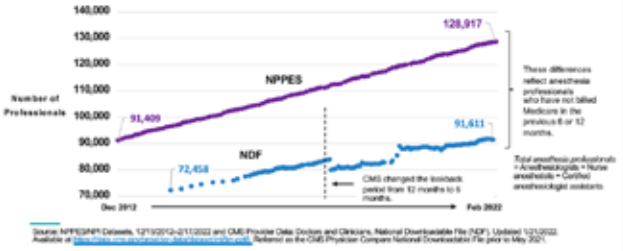
How Many Total Anesthesia Professionals Are There?



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Job Postings: Non-Recruiting Agencies

Oct 2019–Feb 2022

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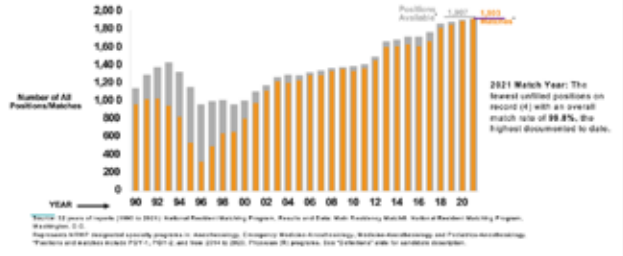
Anesthesiology Positions Available Compared to Total Anesthesiology Candidates Matched*, 1990–2021



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Practice Consolidation

Anesthesiology is becoming increasingly diverse and competitive

Types of practices

- Traditional, small practices
- Medium to large, regional independent practices, often formed as a result of merger
- National corporate
- Hospital or health-system employed
- Academic

22

Practice Consolidation

Type of consolidation

Private equity
Practice mergers and organic growth
Hospital acquisition/employment

Factors accelerating consolidation

Need for scale relative to insurance and health systems negotiation
Ability to compete in marketplace
Increasing expense of information systems, compliance, billing and specialized back-office functions

23

A Trend Throughout Healthcare

In 2018 the valuation of private equity deals in the US health care sector surpassed $100 billion—a twentyfold increase from 2000 (when it was less than $5 Billion)
Private Equity Investments In Health Care; Health Affairs, May 2021

Private Equity is attracted to healthcare because it is recession resistant, has operational inefficiencies, and projected demand for increased services (aging of population)

Key attributes of Private Equity: Diverse structures and source of funds; reliance on leveraged buyouts and outsized returns; seek to grow through acquisition of platform practices in target markets

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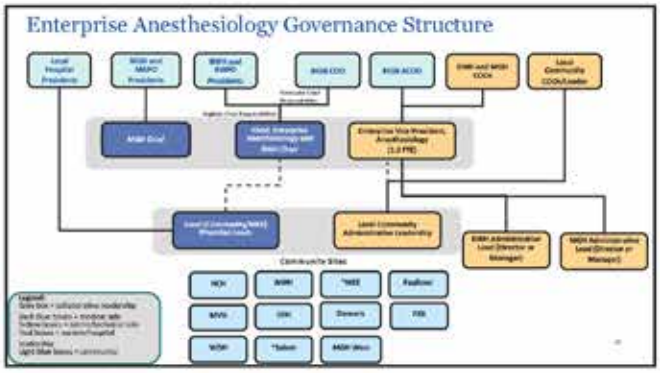

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HANDOUT

Mega-Mergers with Hospital Systems: Presentation 3

B. Scott Segal, MD, MHCM

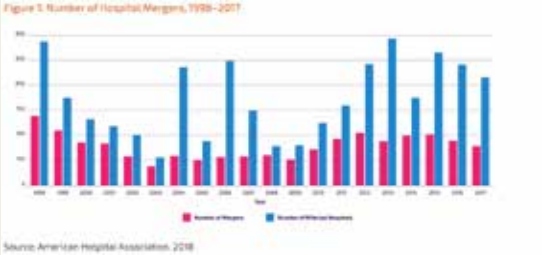
Friday, November 11
8:40 AM – 9:00 AM

Mega-Mergers with Hospital Systems

B. Scott Segal, MD, MHCM
Roy G. Soto, MD
James P. Rathmell, MD

1

Hospital megamergers: a growing trend



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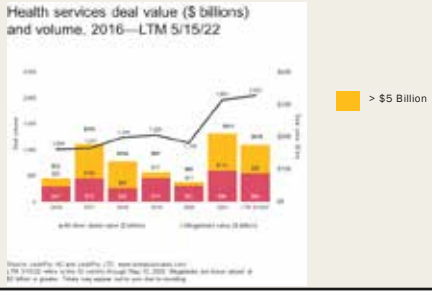
Number, value of deals increasing



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Hospital systems increasingly concentrated

$$HHI = s_1^2 + s_2^2 + s_3^2 + \ldots s_n^2$$

- Herfindahl-Hirschman Index >2500 is "highly concentrated"
- 80% of hospital markets highly concentrated (Gaynor 2020)
- Average HHI for hospital markets 5,092
- Top 10 systems control 24% of total healthcare market (Deloitte 2020)

4

AMCs and mega-mergers

- 36% of CEOs at AMCs said M&A would be main engine of growth (2016 survey)
- Hospital systems financially stressed—likely more coming!
- Today's panel will discuss 3 examples

5

Atrium Health Wake Forest Baptist

Wake Forest School of Medicine

The Wake Forest-Atrium Health Deal

6

A “strategic combination” is announced

- April 2019 announced; regulatory oversight, board approvals
- October 9, 2020 deal completed
- Initially 42 hospitals, 1500 healthcare locations
- North Carolina, South Carolina, Georgia and Virginia
- 70,000 teammates
- 15 M patient interactions

Atrium Health Wake Forest Baptist | Wake Forest School of Medicine

7

Initial features

- Based in Charlotte, NC
  - CEO Gene Woods, in Charlotte is Enterprise CEO
  - Legacy Wake CEO Julie Freischlag, MD remains CEO in Winston-Salem, Dean and CAO for School of Medicine and Enterprise
- Largest US city without a medical school
- Initial terms included
  - Build 2nd campus of WFSOM in Charlotte
  - Large capital infusion (3.4B) into Wake region
- Approximately $14 B, one of top 5 largest academic systems

Atrium Health Wake Forest Baptist | Wake Forest School of Medicine

8

More consolidation

- Acquired Floyd Health in Georgia in July 2021
- Announced merger with Advocate-Aurora May 2022
- When complete (under FTC review)
  - Headquartered in Charlotte, called Advocate Health (keep local brands)
  - Co-CEOs for 18 months, then Woods sole CEO
  - 150,000 teammates
  - 67 more hospitals
  - Combined revenue of $27 B
  - One of top 5 largest healthcare systems of any type

Atrium Health Wake Forest Baptist | Wake Forest School of Medicine

9

Integration

- Variety of clinical entities in CLT
  - Large private practices
  - Enterprise-employed departments
  - “Hybrid” leaders with both affiliations (chief surgical officer)
  - Some residencies, rotating medical students, CRNA school
  - Institutes: larger than individual departments (e.g., cardiovascular, cancer, musculoskeletal, neuroscience)
- Integration efforts divided into waves

Atrium Health Wake Forest Baptist | Wake Forest School of Medicine

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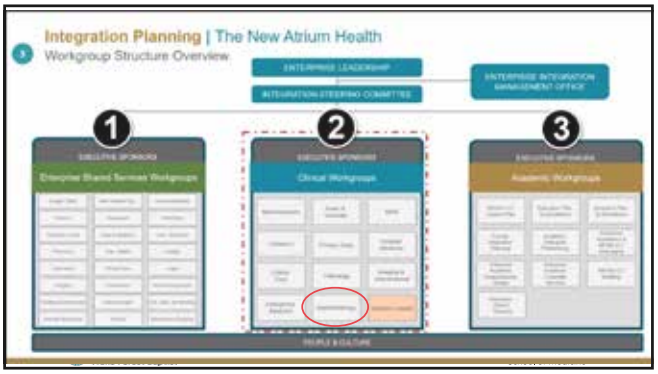

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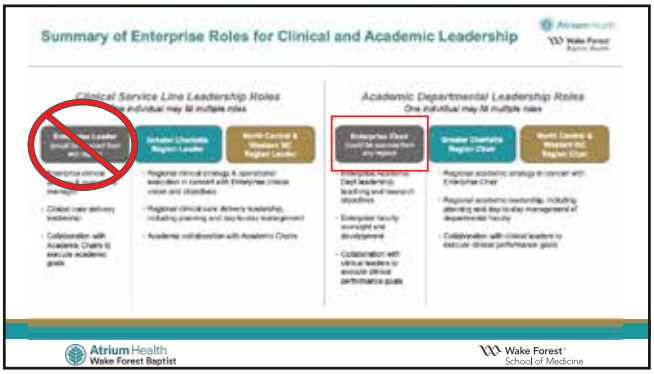

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Capital infusion is *great news*

13

Academic integration

- Adjunct faculty appointments in CLT
- Medical student rotations
- Beginning of collaborative research
- Enterprise seems committed to academic LHS

14

Clinical integration

- Epic “harmonization”
  - Q1 2024 completion target
- Shared quality goals
  - MPOG
  - Resisted OR efficiency metrics
- Shared OR safety program (“Wake Wings”)
- No talk of combining entities

15

Cultural integration

- Clearly different cultures
  - Private anesthesia practice vs. hybrid academic department
  - Very ”corporate” feel from Atrium Health
  - Much less tradition of academics in some services
- Will academic identity continue?
  - Ever smaller fraction of Enterprise
  - Effect of Charlotte campus
  - No plans for residency in Charlotte at present
- As CLT feels more academic, $ differences will be ↑ important
- Upper management consolidation

16

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HANDOUT

RRC Update

Aditee Ambardekar, MD, MSEd
Cheryl Gross, MA, CAE

Friday, November 11
9:20 AM – 9:40 AM

ACGME Review Committee Update

November 11, 2022

Aditee Ambardekar, MD
Chair, Review Committee for Anesthesiology

1

Disclosure

- **No disclosures to report**

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2

Session Objectives

1. Describe current accreditation statistics for core and subspecialty programs
2. Discuss recent and upcoming changes to the Program Requirements
3. List recent and upcoming initiatives at the ACGME and Anesthesiology RC

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The Stats

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Trends in Core Anesthesiology Programs

Academic Year	# Approved Resident Positions	# Core Programs
2021-2022	7,859	166
2020-2021	7,640	161
2019-2020	7,531	160
2018-2019	7,299	153
2017-2018	7,171	153
5-Year Trend	**↑ 9.6%**	**↑8.5%**

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Core Anesthesiology Program Size 2021-2022

Number of Filled Positions	Number of Programs
0 Residents	5
1-24 Residents	49
25-49 Residents	50
50-74 Residents	38
75-99 Residents	16
100+ Residents	8

	Number of Filled Positions
Range	0-113
Mode	20
Median	39
Mean	43

90.5% Fill

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Subspecialty Programs 2020-2021

Subspecialty	Number of Programs	Filled	Active Fellows
Adult Cardiothoracic	74	94.7%	251
Critical Care Medicine	64	83.6%	219
Regional Anesthesiology and Acute Pain Medicine	40	96.1%	98
Obstetric Anesthesiology	41	85.3%	58
Pain Medicine	114	94.7%	4333
Pediatric Anesthesiology	61	83.1%	222

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Pediatric Cardiac Anesthesiology

- Beginning accreditation – July 1, 2022
- Currently accredited
  - *6 programs*
  - *10 approved positions*

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Program Review

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Annual Review Committee Activities

- Applications for new programs
- Permanent complement increase requests
- Annual data
  - *Programs with Citations*
  - *Programs with Annual Data Indicators*
- 10-Year site visit reports

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Annual Program Review 2020-2021

501 Programs Reviewed

- 472 Continued Accreditation
- 5 Continued Accreditation with Warning
- 11 Initial Accreditation
- 2 Accreditation Withheld
- 1 Deferred

Common Citations

- Faculty and Resident Scholarly Activity
- Qualifications of Faculty (subspecialty)
- Responsibilities of Program Director (Failure to provide accurate information)
- Responsibilities of Faculty
- Curricular Development
- Evaluation of Residents
- Educational program—Patient Care Experience and Didactic Components

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Other Initiatives

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Protected Time: Core Program Director

Number of Approved Resident Positions	Minimum Support Required (FTE) for the Program Director	Minimum Additional Support Required (FTE) for Program Leadership	Total Minimum Program Leadership Support
1-20	0.2	0.2	0.4
21-30	0.4	0.2	0.6
31-40	0.4	0.3	0.7
41-50	0.4	0.4	0.8
51-60	0.4	0.5	0.9
61-70	0.4	0.6	1.0
71-80	0.4	0.7	1.1
Over 80	0.4	0.8	1.2

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Protected Time: Core Coordinator

Number of Approved Resident Positions	Minimum Support Required (FTE)
9-10	0.7
11-15	0.8
16-20	0.9
21-25	1.0
26-30	1.1
31-35	1.2
36-40	1.3
41-45	1.4
46-50	1.5
51-55	1.6
56-60	1.7

Number of Approved Resident Positions	Minimum Support Required (FTE)
61-65	1.8
66-70	1.9
71-75	2.0
76-80	2.1
81-85	2.2
86-90	2.3
91-95	2.4
96-100	2.5
101-105	2.6
106-110	2.7
111-115	2.8
116-120	2.9
Over 120	3.0

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Protected Time: Subspecialty PDs

Number of Approved Fellow Positions	Minimum FTE
1-2	0.1
3	0.125
4	0.15
5	0.175
>5	0.2

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Protected Time: Subspecialty Coordinator

Number of Approved Fellow Positions	Minimum FTE
1	0.2
2	0.24
3	0.26
4	0.28
>5	0.02 per each additional approved position

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Major Revisions Program Requirements

- Core – work will begin in 2024 for July 1, 2026 start date
  - Planning for future of anesthesiology
  - JGME article – internal medicine process
- Subspecialties – work will begin in early 2023 for a July 1, 2024 start date

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Milestones 2.0

- Core Anesthesiology in effect July 1, 2021
- Adult Cardiothoracic – working through December
- Critical Care – Working through Jan 2022
- Obstetrics – working through Feb 2022
- Pediatric – working through Feb 2022
- Pediatric Cardiac – working through Feb 2022
- Pain Medicine – Review and Comment Closed Oct 31

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Rural Track Program Designation

- Processes developed to address accredited programs that meet CMS definition of "rural track"
- Urban teaching hospital can obtain DGME and IME financing through partnerships with rural hospitals and sites
- Info on www.acgme.org
- Contact muap@acgme.org or 312.755.7458

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ACGME Equity Matters™

- Framework for continuous learning in DEI and anti-racism practices
- Comprehensive curriculum of ideas, models, and data to support interventions to develop diverse physician workforce to care for diverse patient populations
- Combines educational resources and collaborative learning communities
- Visit the ACGME website or email diversity@acgme.org for more information

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Medical, Parental, Caregiver Leave(s) of Absence

- ACGME Institutional Requirements, effective July 2022
- Minimum of 6 weeks of leave at least once and at any time during an ACGME-accredited program
- Provide residents/fellows equivalent of 100% of salary for first 6 weeks of first approved leave
- At least one week of paid time off outside the first 6 weeks of first approved leave
- Continue health and disability insurance benefits for residents/fellows and eligible dependents during approved leave

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Medical, Parental, Caregiver Leave(s) of Absence

- RC allows flexibility in approved leaves of absence
  - Clinical experience requirements must be met (includes case logs)
  - Clinical Competency Committee must deem the affected resident fully prepared for autonomous practice
- Review ABA's (or AOBA) Absence from Training policy

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Competency-Based Medical Education

- ABMS-ACGME Symposium – held August 2023
- Review Committee plans to incorporate as part of its major program requirement revisions
- In the meantime – AIRE process
  - Promoting innovation for programs
  - Can permit reprieve from specific program requirements based on proposal

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CONTACT ACGME Staff – they want to help!

Review Committee Staff

Cheryl Gross: cgross@acgme.org
Kerri Price: kprice@acgme.org
Aimee Morales: amorales@acgme.org

- *Program requirements*
- *Notification letters*
- *Complement requests*
- *Case Log content*

ADS Staff

ADS@acgme.org

- *ADS*
- *Surveys*
- *Case Log technical support*

Field Activities Staff

fieldrepresentatives@acgme.org

- *Site Visits*
- *Self-Studies*

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HANDOUT

Work-Life Integration

Moderator: Stephanie B. Jones, MD, FASA

Friday, November 11
10:30 AM – 11:45 AM

HANDOUT

Work-Life Integration: Supporting Faculty: A Faculty Administration Perspective

Harriet W. Hopf, MD, FUHM, FASA

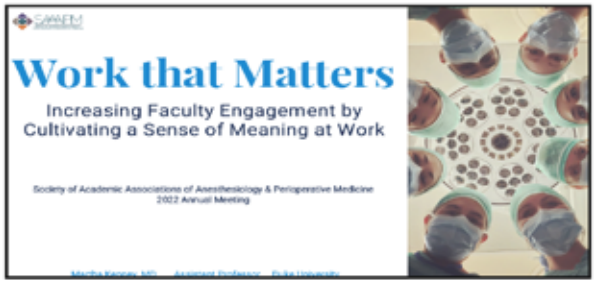
Friday, November 11
10:30 AM – 11:00 AM

HANDOUT

Work-Life Integration: Supporting Faculty: Work that Matters: Increasing Faculty Engagement by Cultivating a Sense of Meaning at Work

Martha Kenney, MD

Friday, November 11
11:00 AM – 11:30 AM


Work that Matters
Increasing Faculty Engagement by Cultivating a Sense of Meaning at Work
Society of Academic Associations of Anesthesiology & Perioperative Medicine
2022 Annual Meeting

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Disclosures
No relevant financial disclosures

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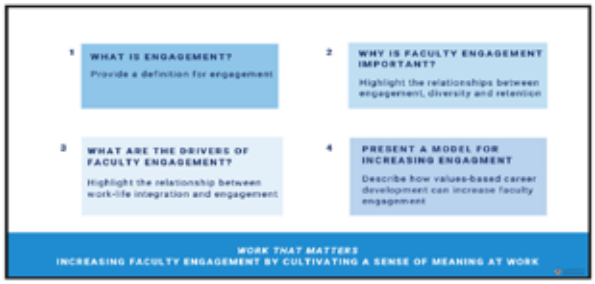
1 WHAT IS ENGAGEMENT?
Provide a definition for engagement
2 WHY IS FACULTY ENGAGEMENT IMPORTANT?
Highlight the relationships between engagement, diversity and retention
3 WHAT ARE THE DRIVERS OF FACULTY ENGAGEMENT?
Highlight the relationship between work-life integration and engagement
4 PRESENT A MODEL FOR INCREASING ENGAGMENT
Describe how values-based career development can increase faculty engagement
WORK THAT MATTERS
INCREASING FACULTY ENGAGEMENT BY CULTIVATING A SENSE OF MEANING AT WORK

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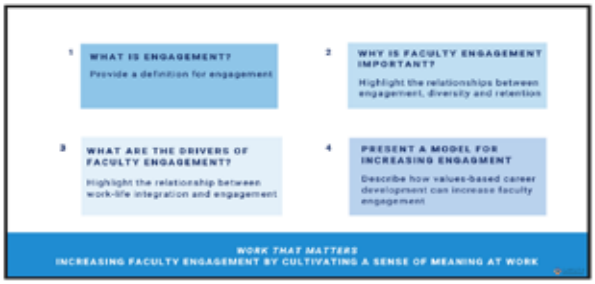
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"When people are financially invested, they want a return. When people are emotionally invested, they want to contribute."
Start With Why by Simon Sinek

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What is engagement?
Authentic connection or commitment to your work and your organization.

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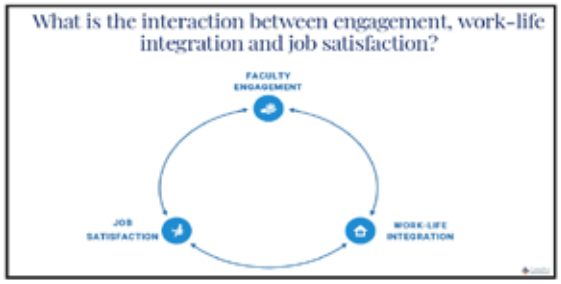
What is the interaction between engagement, work-life integration and job satisfaction?
FACULTY ENGAGEMENT
JOB SATISFACTION
WORK-LIFE INTEGRATION

7


3 Personas of Engagement

8


"BATTERED"
"PRESSURED"
"MISUNDERSTOOD"
"ISOLATED"
3 out of 5
First 3-5 yrs

9


From enthusiastic student
to
disengaged physician

10


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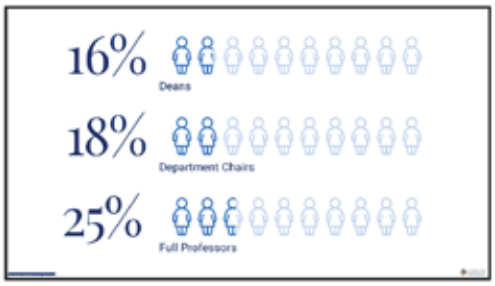

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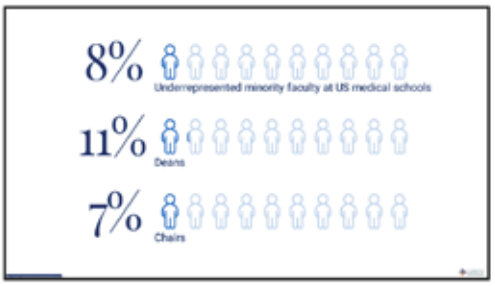

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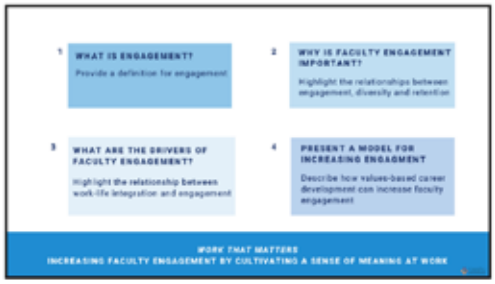

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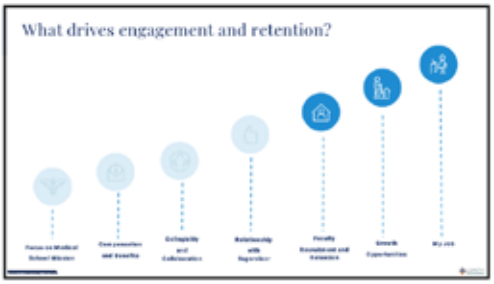

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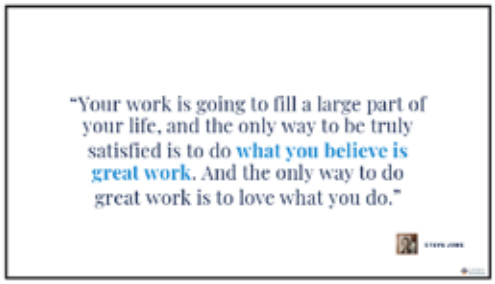

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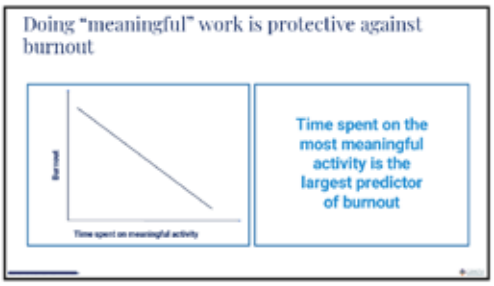

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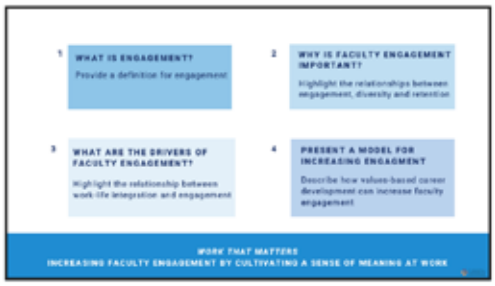

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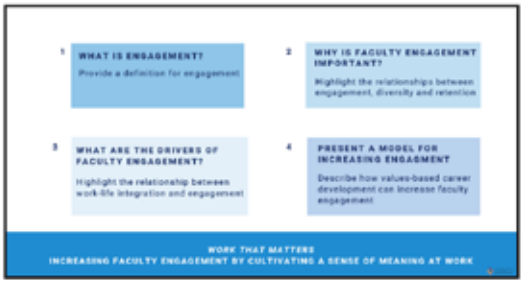

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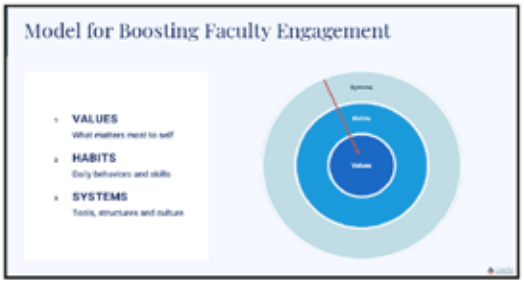

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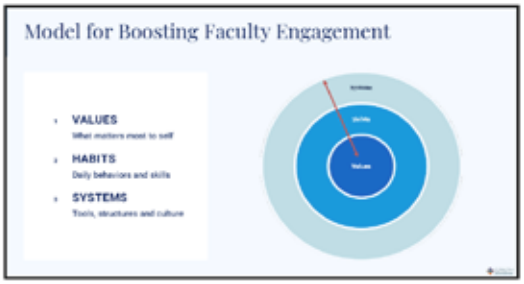

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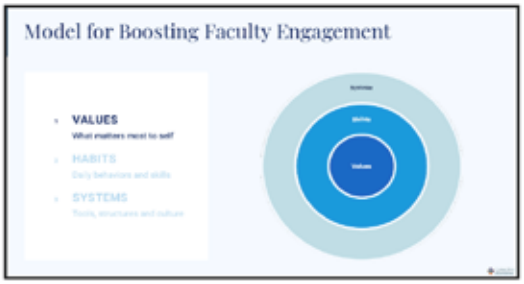

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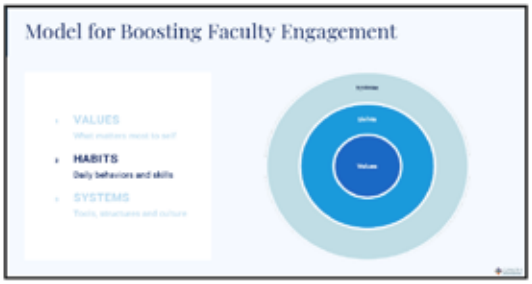

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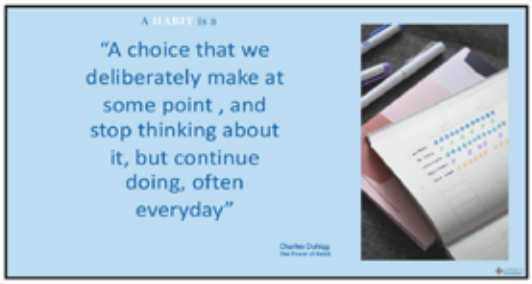

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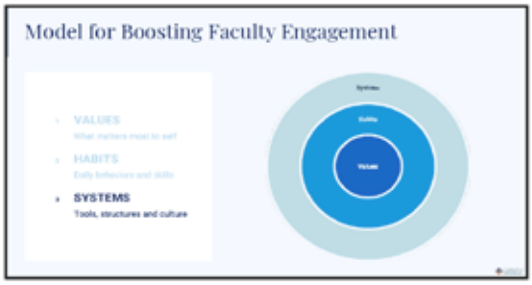

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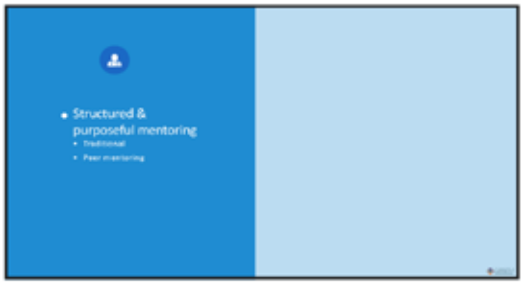

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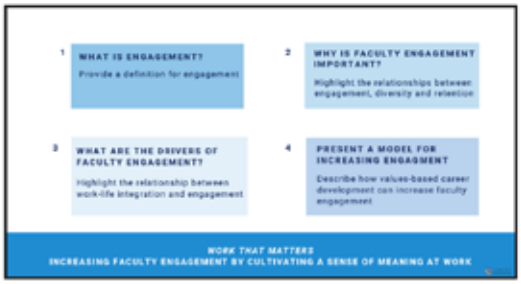

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HANDOUT

AAAC Business Meeting & Introduction of All New and Interim Chairs

Moderator: Michael C. Lewis, MD, FASA

Friday, November 11
12:45 PM – 1:15 PM

HANDOUT

Imperfect Storm: The Complexity of Anesthesiology Staffing and Compensation Metrics

TJ Gan, MD, MBA, MHS, FRCA, FFARCS (IRE), Lic Ac
B. Scott Segal, MD, MHCM

Friday, November 11
1:15 PM – 2:00 PM

Imperfect Storm: The Complexity of Anesthesiology Staffing and Compensation Metrics

T J Gan, M.D., M.B.A., M.H.S., F.R.C.A.
Professor and Division Head
Anesthesiology, Critical Care and Pain Medicine
UT Texas MD Anderson Cancer Center

B. Scott Segal, MD, MHCM
Thomas H. Irving Professor and Chair
Wake Forest School of Medicine.

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Compensation Survey Committee

- Douglas Bacon
- Alex Bekker
- Michael Crowder
- TJ Gan (Chair)
- Vesna Jevtovic-Todorovic
- Michael C. Lewis
- Timothy Morey
- Peter Rock
- B. Scott Segal
- Charles Whitten
- Cynthia Wong
- Sarah Michels - Readex Research
- Andrew Bronson

3

Outline

- Thank you Dr. Charles Whitten for his contributions

• Changes in methodology	Scott Segal
• Results from 2021/22 survey	T J Gan
• Trends over the past 5 years	T J Gan

4

Changes in methodology

- Publication of "data dictionary" explaining how ratios are calculated
- Asked new questions about CRNAs, ICU
- Separated out Pain Medicine FTEs
  - To clarify ASA unit production vs. RVU production by faculty
- Offered a "town hall" style Q&A to clarify instructions
- Provided an institution-specific report
  - Allows easier comparison to benchmarks

5

Number of Filled Faculty Positions at this Rank, Total Paid FTE:

N = 85	Mean	Median	75%	25%
Instructor	5.8	1.0	6.0	0.0
Assistant Professor	37.9	33.4	53.9	22.2
Associate Professor	14.9	12.8	19.0	7.3
Professor	8.9	6.7	11.4	2.0
Non Academic	2.5	0.0	1.0	0.0
Chair	0.9	1.0	1.0	1.0
Total	70.9	60.5	96.0	41.7

6

Faculty Counts at your teaching/academic hospitals/facilities as of June 30,2021

	N	Mean	75%	Median	25%
Total Clinical Chronic Pain **ONLY** FTE	81	5.8	8.0	5.0	2.9
Clinical Chronic Pain FTE	77	4.3	6.2	3.8	2.1
Total Non-Pain FTE	81	67.2	91.9	57.7	40.0
Total Non-Pain Clinical FTE	77	57.6	79.2	49.0	36.9

7

Gender and Race/Ethnicity of the Clinical Anesthesiology and Pain Faculty at your Teaching/Academic Hospitals/Facilities, as of June 30,2021

N=76	Mean	75%	Median	25%
Male:	44.9 (60%)	60	39	28
Female:	28.7 (39%)	38	25	16
Am. Indian:Hispanic, not Hispanic, unknown	1.1			
Asian: Hispanic, not Hispanic, unknown	13.5			
Black: Hispanic, not Hispanic, unknown	2.9			
Hawaii/PI: Hispanic, not Hispanic, unknown	0.1			
White: Hispanic, not Hispanic, unknown	60.1			
Unknown: Hispanic, not Hispanic, unknown	10.3			

8

How many open clinical faculty positions did your department have on June 30,2021, in each of these areas?

N=81	Mean	75%	Median	25%
Vacancy rate	17.1%	18.7%	11.6%	7.9%

9

of ASA units for anesthesia service by FTE

	N	Mean	75%	Median	25%
ASA units for anesthesia service by Total Clinical Anesthesiology and Pain FTE	68	13,527	15,333	12,223	9,570
ASA units for anesthesia service by Total Clinical Anesthesiology and Pain Clinical FTE	68	15,227	18,564	13,655	11,352
ASA units for anesthesia service by Total Non-Pain FTE	67	14,767	17,122	13,143	10,708
ASA units for anesthesia service by Total Non-Pain Clinical FTE	65	16,480	20,622	14,437	11,946
ASA units for anesthesia service by Total Clinical FTE providing ASA	63	20,978	24,836	18,926	15,059

10

of Chronic Pain wRVUs by FTE

	N	Mean	75%	Median	25%
Chronic Pain wRVUs by Physician Chronic Pain Providers by Total Clinical Chronic Pain ONLY Paid FTE	57	4,663	6,230	4,347	2,582
Chronic Pain wRVUs by Physician Chronic Pain Providers by Total Clinical Chronic Pain ONLY Clinical Chronic Pain FTE	56	5,747	7,061	5,804	3,226
Chronic Pain wRVUs by all Providers by Total Clinical Chronic Pain ONLY Paid FTE	57	5,898	6,874	5,024	3,116
Chronic Pain wRVUs by all Providers by Total Clinical Chronic Pain ONLY Clinical Chronic Pain FTE	56	7,168	8,199	6,247	3,403

11

of ICU wRVUs by FTE

N=55	Mean	75%	Median	25%
ICU wRVUs by Physician Providers by Total Clinical FTE providing ICU	6,764	9,061	5,180	2,510

12

During the 12 months prior to June 30,2021, what was the average Unit Value collected by your department at all your hospitals/facilities for each of the following?

	N	Mean	75%	Median	25%
ASA units for anesthesia service	66	$45.86	$51.52	$37.72	$29.57
ICU wRVUs by Physician Providers	57	$68.25	$75.87	$59.02	$47.44
Chronic Pain wRVUs by Physician Chronic Pain Providers	59	$91.83	$102.69	$76.26	$66.03
Regional Anesthesia wRVUs by Physician Providers	53	$82.01	$98.42	$70.14	$54.86
Any other billed services	32	$68.68	$95.06	$68.53	$56.72

13

During the 12 months prior to June 30,2021, what was the average Unit Value collected by your department at ONLY your teaching/academic hospitals/facilities for each of the following?

	N	Mean	75%	Median	25%
ASA units for anesthesia service	61	$45.15	$51.84	$37.95	$29.54
ICU wRVUs by Physician Providers	51	$69.49	$77.25	$60.45	$53.80
ICU wRVUs by all Providers	50	$69.70	$76.48	$58.64	$50.33
Chronic Pain wRVUs by Physician Chronic Pain Providers	55	$91.30	$106.03	$76.34	$61.81
Chronic Pain wRVUs by all Physician Providers	54	$84.84	$93.82	$72.56	$59.88
Regional Anesthesia wRVUs by Physician	51	$80.53	$96.44	$71.50	$58.34

14

AVERAGE COLLECTION [average unit value x total units billed]

	N	Mean	75%	Median	25%
ASA units for anesthesia service	65	$41,717,363	$63,318,331	$34,642,912	$18,927,298
ICU wRVUs by Physician Providers	56	$1,992,485	$2,725,398	$1,302,147	$299,605
ICU wRVUs by all Providers	51	$1,952,935	$2,806,321	$1,557,076	$559,662
Chronic Pain wRVUs by Physician Chronic Pain Providers	58	$2,712,933	$3,912,758	$1,651,307	$901,399
Chronic Pain wRVUs by all Physician Providers	57	$2,772,612	$3,702,640	$1,892,852	$992,158
Regional Anesthesia wRVUs by Physician Providers	52	$1,412,629	$1,981,265	$577,397	$316,082
Any other billed services	30	$789,694	$1,045,319	$596,096	$133,627

15

Average Collection of ASA units for anesthesia service by FTE

	N	Mean	75%	Median	25%
Average collection of ASA units for anesthesia service by Total Clinical Anesthesiology and Pain FTE	65	$577,871	$616,396	$470,692	$340,513
Average collection of ASA units for anesthesia service by Total Clinical Anesthesiology and Pain Clinical FTE	65	$655,109	$664,671	$519,696	$395,219
Average collection of ASA units for anesthesia service by Total Non-Pain FTE	64	$630,313	$665,100	$499,293	$365,073
Average collection of ASA units for anesthesia service by Total Non-Pain Clinical FTE	62	$711,215	$721,504	$553,020	$404,953
Average collection of ASA units for anesthesia service by Total Clinical FTE providing ASA	60	$909,371	$976,878	$729,441	$523,484

16

Average Collection of Chronic Pain wRVUs by FTE

	N	Mean	75%	Median	25%
Average collection of chronic pain wRVUs by Physician Chronic Pain Providers by total clinical chronic pain ONLY	55	$535,641	$707,451	$403,336	$242,681
Average collection of chronic pain wRVUs by all Providers by total clinical chronic pain ONLY FTE	55	$459,952	$579,172	$389,004	$208,520
Average collection of chronic pain wRVUs by all Providers by total clinical chronic pain ONLY	54	$559,379	$763,725	$494,797	$267,538

17

Average Collection of ICU wRVUs by FTE

	N	Mean	75%	Median	25%
Average collection of ICU wRVUs by Physician Providers by Total Clinical FTE providing ICU	53	$522,462	$629,362	$303,188	$136,269
Average collection of ICU wRVUs by all Providers by Total Clinical FTE providing ICU	47	$450,179	$537,839	$351,844	$173,572

18

of Regional Anesthesia wRVUs by FTE

	N	Mean	75%	Median	25%
Regional Anesthesia wRVUs by Physician Providers by Total Clinical Anesthesiology and Pain FTE	52	215	243	142	71
Regional Anesthesia wRVUs by Physician Providers by Total Clinical Anesthesiology and Pain Clinical FTE	52	246	268	153	82
Regional Anesthesia wRVUs by Physician Providers by Total Non-Pain FTE	51	237	271	151	76
Regional Anesthesia wRVUs by Physician Providers by Total Non-Pain Clinical FTE	49	271	292	151	91

19

Do you bill for patient care in your preoperative clinic? If yes, what percentage of your preoperative patients are billed?

N	Mean	75%	Median	25%
23	51.9	100	45	10

20

How may ORs did your anesthesiology department cover on average each weekday (Monday through Friday)? July 1, 2020 to June 30,2021

N	Mean	75%	Median	25%
82	47.4	59	40	30

21

How many non-OR/offsite locations does your anesthesiology department cover on average each weekday (Monday through Friday)?

N	Mean	75%	Median	25%
81	15.1	18	12	7

22

How many total OB deliveries (with anesthesia involvement) did your anesthesiology department have?

N	Mean	75%	Median	25%
78	3,022	3,983	2,396	1,502

23

On an average weekday, how many faculty did your anesthesiology department have on each of these services? July 1, 2020 to June 30, 2021

N=81	Mean	75%	Median	25%
OR	32.9	42.9	26.5	19.0
OB	1.8	2.0	1.0	1.0
ICU	2.4	4.0	2.0	1.0
Acute Pain	1.7	2.0	1.0	1.0
Chronic Pain Clinic	3.2	4.0	3.0	2.0
Pre-Op Clinic	1.0	1.0	1.0	0.7
TOTAL	43.0	54.3	36.0	27.6

24

Please indicate the number of in-house shifts and the length of those shifts needed to be completed for a clinical faculty to be considered full-time in ICU:

	N	Mean	75%	Median	25%
# of in-house shifts/year	60	141.2	182.0	155.0	91.3
Length of shift (hours)	61	11.1	12.0	12.0	10.0
Annual Hours (shifts * hours)	60	1,563	2,016	1,722	1,012

25

What was the average cost (salary plus benefits) per CRNA/AA FTE as of June 30,2021?

N	Mean	75%	Median	25%
73	$249,892	$274,129	$247,000	$213,594

26

What is the total number of ASA units billed in cases involving CRNAs/AAs in the 12 months prior to June 30,2021?

N	Mean	75%	Median	25%
58	456,568	542,134	352,623	144,291

27

What is the total Institutional Support (all sources, including hospital, medical school, state, or another agency for administrative, educational, call, clinical, etc.) your anesthesiology department received in the 12 months prior to June 30,2021?

N=75	Mean	75%	Median	25%
Institutional support by Total Clinical Anesthesiology and Pain Clinical FTE	$334,641	$472,938	$324,269	$175,000

28

Average Total Compensation (of institutions with this rank):

	N	Mean	75%	Median	25%
Instructor	45	$350,252	$414,913	$359,996	$321,262
Assistant Professor	82	$404,939	$428,239	$399,397	$369,507
Associate Professor	82	$439,575	$460,089	$438,054	$409,610
Professor	79	$460,632	$491,109	$455,521	$427,114
Non-Academic	23	$310,534	$402,836	$327,996	$236,425
Chair	76	$688,445	$738,843	$643,632	$592,668

29

Average Fringe Benefit Dollars (of institutions with this rank):

	N	Mean	75%	Median	25%
Instructor	41	$49,639	$67,823	$46,016	$28,174
Assistant Professor	72	$55,367	$68,147	$53,451	$34,124
Associate Professor	72	$60,292	$74,898	$57,271	$38,921
Professor	69	$64,930	$78,803	$61,424	$41,504
Non-Academic	21	$49,736	$63,329	$48,644	$29,165
Chair	65	$95,024	$118,506	$89,107	$53,612

30

Geographic Practice Cost Indices (GPCI)-2022

	GPCI (PW)	GPCI (PE)	GPCI (MP)	Anesthesia Conversion Factor
Alabama	1.0	0.888	0.921	21.07
Alaska	1.5	1.118	0.614	29.81
San Francisco	1.077	1.329	0.458	23.26
Chicago	1.011	1.044	1.871	23.08
Manhattan	1.056	1.203	2.031	24.60
Houston`	1.032	1.029	0.9	22.06
Philadelphia	1.022	1.083	1.199	22.49

31

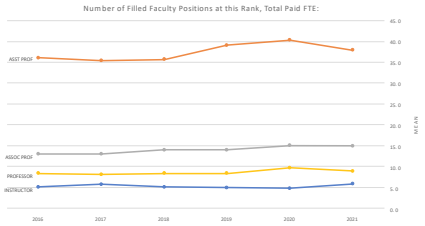
Region: Clinical Anesthesiology and Pain Faculty
Average Total Compensation (of institutions with this rank):

GPCI=1	N	Mean	75%	Median	25%
Instructor	23	$357,444	$414,434	$392,801	$340,116
Assistant Professor	43	$412,595	$430,916	$412,995	$387,806
Associate Professor	43	$438,475	$459,593	$439,029	$419,270
Professor	40	$459,645	$490,139	$458,884	$434,106
Non-Academic	12	$320,529	$442,770	$331,387	$207,642
Chair	41	$644,120	$689,255	$625,000	$576,744

GPCI>1	N	Mean	75%	Median	25%
Instructor	22	$342,733	$428,234	$347,904	$316,384
Assistant Professor	39	$396,499	$417,381	$386,625	$358,159
Associate Professor	39	$440,787	$462,494	$432,000	$401,632
Professor	39	$461,643	$495,000	$455,521	$420,553
Non-Academic	11	$299,630	$402,836	$327,996	$251,502
Chair	35	$740,368	$890,414	$691,648	$604,520

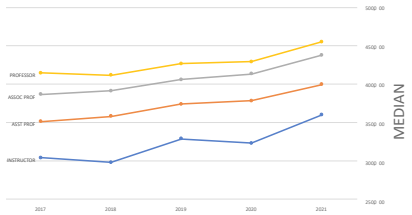
32

Number of Filled Faculty Positions at this Rank, Total Paid FTE



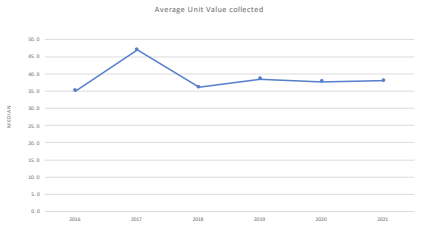
33

Median Total Compensation



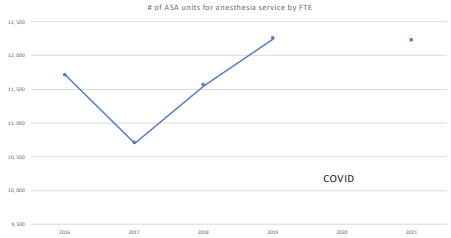
34

Average Unit Value collected



35

of ASA units for anesthesia service by paid FTE



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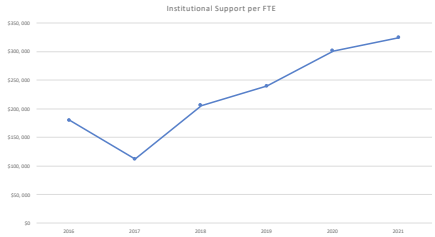
Institutional Support per paid FTE



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Questions

38

HANDOUT

Leaving a Legacy

Moderator: Michael C. Lewis, MD, FASA

Friday, November 11
2:15 PM – 3:20 PM

HANDOUT

Leaving a Legacy: Presentation 1

Holly A. Muir, MD

Friday, November 11
2:15 PM – 2:30 PM

Is it really time to talk about my Legacy?

Holly Muir, MD, FRCPC
Vladimir Zelman Professor and Chair of Anesthesiology
Keck School of Medicine of USC

- I have no disclosures relevant to my presentation today!

Objective

- **Define your legacy**

Legacy

- noun
- **Definition of *legacy***
- **1:** a gift by will especially of money or other personal property :
- **2:** something transmitted by or received from an ancestor or predecessor or from the past
  - the *legacy* of the ancient philosophers The war left a *legacy* of pain and suffering.
- **3:** a candidate for membership in an organization (such as a school or fraternal order) who is given special status because of a familial relationship to a member
  - *Legacies*, or children of alumni, are three times more likely to be accepted to Harvard than other high school graduates with the same (sometimes better) scores

Legacy

- adjective
- **1:** of, relating to, or being a previous or outdated computer system
  - transfer the *legacy* data or a *legacy* system
- **2:** of, relating to, associated with, or carried over from an earlier time, technology, business, etc.
  - And it is about more than just TV—newspapers, magazines, radio, all the "*legacy*" media are feeling the earth move beneath them. Journalists look out and see thousands of empty campus TV lounges and newsprint-less recycling bins and millions of iPads and smart phones and they wonder what's coming next.

Merriam-Webster SINCE 1828

Legacy

- Guess the first thing we need to do is to decide if we want to be a noun or an adjective.

Legacy

Noun

A gift by will especially of money or other personal property

A grateful patient made a donation to create an annual lectureship to honor one of our faculty

Legacy

Noun

A gift by will especially of money or other personal property

A donation allowed us to name a lecture room in honor of a beloved teacher in our department

Legacy - a noun

- Recently – one of our senior faculty made a significant donation to the University to create a named chair in anesthesia
- I now am honored to carry the title of the Vladimir Zelman PhD, MD Professor and chair in Anesthesiology

Legacy

- The value of money….

  A donation big or small can make a difference and create a lasting legacy

Legacy

- Noun
  - something transmitted by or received from an ancestor or predecessor or from the past

Legacy

- Noun
  - something transmitted by or received from an ancestor or predecessor or from the past

Legacy

- **something transmitted by or received from an ancestor or predecessor or from the past**

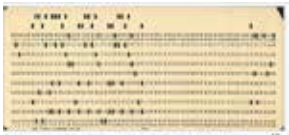
Legacy

- Noun
- a candidate for membership in an organization (such as a school or fraternal order) who is given special status because of a familial relationship to a member
- For many of us who work in older long established departments we may have 'legacy faculty' as their parent or relative may have held a faculty position in the past – or even still currently
- For some this tradition of legacy has created new headaches…

Legacy

- **Adjective**
  - of, relating to, or being a previous or outdated computer system
  - transfer the *legacy* data or a *legacy* system

A deck of punched cards comprising a computer program. The red diagonal line is a visual aid to keep the deck sorted.



A 12-row/80-column IBM punched card from the mid-twentieth century

Legacy

- **Adjectives**
  - of, relating to, associated with, or carried over from an earlier time, technology, business, etc.
  - I believe this is where most of us sit
    - We will become part of an earlier tme for many and exist as a memory

Legacy

- **A memory left with many or a few is a good place to land**
- **The memory will likely be associated with the difference you made in some one's life who you touched in your career – a student, colleague, patient… who knows ?**

Your Legacy

- **How you craft these memories and leave your legacy is important.**
- **I believe in these very wise words.**
- **I am sure we have all touched many in our journey to our current position. You began the build of your legacy many decades ago**
- **I hope you take time to think of the folks you have supported and feel happy!**


How you make others feel says
a lot about who you are.
Leave them with a smile,
a hug, and a kind thought.

HANDOUT

Leaving a Legacy: Presentation 2

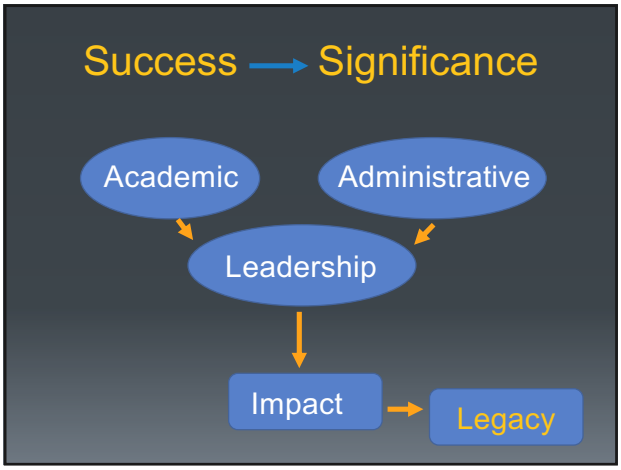
Roberta Hines, MD

Friday, November 11
2:30 PM – 2:50 PM

Building a Legacy : Turning Success into Significance

Roberta L. Hines, MD
Nicholas M. Greene Professor & Chair Emeritus
Department of Anesthesiology
Yale University School of Medicine
New Haven, CT 06520

1



2

Virginia Apgar, MD

3

Virginia Apgar

First woman full Professor at Columbia University College of Physicians and Surgeons

1938: Director of the Division of OB Anesthesia

1952: Apgar Score

In 1959: Took sabbatical to earn MPH

4

Apgar

Looking Beyond Traditional Persuits

1961 : Director of Division of division of Congenital Defects at the National Foundation of Infantile Paralysis

March of Dimes

5

Nicholas M. Greene, MD

6

Nicholas M. Greene, MD
An Academician's Academician

Trained : Yale, Columbia, Harvard (MGH)

1952: Chair of Anesthesiology and Professor of Anesthesiology at Yale University School of Medicine

26 years as Editor and Editor-in-Chief : *Anesthesiology* and *Anesthesia and Analgesia*

7

Overseas Teaching Program
Don't give me a Fish; Teach me how to fish"

Based at the University of Zambia's Teaching Hospital and the Kilimanjaro Christian Medical Center in Moshi, Tanzania

A mission to teach

Objective: "To improve anesthesia care in underdeveloped countries by the recruitment of volunteers to teach anesthesia in a limited number of pre-existing structured anesthesia training programs"

8

apsf
www.apsf.org

Ellison Pierce, MD

9

Ellison Pierce, MD

Chairman, New England Deaconess

ASA Distinguished Service Award

Friend's 18 year old daughter died during dental procedure; undiagnosed / unrecognized esophageal intubation (1960's)

10

Ellison Pierce, MD

Founded Anesthesia Patient Safety Foundation (1985)

"No patient shall be harmed by anesthesia"

Co-founded Anesthesia Closed Claims Project

Father of Modern Anesthesia – Safety Movement

11

FAER
Foundation for Anesthesia Education and Research

William Hamilton, MD

12

William Hamilton, MD

Chair: University of Iowa

↓

Chair: University of California, San Francisco

↓

One of the first Chairs to push for advancing academic careers of faculty

↓

First Executive Secretary of FAER

13

Peter Safar, MD

14

Peter Safar, MD

"Father of Modern CPR"

Rediscovered initial steps in CPR
- Head tilt and chin lift maneuver
- Mouth to mouth breathing

Influenced Norweign Doll Maker to design and manufacture *"Resusci Anne"*

Three time nominee for Nobel Prize in Medicine

15

Advocate for Medicine and Social Justice

Brought national medical standards to ambulance workers

Started private ambulance service in Pittsburgh "Hill District"

Recruited African American men for medical training to run ambulance service in "Hill District"

16

17

Henry Knowles Beecher, MD

18

Henry Knowles Beecher, MD

First Henry Isaiah Dorr Professor at Harvard

WWII experience – Advocate for double-blind placebo-controlled studies

A study to be scientifically valid "must be ethical from its inception"

19

"Ethics and Clinical Research" (JAMA)

Father of Informed Consent in Research

All federally funded studies must have peer review (IRB)

20

Marcelle Willock, MD

21

Marcelle Willock, MD

First woman of color to Chair an academic Department of Anesthesiology

Successfully initiated MD anesthesiologist "care team model" at BU (until 1980 dentists provided anesthesia care)

2002-2005 First female Dean of the Charles R. Drew University of Medicine

President of Louis and Martha Deveaux Foundation (Republic of Panama)

22

Laura Niklasson, MD, PhD

23

Anesthesiologist

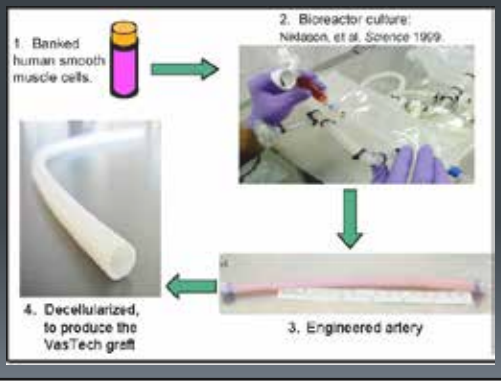
Scientist

Entrepreneur

National Academy of Medicine
National Academy of Inventors

24

Method for Growing Engineered Arteries



25

Humacyte

Bioengineering Company

Leaders in novel acellular products for vascular applications

Time Magazine / Regenerative artery - One of the top ten inventions

Completing clinical trials of implanting vascular grafts for dialysis

26

Medge Owen, MD

27

Medge Owen

Professor at Wake Forest

Passion:
Improve maternal and newborn safety during childbirth

Kybele
Creates Healthcare Partnerships

Anesthesiologists
Neonatologists
Midwifes / Nurses
Obstetricians

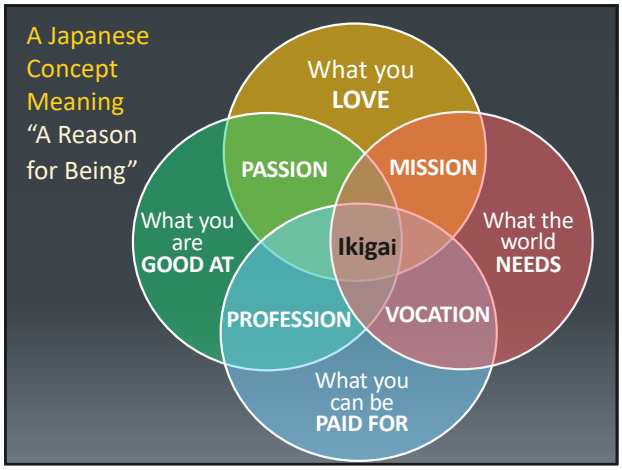
28

Medge Owen

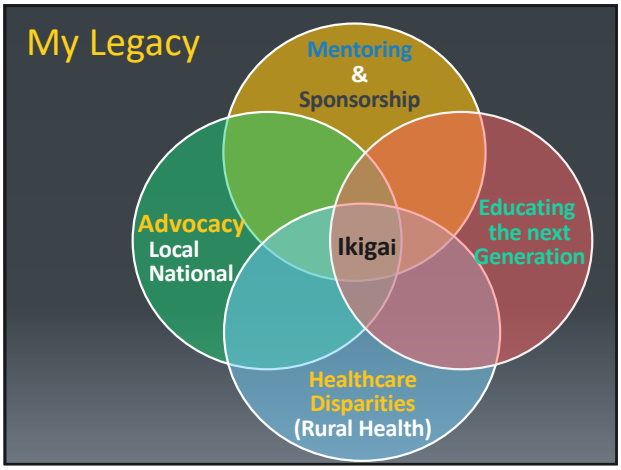
Nicholas M. Greene Award for Outstanding Humanitarian Contribution

29

30


A Japanese Concept Meaning "A Reason for Being"
What you LOVE
PASSION
MISSION
What you are GOOD AT
Ikigai
What the world NEEDS
PROFESSION
VOCATION
What you can be PAID FOR

31


My Legacy
Mentoring & Sponsorship
Advocacy Local National
Ikigai
Educating the next Generation
Healthcare Disparities (Rural Health)

32


Your Legacy

33

34

35

HANDOUT

Leaving a Legacy: Presentation 3

Douglas R. Bacon, MD, MA, FASA

Friday, November 11
2:50 PM – 3:15 PM

Creating a Legacy: John Henry Evans and Ralph Milton Waters

Douglas R. Bacon, M.D., M.A., F.A.S.A.
Former Chair
University of Mississippi Medical Center
And
Wayne State University

1

Conflict of Interest

- I have no financial conflict of interest

2

Learning Objectives

- The learner will appreciate elements in an individual's legacy
- The learner may apply historical lessons from Evans and Waters to understand how their legacy might be created
- The learner will comprehend that a legacy is created over time by interactions with others and may be out of the control of the individual
- The learner will understand the concept of the silent legacy

3

What is Your Legacy?

- How will Richard Nixon be remembered?
- As the "goat" of Watergate?
- As the President who normalized international relations with China?

4

A Show of Hands Please

- Who is this gentleman?
- Prior to today, have you heard of him?

5

A Show of Hands Please

- Who is this gentleman?
- Prior to today, have you heard of him?

6

John Henry Evans and Ralph Waters

- Evans and Waters were contemporaries
- They corresponded with each other and most likely interacted at meetings
- Ralph Waters is credited with the first Academic Department of Anesthesia in the country and is still revered almost 80 years after his retirement and almost 45 years after his death
- Evans remains, unfortunately, a footnote in history

7

The Legacy of John Henry Evans in the 1980s

- Richard Ament remembered him as the "crazy old man" at the Buffalo General Hospital

8

The Legacy of John Henry Evans in the 1980s

- Richard Terry remembered him as a medical student in 1937.
- Terry vividly recalled Evans' demonstration of intravenous oxygen.
- Terry also recalled Evans as his residency program director

9

Why is There Such A Divergent Opinion of Evans and Waters?

10

John Henry Evans Brief Biography I

- Born on September 24, 1876 in Freedom, NY
- Spoke Welsh until the family moved to Machias in 1886
- Spent 6 Years in the Merchant Marine

11

John Henry Evans Brief Biography

- Graduated from the University of Buffalo in 1908 with honors
- Spent one year as a house officer at the Buffalo General Hospital

12

John Henry Evans Brief Biography

- Returned to Machias and opened a general practice
- Stayed until his brother was killed in a train accident

13

John Henry Evans Brief Biography

- Returned to the Buffalo General Hospital
- Specialized in Anesthesia at the insistence of the Chairman of Surgery, Roswell Park

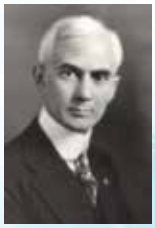
14

Evans Academic Practice

- On June 2, 1913 Evans was appointed assistant in anesthetics
- He was paid $2.00 per student taught--averaging 40 students a term
- In 2022 dollars that is about $60.00 per student or about $4,800 dollars a year
- Salary was cut after his return from the First World War

15

Evans' Contribution to the Practice of Anesthesia



- Was an expert with Nitrous Oxide
- Did not favor the use of intravenous or regional anesthetics
- Firm believer in the preoperative assessment and risk stratification of patients

16

Evans' Contribution to the Practice of Pediatric Anesthesia

- Worked with Tonsillectomy patients
- A pleasant induction and good overall experience was critical
- Played a "game"--the winner received five shiny pennies!

17

Politics--National and International

- Evans was the President of the Board of Governors of the International Anesthesia Research Society from 1925 through the end of the Second World War
- Served as President of the Associated Anesthetists of the United States and Canada (1927), the Eastern Society (1928)
- Was a leader on the first international meeting of the Section on Anaesthetics of the British Medical Society and the IARS in 1926

18

Politics National and International

- Given a 15 inch silver loving cup for his work
- July 1927 issue of the *British Journal of Anesthesia* was dedicated to him

19

Evans' Most Remembered Contribution--Oxygen Therapy

- Believed that oxygen should be administered until cyanosis disappeared
- Was requested to help treat the victims of the Coconut Grove fire in Boston in November 1942

20

The End?

- Was Replaced as Chairman in 1940 by Paul Searles from the Mayo Clinic
- Searles lasted until the end of World War Two
- Evans continued to practice until the mid 1950s
- Evans partner, Clarence Durshordwe, was one of the ASA's observers at the First World Congress of Anesthesiologists

21

Ralph Milton Waters

22

Ralph Waters Biography

- Born October 9, 1883 in Bloomfield, Ohio
- He had two sisters and was raised on a farm
- Graduated from Grand River Institute in 1902
- BA in General Arts from Western Reserve University
- Received his MD in 1912 from Western Reserve

23

Ralph Waters Biography

- Began practicing obstetrics and giving anesthetics in Sioux City, Iowa
- To insure financial viability eventually switched exclusivity practicing anesthesia
- After WWI established the Downtown Anesthesia Clinic—the first Ambulatory Surgical Center!

Waters RM. The downtown anesthesia clinic. Am J Surg Q Supp. 191;33:71

24

Ralph Waters Biography

- 1924 Waters moved to Kansas City
- Back injury
- July 1, 1926 spends 3 months at the Mayo Clinic learning regional anesthesia under the tutelage of John Lundy
- Established a strong friendship with Lundy which would have profound effects on American Anesthesiology

25

The University of Wisconsin (Madison)

- Arrived at UW in Madison in 1927
- Chair of the Agricultural Bacteriology Department Edwin George Hastings (1872-1953) had married Waters' sister
- Chauncy Leake welcomed Waters and invited him to lecture in Pharmacology

26

The University of Wisconsin (Madison)

- Waters' motivation was to "get medical schools right" on the teaching of anesthesia
- Health Issues
- Desire to be closer to family

27

The University of Wisconsin (Madison)

- Waters established a three-year training program
- First and third years were clinical
- Second year was spent in the lab
- Exposed residents to the world of anesthesia as Madison was a destination for visitors from across the globe

28

Waters Residents

- The Aqua Alumni represent a substantial part of the leadership of American Anesthesiology in the 30, 40, 50s 60s and beyond
- In 1934 Waters supported Emery Andrew Rosenstein as he left Madison and ventured forth to Bellevue and NYC

29

Organizational History

- Waters was instrumental in the success of:
  - The Anaesthetists Travel Club
  - The Section on Anesthesia of the AMA
  - The evolution of the American Society of Anesthesiologists
  - The original American Society of Regional Anesthesia
  - And many, many more

30

Retirement

- In 1948, Waters retired from the University and the practice of anesthesiology
- He grew oranges outside of Orlando, Florida
- He rarely if ever attended anesthesia meetings
- The once notable exception was the1964 World Congress inSao Paulo, Brazil where he was feted by the world and invited by his former resident Carlos Parsloe

31

Why is There Such A Legacy Gap Between Evans and Waters?

32

Legacy Lessons From Evans and Waters

- Much of Waters legacy as a founder, through well deserved, has come through the writings and talks of his residents and colleagues
- Waters choice of the University of Wisconsin—a leading institution during his career--and was a salaried employee Evans never had that financial freedom
- Waters worked to ensure that his residents would be successful and that the mission of academic anesthesiology would continue
- Waters left anesthesiology at the hight of his popularity and effectiveness.

33

Legacy Lessons From Evans and Waters

- Evans did not practice in a nationally known university
- Evans never had trainees—the residency began in 1939 and was interrupted by World War Two
- He was not salaried and therefore spent a great deal of his time supporting his family
- Evans, like Waters was an innovator—but the subject he chose—subcutaneous oxygen for pain relief was quickly supplanted by more effective therapies
- Evans practiced too long and was ineffective at the end of his career

34

A Few Final Thoughts

- How you treat people day in and day out is critical to your legacy
- What you do on the national and international scene in organized anesthesia may influence your legacy
- Trainees are critical to keeping the memory fresh (Rovenstine, Waters, Dripps)
- A discovery may also secure your future memory (Apgar)

35

The Silent Legacy

- George Russell, the Chair of Orthopedics has a theorem
- A significant change made in the operations of medical center by an individual who is not remembered for it
- Fixing the weekend OR schedule

36

HANDOUT

The Great Resignation

Moderator: Cynthia A. Lien, MD

Friday, November 11
3:50 PM – 5:00 PM

HANDOUT

The Great Resignation: Presentation 1

Jill M. Mhyre, MD

Friday, November 11
3:50 PM – 4:10 PM

Sustainable Solutions for Faculty Retention

Jill M Mhyre, MD
The Dola S Thompson Professor and Chair of Anesthesiology
The University of Arkansas for Medical Sciences

1

2

Lessons learned from a 2019 staffing crisis

- Recognize attrition risk early
- Build effective systems to ascertain and address common grievances
- Aggressively implement internal solutions
- Communicate clearly with senior leadership and negotiate for resources
- Create structure

3

The faculty pain points

1. Schedule was not predictable
2. Excess uncompensated work during periods of short staffing
3. Part time faculty working less than commitment
4. Time off was not competitive

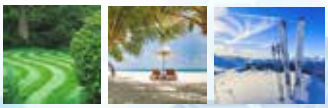
4

Time off at UAMS

- Vacation: 15 hours per month of service
- Sick leave: 8 hours per month of service
- Education leave: 10 days per year
- Children's Educational Activity Leave: 8 hours per year
- Holidays: 10 public holidays per year
- Day After Thanksgiving sometimes
- Birthday

Time off at Private Practices

- 14 weeks Paid Time Off



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Stabilize the team

- Salary adjustment
- Signing bonuses
- Locum tenens contracts (not available post-COVID)
- Consolidate off sites to align schedules (7am-5pm)
- Reduce the total number of OR sites

6

Shift Model Math

COM Definition of a 1.0 Faculty FTE

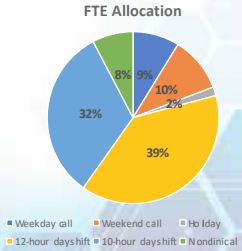
- 50 hours per week / 2600 hours per year
- Subtract Leave:
  - Federal and state holidays, birthday: 12 shifts
  - Annual Vacation, CEAL: 22.5 shifts
  - Academic Time: 14 shifts
- 2600 hours – (48.5 shifts * 12 hours/shift) = **2018 clinical hours**

1.0 FTE

7

Call Subtractions

- 1.0 General Call FTE: 16 weekday + 19 weekend + 3 holiday = 38 call shifts
  - 2018 – (38*12) = 1562 hours divided between 72 10-hour shifts and 72 12-hour shifts
- Cardiac and Liver transplant teams also work 1562 daytime hours
- Critical Care team credited with 15 hours per 24 hours in the ICU



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End of Shift Solutions

9

Transparency & Flexibility

- Academic Inventory – Annual Excel spreadsheet with non-clinical work
- Option to scale FTE / salary / shift commitment below 1.0
- Transparent buy out for non-clinical time
- Excess Clinical Shifts

10

Service Expansion Requests 2023

8 ORs * 250 days/year * 10 hour blocks = 20000 hours

2.7 Faculty FTEs

13 CRNA FTEs

3 ORs * 250 days/year * 8 hour blocks = 6000 hours

1.25 Faculty FTEs

4 CRNA FTEs

11

HANDOUT

The Great Resignation: Presentation 2

Jeffrey Berger, MD, MBA

Friday, November 11
4:10 PM – 4:30 PM

HANDOUT

The Great Resignation: Presentation 3

Kenichi Tanaka, MD

Friday, November 11
4:30 PM – 4:50 PM

Locums to Respond to the Great Resignation (in Sooner State)

Kenichi Tanaka, MD, MSc
John Plewes Professor and Chair
University of Oklahoma College of Medicine

1

COI

- No COI relating to the presentation

2

Talking points:

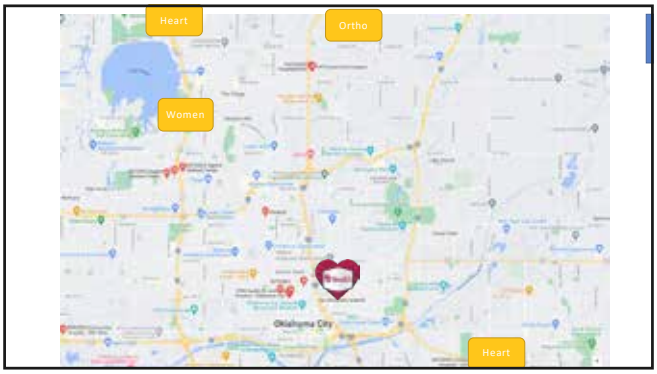
- Background
  - Healthcare in OKC
  - Timelines
- Locums
  - Costs and other practical issues
- Opportunities

3

Who We Are

- Oklahoma's only Level-1 trauma center
- 804 beds
- Total ORs and off-sites to cover: adult 36 + NORAs; Peds 11 + NORAs
- Full staff: 36 Adult/18 Peds Anes physicians, 44/14 CRNAs, 50 trainees
- 10 J-1 waiver slots, but competitive process

4



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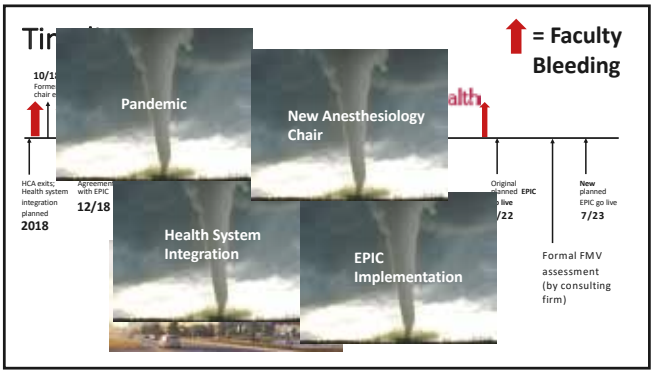

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Options to Cover ORs

Locum	OT by Faculty
• Helps keep ORs open • Multiple vendors to choose • Reduce burdens on faculty	• Work pre or post call days • Higher income potential • Least cost to the system
• Most expensive option • Sunk costs (no show, termination) • Only covers day shifts • Negative impact on faculty retention/recruitment	• Faculty burnout • Negative impact on faculty retention/recruitment

7

Getting Locum Providers into the Team

- Screening: Admin time 6h per person (x 7); predicting needs, interviewing, and obtaining approvals
- Credentialing: lead time ~3 months; lots of admin time spent
- Quality: Unpredictable, some great, but others with difficult personalities
- Specialist locum: more expensive, hard to find (liver, cardiac, etc.)

8

Financial costs

- Direct costs
  - Labor
  - Per diem
  - $80,000 per month/FTE
- Indirect costs
  - Screening (Vice chair, hospital and office staff)
  - Credentialing (2-3 months)
  - Onboarding
  - Logistics of scheduling, continuous challenge
  - Accounts payable (incomplete charts, unbillable procedures)

9

Difficult Scheduling

- Agency provides a locum for certain durations, but individual shift request varies
  - 1 week on / 1 week off
  - 2 weeks on / 2 weeks off
  - 4 days/1 off per week for 6 weeks
  - Seasonal

10

Resentment

- Faculty members do not appreciate locums
  - "they get paid more for the same work"
  - "we have to teach while they get paid more"
  - "they work only when they like to"
  - "difficult in assigning trainees and students"

11

Buying out your favorite locum?

- Most agencies allow buyouts
  - Total compensation (benefits) may attract some locums
  - Hiring some with known clinical skills and personality
  - Variable costs, $30,000 - $60,000 per individual

12

Support from Health System

- Health System Costs
  - Surgical revenue remains a top priority
  - Monthly costs for locums physicians/CRNAs >$500k
  - Unpredictable and Unsustainable
- Solutions
  - Support to the Dept to engage with a recruitment firm
  - Formal FMV assessment and adjust faculty comp
  - Improving revenue cycle via better EMR

13

Conclusions

- Hospital wants to keep ORs open despite costs (opportunity)
- Major burden on dept staff; a learning process in screening/credentialing

14

HANDOUT

AACPD

Introduction / Welcome

Timothy Long, MD

Friday, November 11
8:00 AM – 8:05 AM

HANDOUT

AACPD

Novel Practices

Moderator: Kristina Sullivan, MD

Friday, November 11
8:05 AM – 9:15 AM

HANDOUT

AACPD

Novel Practices: Holistic Review of Residency Applicants

Jack Buckley, MD

Friday, November 11
8:05 AM – 8:20 AM

Holistic Review

Jack Buckley M.D.
UCLA Medical Center

1

Disclosures

- No relevant disclosures

2

Relevant Experiences

- Assoc. Program Director 2014-2020
- Program Director 2020-Current
- Director of Residency Recruitment 2014 – Current

- Chair ASA Program Director Advisory Group
- Member of the ABA OSCE Committee

3

Negatives of Holistic Review

- Resource intensive (30+ faculty)
- Time intensive
- Invitations for interview late

4

Why Do Holistic Review?

Finding diamond in the rough

Additional benefits

Interview fewer applicants
Total cost is likely less

5

Our Data – Recruitment Season 2021

	UCLA	25%	50%	75%
Ranks per position	5.9	15.9	12.2	10.2
Ranks per position to fill	2.3	7.8	6	4

6

Our process

- 1400+ applicants this year
- Do we review every application?
- We do an in-depth review of some applications
- Faculty reviewers 25-30 files
- Who gets reviewed?
  - Token
  - Geographic preference
  - Sub-I (told sub-I no need to send us a token- sub-I is a super token)
  - California address
  - California medical school
  - Historically black medical schools

7

Additional Ways Applicants Get Reviewed

- ASA Meet and Greet Event
- Participation in our Virtual Open House
- Email PD
- Contact our residents or faculty member

8

Faculty Reviewers

- Not compensated
- Expected to review the file in full
- Implicit Bias training
- Detailed instructions
- Significant variability
  - Reviewer "recommend" offering an interview
  - Reviews are reviewed by PD/APD
- PD/APD offer interviews

9

Factors Considered In The Review

- Medical School
- College/other degree
- AOA
- Step scores
- Dean's letter
- Letters of rec
- Research
- Leadership
- Extracurricular and community engagement
- Work Experience
- Resilience and life challenges
- Supplemental application

10

Research	Rating	
	4 Transformative	First Author publication, funded research (ie FAER fellowship)
	3 Sustained	several middle author publications
	2 Casual	abstract
	1 Observer/none	none
	1 Observer/none	none

11

Process

- Reviewers given 3 weeks to review
- Reviews uploaded to excel document
- Goal to invite 2/3 interview spots round 1
- Remaining positions rounds 2-3

12

Interview Day

- 7 applicants interviewed per day
- PD, 2 faculty and 1 Chief resident interviews
  - Goal each faculty member interviews 3 times
- Chair group session
- 20 minute interview

13

Interview Form

14

Rank List Meeting

- Goal to make it objective as possible
- Minimize
  - "They would be a good fit"
  - "I like this applicant better"
- Rank list is a massive excel document

15

Jack Buckley M.D.

UCLA Program Director

jcbuckley@mednet.ucla.edu

16

HANDOUT

AACPD

Novel Practices: A Novel Community Engagement Curriculum

Stacy Fairbanks, MD

Friday, November 11
8:20 AM – 8:35 AM

A Novel Community Engagement Curriculum

Stacy L Fairbanks, MD
Medical College of Wisconsin
11/11/2022

1

Conflict of Interest

- No conflicts of interest
- Some of my work is now funded by the Advancing a Healthier Wisconsin foundation.

2

Objectives

- Describe a system in which inequities can be examined first-hand.
- Begin to design a plan of action for community engagement in your own residencies and communities.

3

Community Engagement at MCW

4

Our Story

5

What we are up Against

- 72-77% of MCW trainees attended medical school outside of the Milwaukee area
- Many trainees are unaware of MKE's racial and opioid epidemic struggles

6

What we are up Against

- The problem of racial segregation in Milwaukee:
  - Self-perpetuating as systemic/structural racism continues to exist
  - Educational funding discrepancies contribute to the largest achievement gap between Black and white children in the country
  - 4 out of 5 Black children in Wisconsin live in poverty
  - Massive & disproportionately African American state prison population
  - Limited access to adequate, safe housing
  - Limited access to convenient, accessible healthcare

7

Step 1: Have a Vision

8

Vision

- Residents feel called
- Residents learn perspective-taking
- Marginalized Community members will interact with healthcare professionals
- Our residency will form relationships; improve our relationship with the community

9

Step 2: Establish a Focus Group

10

Step 3: Decide on Time Commitment

- Our Time Commitment:
  Didactics + two half-days of community engagement

11

Step 4: Curriculum?

12

Step 5: Establish your Community Partners

- Our Partners:
  - All-Saints Community Health Center
  - Streetlife MKE

13

All Saints Community Health Center

- Home to All Saints Family Medicine Residency Program
- Focus on Community Medicine
- Nurse Jenny Ovide: Community Medical Clinical Coordinator
- Garden, Collaborative Farm, workout track, Greenhouse


14

StreetLife Communities

- Provide emergency resources
- Support for those emerging from addictions
- Youth gang rescue
- Outreach to sex workers
- We teach and inspire others to do the same


15

Step 6: Give it a Go!


16

Community Engagement at MCW



17

Step 7: Evaluate and Redefine

Excellent 10 9 8 7 6 5 4 3 2 1 Poor	Average Score
Perspective - The professional development week gave me a better sense of the short and long term professional opportunities available to me.	8
Goals - The professional development week helped me set professional and personal goals beyond simply "getting through" residency.	7.8
Value - Overall, the physician development week was a valuable part of my residency.	8.7
Valued - The professional development week helped me feel individually valued by my residency program.	9

18


SAMPM
Step 8: Expand as Able
MCW
MEDICAL SCHOOL
ADVANCING A HEALTHIER WISCONSIN ENDOWMENT

19

20


"If you don't like the road you're walking, start paving another one."

21

HANDOUT

AACPD

Novel Practices: Efficiently Changing Program Culture

Mada F. Helou, MD

Friday, November 11
8:35 AM – 8:50 AM

Novel Practices: Efficiently Changing Program Culture

Mada F. Helou MD
Nicholas Pesa MD

1

Learning Objectives

- 1. Clearly Articulate the 3 steps of Appreciative Inquiry (AI) Methodology
- 2. Describe a method for efficient task assignment during AI sessions
- 3. Describe the purpose of an Education Fund Policy
- 4. Describe the purpose of a Curriculum Change Form

2

3

Positive Culture

4

Productive Town Hall

5

Appreciative Inquiry (AI)

6

Resident Recruitment & AI

- **Definition** – Clarifying
  - What is the focus of the inquiry?
- **"Is our recruitment strategy as successful as it could be?"**

7

Resident Recruitment & AI

- **Discovery** – Appreciating
  - What gives life?
- **Positives**
  - **Camaraderie amongst residents**
  - **Responsive leadership**
  - **Strong clinical training**

8

Resident Recruitment & AI

- **Dream** – Envisioning Results
  - What is the world calling for? What might be?
- **Ideal State? More contemporary style**
  - **Updated Website**
  - **Updated Social Media**
  - **Increased web opportunities to learn about the program**
  - **Basically… Updated *everything*!**

9

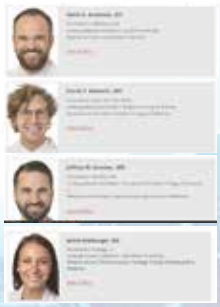
Resident Recruitment & AI

- **Design** – Ideal, Co-Constructing
  - What *should* be?
- **What is more contemporary?**
  - **Website that includes personal information (in addition to achievements)**
  - **Social Media that reflects the current state of the residency**
    - **Student Doctor**
    - **Twitter**
    - **Instagram**
  - **Meet and greets etc.**

10

How was work divided?

- Website profile creation
- Student Doctor profile update
- Twitter creation & maintenance
- Instagram (created later)



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Resident Recruitment & AI

- **Destiny** – Sustaining
  - How to empower, learn, and adjust / improvise
- **Incorporate suggestions into existing processes**
  - **E.g. When residents match with us, they are asked to fill a personal page template**

12

Celebrate Success!!

13

14

B/c it usually has people feeling like, well, this….

15

What it's really about…

16

(Limited) Education Fund Allocation

- Option 1
  - Equally
- Option 2
  - To "good citizens" preferentially
  - Surplus dollars reallocated for group projects

17

Strategy – Definition

Education Fund Accountability Booster Introduction

Purpose: To provide a framework for expected academic performance, scholarly activity, professionalism, citizenship, and documentation.

How it Works: There are 5 equally weighted categories, each made up of sub-categories, that include important/required components of residency. Each category has specific requirements to receive credit for that category and are scored as noted. The money for the individual resident's education fund and departmental support for academic presentations for the subsequent year will be rewarded as outlined below.

18

Strategy – Transparent Scoring

Scoring:

5/5 Completed Categories = 100% of subsequent academic year's education fund, departmental support of scholarly presentations at conferences, equal share of redistributed education funds

4/5 Completed Categories = 100% of subsequent academic year's education fund, departmental support of scholarly presentations at conferences, no redistributed education funds

3/5 Completed Categories = 50% of subsequent academic year's education fund, no further support

0,1, or 2/5 Completed Categories = 0% of subsequent academic year's education fund

19

Strategy – Clear Expectations

Professionalism

(3/4 of the following sub-categories must be complete to gain full credit for this category)

Conference Attendance
Attendance at >80%

ACGME Survey
Completion prior to February 1st

Journal Club
Attendance >80%

MyEvaluations
Completion rate >80%

Note: Conference and journal club attendance denominator will be adjusted according to the number of conferences the resident could have gone too. If the resident was post-call, on-call, etc (outlined in the resident manual)… this will not count against them.

20

21

Curriculum Change Form

22

23

24

HANDOUT

AACPD

Novel Practices: The Board Runner Rotation

Timothy W. Martin, MD, MBA

Friday, November 11
8:50 AM – 9:05 AM

Anesthesiology Resident "Board Runner" Rotation

Timothy W. Martin, MD, MBA, FASA
Professor and Associate Chair (Education)
Anesthesiology Residency Program Director
Chief, Division of Pediatric Anesthesia
University of Florida College of Medicine (Gainesville)

1

Anesthesiology "Board Runner" Rotation

Learning Objectives:

1. Explain the rationale for an elective, senior-level anesthesia resident "board runner" rotation
2. Describe the activities of the anesthesia resident on the "board runner" rotation
3. List possible didactic topics to be explored during the resident "board runner" rotation
4. Link elements of this rotation to ACGME anesthesiology program requirements and milestones

2

Anesthesiology "Board Runner" Rotation

This speaker has no relevant conflicts of interest to disclose, and there will be no off-label discussion of pharmaceuticals.

3

Anesthesiology Resident "Board Runner" Rotation

- "Board Runner"
- "Anesthesiologist-in-Charge" (AIC)
- "Anesthesiologist-of-the-Day" (AOD)
- "Board Boss"
- "Clinical Director"
- "Anesthesiologist on Call"
- "Schedule Master"
- "Traffic Cop"

4

5

Preamble to "Board Runner" Rotation

"To be leaders in the profession, practicing anesthesiologists must not only have the clinical proficiency and technical knowledge, but must also exhibit excellence in non-technical skills such as task management, teamwork, situational awareness, and decision-making. They must be able to simultaneously incorporate social, clinical, and textual information on their patients while organizing the operating room and facilitating the work of other members of the healthcare team toward the patient's wellbeing."

6

Rotation Description

- Two-week CA-3 year elective w option of four weeks (space permitting)--but mandatory for newly selected chief residents (3) in spring of CA-2 year
- Assist weekly faculty "board runner" (AOD) in daily OR management
- Duty hours 06:30-17:00
- Share in Saturday resident call team pool (one Saturday/4-week block)
- Evaluated by group of 4-5 faculty AODs at conclusion of rotation

7

About UF Health

- Level-1 Trauma designation
- 1,232 beds
- 7 hospitals and 4 HOPDs in Gainesville, FL
- Other Locations
  - Jacksonville, FL
- Regional Network
  - Leesburg, The Villages®, Daytona, Deltona, Pensacola, Orlando

8

University of Florida (Gainesville)

9

UF Health/Shands Bed Towers

10

Our Clinical Coverage Obligations

A Trending View of Locations We Staff

Location Type	OR Coverage Location	Jul 17	Jul 18	Jul 19	Jul 20	Jul 21
Main ORs	North Tower	108	66	86	90	95
	HVMM Tower	0	64	65	70	70
	South Tower	65	65	75	75	75
	FSC/CSC	53	52	55	54	55
	Oaks					25
	Main OR Locations	226	247	281	289	320
NORA	NT Cath Lab	10	5	5	5	5
	ECT	6	6	6	6	6
	OB	15	15	15	20	20
	NT Interventional Radiology	10	2	5	5	5
	NT MRI	4	4	5	5	5
	ST Interventional Radiology	0	5	4	4	4
	GI	20	20	20	20	20
	HVMM MRI	0	0	1	1	1
	HVMM Cath Lab		10	10	10	10
	SRC				5	10
	Ayers Pain Medicine	2	2	2	2	3
	NT Endo Suite (Cath Lab Remodel)					15
	NORA Locations	67	69	73	83	104
Other Assignments	NT PACU	5	5	5	5	5
	ST PACU	0	0	0	0	0
	HVMM PACU	5	5	5	5	5
	PreOp	10	10	15	15	15
	NT APS	5	5	5	5	5
	ST APS	5	5	5	5	5
	HVMM APS	5	5	5	5	5
	FSC APS	5	5	5	5	5
	Call-outs	10	10	10	10	10
	Late Stays	15	15	15	15	15
	Assignments	65	65	70	70	70
Total Block Coverage Per Week		358	381	424	442	494

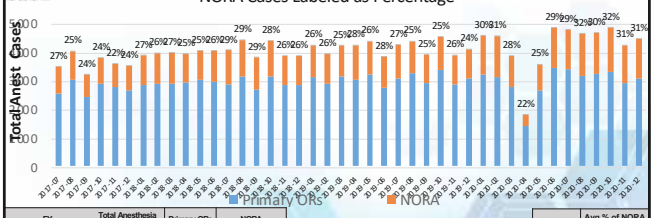
Assignments Per Week

Coverage Location	Jul 17	Jul 18	Jul 19	Jul 20	Jul 21
Main OR Locations	226	247	281	289	320
NORA Locations	67	69	73	83	104
Assignments	65	65	70	70	70
Total Block Coverage Per Week	358	381	424	442	494
OR YoY Growth		9%	14%	3%	11%
NORA YoY Growth		3%	6%	14%	25%

11

Primary ORs & NORA Cases

NORA Cases Labeled as Percentage



FY	Total Anesthesia Volume	Primary ORs	NORA
FY15	41,952	32,520	9,432
FY16	43,503	34,605	8,898
FY17	48,225	37,368	10,857
FY18	49,849	38,301	11,548
FY19	54,876	41,428	13,448
FY20	51,750	40,119	11,631
FY21 (Proj)	60,454	43,370	17,084
Growth (FY15 to FY21 Proj.)	44%	33%	81%

NORA growth has greatly outpaced OR growth

Fiscal Year	Avg % of NORA Case Volume
FY15	22%
FY16	20%
FY17	23%
FY18	23%
FY19	25%
FY20	27%
FY21 (Proj.)	31%

12

Daily Resident "Board Runner" Tasks

- Arrive 06:30 and ascertain OR/NORA operational status of three bed towers
- Assess status of preoperative holding, PACUs, OR's
- Manage Anesthesia Periop Personnel and Assignment Changes
  - Sick Call-outs
  - Opened ORs for urgent/emergency add-ons
  - Case cancellations
  - Attending Anesthesiologists
  - Anesthesiology Residents
  - Anesthetist Staff (CRNAs and CAAs)
- Collaborate with
  - OR Charge Nurses
  - Circulating Nurses
  - Anesthesia Technicians
  - Surgeons

13

Daily Resident "Board Runner" Tasks

- Respond to "Green Button" alerts (anesthesia emergencies)
- Assist Anesthesiology Attendings with multiple OR starts/finishes
- Delegate or respond to external difficult airway/intubation assist requests
  - ED
  - Critical care units
- Work with scheduling office staff to complete next day clinical assignments (EPIC OpTime)
- Coordinate anesthesia resident and anesthetist breaks/lunches
- Coordinate afternoon relief for shift personnel and post-late stay residents
- Provide hand-off report for oncoming evening late stay, night float ("mole team") residents, and in-house anesthesiology attending staff

14

"Board Runner" Rotation Didactic /Reading Topics

1. OR Scheduling Strategy Schema (block, open, "flex" or "swing")
2. Metrics of OR/NORA utilization and associated definitions
3. Staffing and billing compliance regulations and guidelines
   1. Concurrency ratios
   2. Subspecialty skill sets
   3. Resident experience levels
4. Allocation of resources
5. Conflict resolution
6. Negotiation

15

ACGME Common and Anesthesiology Program Requirements

- Medical Knowledge
  - IV.B.1.c).(1) Residents must demonstrate appropriate medical knowledge in the topics related to the anesthetic care of patients, including
    - Practice management to address issues such as operating room management
  - IV.B.1.c).(1).(b)
    - Management skills, to include basic knowledge of organizational culture, decision making, change management, conflict resolution, and negotiation and advocacy

16

ACGME Common and Anesthesiology Program Requirements

- Interpersonal Skills
  - IV.B.1.e).(1) Residents must demonstrate competence in:
    - Communicating effectively with physicians, other health professionals, and health-related agencies
    - Working effectively as a member or leader of a health care team or other professional group
    - Acting in a consultative role to other physicians and health professionals
- Systems-Based Practice
  - IV.B.1.f).(1) Residents must demonstrate competence in:
    - Working effectively in various health care delivery settings and systems relevant to their clinical specialty
    - Coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty

17

ACGME Anesthesiology Milestones

- PC 7—Situational awareness and crisis management
- SBP 2—System Navigation for Patient-Centered Care
- SBP 3—Physician Role in Health Care Systems
- Prof 1—Professional Behavior and Ethical Principles
- Prof 2—Accountability/Conscientiousness
- ICS 2—Interprofessional and Team Communication
- ICS 3—Communication within Health Care Systems

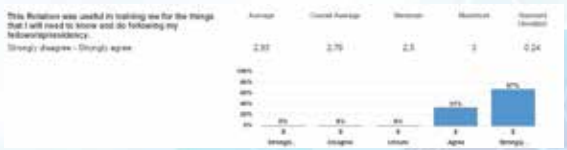
18

Resident Rotation Evaluation Comments

- "Fantastic rotation. I learned so much about scheduling, resource management, and ways to monitor and improve efficiency of the operating flow."
- "Great rotation. Gave me perspective on how stressful the "board runner (AOD) job is. I am now happy to do any assignment given to me without complaints. Being in a room is easier than running the board."
- "Great rotation! I was especially lucky to work with several attendings and observe their different strategies for organizing such a vast department."

19

Resident Evaluation Utility for Future



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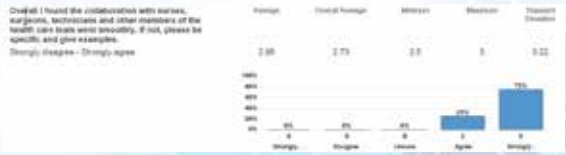
Resident Evaluation of Collaboration



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Resident Evaluation Overall Value of Rotation

22

23

HANDOUT

AACPD

Competency-Based Medical Education and Time-Variable Training in Anesthesiology

Moderator: Daniel Saddawi-Konefka, MD, MBA

Friday, November 11
9:15 AM – 10:00 AM

HANDOUT

Competency-Based Medical Education and Time-Variable Training in Anesthesiology

Glenn Woodworth, MD

Friday, November 11
9:15 AM – 9:45 AM

CBME: Problems and Potential Solutions for Time-Variable Anesthesiology Residency Training

GLENN WOODWORTH MD and SKYLAR FULLER MS-IV
Oregon Health & Science University

1

Disclosures

- None

2

2

Learning Objectives

Upon completion of this presentation, participants will be able to:

- Identify the main principles of Competency-based Medical Education (CBME)
- Describe the role of Time-Variable Training (TVT) in CBME
- Identify potential problems and solutions to the implementation of TVT Anesthesiology training

3

3

Principles of CBME

- Defined Learning Outcomes
- Outcomes focus on KSA
- Curricula Target Outcomes
- Individualized Learning based on Assessment
- Advancement based on Achievement
- Assessment

4

Time-variable Training

Advancement and transitions in training occur with demonstration of achievement of competencies **rather than by time**

Lucy CR, et al. Competency-based, time-variable education in health professions: crossroads. Acad Med. 2018;93:S1-S5.

5

Time-Variable Training, CBME, and the Pandemic

Schumacher DJ, et al. Competency-based time-variable training internationally: ensuring practical next steps in the wake of the COVID-19 pandemic. Med Teach. 2021;43(7):810-816.

6

Why do I care about CBME and TVT?

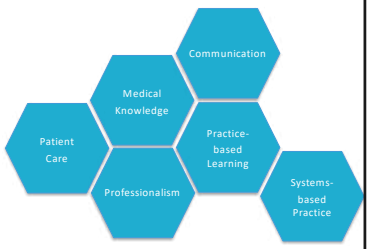
Has the train left the station?

7

7

ACGME and CBME

- **1999** - ACGME core competencies
- **2013** - Milestones



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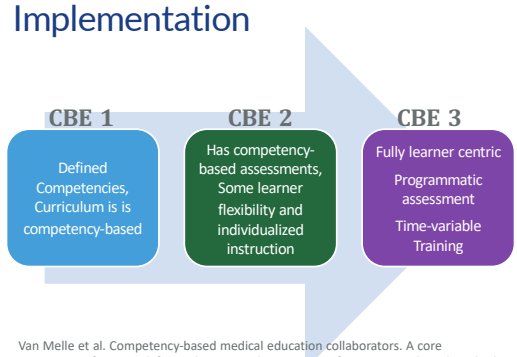
Progression of CBME Implementation



Van Melle et al. Competency-based medical education collaborators. A core components framework for evaluating implementation of competency-based medical education programs. Acad med. 2019;94:1002-9.

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9

ACGME and ABMS Joint Meeting on CBME

RRCs and Boards asked what it would take to implement

10

Time-Variable Training is likely a VERY Heavy Lift

Who will staff the ORs?

11

TVT Implementation Issues

1. Identify potential barriers to the implementation of TVT
2. Rank the importance of these problems, perceived difficulty
3. Propose solutions to the problems

Van Rossum TR, et al. Effects of implementing time-variable postgraduate training programmes on the organization of teaching hospital departments. Med Teach. 2018;40(10):1036-1041.

12

Important Stakeholders (past or present member)
ACGME or RRC Member
ABA Board Member
Anesthesiology Dept Chair
Anesthesiology Vice Chair for Education **or** Program Director
Anesthesiology Residency Program Administrator
Designated Institution Official
Anesthesiology Fellowship Director
Anesthesiology Resident
Anesthesiology Sub-specialty Fellow
Anesthesiology Community Practice Leader
Clinical Operations Director
Other

13

Problems: Assessment

1. **Competency assessment**
   - Milestones may not be sufficient
   - Lack of valid unbiased assessment tools
   - Honest assessment
   - Assessment burnout

14

Problems: Incentives

2. **Mis-alignment of Incentives**

Incentives to graduate early but.....

- Affect on learning
- Affect on culture
- Affect on program

15

Problems: Regulatory

3. **Regulatory/Organizational**
   - ACGME and ABA
   - CMS
   - Funding mechanisms for training

16

Problems: Resources

4. **Requires Lots of Resources**
   - Replace resident work force
   - Faculty/Program time
   - Technology

17

Some Initial Progress

- Workplace-based assessments
- Online-learning
- Programmatic system of assessment

18

19

Regulatory Solutions

ACGME and ABA

- Time in training
- Procedure minimums
- Exam schedules
- Assessment tools
- Training materials

20

20

Culture Change: Assessment

- Role in advancement
- Frequency
- Culture of feedback

21

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Precision-guided Education

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Variable Graduation Dates

23

23

Promotion-in-Place

- Staffing
- Additional development time
- Increase autonomy
- Peer teaching
- Meet Resident financial goals
- Fellowship matching

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24

Faculty Time and Resources

- Almost all solutions require faculty time
- Departments, Deans, …. will need to fund CBME

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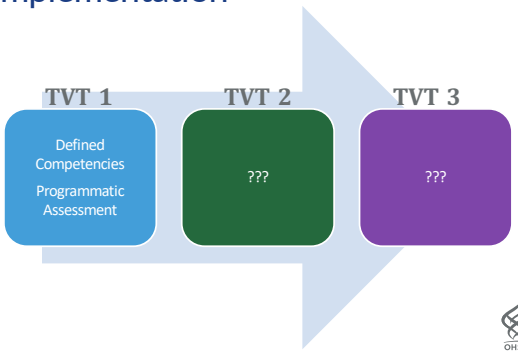
Phased Time-Variable Training Implementation



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Pilot Testing

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Questions

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HANDOUT

AACPD

Mistakes Made/Lessons Learned

Moderator: Susan M. Martinelli, MD

Friday, November 11
10:30 AM – 11:30 AM

HANDOUT

AACPD

Mistakes Made/Lessons Learned

Bryan Mahoney, MD

Friday, November 11
10:30 AM – 10:40 AM

Mistakes Made, Lessons Learned

Bryan Mahoney, M.D.
Residency Program Director
Department of Anesthesiology, Perioperative and Pain Medicine
Mount Sinai Morningside and West

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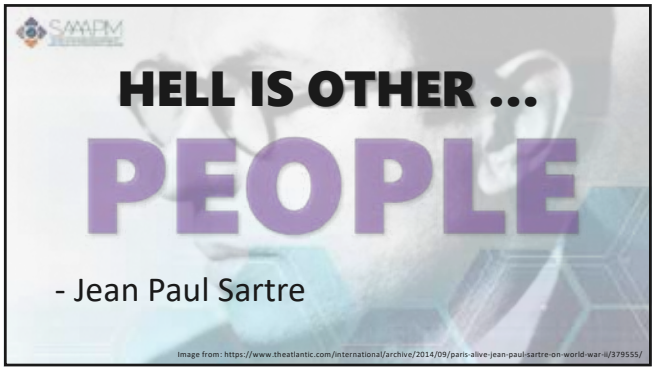

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5

6


PEOPLE
..will only see what they want to see

7


PEOPLE
..will recognize authenticity & integrity over time

8


PEOPLE
..matter

9


Universal (abstract)...
PEOPLE
..matter

10


Particular...
PEOPLE
..matter

11


Singular...
PEOPLE
..matter

12

13

HANDOUT

AACPD

Mistakes Made/Lessons Learned

Kate McCartney, MD, FASA

Friday, November 11
10:40 AM – 10:50 AM

Fearing the ACGME Survey

Mistakes Made / Lessons Learned

1

- Conflict of Interest:
  No Disclosures
- Target Audience:
  Newer PDs or APDs considering taking on the job.

2

Learning Objectives:

1. Recognize that you are personally invested in ACGME survey results, without taking results personally.
2. Prepare to have Chiefs discuss results with survey-takers immediately.
3. Construct an anonymous internal survey by PGY level to identify reasons (and solutions) for underperformance areas.
4. Empower residents to take ownership of their responses, find & enact solutions: hold team accountable to these action items with quarterly PEC meetings.

3

Mistake Made: "Fearing the ACGME Survey"

Lessons Learned:

- Do not take anything personally.
- You can't run a program alone, it's not all your fault when it's bad, nor all your glory when it's good. Your job is to leverage the strengths of all faculty and institutional resources.
- Do not blame yourself: most issues are long-seeded and multi-dimensional. Residents are canaries in a coal mine, and the survey may reveal institutional or interdisciplinary issues before you see/hear it in your own faculty.
- Your career does not ride on this survey (but it may change the amount and nature of work you do in the next AY.)

4

Mistake Made: "Sitting on results, taking sole responsibility or trying to find solutions on own or with your APDs."

Lessons Learned:

- Review results ASAP with Education Leadership Team & Chiefs
- Trust your chiefs to present the survey results at the very next resident mtg. They will get more honest reasons for the responses and ideas for solutions without faculty present.

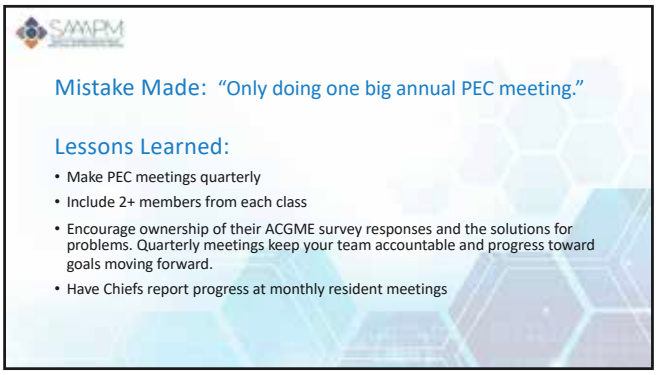
5

Mistake Made: "Doing the Internal program survey a few months before the ACGME survey"

Lessons Learned:

- Do the anonymous Internal program survey -*tagged by class*- immediately (within a few weeks) *after* ACGME results
- Create focused questions seeking reasons and solutions for lower scoring survey items
- Find trends by PGY year
- Now you have reasons for responses and a list of solutions to bring to your PEC, and can add this to your state of the residency report, SWOT analysis, and upcoming PEC goals/improvements, without anyone having to call themselves out

6


SAMPM
Mistake Made: "Only doing one big annual PEC meeting."
Lessons Learned:
• Make PEC meetings quarterly
• Include 2+ members from each class
• Encourage ownership of their ACGME survey responses and the solutions for problems. Quarterly meetings keep your team accountable and progress toward goals moving forward.
• Have Chiefs report progress at monthly resident meetings

7

HANDOUT

AACPD

Mistakes Made/Lessons Learned

Lee Chang, MD

Friday, November 11
10:50 AM – 11:00 AM

The Importance of Professionalism

Lee Chang, MD
Program Director
Baylor College of Medicine

1

Mistakes Made

As a new program director, I did not realize the importance of developing a culture of professionalism.

There were occurrences within the residency program of lapses in both professional behavior and accountability/conscientiousness.

2

Mistakes Made

These occurrences may have been avoidable if there was more of an emphasis on professionalism.

3

Examples of lapses in professionalism

- Tardiness/late
- Failure to follow program policies (including work hour submissions, case logs, etc.)
- Unexcused absences from grand rounds and lectures
- Interaction between other residents, faculty or other members of the health care team

4

Residency Professionalism Committee

A residency professionalism committee was established, consisting of both junior and senior faculty from each of the different teaching sites.

An associate program director was assigned to be chair of the committee.

5

Goals of the Committee

Develop methods of promoting a culture of professionalism

Develop a policy for managing professionalism issues

6

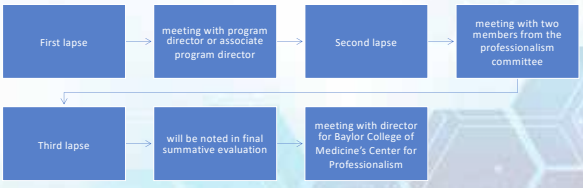
Lapses in Professional Behavior

Committee decided that lapses needed to be addressed formally.

Three stages of formal interventions.

7

Lapses in Professional Behavior



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Lapses in Professional Behavior

But not all lapses needed to be elevated to the next stage (not submitting work hours on time).

For each minor lapse in professional behavior, a "professionalism demerit" was assigned to the resident.

If more than three professionalism demerits were assigned for the academic year, certain benefits would be lost (unable to do internal moonlighting, CME funding, etc.)

9

Recognition - Professionalism Award

Faculty and Residents submit nominations and provide examples of how the resident acted in a professional manner.

Based on the nominations, the professionalism committee members would select one resident every three months to win the award.

10

Recognition - Professionalism Award

11

Recognition - Professionalism Award

Initially, did need to send reminders to request faculty and resident to submit nominations, but now often receive several nominations without any solicitation.

Decision made by the committee to award the winner $50 gift card (there has been discussion if this is a good way of promoting professionalism).

12

Recognition - Professionalism Award

The recipients have expressed gratitude for the opportunity to win this award and when I write the letters of recommendation, I notice them including it in their CV.

Helps with fellowship applications and hiring for private practice groups.

13

Recognition - Professionalism Award

Purpose of recognition is to demonstrate to the residents of the importance that we place on professionalism.

By sharing the nominations with them, it provides real examples to residents on acts of professionalism and hopefully something they can also strive for.

14

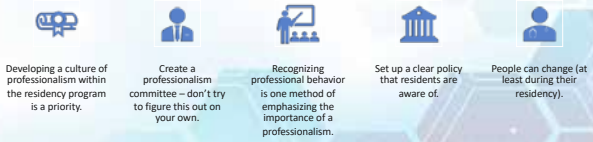
Informing the residents

Committee wanted to be sure that the policies and expectations were clear and understood.

Residents were informed of the policies, both during orientation for new residents and at the start of each academic year during a resident only grand rounds. Policy was sent to all residents by email.

15

Lessons Learned



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HANDOUT

AACPD

Mistakes Made/Lessons Learned

Tanaya Sparkle, M.B.B.S., D.ABA

Friday, November 11
11:00 AM – 11:10 AM

Mistakes Made/Lessons Learned: Not advocating for my Program Coordinator

Tanaya Sparkle, M.B.B.S.
Assistant Professor & Residency Program Director,
University of Toledo Medical Center, Toledo, Ohio

1

Our Story

- Associate Program Director for 9 months and Program Director for little over 1 year
- On my 3rd Program Coordinator
- Using numbers for privacy:
  - PC#1-Retired (Me: No administrative role yet)
  - PC#2-Moved to a completely different field (Associate PD transitioning to PD)
  - PC#3-Moved to a job in higher education but not related to GME
  - PC#4-Powering through our first interview season

2

My mistake as a New Program Director

- Not realizing how much the success of my program depends on the Program Coordinator (PC)
- Not checking in with our PC
- Assuming our PC was happy and satisfied in her role because things were getting done
- Focusing on Resident Wellness but ignoring Coordinator Wellness

3

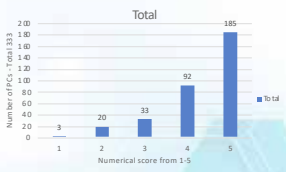
Is it just my Program? What is the evidence?

- LIMITED EVIDENCE
- Burnout is a syndrome defined by three composite elements—emotional exhaustion, depersonalization, and decreased personal accomplishment.[1]
- Ewen et.al. utilized the Copenhagen Burnout Inventory and found elevated mean burnout scores in all 3 domains (personal, work-related, and client-related) for GME Program Administrators.[2,3]
- Factors such as years in GME and lack of wellness activities offered by the institution accounting for higher burnout scores.[2,3]
- Burnout scores differed between those contemplating leaving their jobs and those who were not, across all subscales of CBI
- Dr. Gilbert and Terri Feist (Neurology) suggested that ACGME could track PC turnover.[4]

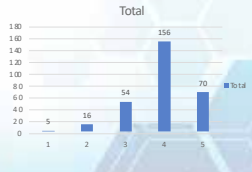
4

- ACGME is conducting a survey of coordinators

Anonymous survey of Anesthesia Program Coordinators:



How well does your Program Director support you?



How satisfied are you with your job?

5

Lessons learned – What I should have done

- Advocated for an increase in their base pay or overtime allowances
- Advocated for more paid training time
- Supported and pushed for a second title/responsibility within the department I
- Appreciated their hard work and organized appreciation/birthday events
- Periodically check in with them to ensure that they are not overwhelmed/stressed, especially when new
- Direct them towards social media groups for coordinators and GME leadership

6

References

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2) Ewen AM, Higgins MCSS, Palma S, Whitley K, Schneider JI. Residency and Fellowship Program Administrator Burnout: Measuring Its Magnitude. J Grad Med Educ. 2019 Aug;11(4):402-409. doi: 10.4300/JGME-D-18-00860.1. PMID: 31440333; PMCID: PMC6699536.

3) Ewen AM, Gittus N, Higgins MCSS, Palma S, Whitley K, Schneider JI. Program Administrator Burnout in Graduate Medical Education: a Longitudinal Study. J Gen Intern Med. 2020 Nov;35(11):3248-3253. doi: 10.1007/s11606-020-05853-8. Epub 2020 May 12. PMID: 32399913; PMCID: PMC7661571.

4) Feist TB, Gilbert DL. Program Administrator Burnout: More Than a Wellness Issue. J Grad Med Educ. 2019 Dec;11(6):732. doi: 10.4300/JGME-D-19-00622.1. PMID: 31871580; PMCID: PMC6919179.

7

Thank You

8

HANDOUT

AACPD

Business Meeting

Moderator: Timothy Long, MD

Friday, November 11
11:30 AM – 11:45 AM

HANDOUT

AACPD

Annual Updates

Moderator: Andrea Dutoit, MD

Friday, November 11
1:00 PM – 3:00 PM

HANDOUT

AACPD

Annual Updates: ABA/ITE Update

Mark Keegan, MB, BCh, BAO, MRCPI, DABA, MSc, FCCM
Alex Macario, MD

Friday, November 11
1:00 PM – 1:40 PM

ABA The American Board of Anesthesiology

ABA UPDATE

SAAA-PM 2022

Alex Macario, M.D., MBA
ABA Secretary

Mark Keegan, M.B., B.Ch.
Chair, Assessments Committee

1

THANK YOU

2

AGENDA

- Overview
- RTID Redesign & ITE 2023 Exam Dates
- The Latest
- Subspecialty Update
- Assessment Update
  - ITE, BASIC, ADVANCED Exams
  - APPLIED Exam

3

OVERVIEW

4

WHO WE ARE: OUR BOARD OF DIRECTORS

12 Diplomate Directors; 1 Public Member Director

5

PATIENTS PERCEIVE ABA CERTIFICATION TO SIGNIFY

1. High level of clinical knowledge, judgement & skills
2. Up-to-date with recent advances
3. Professionalism

6

RESIDENCY TRAINING INFORMATION DATABASE (RTID) REDESIGN & ITE EXAM DATES

7

RTID REDESIGN COMING NOV. 14

NEW DESIGN

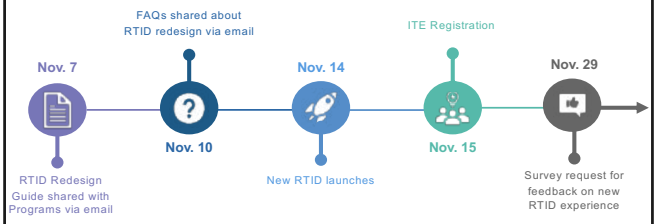
- Based on your feedback
- New look and user-friendly design
- Improved navigation and fewer clicks to complete tasks
- New homepage shows current resident list

NEW FEATURES

- Enter reports en masse for trainees with six months of continuous satisfactory training
- Advanced roster sorting by track type, ABA ID, name or year
- Streamlined report approval process
- Program Director Reference Form (PDIR) and final Certificate of Clinical Competence (CCC) reports combined
- Automatic credit given for prior Clinical Base training

8

RTID LAUNCH TIMELINE



9

2023 & 2024 IN-TRAINING EXAM DATES

10

THE LATEST

11

2023 POLICY BOOK

- 2023 Policy Book will be shared in Dec. 2022 via email and on our website
- Document indicating changes to 2023 Policy Book will be included during distribution

Notable changes

- Temporary criteria for ACA certification
- Extended leave policy now includes the clinical base year for 4 yr programs

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JOIN ABA PREPAY

Allows payment of the annual MOCA fees for the diplomates by streamlining credit for their registration

Simplify and streamline your finances by eliminating reimbursement requests from physicians and accurately allocating your budget for board certification

Show your appreciation for board certification to the anesthesiologists in your department, highlighting the value of continuous learning

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2023 PROGRAM DIRECTOR MEETING

- Prior to the COVID-19 pandemic the ABA met with Program Directors annually to share updates that impact programs and residents, including for example to inform residency programs about OSCE
- PD Meeting is being scheduled for early in 2023
- **Meeting topics:**
  - Policy updates
  - Program changes
  - Examination results
  - Examination prep

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PROGRAM IN FOCUS

New quarterly e-newsletter for improving communication with residency programs

- First edition launched in Summer 2022
- Shares latest news and updates regarding exam dates, changes to policy and more
- Please keep your contact list up-to-date and share with our Credentialing team to ensure your current program contacts receive these e-Newsletters

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DIVERSITY, EQUITY & INCLUSION

Our Commitment

We have long recognized that we play a distinct role in addressing biases that endanger healthcare outcomes, and in advancing equity and inclusion, particularly as it relates to our organization and assessments.

Exploring ways to embed DEI/healthcare disparities into assessments

- Patient diversity in OSCE scenarios
- Transparency of volunteer selection
- Differential item type analyses
- Director/Volunteer training

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NEW ABMS STANDARDS FOR CONTINUING CERTIFICATION

- In January 2024, changing to a five-year certification cycle instead of current 10-year cycle
- MOCA fees will not be impacted by the change
- Do not anticipate new standards to impact ABA diplomate experience significantly — currently have requirements to meet every five years
- Evolution of the MOCA program has positioned the ABA favorably to implement new standards
  - Transitioned from high-stakes exams every 10 yrs to current MOCA minute longitudinal assessment

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SUBSPECIALTY UPDATE

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ADULT CARDIAC ANESTHESIOLOGY

First ACA Subspecialty Board Certification Exam will be administered on Dec. 2, 2023

Three eligibility pathways for diplomates who have completed:
- An ACGME-accredited CTA Fellowship
- A Non-ACGME-accredited Adult Cardiac Fellowship
- < 12 months Adult Cardiac Fellowship Training

To qualify diplomates must also:
- Be ABA certified
- Have License to practice medicine/osteopathy in the U.S. or Canada
- Attest to their clinical activity in ACA care (practicing at least one day per week during 12 consecutive months over the previous three years)
- Be meeting MOCA requirements

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NEUROCRITICAL CARE

- First exam was administered Oct. 4-8, 2021, by the American Board of Psychiatry and Neurology (ABPN) to eligible diplomates of the American Boards of Anesthesiology, Emergency Medicine, and Surgery
- Second neurocritical care exam was administered Oct. 11-15, 2022, by the ABPN and will be provided every even-numbered year thereafter
- 110 ABA Diplomates certified to date

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ASSESSMENTS UPDATE

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WRITTEN EXAM UPDATE

22

CANDIDATE BEHAVIOR EXPECTATIONS

- Recent instances of irregular candidate behavior during the ADVANCED Exam
  - Policy violations as candidates accessed phones during unscheduled breaks

Please advise candidates:
- Cell phone use during their assessment is prohibited
- Candidates who violate policy will have results invalidated
- ABA will not consider a registration for offenders for readmission to the ABA examination system for two years

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THREE-OPTION MCQ

- In 2019, the ABA Board of Directors approved transitioning our **computer-based exams from four-option multiple-choice items to three**
- **This is an unprecedented change in our sector and standardized testing as a whole and does not impact the difficulty, validity or reliability of the exam**
- We successfully transitioned the Critical Care Medicine and Pediatric Anesthesiology exams in 2020, the Pain Medicine exam in 2022 and are completing the transition with the ITE, BASIC and ADVANCED exams in 2023

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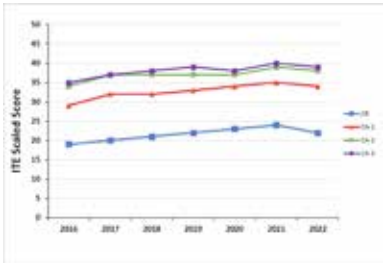
ITE PERFORMANCE
BY TRAINING LEVEL & EXAM YEAR



25

2022 JUNE BASIC EXAM RESULTS

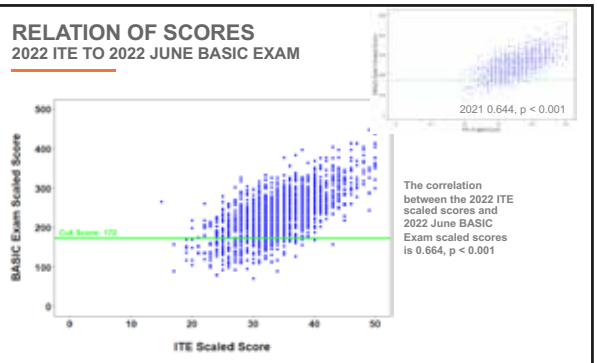
- Key validation eliminated eight items in two forms
- Mean Scaled Score: **236.0**
- Reliability: 0.83 (Form A) & 0.84 (Form B)
- Pass rate breakdown:
  - First time-takers' pass rate: **88.8%**
  - Second time-takers' pass rate: **73.1%**
  - Third time-takers' pass rate: **76.9%**

1,929
residents examined

88.4%
of residents passed

26

RELATION OF SCORES
2022 ITE TO 2022 JUNE BASIC EXAM



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RELATION OF SCORES
2022 ITE TO 2022 JUNE BASIC EXAM

2022 ITE Scaled Score	2022 ITE Percentile Rank in CA-1	N	2022 June BASIC Scaled Score Mean (S.D.)	BASIC Pass Rate
≤ 25	≤5	104	173(43)	50%
26-30	7-22	345	201(43)	77%
31-35	28-58	708	225(41)	90%
36-40	64-85	495	256(43)	98%
41-45	88-96	176	295(41)	99%
≥ 46	≥97	63	341(46)	100%

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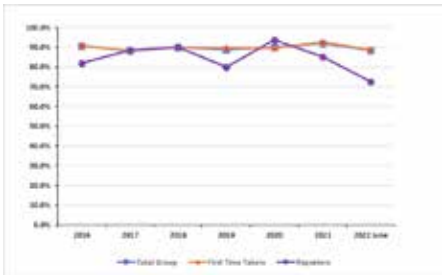
BASIC EXAM
SUCCESS RATES (TO 2022 JUNE)



29

2022 JULY ADVANCED EXAM RESULTS

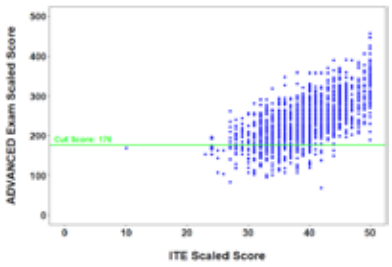
- Candidates were assigned to examine on Friday or Saturday
- Key validation eliminated five items in two forms
- Mean Scaled Score: **235.1**
- Reliability: 0.82 (Form A) & 0.79 (Form B)

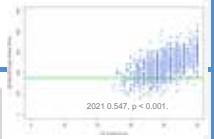
1,854
candidates examined

85.9%
of candidates passed

30

RELATION OF SCORES
2022 ITE TO 2022 JULY ADVANCED EXAM





The correlation between the 2022 ITE scaled scores and 2022 July ADVANCED Exam scaled Scores is 0.635, p < 0.001.

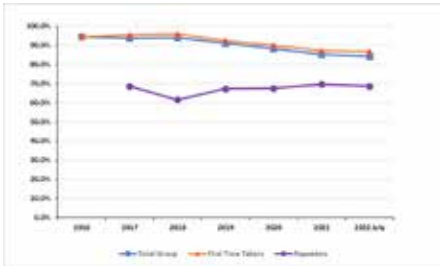
31

RELATION OF SCORES
2022 ITE TO 2022 JULY ADVANCED EXAM

2022 ITE Scaled Score	2022 ITE Percentile Rank in CA-3	N	2022 July ADVANCED Scaled Score Mean (S.D.)	ADVANCED Pass Rate
≤ 25	≤1	11	162(25)	18%
26-30	1-5	80	182(40)	53%
31-35	7-23	321	203(42)	73%
36-40	29-55	565	226(42)	89%
41-45	63-83	440	258(42)	98%
≥ 46	≥87	249	298(49)	100%

32

ADVANCED EXAM
SUCCESS RATES (TO 2022 JULY)



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APPLIED EXAM

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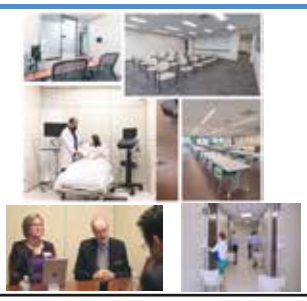
APPLIED EXAM — RETURNS TO RALEIGH

- Starting in Dec. 2020 and throughout 2021 the ABA administered the oral and OSCE components of the APPLIED Exam virtually to 3,304 candidates across 18 weeks during the COVID-19 pandemic
- In 2022, the ABA returned to in-person assessments for the APPLIED Exams in our expanded assessment facility, the AIME Center



35

OSCE STRUCTURE

- Seven station circuit
  - Seven of the nine skills from the OSCE Content Outline
  - Six communication & professionalism skills
  - Three technical skills
- Each station: 8 minutes long; 4 minutes between stations to review next scenario
- Candidates interact with either a standardized patient/clinician actor or directly with an examiner

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2022–23 APPLIED EXAM: OSCE UPDATES

1. **Application of Ultrasonography** (Point-of-Care Ultrasound)
   - Heart (2022)
   - Lung (2023)
2. **Interpretation of Echocardiogram & Surface Ultrasound of Lung**
   - Transthoracic echocardiography images (2022)
   - Lung and diaphragm ultrasound images (2023)
3. **Off-site scoring continues to be effective**

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NEW EXAMINER SELECTION & TRAINING

1) **New APPLIED examiner selection**
   - Carefully review applications for APPLIED examiner positions
   - **Hundreds of excellent, well-qualified applicants for 30-40 positions**

2) **New APPLIED examiner training**
   - Aptitude and previous experience variable
   - Training and mentorship are critical

3) **Retiring examiner sentiments**
   - Willingness and desire to remain involved

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2022 APPLIED EXAM RESULTS (WEEKS 1-6)

381 examiners delivered exam

2,203 candidates completed exam

1,497* achieved certification (so far)

*Week 6 scores processed on Nov. 8

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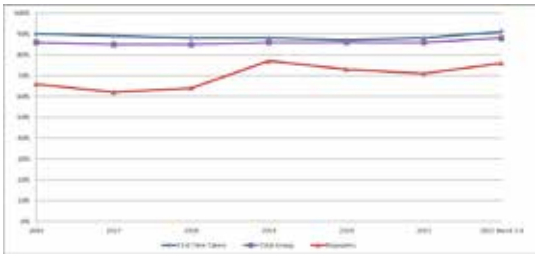
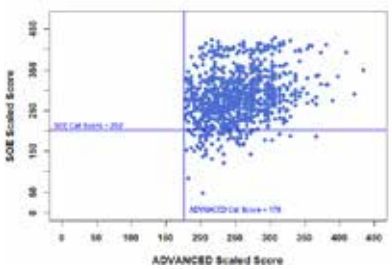
STANDARDIZED ORAL EXAM
SUCCESS RATES



40

RELATION OF SCORES
2022 SPRING SOE TO FIRST ATTEMPT ON 2021 JULY ADVANCED EXAM



2021 SOE and first attempt on 2019 JULY ADVANCED 0.252, $p < 0.001$

The correlation between the 2022 SOE scaled scores and first attempt on 2021 JULY ADVANCED Exam scaled scores is 0.274, $p < 0.001$

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2022 OSCE RESULTS
(WEEKS 1-4)

- Mean Scaled Score: **250.4**
- Standard Deviation: **38.4**
- 1,228 candidates took both SOE and OSCE

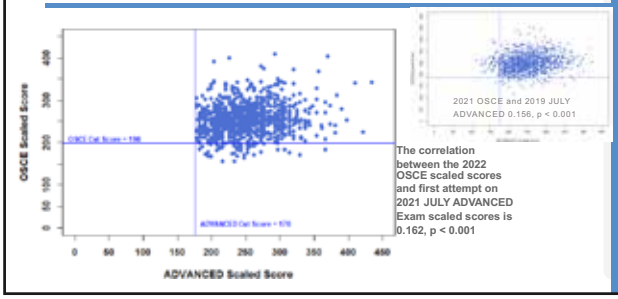
	OSCE: Fail	OSCE: Pass	Total
SOE: Fail	42 (3.4%)	87 (7.1%)	129 (10.5%)
SOE: Pass	59 (4.8%)	1,040 (84.7%)	1,099 (89.5%)
Total	101 (8.2%)	1,127 (91.8%)	1,228 (100%)

1,251
candidates took OSCE component

92.6%
of candidates passed OSCE component

42

RELATION OF SCORES
2022 SPRING OSCE TO FIRST ATTEMPT ON 2021 JULY ADVANCED EXAM



The correlation between the 2022 OSCE scaled scores and first attempt on 2021 JULY ADVANCED Exam scaled scores is 0.162, p < 0.001

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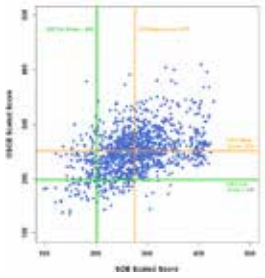
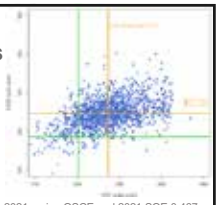
RELATION OF SCORES
BETWEEN THE OSCE AND SOE COMPONENTS



The correlation between the 2022 spring OSCE scaled scores and 2022 spring SOE scaled scores is 0.409, p < 0.001



2021 spring OSCE and 2021 SOE 0.467, p < 0.001

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Questions? We are here to help.

coms@theaba.org

(866) 999-7501

www.theaba.org

4200 Six Forks Road, Suite 1100
Raleigh, North Carolina 27609

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HANDOUT

Annual Updates: ACGME Update

Aditee Ambardekar, MD MSEd
Cheryl Gross, MA, CAE

Friday, November 11
1:40 PM – 2:10 PM

ACGME Review Committee Update

November 11, 2022

Aditee Ambardekar, MD
Chair, Review Committee for Anesthesiology

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Disclosure

- **No disclosures to report**

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Session Objectives

1. Describe current accreditation statistics for core and subspecialty programs
2. Discuss recent and upcoming changes to the Program Requirements
3. List recent and upcoming initiatives at the ACGME and Anesthesiology RC

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3

The Stats

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4

Trends in Core Anesthesiology Programs

Academic Year	# Approved Resident Positions	# Core Programs
2021-2022	7,859	166
2020-2021	7,640	161
2019-2020	7,531	160
2018-2019	7,299	153
2017-2018	7,171	153
5-Year Trend	**↑ 9.6%**	**↑8.5%**

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Core Anesthesiology Program Size 2021-2022

Number of Filled Positions	Number of Programs
0 Residents	5
1-24 Residents	49
25-49 Residents	50
50-74 Residents	38
75-99 Residents	16
100+ Residents	8

	Number of Filled Positions
Range	0-113
Mode	20
Median	39
Mean	43

90.5% Fill

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Subspecialty Programs 2020-2021

Subspecialty	Number of Programs	Filled	Active Fellows
Adult Cardiothoracic	74	94.7%	251
Critical Care Medicine	64	83.6%	219
Regional Anesthesiology and Acute Pain Medicine	40	96.1%	98
Obstetric Anesthesiology	41	85.3%	58
Pain Medicine	114	94.7%	4333
Pediatric Anesthesiology	61	83.1%	222

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Pediatric Cardiac Anesthesiology

- Beginning accreditation – July 1, 2022
- Currently accredited
  - *6 programs*
  - *10 approved positions*

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Program Review

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Annual Review Committee Activities

- Applications for new programs
- Permanent complement increase requests
- Annual data
  - *Programs with Citations*
  - *Programs with Annual Data Indicators*
- 10-Year site visit reports

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Annual Program Review 2020-2021

501 Programs Reviewed

- 472 Continued Accreditation
- 5 Continued Accreditation with Warning
- 11 Initial Accreditation
- 2 Accreditation Withheld
- 1 Deferred

Common Citations

- Faculty and Resident Scholarly Activity
- Qualifications of Faculty (subspecialty)
- Responsibilities of Program Director (Failure to provide accurate information)
- Responsibilities of Faculty
- Curricular Development
- Evaluation of Residents
- Educational program—Patient Care Experience and Didactic Components

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Other Initiatives

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Protected Time: Core Program Director

Number of Approved Resident Positions	Minimum Support Required (FTE) for the Program Director	Minimum Additional Support Required (FTE) for Program Leadership	Total Minimum Program Leadership Support
1-20	0.2	0.2	0.4
21-30	0.4	0.2	0.6
31-40	0.4	0.3	0.7
41-50	0.4	0.4	0.8
51-60	0.4	0.5	0.9
61-70	0.4	0.6	1.0
71-80	0.4	0.7	1.1
Over 80	0.4	0.8	1.2

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Protected Time: Core Coordinator

Number of Approved Resident Positions	Minimum Support Required (FTE)
9-10	0.7
11-15	0.8
16-20	0.9
21-25	1.0
26-30	1.1
31-35	1.2
36-40	1.3
41-45	1.4
46-50	1.5
51-55	1.6
56-60	1.7

Number of Approved Resident Positions	Minimum Support Required (FTE)
61-65	1.8
66-70	1.9
71-75	2.0
76-80	2.1
81-85	2.2
86-90	2.3
91-95	2.4
96-100	2.5
101-105	2.6
106-110	2.7
111-115	2.8
116-120	2.9
Over 120	3.0

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Protected Time: Subspecialty PDs

Number of Approved Fellow Positions	Minimum FTE
1-2	0.1
3	0.125
4	0.15
5	0.175
>5	0.2

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Protected Time: Subspecialty Coordinator

Number of Approved Fellow Positions	Minimum FTE
1	0.2
2	0.24
3	0.26
4	0.28
>5	0.02 per each additional approved position

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Major Revisions Program Requirements

- Core – work will begin in 2024 for July 1, 2026 start date
  - Planning for future of anesthesiology
  - JGME article – internal medicine process
- Subspecialties – work will begin in early 2023 for a July 1, 2024 start date

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Milestones 2.0

- Core Anesthesiology in effect July 1, 2021
- Adult Cardiothoracic – working through December
- Critical Care – Working through Jan 2022
- Obstetrics – working through Feb 2022
- Pediatric – working through Feb 2022
- Pediatric Cardiac – working through Feb 2022
- Pain Medicine – Review and Comment Closed Oct 31

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Rural Track Program Designation

- Processes developed to address accredited programs that meet CMS definition of "rural track"
- Urban teaching hospital can obtain DGME and IME financing through partnerships with rural hospitals and sites
- Info on www.acgme.org
- Contact muap@acgme.org or 312.755.7458

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ACGME Equity Matters™

- Framework for continuous learning in DEI and anti-racism practices
- Comprehensive curriculum of ideas, models, and data to support interventions to develop diverse physician workforce to care for diverse patient populations
- Combines educational resources and collaborative learning communities
- Visit the ACGME website or email diversity@acgme.org for more information

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Medical, Parental, Caregiver Leave(s) of Absence

- ACGME Institutional Requirements, effective July 2022
- Minimum of 6 weeks of leave at least once and at any time during an ACGME-accredited program
- Provide residents/fellows equivalent of 100% of salary for first 6 weeks of first approved leave
- At least one week of paid time off outside the first 6 weeks of first approved leave
- Continue health and disability insurance benefits for residents/fellows and eligible dependents during approved leave

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Medical, Parental, Caregiver Leave(s) of Absence

- RC allows flexibility in approved leaves of absence
  - Clinical experience requirements must be met (includes case logs)
  - Clinical Competency Committee must deem the affected resident fully prepared for autonomous practice
- Review ABA's (or AOBA) Absence from Training policy

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Competency-Based Medical Education

- ABMS-ACGME Symposium – held August 2023
- Review Committee plans to incorporate as part of its major program requirement revisions
- In the meantime – AIRE process
  - Promoting innovation for programs
  - Can permit reprieve from specific program requirements based on proposal

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CONTACT ACGME Staff – they want to help!

Review Committee Staff

Cheryl Gross: cgross@acgme.org
Kerri Price: kprice@acgme.org
Aimee Morales: amorales@acgme.org

- *Program requirements*
- *Notification letters*
- *Complement requests*
- *Case Log content*

ADS Staff

ADS@acgme.org

- *ADS*
- *Surveys*
- *Case Log technical support*

Field Activities Staff

fieldrepresentatives@acgme.org

- *Site Visits*
- *Self-Studies*

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HANDOUT

Annual Updates: ERAS Supplemental Application

Andrea Dutoit, MD
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Friday, November 11
2:10 PM – 2:40 PM

View Recording at: https://vimeo.com/767519236/a1a446a895

HANDOUT

AACPD

Everything You Wanted to Know

Moderator: Jed T. Wolpaw, MD, Med

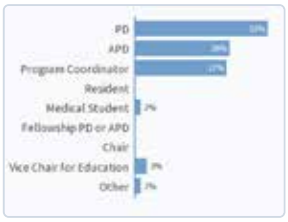
Friday, November 11
3:30 PM – 5:00 PM

2022 Everything You Wanted to Know

Current run (last updated Nov 22, 2022 3:19pm)

69	168	89	52%
Activities	Participants	Average responses	Average engagement

What is your primary role?

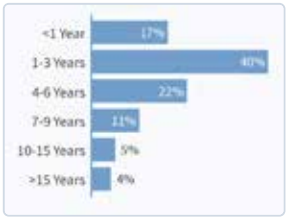


Response options	Count	Percentage
PD	**45**	**39%**
APD	32	28%
Program Coordinator	31	27%
Resident	0	0%
Medical Student	2	2%
Fellowship PD or APD	0	0%
Chair	0	0%
Vice Chair for Education	4	3%
Other	2	2%

69%
Engagement

116
Responses

How many years has your PD been in their position?

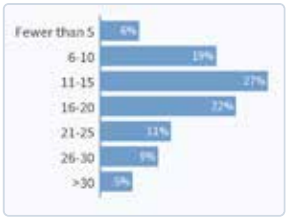


Response options	Count	Percentage
<1 Year	16	17%
1-3 Years	**37**	**40%**
4-6 Years	20	22%
7-9 Years	10	11%
10-15 Years	5	5%
>15 Years	4	4%

55%
Engagement

92
Responses

How many residents PER YEAR are in your core residency program?

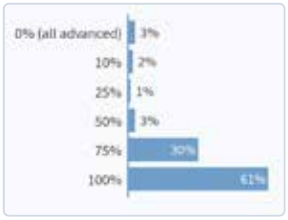


Response options	Count	Percentage
Fewer than 5	6	6%
6-10	18	19%
11-15	**26**	**27%**
16-20	21	22%
21-25	11	11%
26-30	9	9%
>30	5	5%

57%
Engagement

96
Responses

What percentage of your total positions offered each year in the match are categorical? Ignore R positions for this, and choose the closest value

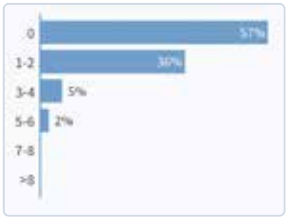


Response options	Count	Percentage
0% (all advanced)	3	3%
10%	2	2%
25%	1	1%
50%	3	3%
75%	31	30%
100%	**62**	**61%**

61%
Engagement

102
Responses

How many R positions, on average, do you offer in each match cycle?

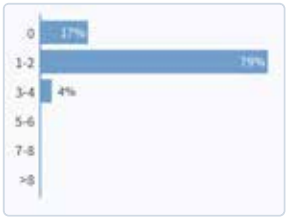


Response options	Count	Percentage
0	**52**	**57%**
1-2	33	36%
3-4	5	5%
5-6	2	2%
7-8	0	0%
>8	0	0%

55%
Engagement

92
Responses

How many residents, on average, fail the basic exam in your program each year averaged over the past 5 years?

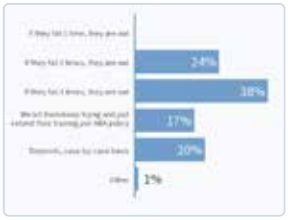


Response options	Count	Percentage
0	17	17%
1-2	**81**	**79%**
3-4	4	4%
5-6	0	0%
7-8	0	0%
>8	0	0%

61%
Engagement

102
Responses

How many attempts do you give residents on the Basic Exam before they must leave the program?

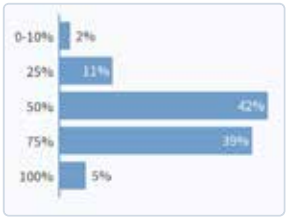


Response options	Count	Percentage
If they fail 1 time, they are out	0	0%
If they fail 2 times, they are out	24	24%
If they fail 3 times, they are out	**38**	**38%**
We let them keep trying and just extend their training per ABA policy	17	17%
Depends, case-by-case basis	20	20%
Other	1	1%

60%
Engagement

100
Responses

Approximately What percentage of your residents did fellowships in last year's graduating class?



Response options	Count	Percentage
0-10%	2	2%
25%	10	11%
50%	**39**	**42%**
75%	36	39%
100%	5	5%

55%
Engagement

92
Responses

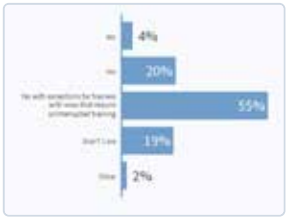
When do fellowships at your institution start?

Response options	Count	Percentage
July 1	34	35%
July 15	0	0%
August 1	16	16%
After August 1	1	1%
It varies by fellowship	**46**	**47%**

58%
Engagement

97
Responses

Would you like to see an August 1st start date for all fellowships?

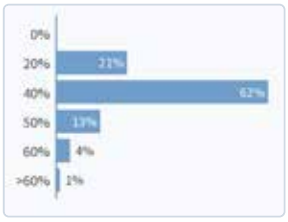


Response options	Count	Percentage
No	4	4%
Yes	20	20%
Yes with exceptions for trainees with visas that require uninterrupted training	**54**	**55%**
Don't Care	19	19%
Other	2	2%

59%
Engagement

99
Responses

How much protected time do you get in your role as PD (or if you are not a PD, how much protected time does your PD get)?

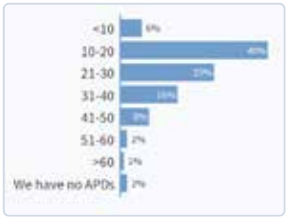


Response options	Count	Percentage
0%	0	0%
20%	21	21%
40%	**63**	**62%**
50%	13	13%
60%	4	4%
>60%	1	1%

61%
Engagement

102
Responses

How many residents per APD in your program (so if you have 40 total residents and 2 APDs the answer would be 20)?

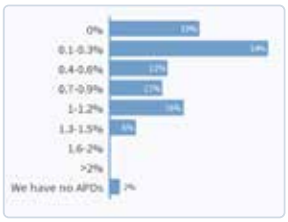


Response options	Count	Percentage
<10	6	6%
10-20	**41**	**40%**
21-30	26	25%
31-40	16	16%
41-50	8	8%
51-60	2	2%
>60	1	1%
We have no APDs	2	2%

61%
Engagement

102
Responses

How much protected time does your entire APD group get per resident (add up the protected time of all APDs and divide by total residents)? So if you have 2 APDs each with 20% protected time, that's 40% total and if you have 40 residents that's 1% APD time

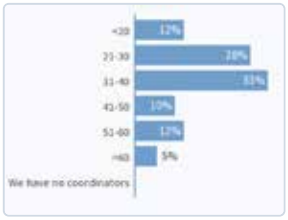


Response options	Count	Percentage
0%	17	19%
0.1-0.3%	**30**	**34%**
0.4-0.6%	11	12%
0.7-0.9%	10	11%
1-1.2%	14	16%
1.3-1.5%	5	6%
1.6-2%	0	0%
>2%	0	0%
We have no APDs	2	2%

53%
Engagement

89
Responses

How many residents per coordinator do you have?

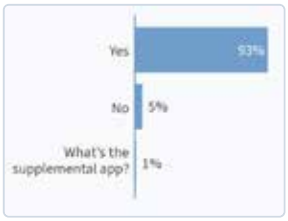


Response options	Count	Percentage
<20	11	12%
21-30	26	28%
31-40	**30**	**33%**
41-50	9	10%
51-60	11	12%
>60	5	5%
We have no coordinators	0	0%

55%
Engagement

92
Responses

Are you participating in the supplemental app this year?

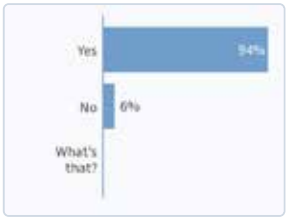


Response options	Count	Percentage
Yes	**86**	**93%**
No	5	5%
What's the supplemental app?	1	1%

55%
Engagement

92
Responses

Are you using preference signaling in any way?

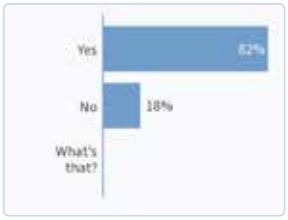


Response options	Correct	Count	Percentage
Yes	✓	87	94%
No	✓	6	6%
What's that?	✓	0	0%

55%
Engagement

93
Responses

Are you using geographic signaling in any way?



Response options	Count	Percentage
Yes	**75**	**82%**
No	17	18%
What's that?	0	0%

55%
Engagement

92
Responses

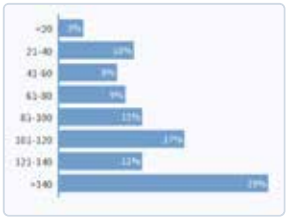
Are you telling your own med students to give you a preference signal if they're interested in your program?

Response options	Count	Percentage
Yes	7	8%
No, we're telling them not to signal us, we will interview them anyway	**67**	**74%**
We aren't telling them one way or the other	12	13%
We don't have med students of our own	4	4%

54%
Engagement

90
Responses

How many program signals did your program receive?

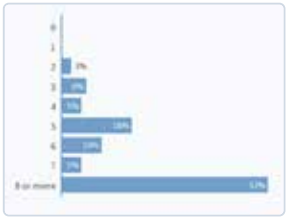


Response options	Count	Percentage
<20	3	3%
21-40	9	10%
41-60	7	8%
61-80	8	9%
81-100	10	11%
101-120	15	17%
121-140	10	11%
>140	**25**	**29%**

52%
Engagement

87
Responses

How many program signals did you get per spot offered (So if you got 100 signals and are offering 20 spots in the match your answer would be 5)? Round to the closest whole number.

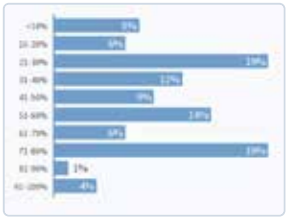


Response options	Count	Percentage
0	0	0%
1	0	0%
2	2	3%
3	5	6%
4	4	5%
5	14	18%
6	8	10%
7	4	5%
8 or more	**41**	**53%**

46%
Engagement

78
Responses

What percentage of your interview spots did you fill with candidates who signaled your program?

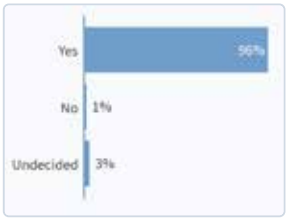


Response options	Count	Percentage
<10%	6	8%
10-20%	5	6%
21-30%	**15**	**19%**
31-40%	9	12%
41-50%	7	9%
51-60%	11	14%
61-70%	5	6%
71-80%	**15**	**19%**
81-90%	1	1%
91-100%	3	4%

46%
Engagement

77
Responses

Do you think our specialty should continue participating in the signaling system in future years?

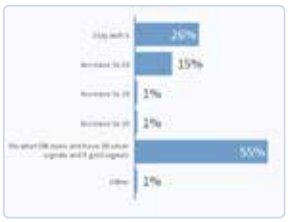


Response options	Count	Percentage
Yes	**71**	**96%**
No	1	1%
Undecided	2	3%

44%
Engagement

74
Responses

If we continue, how many signals do you think we should allow each candidate to have?

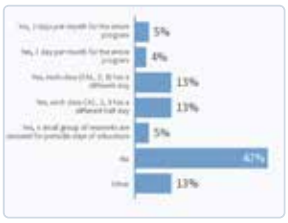


Response options	Count	Percentage
Stay with 5	24	26%
Increase to 10	14	15%
Increase to 20	1	1%
Increase to 30	1	1%
Do what OB does and have 20 silver signals and 5 gold signals	**50**	**55%**
Other	1	1%

54%
Engagement

91
Responses

Does your program have a dedicated resident education day (combines all education activities including didactics, simulation, other conferences into a single day)?

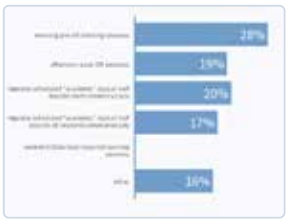


Response options	Count	Percentage
Yes, 2 days per month for the entire program	5	5%
Yes, 1 day per month for the entire program	4	4%
Yes, each class (CA1, 2, 3) has a different day	13	13%
Yes, each class CA1, 2, 3 has a different half day	13	13%
Yes, a small group of residents are excused for periodic days of education	5	5%
No	**47**	**47%**
Other	13	13%

60%
Engagement

100
Responses

What are you doing to provide "protected" academic or learning time for residents?

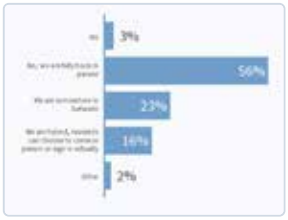


Response options	Count	Percentage
morning pre-OR learning sessions	**29**	**28%**
afternoon post-OR sessions	20	19%
regularly scheduled "academic" days or half days for each residency class	21	20%
regularly scheduled "academic" days or half days for all residents simultaneously	18	17%
weekend (Saturday) required learning sessions	0	0%
other	17	16%

63%
Engagement

105
Responses

Are you still having resident didactics virtually?

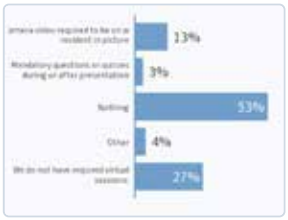


Response options	Count	Percentage
Yes	3	3%
No, we are fully back in person	**52**	**56%**
We are somewhere in between	21	23%
We are hybrid, residents can choose to come in person or sign in virtually	15	16%
Other	2	2%

55%
Engagement

93
Responses

If you have virtual sessions, what are you doing to enforce "attendance" and participation and avoid "multitasking" during virtual conferences and teaching sessions?

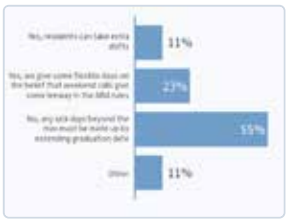


Response options	Count	Percentage
Camera video required to be on w resident in picture	12	13%
Mandatory questions or quizzes during or after presentation	3	3%
Nothing	**49**	**53%**
Other	4	4%
We do not have required virtual sessions.	25	27%

55%
Engagement

93
Responses

Do you have a way to "make up" sick days beyond the maximum allowed ABA absences so residents don't have to extend training?

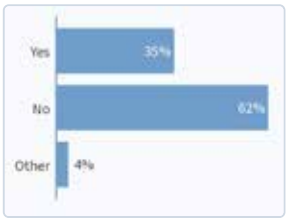


Response options	Count	Percentage
Yes, residents can take extra shifts	11	11%
Yes, we give some flexible days on the belief that weekend calls give some leeway in the ABA rules	22	23%
No, any sick days beyond the max must be made up by extending graduation date	**53**	**55%**
Other	11	11%

58%
Engagement

97
Responses

Has anyone noticed residents reporting or feeling that they have less protected education time now that they can attend didactics virtually while doing other things?

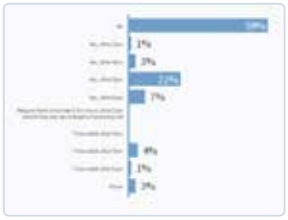


Response options	Count	Percentage
Yes	29	35%
No	**52**	**62%**
Other	3	4%

50%
Engagement

84
Responses

Do you pay your residents to be in the OR after a certain time of day (not moonlighting, just if they happen to still be in the OR after a certain time)?

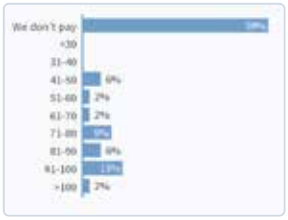


Response options	Count	Percentage
No	**59**	**59%**
Yes, after 3pm	1	1%
Yes, after 4pm	3	3%
Yes, after 5pm	22	22%
Yes, after 6pm	7	7%
We give them time credit for hours after 3pm which they can bank to get a future day off	0	0%
Time credit after 4pm	0	0%
Time credit after 5pm	4	4%
Time credit after 6pm	1	1%
Other	3	3%

60%
Engagement

100
Responses

How much do you pay per hour for your residents who stay past a certain time (not moonlighting)?

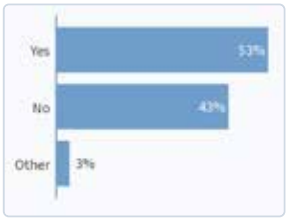


Response options	Count	Percentage
We don't pay	**51**	**59%**
<30	0	0%
31-40	0	0%
41-50	5	6%
51-60	2	2%
61-70	2	2%
71-80	8	9%
81-90	5	6%
91-100	11	13%
>100	2	2%

51%
Engagement

86
Responses

Do you pay your residents for certain types of call or shifts?



Response options	Count	Percentage
Yes	**48**	**53%**
No	39	43%
Other	3	3%

54%
Engagement

90
Responses

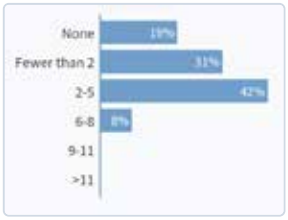
How many hours do your residents average per week across the CA1-3 years of their residency?

Response options	Count	Percentage
<40	1	1%
40-50	2	2%
51-60	**72**	**77%**
61-70	17	18%
71-80	1	1%
>80	0	0%

55%
Engagement

93
Responses

How many 24h calls do your residents take per month on average during the CA1-3 years?

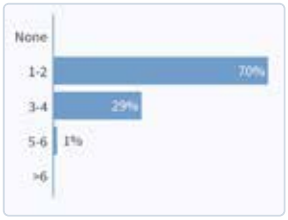


Response options	Count	Percentage
None	17	19%
Fewer than 2	27	31%
2-5	**37**	**42%**
6-8	7	8%
9-11	0	0%
>11	0	0%

52%
Engagement

88
Responses

How many weekend calls (Friday night, Saturday day or night, Sunday day or night) do your residents take per month on average during their CA1-3 years?

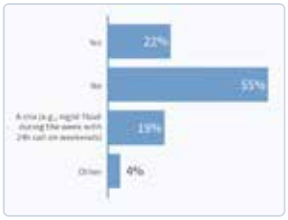


Response options	Count	Percentage
None	0	0%
1-2	**61**	**70%**
3-4	25	29%
5-6	1	1%
>6	0	0%

52%
Engagement

87
Responses

Do you have a night float system to cover the ORs at night?

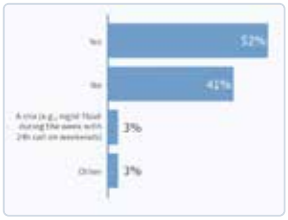


Response options	Count	Percentage
Yes	20	22%
No	**51**	**55%**
A mix (e.g., night float during the week with 24h call on weekends)	18	19%
Other	4	4%

55%
Engagement

93
Responses

Do you have a night float system to cover the ICU at night?

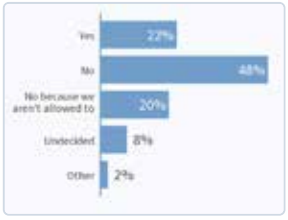


Response options	Count	Percentage
Yes	**46**	**52%**
No	36	41%
A mix (e.g., night float during the week with 24h call on weekends)	3	3%
Other	3	3%

52%
Engagement

88
Responses

Are you planning to do an in-person second look after your virtual interview season?

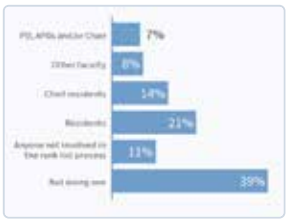


Response options	Count	Percentage
Yes	20	22%
No	**44**	**48%**
No because we aren't allowed to	18	20%
Undecided	7	8%
Other	2	2%

54%
Engagement

91
Responses

If you do an in person second look, who will be present (select as many as needed)?

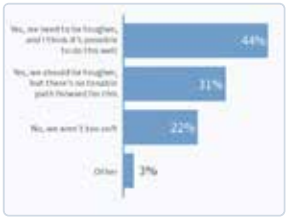


Response options	Count	Percentage
PD, APDs and/or Chair	9	7%
Other faculty	10	8%
Chief residents	18	14%
Residents	27	21%
Anyone not involved in the rank list process	14	11%
Not doing one	**50**	**39%**

49%
Engagement

128
Responses

Have we become too soft on our learners?

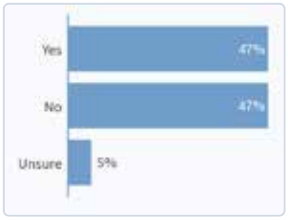


Response options	Count	Percentage
Yes, we need to be tougher, and I think it's possible to do this well	**41**	**44%**
Yes, we should be tougher, but there's no tenable path forward for this	29	31%
No, we aren't too soft	21	22%
Other	3	3%

56%
Engagement

94
Responses

Has your program or department dismissed a faculty member exclusively or primarily due to poor conduct or behavior with residents?

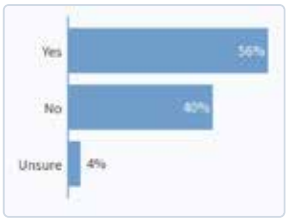


Response options	Count	Percentage
Yes	**43**	**47%**
No	**43**	**47%**
Unsure	5	5%

54%
Engagement

91
Responses

Has your department said that a faculty member cannot work with residents due to poor conduct or behavior with residents?

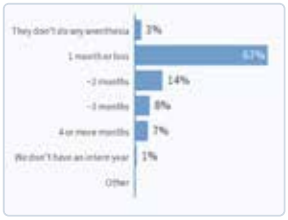


Response options	Count	Percentage
Yes	**47**	**56%**
No	34	40%
Unsure	3	4%

50%
Engagement

84
Responses

If you have an intern year, how many months of OR anesthesia do your interns do (not counting pain service or other non-OR rotations)?

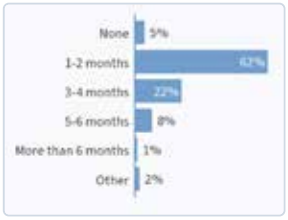


Response options	Count	Percentage
They don't do any anesthesia	3	3%
1 month or less	**62**	**67%**
~2 months	13	14%
~3 months	7	8%
4 or more months	6	7%
We don't have an intern year	1	1%
Other	0	0%

55%
Engagement

92
Responses

How much non-OR elective time, on average, do your residents get?

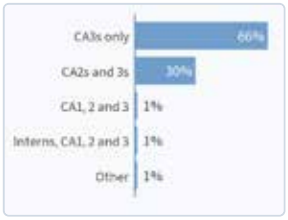


Response options	Count	Percentage
None	4	5%
1-2 months	**54**	**62%**
3-4 months	19	22%
5-6 months	7	8%
More than 6 months	1	1%
Other	2	2%

52%
Engagement

87
Responses

What years are allowed to do non-OR electives?

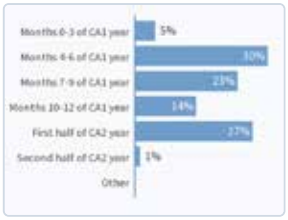


Response options	Count	Percentage
CA3s only	**55**	**66%**
CA2s and 3s	25	30%
CA1, 2 and 3	1	1%
Interns, CA1, 2 and 3	1	1%
Other	1	1%

49%
Engagement

83
Responses

When is the earliest your residents first do Cardiac?

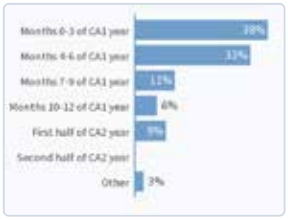


Response options	Count	Percentage
Months 0-3 of CA1 year	4	5%
Months 4-6 of CA1 year	**26**	**30%**
Months 7-9 of CA1 year	20	23%
Months 10-12 of CA1 year	12	14%
First half of CA2 year	23	27%
Second half of CA2 year	1	1%
Other	0	0%

51%
Engagement

86
Responses

When is the earliest your residents first do OB?

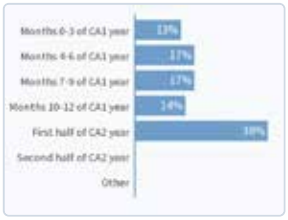


Response options	Count	Percentage
Months 0-3 of CA1 year	**30**	**38%**
Months 4-6 of CA1 year	26	33%
Months 7-9 of CA1 year	9	11%
Months 10-12 of CA1 year	5	6%
First half of CA2 year	7	9%
Second half of CA2 year	0	0%
Other	2	3%

47%
Engagement

79
Responses

When is the earliest your residents first do Peds?

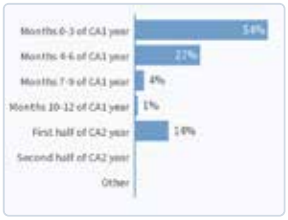


Response options	Count	Percentage
Months 0-3 of CA1 year	10	13%
Months 4-6 of CA1 year	13	17%
Months 7-9 of CA1 year	13	17%
Months 10-12 of CA1 year	11	14%
First half of CA2 year	**29**	**38%**
Second half of CA2 year	0	0%
Other	0	0%

45%
Engagement

76
Responses

When is the earliest your residents first do ICU (not including the CBY year)?

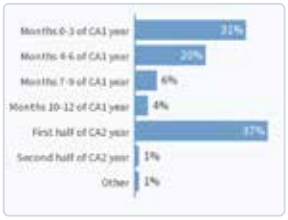


Response options	Count	Percentage
Months 0-3 of CA1 year	**43**	**54%**
Months 4-6 of CA1 year	21	27%
Months 7-9 of CA1 year	3	4%
Months 10-12 of CA1 year	1	1%
First half of CA2 year	11	14%
Second half of CA2 year	0	0%
Other	0	0%

47%
Engagement

79
Responses

When is the earliest your residents first do Regional?

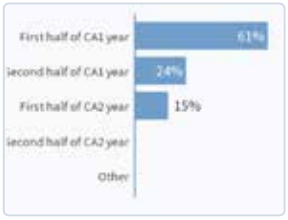


Response options	Count	Percentage
Months 0-3 of CA1 year	25	31%
Months 4-6 of CA1 year	16	20%
Months 7-9 of CA1 year	5	6%
Months 10-12 of CA1 year	3	4%
First half of CA2 year	**30**	**37%**
Second half of CA2 year	1	1%
Other	1	1%

48%
Engagement

81
Responses

When is the earliest your residents first do Neuro?

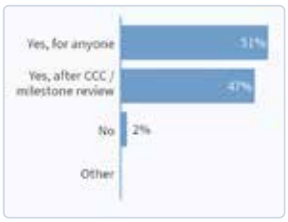


Response options	Count	Percentage
First half of CA1 year	**52**	**61%**
Second half of CA1 year	20	24%
First half of CA2 year	13	15%
Second half of CA2 year	0	0%
Other	0	0%

51%
Engagement

85
Responses

Do you request ABA exception for extension of training for maternity/paternity leave?

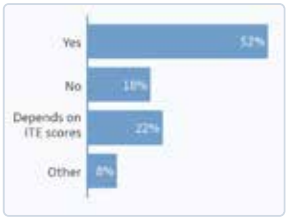


Response options	Count	Percentage
Yes, for anyone	**44**	**51%**
Yes, after CCC / milestone review	40	47%
No	2	2%
Other	0	0%

51% Engagement

86 Responses

Does your department pay for the BASIC exam?

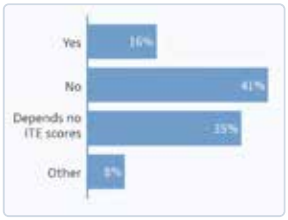


Response options	Count	Percentage
Yes	**43**	**52%**
No	15	18%
Depends on ITE scores	18	22%
Other	7	8%

49% Engagement

83 Responses

Does your department pay for the ADVANCED exam?

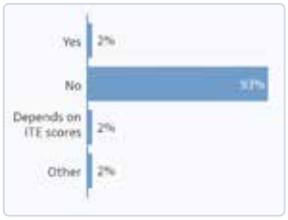


Response options	Count	Percentage
Yes	13	16%
No	**34**	**41%**
Depends no ITE scores	29	35%
Other	7	8%

49% Engagement

83 Responses

Does your department pay for the APPLIED Exam (oral boards/OSCEs)?

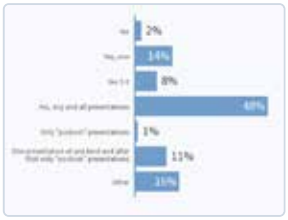


Response options	Count	Percentage
Yes	2	2%
No	**79**	**93%**
Depends on ITE scores	2	2%
Other	2	2%

51%
Engagement

85
Responses

Do you pay for residents to attend national meetings?



Response options	Count	Percentage
No	2	2%
Yes, one	12	14%
Yes 2-3	7	8%
Yes, any and all presentations	**42**	**48%**
Only "podium" presentations	1	1%
One presentation of any kind and after that only “podium” presentations	10	11%
Other	14	16%

52%
Engagement

88
Responses

Are your residents unionized? (Last time (2020) it was 80% no, 20% yes)

Response options	Count	Percentage
Yes	14	17%
No	**68**	**82%**
In process	1	1%
Other	0	0%

49%
Engagement

83
Responses

How many interviews do you do per available position?

Response options	Count	Percentage
1-5	0	0%
6-10	20	25%
11-15	**47**	**58%**
16-20	9	11%
21-25	3	4%
26-30	1	1%
>30	1	1%

48%
Engagement

81
Responses

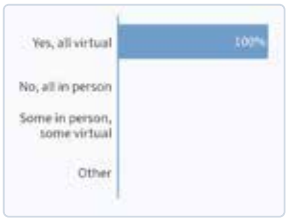
Will you be changing the number of interviews you offer this year with the preference signaling system?

Response options	Count	Percentage
Yes, we are decreasing the number of interviews	11	14%
Yes, we are increasing the number of interviews	3	4%
No	**67**	**83%**
Other	0	0%

48%
Engagement

81
Responses

Are you doing virtual interviews this year?

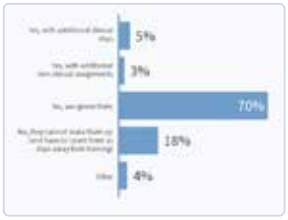


Response options	Count	Percentage
Yes, all virtual	**76**	**100%**
No, all in person	0	0%
Some in person, some virtual	0	0%
Other	0	0%

45%
Engagement

76
Responses

Do you residents have to make up days missed due to COVID quarantine?

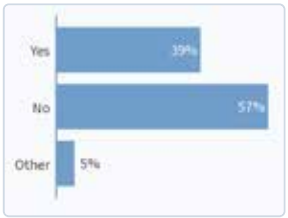


Response options	Count	Percentage
Yes, with additional clinical days	4	5%
Yes, with additional non-clinical assignments	2	3%
No, we ignore them	**53**	**70%**
No, they cannot make them up (and have to count them as days away from training)	14	18%
Other	3	4%

45%
Engagement

76
Responses

Does your program consider your post call day (or time before call if you have a late start call) as a non-clinical day when calculating nonclinical time?

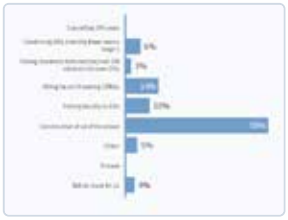


Response options	Count	Percentage
Yes	32	39%
No	**47**	**57%**
Other	4	5%

49%
Engagement

83
Responses

How is your program dealing with shortages of CRNAs/APPs and OR nurses:

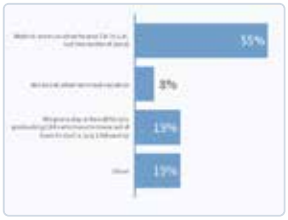


Response options	Count	Percentage
Cancelling OR cases	0	0%
Combining ORs (running fewer rooms longer)	5	6%
Pulling residents from elective/non-OR rotations to cover ORs	2	3%
Hiring locum/traveling CRNAs	11	14%
Putting faculty in ORs	8	10%
Combination of all of the above	**47**	**59%**
Other	4	5%
Unsure	0	0%
Not an issue for us	3	4%

48%
Engagement

80
Responses

How do you manage the CA-3 exodus in June?

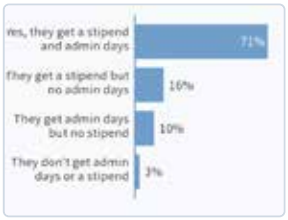


Response options	Count	Percentage
Restrict June vacation to only CA-3s (i.e., last two weeks of June)	**41**	**55%**
We do not allow terminal vacation	6	8%
We give a day or two off for any graduating CA3s who have to move out of town to start a July 1 fellowship	14	19%
Other	14	19%

45%
Engagement

75
Responses

Do you pay your chief residents a stipend or give them admin days?

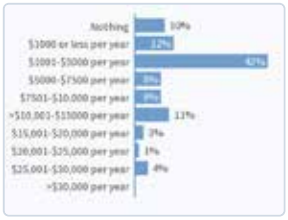


Response options	Count	Percentage
Yes, they get a stipend and admin days	**55**	**71%**
They get a stipend but no admin days	12	16%
They get admin days but no stipend	8	10%
They don't get admin days or a stipend	2	3%

46%
Engagement

77
Responses

If you pay your chiefs a stipend, how much do they get total (if you have multiple chiefs please add the stipends from each chief to get a total)?



Response options	Count	Percentage
Nothing	7	10%
$1000 or less per year	9	12%
$1001-$5000 per year	**31**	**42%**
$5000-$7500 per year	6	8%
$7501-$10,000 per year	6	8%
>$10,001-$15000 per year	8	11%
$15,001-$20,000 per year	2	3%
$20,001-$25,000 per year	1	1%
$25,001-$30,000 per year	3	4%
>$30,000 per year	0	0%

43%
Engagement

73
Responses

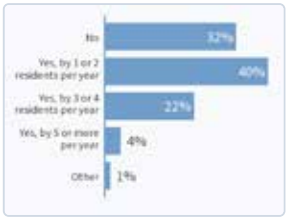
If you give admin days to your chiefs, how many days do you give total (if you have multiple chiefs please add all of their days to get a total)?

Response options	Count	Percentage
1 per month	**21**	**30%**
2 per month	11	15%
3 per month	11	15%
4 per month	11	15%
5 or more per month	4	6%
None	13	18%

42%
Engagement

71
Responses

Is your department considering increasing the size of your residency program?



Response options	Count	Percentage
No	25	32%
Yes, by 1 or 2 residents per year	**31**	**40%**
Yes, by 3 or 4 residents per year	17	22%
Yes, by 5 or more per year	3	4%
Other	1	1%

46%
Engagement

77
Responses

HANDOUT

Welcome and Announcements

Moderator: Magdalena Anitescu, MD, PhD

Friday, November 11
8:00 AM – 8:05 AM

HANDOUT

How to Develop Your Reputation

Moderators: Magdalena Anitescu, MD, PhD & Edward R. Mariano, MD, MAS, FASA

Friday, November 11
8:05 AM – 9:00 AM

HANDOUT

AASPD

How to Develop Your Reputation: Administrative Service

Daryl Oakes, MD

Friday, November 11
8:05 AM – 8:15 AM

Being an Effective Organizational Leader

Daryl Oakes, MD

Associate Dean,
Post Graduate Medical Education & CME
Vice Chair,
Clinician Educator Affairs
Fellowship Program Director,
Adult Cardiothoracic Anesthesiology

Stanford | MEDICINE

1

Disclosures

No Financial Conflicts to Disclose

2

1 Be Trustworthy

Why is trust important?
Provides the loyalty to get things done
Referent power

How is trust build?
Fill the marble jar, one marble at a time

3

1 Be Trustworthy

What does building trust look like as a leader?

Be who you say you are.
Acknowledge any "say-do" gaps

Treat others with dignity.
Be a safe place to fail

Balance transparency with discretion.
Information is a form of power, use it responsibly

Adapted from Ron Carucci, "Build your reputation as a trustworthy leader", Harvard Business Review, June 11, 2021

4

2 Be Self- Aware

1

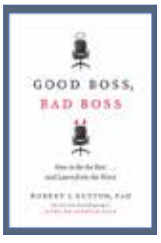
Stay "in tune" with how others perceive you

Take note of how they react to what you say and do

2

Acknowledge your strengths & weaknesses

Be straightforward about what you offer



5

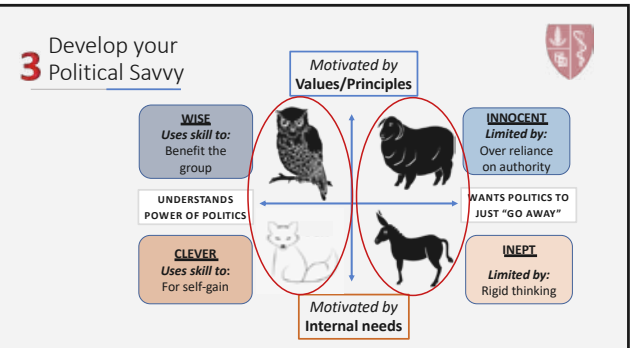
3 Develop your Political Savvy

- **Political savvy is a critical leadership skill**
- **Politics, used responsibly, leads to positive change**
- **Politics is fundamental to social dynamics**
- **Political savvy can be learned**

Simon Baddeley; Kim James, "Owl, Fox, Donkey or Sheep: Political Skills for Managers", Management Education and Development ,Vol.18 1987

6

3 Develop your Political Savvy



Simon Baddeley; Kim James, "Owl, Fox, Donkey or Sheep: Political Skills for Managers", Management Education and Development ,Vol.18 1987

7

4 Create a Supportive Network

Who is in your inner circle?

Is your network diverse?

CRITICAL PEOPLE TO HAVE IN YOUR NETWORK:

Information Person
go to for critical data

Connector
knows everything that is going on

Mentor
a senior trusted advisor

Energizer
who you call when having a bad day

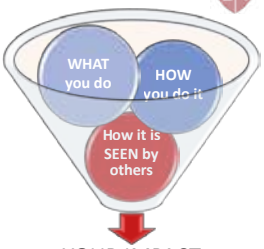
Savvy Advisor
who understands the politics of your organization

Jane Horan, *I Wish I'd Known That Earlier in My Career: The Power of Positive Workplace Politics*

8

Being an Effective Organizational Leader

1. Be Trustworthy
2. Be Self-Aware
3. Develop your political savvy
4. Create a supportive network



YOUR IMPACT

9

Thank you!

Email:
doakes@stanford.edu

10

11

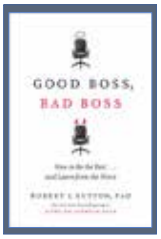
1 Be Trustworthy

"Trust is not built in huge sweeping moments. It's built in tiny moments everyday."
-Bréne Brown

12

2 Be Self- Aware

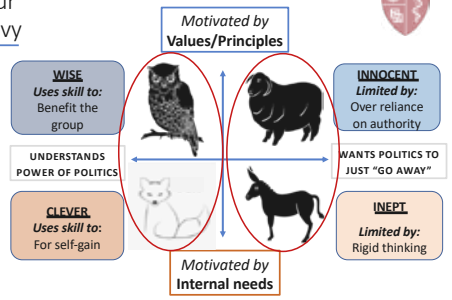
1. **Stay "in tune" with how others perceive you**
   Take note of how they react to what you say and do
2. **Acknowledge your strengths & weaknesses**
   Set expectations and avoid misunderstandings
3. **Keep your cool**
   Stay curious and avoid reacting in the moment



13

3 Develop your Political Savvy

Political savvy is a critical leadership skill



Simon Baddeley; Kim James, "Owl, Fox, Donkey or Sheep: Political Skills for Managers", Management Education and Development ,Vol.18 1987

14

HANDOUT

AASPD

How to Develop Your Reputation: Education

Lynn R. Kohan, MD

Friday, November 11
8:15 AM – 8:25 AM

Advancing Reputation in Education

Lynn Kohan M.D.
Professor of Anesthesiology and Pain Medicine
University of Virginia Health System
@kohanlynn

1

Why advance your reputation?

- Promotion
- Involvement in societies
- Advancing teaching techniques
- Network of colleagues and friends
- Reward/recognition for your work

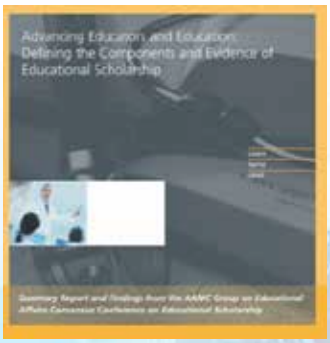
2

Promotion

- Identify criteria for promotion in your institution
  - Need to establish excellence
  - Education

https://innovation.medicine.umich.edu/the-innovators-academic-dilemma-a-primer/

3



4

Education

What are the core elements of educational scholarship?

What are the criteria for educational scholarship?

What are the necessary resources and infrastructure required to support educators as scholars?

How do educators document their work for recognition and academic promotion?

https://www.aamc.org/professional-development/affinity-groups/gfa/faculty-vitae/defining-educational-scholarship

5

Education categories-Core Elements

1. **Teaching:** Any activity that fosters learning, including direct teaching and the creation of associated instructional materials.
2. **Learner Assessment:** All activities associated with measuring learners' knowledge, skills, and attitudes related to one or more of the following activities: development, implementation, analysis, or synthesis and presentation.
3. **Curriculum Development:** A longitudinal set that is more than one teaching session or presentation of designed educational activities that includes evaluation, which may occur at any training level.
4. **Mentoring and Advising:** Mentoring: a sustained, committed relationship from which both parties obtain reciprocal benefits. Advising: a more limited relationship than mentoring that usually occurs over a limited period, with the advisor serving as a guide.
5. **Educational Leadership and Administration:** Achieving results through others, transforming organizations through the vigorous pursuit of excellence with their work's value demonstrated through ongoing evaluation, dissemination of results, and maximization of resources.

https://www.aamc.org/professional-development/affinity-groups/gfa/faculty-vitae/defining-educational-scholarship

6

Criteria: Associate Professor

Emerging national **reputation** as a clinician educator, supported by letters from external referees and as indicated by:

- Invited lectureships
- Service on
  - Grant review panels
  - Editorial boards of journals recognized in the faculty member's field
  - National/international advising boards
- Service as board examiner
- Leadership in professional society governing boards.

7

Criteria: Full Professor

- **Established** national and international **reputation** as a clinician educator supported by letters from external referees, and as indicated by:
  - Invited lectureships
  - Service on grant review panels
  - Editorial boards of journals recognized in the faculty member's field
  - National/international advising boards
  - Service as board examiner
  - Leadership in professional society governing boards

8

But how do I do these things?

- Find area of expertise
  - What area are you most interested
- Identify Skill set
  - Prioritize work
  - Collaborate
- **Network**

9

Ways to advance your reputation

- Professional organizations
- Publications
- Reviewer
- Presenting at conferences
- Webinars
- Online conferences
- Curriculum development
- Mentorship
- Administrative duties

10

Process

- Local, regional, and national **service** is also an essential component of the educator's portfolio.
- What is service?
  - Academic pursuits other than publishing and presenting.
- Common types of service
  - Work on committees of academic societies
  - Reviewing for journals
  - Moderating panels or poster presentations at national meetings.

Hanks CA, Weinger MB. Know Yourself, Know the System: Developing a Successful Career and Being Promoted as an Academic Anesthesiologist. Int Anesthesiol Clin. 2016 Summer;54(3):155-69. doi: 10.1097/AIA.0000000000000104. PMID: 27285078.

11

Where to start?

Start locally

- Give talks at your own department and others
- Serve on the medical school's or department's applicant selection committee
- Get help
  - Division chief, chair, faculty development, friends

Regional

- Expand your network
- Meet someone at a regional conference
- Stay in touch
- Ask to present at their institution
- Easier now because of zoom

Hanks CA, Weinger MB. Know Yourself, Know the System: Developing a Successful Career and Being Promoted as an Academic Anesthesiologist. Int Anesthesiol Clin. 2016 Summer;54(3):155-69. doi: 10.1097/AIA.0000000000000104. PMID: 27285078.

12

Where to start?

National

- Plenary talks
- Panels
- Workshop leads
- Visiting professorships
- Lots of focused opportunities
  - Ex. Database Committee of the Congenital Cardiac Anesthesia Society
- Seek to get involved in such organizations with the goal of achieving leadership responsibilities (eg, chairing a committee and then serving on the society's board of directors).

Hanks CA, Weinger MB. Know Yourself, Know the System: Developing a Successful Career and Being Promoted as an Academic Anesthesiologist. Int Anesthesiol Clin. 2016 Summer;54(3):155-69. doi: 10.1097/AIA.0000000000000104. PMID: 27285078.

13

Resources

Go to meetings
Establish contacts
Follow up with contacts

Get help
Faculty Development
Chair
Division Chief

Society
Medical education groups

14

THE ASSOCIATION OF PAIN PROGRAM DIRECTORS

PAPDA

OB
Regional and Acute Pain
Critical Care

15

Collaboration- you need to build a network

- Group of PD's
  - Sharing ideas
  - Work together to publish
  - Ask to present
  - Run for council/board positions
  - Get involved in ACGME
  - Letter writers

16

ACGME Resources

Faculty Members
Resources for Faculty Development

17

Explore opportunities for faculty development

CLER Pursuing Excellence: Faculty Development Innovations in Quality, Safety, Equity, and Value

Lei N. Choi, MD, MPH; Christopher Moriates, MD; Asha S. Payne, MD, MPH; Kalli Varaklis, MD, MSEd; Ralph Gonzales, MD, MSPH; Robert B. Baron, MD, MS

J Grad Med Educ (2021) 13 (5): 746–752.

https://doi.org/10.4300/JGME-D-21-00793.1

18

Explore Opportunities for Faculty Development

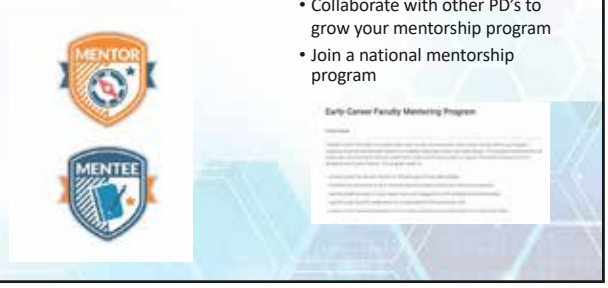
Accreditation Council for Graduate Medical Education

Milestones

19

Mentorship

- Develop a mentorship program
- Collaborate with other PD's to grow your mentorship program
- Join a national mentorship program



20

Search for opportunities

Academy for Excellence in Education

Mission

Center for Medical Education Research and Scholarly Innovation (MERSI)

21

How are educational achievements assessed?

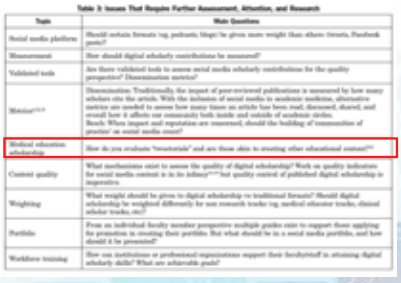
https://www.aamc.org/professional-development/affinity-groups/gfa/faculty-vitae/defining-educational-scholarship

22

How is academic reputation measured?

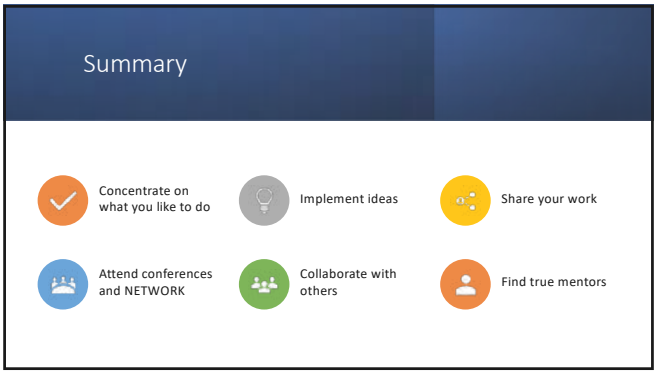
- Publications (quantity, citations, impact factor)
  - Bibliometrics
  - H-index
  - Almetrics
- Word of mouth
  - Social media
  - Mainstream Media
- Slide share
- Public engagement

23



Johng SY, Mishori R, Korostyshevskiy VR. Social Media, Digital Scholarship, and Academic Promotion in US Medical Schools. Fam Med. 2021;53(3):215-219. https://doi.org/10.22454/FamMed.2021.146684.

24


Summary
Concentrate on what you like to do
Implement ideas
Share your work
Attend conferences and NETWORK
Collaborate with others
Find true mentors

25

HANDOUT

AASPD

How to Develop Your Reputation: Publications

Holly Ende, MD

Friday, November 11
8:25 AM – 8:35 AM

How to Develop Your Reputation: Publications

Holly Ende, MD
holly.ende@vumc.org
@hollyende

1

DISCLOSURES

NONE

2

AGENDA

- Chart Your Course
- Find the Right Question
- Find the Right Funding
- Learn the Language
- Find the Right "Home"

3

4

CHART YOUR COURSE

MAKE YOUR TIME COUNT

CONSIDER THE PYRAMID

AVOID WASTE

5

AGENDA

- Chart Your Course
- Find the Right Question
- Find the Right Funding
- Learn the Language
- Find the Right "Home"

6

FIND THE RIGHT QUESTION

READ

DISCUSS

INQUIRE

7

AGENDA

Chart Your Course

Find the Right Question

Find the Right Funding

Learn the Language

Find the Right "Home"

8

FIND THE RIGHT FUNDING

apsf Anesthesia Patient Safety Foundation

NIH

FAER Foundation for Anesthesia Education and Research

IARS

9

NIH

- 246 activity codes
- Research Grants (R series)
- Career Development Awards (K series)
- Research Training and Fellowships (T & F series)

Types of Grant Programs

https://grants.nih.gov/grants/funding/funding_program.htm

10

11

AGENDA

Chart Your Course

Find the Right Question

Find the Right Funding

Learn the Language

Find the Right "Home"

12

LEARN THE LANGUAGE

Purdue Writing Lab

The Purdue Writing Lab

13

LEARN THE LANGUAGE

1. Shorten words.
2. Shrink sentences.
3. Stick with periods.
4. Avoid jargon.
5. Favor active voice.

14

LEARN THE LANGUAGE

equator network

Enhancing the QUAlity and Transparency Of health Research

15

AGENDA

Chart Your Course

Find the Right Question

Find the Right Funding

Learn the Language

Find the Right "Home"

16

FIND THE RIGHT "HOME"

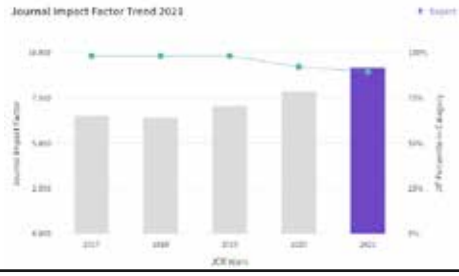
Clarivate™

17

FIND THE RIGHT "HOME"

18

FIND THE RIGHT "HOME"



19

FIND THE RIGHT "HOME"

20

AGENDA

- ✓ Chart Your Course
- ✓ Find the Right Question
- ✓ Find the Right Funding
- ✓ Learn the Language
- ✓ Find the Right "Home"

21

ADDITIONAL RESOURCES

- https://www.apsf.org/grants-and-awards/
- https://iars.org/research-awards/
- https://www.asahq.org/faer/grants/what-we-fund
- https://grants.nih.gov/grants/funding/funding_program.htm
- https://www.quickanddirtytips.com/grammar-girl/
- https://owl.purdue.edu/owl/purdue_owl.html
- https://www.equator-network.org/
- https://mjl.clarivate.com/home

22

HANDOUT

AASPD

How to Develop Your Reputation: Social Media and Online Platforms

Emily E. Sharpe, MD

Friday, November 11
8:35 AM – 8:45 AM

How to Develop Your Reputation: Social Media and Online Platforms

Emily E. Sharpe, M.D.
November 11, 2022

#SAAAPM22

@emilysharpe

1

DISCLOSURES

Relevant Financial Relationships

None

Off-Label/Investigational Uses

None

#SAAAPM22

2

LEARNING OBJECTIVES

Describe risks, benefits, and best practices for professional social media use

Discuss basic social media etiquette and tips

3

WHY PHYSICIANS SHOULD BE ON SOCIAL MEDIA

4

THE CHANGING LANDSCAPE OF ACADEMIC MEDICINE

THEN	NOW
• Publish a peer-reviewed manuscript	• Post-publication dissemination and discussion
• Citations	• Views, Altmetric
• Lecture	• Live tweet, blog, podcast
• Rumored to have strong educators	• Educators on Twitter
• Dogma in medical education	• Dogma is challenged daily online

#MayoGRIT

@emilysharpe

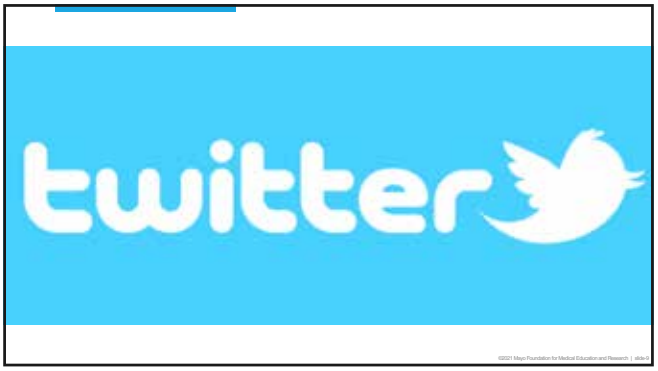
5

6

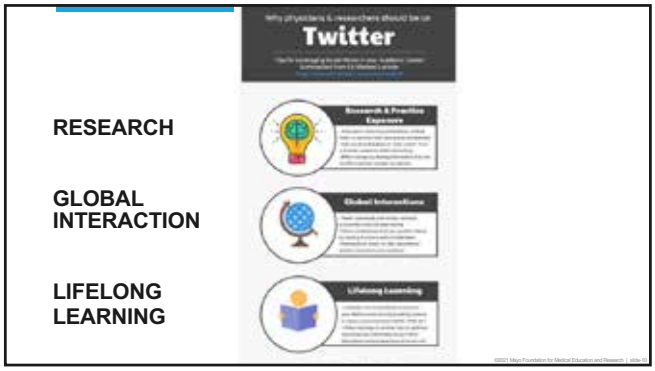
7


FTE Support
Committees
Faculty Development
Editorship
Knowledge Acquisition
Grand Rounds
New networks Collaborations
National Recognition
Mentorship
Job Opportunities
National Meetings
What has Social Media Done For Me Lately?
@DrJRMarcelin

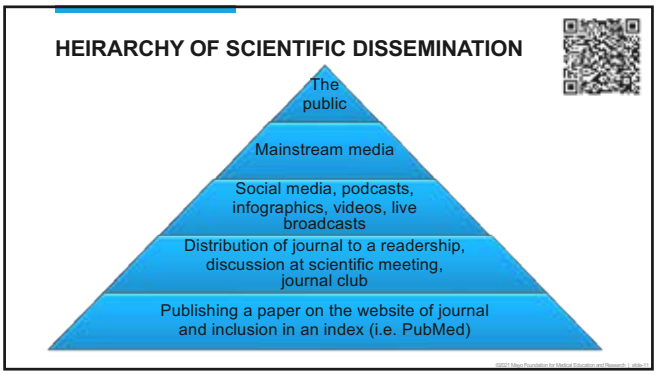
8


twitter

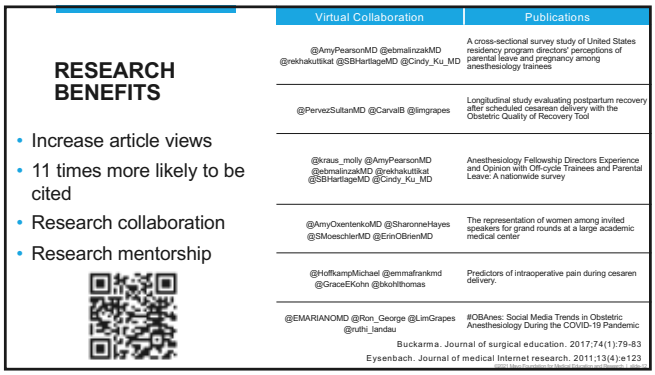
9


Twitter
RESEARCH
GLOBAL INTERACTION
LIFELONG LEARNING

10


HEIRARCHY OF SCIENTIFIC DISSEMINATION
The public
Mainstream media
Social media, podcasts, infographics, videos, live broadcasts
Distribution of journal to a readership, discussion at scientific meeting, journal club
Publishing a paper on the website of journal and inclusion in an index (i.e. PubMed)

11


RESEARCH BENEFITS
• Increase article views
• 11 times more likely to be cited
• Research collaboration
• Research mentorship
Virtual Collaboration
Publications
@AmyPearsonMD @ebmalinzakMD @rekhakuttikat @SBHartlageMD @Cindy_Ku_MD
A cross-sectional survey study of United States residency program directors' perceptions of parental leave and pregnancy among anesthesiology trainees
@PervezSultanMD @CarvalB @limgrapes
Longitudinal study evaluating postpartum recovery after scheduled cesarean delivery with the Obstetric Quality of Recovery Tool
@kraus_molly @AmyPearsonMD @ebmalinzakMD @rekhakuttikat @SBHartlageMD @Cindy_Ku_MD
Anesthesiology Fellowship Directors Experience and Opinion with Off-cycle Trainees and Parental Leave: A nationwide survey
@AmyOxentenkoMD @SharonneHayes @SMoeschlerMD @ErinOBrienMD
The representation of women among invited speakers for grand rounds at a large academic medical center
@HoffkampMichael @emmafrankmd @GraceEKohn @bkohlthomas
Predictors of intraoperative pain during cesaren delivery.
@EMARIANOMD @Ron_George @LimGrapes @ruthi_landau
#OBAnes: Social Media Trends in Obstetric Anesthesiology During the COVID-19 Pandemic
Buckarma. Journal of surgical education. 2017;74(1):79-83
Eysenbach. Journal of medical Internet research. 2011;13(4):e123

12

ACADEMIC SCHOLARSHIP IMPACT

Low Impact

- Editor-in-chief (or major editorial duties) of an academic/clinical blog with >2000 page views/month
- Editor-in-chief of an academic or clinical podcast/vodcast > 2000 downloads/views per month
- Top 5% influencers in health care
- Author of a blog post, article, or media piece > 3000 views with no DOI
- Author of a blog post, article, or media piece > 1000 views with DOI

Medium Impact

- Editor-in-chief of an academic or clinical blog > 5000 page views per month
- Editor-in-chief of an academic/clinical podcast/vodcast > 5000 downloads/views per month
- Editor-in-chief or manager of a social media network > 10,000 active users
- Author of a blog post, article, or media piece > 15,000 views with no DOI
- Author of a blog post, article, or media piece > 7500 views with DOI

Cabrera. J Grad Med Educ. 2017 Aug;9(4):421-425.

13

ACADEMIC SCHOLARSHIP IMPACT

High Impact

- Editor-in-chief (or major editorial duties) of an academic/clinical blog with >20,000 page views/month
- Editor-in-chief of an academic or clinical podcast/vodcast > 20,000 downloads/views per month
- Editor-in-chief or manager of a social media network > 50,000 active users

Cabrera. J Grad Med Educ. 2017 Aug;9(4):421-425.

14

GLOBAL INTERACTION

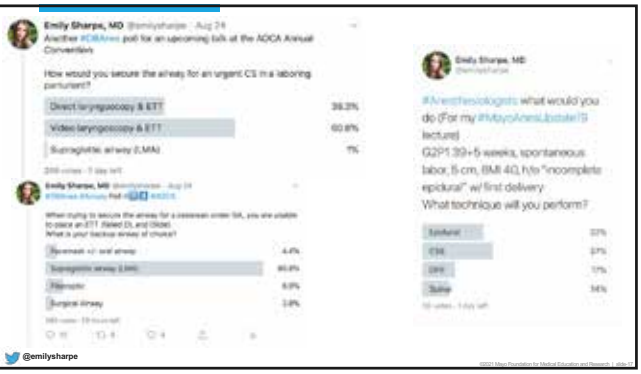
@emilysharpe

15

NETWORKING FOR INTROVERTS

#MOTTIRL

16



17

LIFELONG LEARNING

Dr Andrea Strathman

Things I didn't expect to say to my resident today: "Hang on, let me find this reference about zofran and spinals in OB. I don't know what journal it was in- saw it on Twitter." 🤦

@emilysharpe for the win!

@SOAPHQ

#MedTwitter

9:29 PM · Aug 24, 2023 · Twitter for Android

18

LinkedIn

- Have a professional profile photo
- Optimize Your Profile Headline
- Refresh your 'About' summary (1st person)
- Be open to recruiters for future career opportunities
- Update your skills section

19

PITFALLS OF SOCIAL MEDIA

- Violating patient confidentiality
- Permanent
- Lack of context/tone/ability to explain
- Trolls
- Responding to Negative Tweets
  - Ignore
  - Challenge or Argue
  - Apologize and Resolve

20

21

TIPS FOR IMPROVING YOUR SOME IMPACT

- Tweet "hot" and/or timely topics
- Personal Twitter accounts foster higher engagement than organizational or business accounts.
- Media attachments increase tweet engagement by a factor of three.
- Create advanced "buzz" before a Twitter event

George. Can J Anesth (2017) 64:1169–1175

22

THE RULES OF SOCIAL MEDIA

- Do not fear social media
- Never post when angry
- Strive for accuracy
- When in doubt, pause
- Don't post anything that can identify a patient
- Ask for permission
- Be respectful
- Assume beneficence
- Beware of friending patients
- Educate yourself

https://www.kevinmd.com/blog/2013/05/10-simple-rules-doctors-social-media.html

23

QUESTIONS & ANSWERS

Emily Sharpe, M.D. @emilysharpe | sharpe.emily@mayo.edu

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HANDOUT

AASPD

Combined Fellowships Demystified: Lessons Learned and Road Ahead

Moderators: Ammeka Pannu, MD & Andi Traynor, MD

Friday, November 11
9:00 AM – 10:00 AM

HANDOUT

Combined Fellowships Demystified: Lessons Learned and Road Ahead: OB Anesthesia/Regional

Naida M. Cole, MD, MM

Friday, November 11
9:00 AM – 9:20 AM

HANDOUT

AASPD

Combined Fellowships Demystified: Lessons Learned and Road Ahead: Cardic/CC

Shahzad Shaefi, MD, MPH

Friday, November 11
9:20 AM – 9:40 AM

HANDOUT

Breakout 1: How Do You Choose a Fellow to Interview: Tips on Evaluation of Applicants

Lynn R. Kohan, MD
Jody Leng, MD, MS

Friday, November 11
10:30 AM – 11:30 AM

How do you choose a fellow to interview-tips on evaluation of applicants

Jody Leng M.D., M.S
Associate Professor
Stanford University Medical Center
Lynn Kohan M.D, M.S
Professor
University of Virginia Health System
@kohanlynn

1

Objectives

- Differentiate fellow attributes to effectively select fellow applicants to interview.
- Discuss differences among subspecialties in applicant screening and selection
- Evaluate potential for implicit bias in review and selection of fellow applicants.

2

Outline

- Factors valued by program directors in various medical specialties - what's in the literature
- AAMC Best Practices for conducting interviews
- Sample application evaluation tools
- Group activity: choose your final applicant to interview

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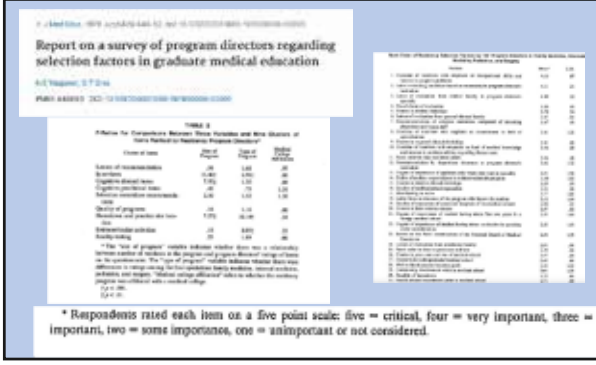

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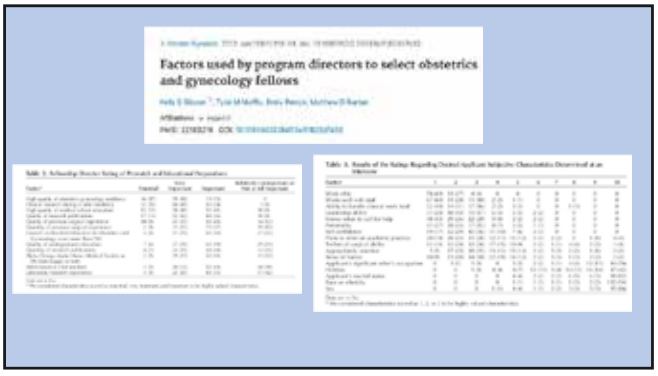

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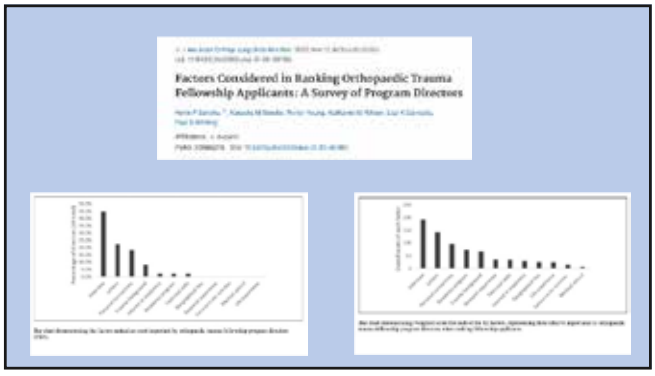

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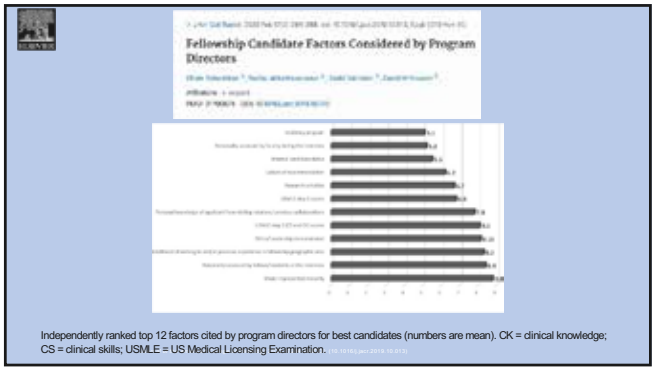

Independently ranked top 12 factors cited by program directors for best candidates (numbers are mean). CK = clinical knowledge; CS = clinical skills; USMLE = US Medical Licensing Examination.

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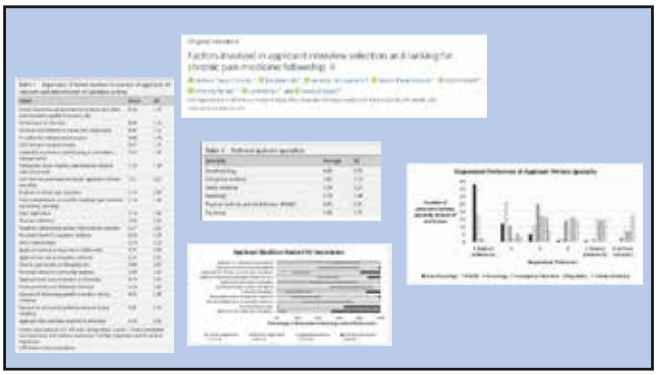

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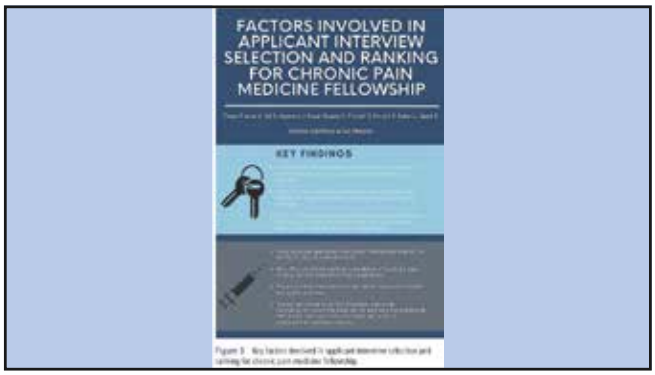

12

Factors Predicting Clinical Success


Predicting Quality of Clinical Performance From Cardiology Fellowship Applications


Does Residency Selection Criteria Predict Performance in Orthopaedic Surgery Residency?

- AOA
- Residency reputation
- Strength of comparative statements in LOR

- USMLE Step 2
- Number of honors in clerkships
- AOA membership

13

Factors Predicting Clinical Success


Evaluation of house staff candidates for program fit: a cohort-based controlled study

Selecting house staff based on residency program values and objective may yield higher job performance because trainees benefit more from a better fit training program

14

Defining "fit" in the context of residency selection

Fit is often reported as one of the most important factors in the residency selection process by program directors and applicants. However, there isn't a common definition of fit in the medical education literature. Programs should discuss the definition of fit in the context of their program's mission, goals, and learning environment.[1] For the purposes of clarity, in this guide, we identify two dimensions of fit:

Person-organization fit refers to compatibility between an applicant's personality, attitudes, work and learning style/preferences, and goals and the organization's culture.

Person-job fit refers to compatibility between an applicant's competencies, knowledge, skills, abilities, and other attributes and the competencies and characteristics required to learn and perform the job successfully.

AAMC

15

16

Research consistently shows that structured interviews have higher levels of reliability, validity, and fairness, including smaller group differences,[1] than unstructured interviews.

AAMC

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Table 1. The Effects of Components of Structure on Reliability, Validity, Fairness, and Applicant Reactions

Content	Reliability	Validity	Fairness	Applicant Reactions
Ask questions that are job-related		+	+	+
Ask all applicants the questions that cover the same topics	+	+	+	
Limit probing questions	+	+	+	–
Use behavioral or situational questions	+	+	+	
Use a longer interview	+	+		–
Have no access to applicant information before or during interview	+		+	–
Have applicants not ask any questions	+			–
Evaluation				
Rate each answer or use multiple rating scales	+	+		
Use defined rating scales	+	+	+	
Take detailed notes	+	+	+	
Use multiple interviewers	+	+	+	–
Use the same interviewers for all applicants	+		–	
Have no discussion between interviews	–		+	
Train interviewers	+	+	+	+
Use formulas to create interview total scores	+	+	+	

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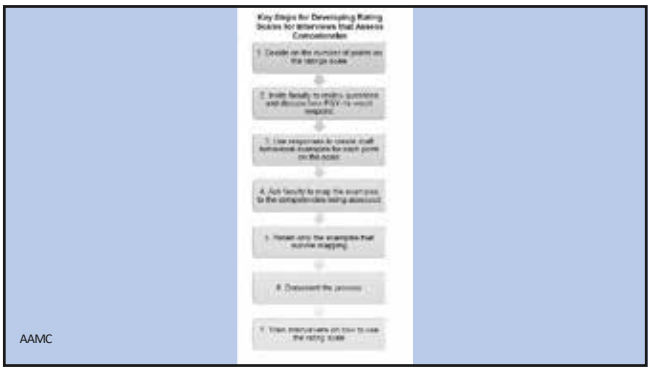
Source: Adapted from Campion et al. (1997) and Levashina et al. (2014).

18



19

Evaluating the Interview

- As soon as possible after the applicant leaves the room, review your notes.
- Fill in any important details you may have missed.
- Evaluate the applicant using the approach designed by your program—ideally, before the next interview begins.
- Ratings of the applicant should be supported by the notes.

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20

Be aware of your unconscious bias. Everyone holds unconscious biases about other people or groups of people based on attitudes, associations, and stereotypes. Interviewers can help mitigate their individual biases through:

Awareness of strong reactions for or against a particular applicant or type of applicant,

Basing scores on deliberate thinking and decision-making rather than on first impressions, and

Perspective taking

AAMC

21

- For more information, please see the AAMC's virtual seminar What You Don't Know: The Science of Unconscious Bias and What to Do about it in the Search and Recruitment Process *AAMC Reporter* article and an on unconscious bias in academic medicine
- What You Don't Know: The Science of Unconscious Bias and What to Do about it in the Search and Recruitment Process
- https://www.aamc.org/about-us/equity-diversity-inclusion/unconscious-bias-training

AAMC

22

AAMC

Dos and Don'ts for Evaluating Interviews

Do
Stay objective—focus on facts, not opinions.
Focus on the applicant's responses to interview questions.
Focus on one question or dimension at a time.
Focus on comparing applicants' responses with scale anchors (if your program uses a rating scale).
Don't
"Fill in" parts of the answer based on your own interpretations of the applicant's response.
Judge an applicant based on anything outside the scoring rubric (for example, personal appearance or your "chemistry").
Compare responses of one applicant with those of other applicants during the interview.

23

Evaluation Tools

24

Evaluation Tools

25

Evaluation Tools

26

Applicant Examples (completely fictitious)

You have one interview slot left to fill and the two following candidates. As a group, discuss which candidate you will choose to interview, and what elements of each application helped you make that decision.

Once you've selected, add in each application "twist" individually. Discuss whether any of these changes will alter your selection.

Best practices to help this session run smoothly:

- Honor the timeline of the small group discussion
- Assume positive intent
- Communicate respectfully in order for all voices to be considered
- Maintain a collaborative team mindset as we are all here to support our trainees
- Be attentive to participation: share the air

27

Applicant Examples (completely fictitious)

You have one interview slot left to fill and the two following candidates. As a group, discuss which candidate you will choose to interview, and what elements of each application helped you make that decision. Once you've selected, add in each application "twist" individually. Discuss whether any of these changes will alter your selection.

Candidate #1
USMLE step 1 232
ITE 50%ile
Residency program: good reputation (not top 10), 1 excellent former fellow from this program
Personal statement about the utility of this subspecialty in medical mission work
Has an MS in bioethics
Volunteer work during undergrad, worked at free clinic in medical school
Eagle scout
Letter of recommendation with personal anecdotes from faculty within this subspecialty that you don't know

Twist #1: personal email from a trusted colleague that this candidate is great and really wants to go to your program
Twist #2: personal statement about being the first in their family to go to college
Twist #3: one of the letters is short and very generic, from someone you don't know

28

Applicant Examples (completely fictitious)

You have one interview slot left to fill and the two following candidates. As a group, discuss which candidate you will choose to interview, and what elements of each application helped you make that decision. Once you've selected, add in each application "twist" individually. Discuss whether any of these changes will alter your selection.

Candidate #2
USMLE step 1 245
ITE 90%ile
Residency program: excellent reputation (top 10), never had a fellow from this program before
Personal statement about how they loved the rotation in this subspecialty and would like to pursue an academic career after fellowship
Resident rep of your state society of anesthesiologists
Prior to medical school, worked in business consulting for 2 years
Letters of recommendation mostly average, PD letter with superlative "one of the best residents, will very likely be elected chief resident for the coming year"

Twist #1: switch "excellent reputation" residency program to a program you have heard little about
Twist #2: personal statement about volunteering as a <fill in the blank with something you personally resonate with: fosters dogs, women's rights court advocate, etc.>
Twist #3: personal statement about their experience playing college varsity squash (different if it's another sport like soccer or football?)

29

Applicant Examples (completely fictitious)

You have one interview slot left to fill and the two following candidates. As a group, discuss which candidate you will choose to interview, and what elements of each application helped you make that decision. Once you've selected, add in each application "twist" individually. Discuss whether any of these changes will alter your selection.

Candidate #3
USMLE step 1 220
ITE 29%ile
Residency program: excellent reputation (top 10), excellent fellows from this program before
Personal statement about being first in their family to complete college
Presented case report poster at state anesthesia resident conference during residency
Prior to medical school, managed an auto parts store for 2 years
Letters of recommendation outstanding, PD letter with superlative "one of the best residents we've ever had"

Twist #1: switch outstanding letters to just average - some anecdotes but no superlatives
Twist #2: same letters but one notes this resident had a "unique bedside manner" earlier in training that has been addressed and improved
Twist #3: change residency program to one you don't know much about, you've had one fellow from this program before that did not perform well

30

Applicant Examples (completely fictitious)

You have one interview slot left to fill and the two following candidates. As a group, discuss which candidate you will choose to interview, and what elements of each application helped you make that decision. Once you've selected, add in each application "twist" individually. Discuss whether any of these changes will alter your selection.

Candidate #4
USMLE step 1 265
ITE 99%ile
Residency program: excellent reputation (top 10), you haven't had fellows from this program before
Personal statement about interest in your subspecialty since their rotation
No research experience during residency
Letters of recommendation average

Twist #1: has a number of publications co-authored with an academic physician parent
Twist #2: email from trusted colleague that this resident really wants to train at your program
Twist #3: personal statement about experience and interest in sailing

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2022 Regional Anesthesia and Acute Pain Medicine Breakout Session

Moderator:
Christina L. Jeng, MD, FASA
Associate Professor
Icahn School of Medicine at Mount Sinai

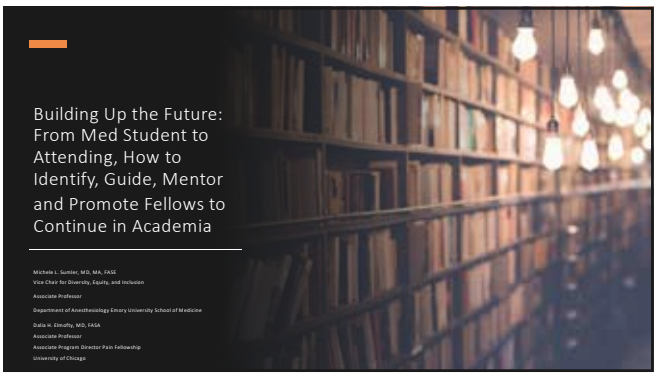
1. Status of RAAPM match
2. Status of formalization of the fellowship directors' group
3. Discussion

HANDOUT

Breakout 2: Building Up the Future: From Med Student to Attending, How to Identify, Guide, Mentor and Promote Fellows to Continue in Academia

Dalia Elmofty, MD
Michele Sumler, MD, MA, FASE

Friday, November 11
10:30 AM – 11:30 AM


Building Up the Future: From Med Student to Attending, How to Identify, Guide, Mentor and Promote Fellows to Continue in Academia
Michele L. Sumler, M.D., MA, FASE
Vice Chair for Diversity, Equity, and Inclusion
Associate Professor
Department of Anesthesiology Emory University School of Medicine
Dalia H. Elmofty, M.D, FASA
Associate Professor
Associate Program Director Pain Fellowship
University of Chicago

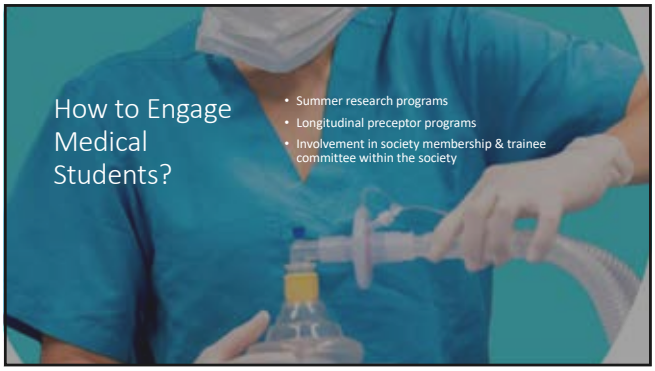
1


Path into Academic Medicine
Your fellow approaches you and asks if you could provide advice on the path towards a career in academia. She questions if this is the right path for her and her family.
Three Major Academic Missions
Research
Teaching
Clinical Care

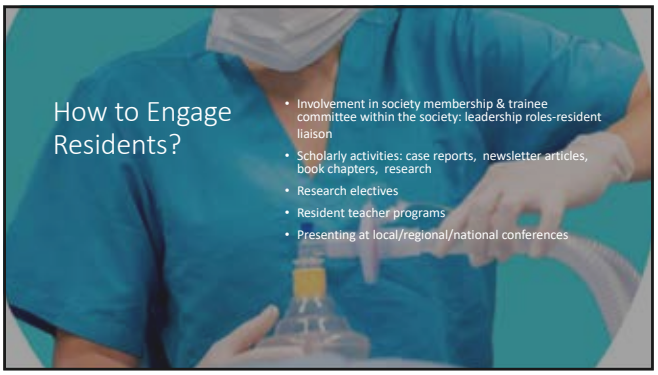
2


How can we Cultivate a Culture of Belonging in Academia?
• "Provide greater access to role models whose life experience mimics that of the trainee"
• Overcome the "burden of proof"

3


How to Engage Medical Students?
• Summer research programs
• Longitudinal preceptor programs
• Involvement in society membership & trainee committee within the society

4


How to Engage Residents?
• Involvement in society membership & trainee committee within the society: leadership roles-resident liaison
• Scholarly activities: case reports, newsletter articles, book chapters, research
• Research electives
• Resident teacher programs
• Presenting at local/regional/national conferences

5


How to Engage Fellows?
• Involvement in society membership & trainee committee within the society: leadership roles
• Adjunct attending role in teaching
• Chief Fellow role during fellowship training
• Scholarly activities

6

HANDOUT

Breakout 3: The Tripartite Missions: The Research Component

Magdalena Anitescu, MD, PhD
Brandi Bottiger, MD

Friday, November 11
10:30 AM – 11:30 AM

Breakout Session 3: The Tripartite Missions: The Research Component

Magdalena Anitescu, MD, PhD
Brandi A Bottiger, MD
Nov 4, 2022

Disclosures: BB is on advisory board for CSL Behring

1

Learning Objectives

- With ACGME requirements in mind, review successful models for research productivity during anesthesiology fellowships
- Identify existing challenges and/or barriers to success, understand internal and external resources
- Discuss existing resources and identify opportunities for improvement.

2

ACGME Requirements for Anesthesiology Fellowships

In addition to clinical education, many fellowship programs advance fellows' skills as physician-scientists. While the ability to create new knowledge within medicine is not exclusive to fellowship-educated physicians, the fellowship experience expands a physician's abilities to pursue hypothesis-driven scientific inquiry that results in contributions to the medical literature and patient care. Beyond the clinical subspecialty expertise achieved, fellows develop mentored relationships built on an infrastructure that promotes collaborative research.

3

ACGME Requirements for Anesthesiology Fellowships

must include demonstration of ongoing academic achievements appropriate to the subspecialty, including publications, the development of educational programs, or the conduct of research

A research project in cardiothoracic anesthesiology may be substituted for one or two months of clinical elective rotations.

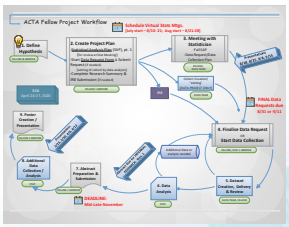
facilities and equipment for research in cardiothoracic anesthesiology; and,

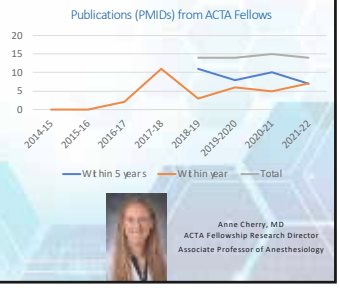
The program must provide instruction in the fundamentals of research design and conduct, and the interpretation and presentation of data.

The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

4

Models for Research in a 12- month fellowship





Anne Cherry, MD
ACTA Fellowship Research Director
Associate Professor of Anesthesiology

5

Research models

- Need sustainable infrastructure: research manager, research coordinator
- Many moving parts: regulatory, communication with sponsor, budgeting, EPIC integration, compliance, recruiting, enrollment, patient follow up
- Types of studies
  - Industry sponsored
  - Investigator initiated sponsored
  - Government agencies sponsored
  - Regional/institutional sponsored
  - Department sponsored: retrospective/prospective

6

Fellows need to know

- Regulatory: How to write and troubleshoot an IRB
- Ethics: how to recruit a patient, understand the study
- Financial: budget for an individual patient
- Procedural: follow specific protocols and understand difference between protocol deviation and adverse events
- Communication: proper reporting/initiation visits/audits
- Integration: role of research in a busy practice

7

Example of fellows involvement

- Sponsored, prospective: Identification of patients
  - Follow training protocols by company
  - Consent patients with the research coordinator
  - Participate in procedure
  - Follow up with patient in visits and understand adverse events vs normal healing process
- Internally sponsored, retrospective
  - IRB writing
  - Create protocol
  - Chart review/analysis/stats discussion
  - Submit abstract/write paper

8

HANDOUT

Breakout 4: Fellowship Matches: How Common and What are the Challenges?

Franklyn P. Cladis, MD, MBA, FAAP
Chandrika Garner, MD
Mark Stafford-Smith, MD, MBA

Friday, November 11
10:30 AM – 11:30 AM

Breakout 4:

Fellowship Matches: How Common and What are the Challenges?

Friday November11th, 2022
SAAAPM 2022 Annual Meeting
Chicago, IL

Mark Stafford-Smith, MD, CM, FRCPC, MBA, FASE
Vice Chair of Education,
Director of Fellowship Education
Duke University Medical Center
Durham, NC, USA

1

ACTA Recruitment History

ACGME appr. 2007 → SCA PD cmte
…..by recruitment focus/concerns

2008 Problem - pressured residents
- earlier interview seasons (filling by January)
- lack of exposure to subspecialties
- competition among programs (+/- ok with status quo)

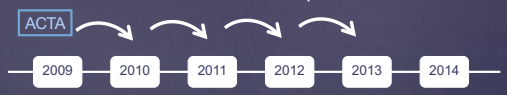
PDs - "we need a plan":
- offer date restraint
- address hurdles (e.g., internal candidates)

2008-9 honor code proposal:
Date restraint with "Exceptions" (?april, 7 day accept clause → scramble)
- internal candidates
- >1yr programs (e.g., CT – ICU)
- Military
- Couples
- Visa

2

ACTA Anesthesia Fellowship Match

Agreements
fixed offer dates + *"exceptions"*



? Match

3

Barriers to a Match

PD survey: Participation contingency
**Chair support
(esp. internal candidates)

Need to keep +/- all positions in the match
**Match costs (vs. SCA sponsorship)
SCA vs. Program contract
Challenges of incomplete participation
Value of trending annual data

4

ACTA Approach : Match Tool Choices

NRMP
+ ERAS

SF Match
(opthalmology)

AUA Match
(urology)

VIAR Match
(veterinary clinicians)

ORMS Match
(optometry)

ASTS Match
(abd txplt surgery)

ASHP Match
(pharmacy)

5

Match Tool Choices

	NRMP	SF Match
Match Dates	inflexible	flexible
Application Dates	fixed window	flexible
Electron. Appl. (ERAS)	optional	optional
Fees	- Inst./Program - Applicant - ERAS/CAS $235 + $35/pos $50 or $85 for first 10	equivalent ($325 init.) $150/yr $50 or $60 for first 10
Required minimum	75% programs	none
"Exceptions"	not an option	** not an option

6

ACTA Contract development - Flexibility of SF Match

Contract

- Sponsorship - parent organization vs. programs
- Contract language - liability for match cost over-run
  - escrow account

Participation (PD survey of barriers)

- SF Match "exceptions" perspective
  - SF match ok with "agreements" among PDs/applicants as long as independent of SF match process
  - SF Match ok with a process where:
    match review by PD leadership :
    actual vs. promised rank list behavior
    (2 wk window, re-runs no charge)

7

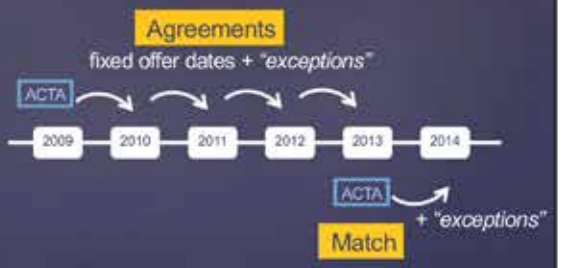
Generating the "Exceptions" Registry

8

SF Match Process : Under the Hood

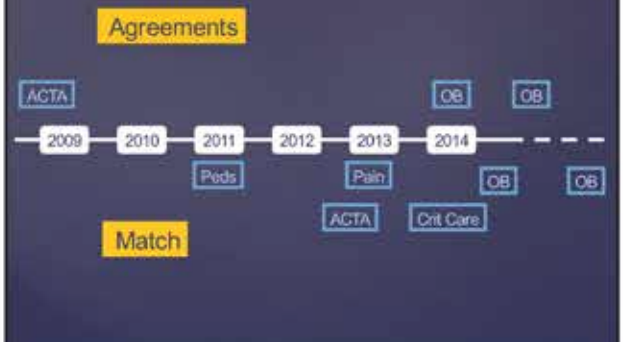
9

ACTA Anesthesia Fellowship Match



10

Evolution of Fellowship Agreements / Matches

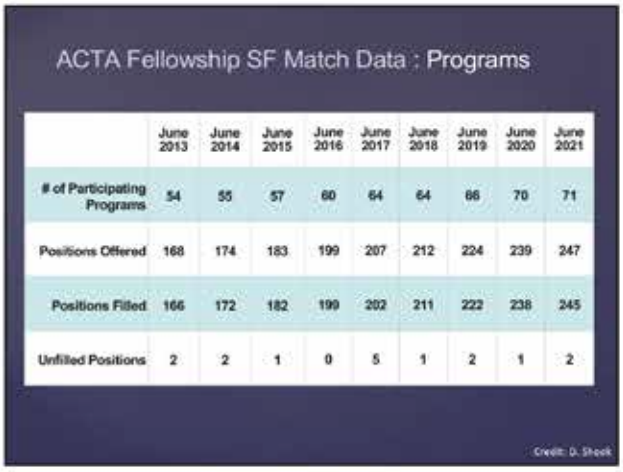


11

ACGME ACTA Fellowship Programs + SF Match

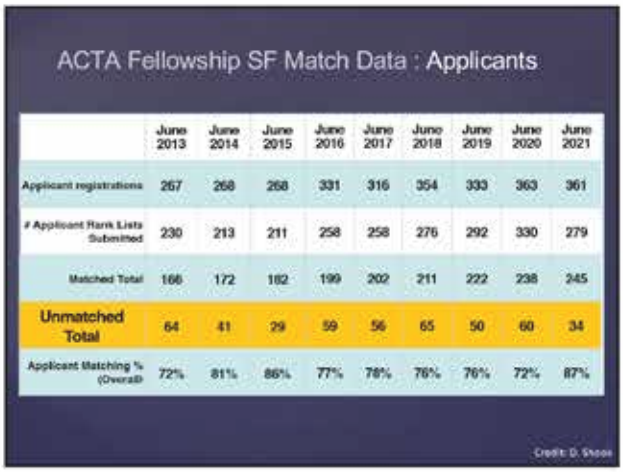
12

13



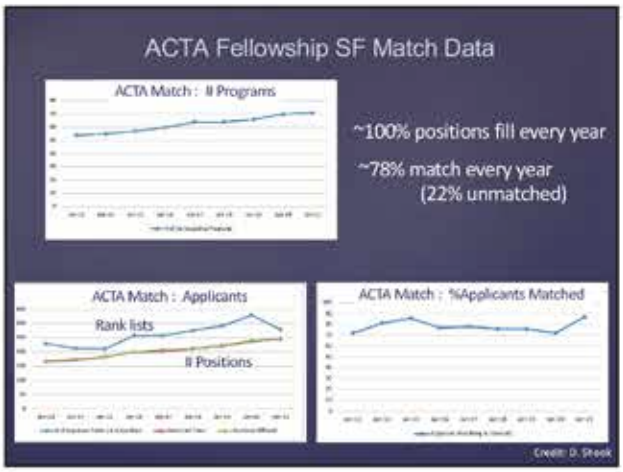
	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018	June 2019	June 2020	June 2021
# of Participating Programs	54	55	57	60	64	64	66	70	71
Positions Offered	168	174	183	199	207	212	224	239	247
Positions Filled	166	172	182	199	202	211	222	238	245
Unfilled Positions	2	2	1	0	5	1	2	1	2

14



	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018	June 2019	June 2020	June 2021
Applicant registrations	267	268	268	331	316	354	333	363	361
# Applicant Rank Lists Submitted	230	213	211	258	258	276	292	330	279
Matched Total	166	172	182	199	202	211	222	238	245
Unmatched Total	64	41	29	59	56	65	50	60	34
Applicant Matching % (Overall)	72%	81%	86%	77%	78%	76%	76%	72%	87%

15



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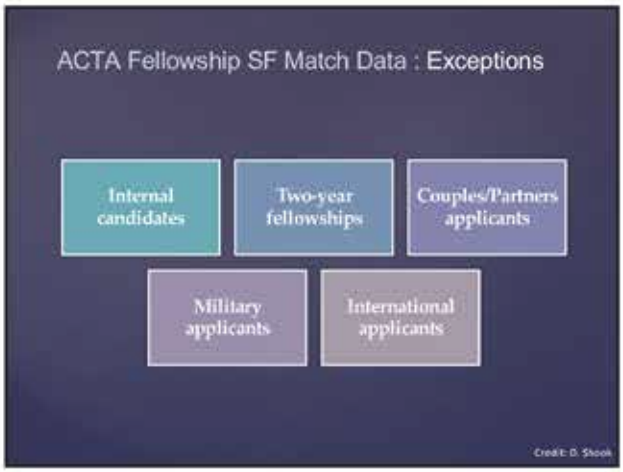

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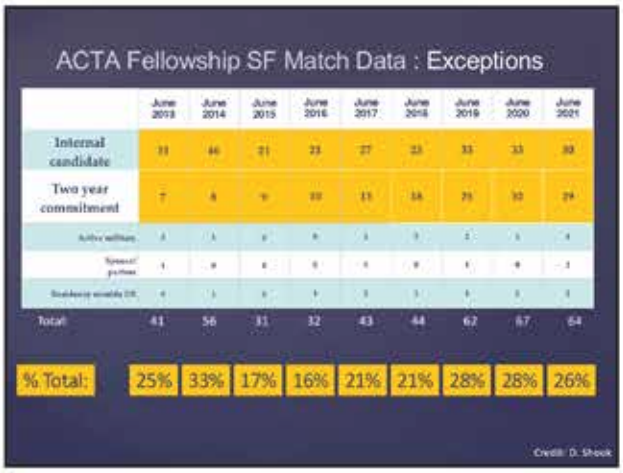
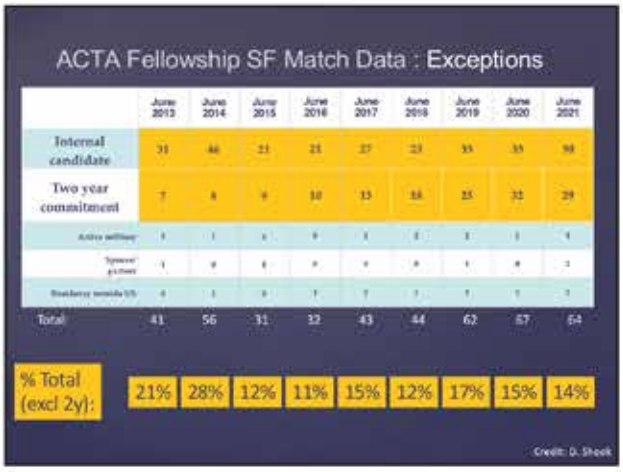


18


ACTA Fellowship SF Match Data : Exceptions
>1 yr Applicant Exceptions
Commitment to institution for more than 1 year
Credit: D. Shook

19


ACTA Fellowship SF Match Data : Exceptions
Internal candidate
Two year commitment
Total
% Total (excl 2y):
21% 28% 12% 11% 15% 12% 17% 15% 14%
Credit: D. Shook

20


ACTA Fellowship SF Match : 2022-3 Applicant Timelin
November 8, 2022 Applicant registration begins.
March 2, 2022 Target Date for applicants to complete the requirements for application distribution.
June 2, 2022 ALL rank lists must be submitted.
June 9, 2022 Match results are made available.
June 10, 2022 Unmatched position posted.
July 2024 ACTA training begins.

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HANDOUT

AASPD

Updates from the Subspecialties

Moderator: Magdalena Anitescu, MD, PhD

Friday, November 11
1:30 PM – 2:15 PM

HANDOUT

AASPD

Updates from the Subspecialties: Regional Anesthesiology and Acute Pain Medicine

Edward R. Mariano, MD, MAS, FASA

Friday, November 11
1:30 PM – 2:15 PM

HANDOUT

Updates from the Subspecialties: Critical Care Medicine

Erin Hennessey, MD, MEHP

Friday, November 11
1:30 PM – 2:15 PM

AASPD: Updates from the Subspecialties

Anesthesia Critical Care Medicine Fellowship

Anesthesia Critical Care Medicine Fellowship
Erin K Hennessey, MD MEHP
Chair, SOCCA Program Director's Advisory Council
Program Director, ACCM Fellowship at Stanford University
Clinical Associate Professor, Stanford University

#SAAAPM22
@ErinH_MD
@SOCCA_CritCare

November 11, 2022

1

Anesthesia Critical Care Medicine Match with SFMatch

2

ACCM Fellowship Trends

3

Applicant Trends for Adult Critical Care Programs

4

ACCM Fellowship Recruitment Cycle

5

Virtual Interviews

13-14 applications submitted per applicant

6-7 interviews completed per applicant

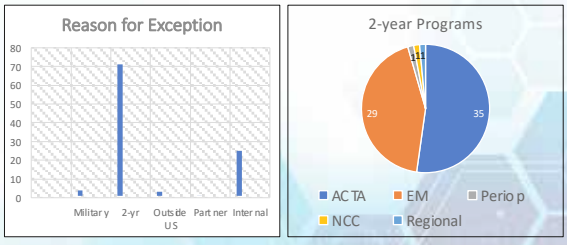
6

SOCCA Match Exceptions

1. Applicants who are in active military service at the time of the application.
2. Applicants who are making a commitment to come to the institution of the CCM fellowship for more than one year.
3. Applicants who are enrolled in an anesthesiology residency outside of the USA at the time of the application.
4. Applicants whose spouse or partner is applying for a GME-approved post-graduate training program in a medical specialty in the same region as the CCM fellowship.
5. Internal candidates.

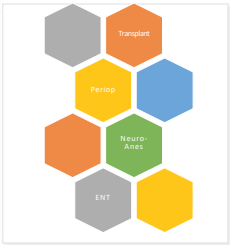
7

2021-2022 Match Exceptions



8

Anesthesia Subspecialty Training Opportunities



9

Combined Fellowships Opportunities

- Collaboration across subspecialities regarding Match Exception Date and Process
- Consideration of a combined match for dual ACTA-CCM candidates given increasing interest in the program
- Future innovation and integration ideas regarding dual-interest candidates

10

Match Enhancements and Policies

- Standard Letter of Evaluation – Website PDF generator coming soon!
- Withdrawal Letter – Asks to disclose on future match applications

11

Recruitment Strategies

- Outreach to medical students and residents through national societies
- Mentoring at local institutions
- Working through SAAAPM with Core PDs for innovative programs
- Visibility about scope of CCM practice with publications and social media
- Return-to-training models to meet community needs
- Partnering with Non-Anesthesia Training Programs (OBGYN, Neurosurgery, Surgery, Emergency Medicine)

12

13

HANDOUT

AASPD

Updates from the Subspecialties: Pain Medicine

Magdalena Anitescu, MD, PhD

Friday, November 11
1:30 PM – 2:15 PM

THE UNIVERSITY OF CHICAGO MEDICINE

Updates on Pain Medicine 2022

Magdalena Anitescu, MD, PhD
Professor of Anesthesia and Pain Medicine
Program Director, Pain Medicine
Department of Anesthesia and Critical Care
University of Chicago Medicine

1

Pain Medicine Programs-2023-24

- Total for 2023 programs: 114, 4 withdrawn programs
- Participating (certified) in match: 110, 96% participation
- Filled: 98 (89%), Unfilled: 12 (11%)

2

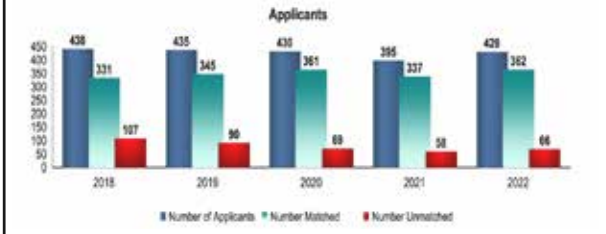
Pain Medicine Positions-2022-23

- Total for 2023 positions: 377 positions
- Filled: 358 (95%), unfilled 16 (5%)

3

Applicants

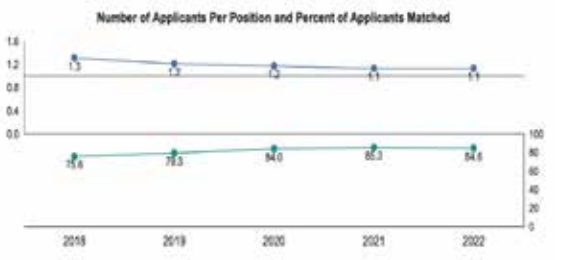
- Applicants for 2023 : 416
- Matched: 358 (86%)
- Not matched: 58 (14%)



4

Positions and applicants

- Stable from 2018:
  - 1.1 applicants per position



5

The applicants

Year	Program	Positions	Filled	% not matched	%US Grad	% FMG	Osteopaths	US International
2014	82	261	256	36	73	8	9	10
2015	84	286	286	27	69	9	14	7
2016	90	305	303	37	71	10	14	5
2017	93	316	309	23	70	9	15	6
2018	98	335	331	24	61	8	14	7
2019	103	359	345	21	65	11	16	8
2020	104	367	361	15	69	4	17	10
2021	102	349	337	15	64	5	19	11
2022	109	372	362	15	64	6	21	8
2023	114	377	358	19	58	6	27	7

6

Activities in last year

- Trimestrial meetings for the APPD board and monthly for AASPD board
- Launch Hot Topics through APPD/ASRA
- Bi-annual virtual meeting with all PD to keep all engaged and bring problems to discuss
- Web based educational endeavors for fellows and residents: AAPM, NANS, INS webinars
- Various cadaver courses through various organizations
- Virtual interviews continue
- Residents activities: in person and virtual meet and greet with PD, engage medical students
- Increase in number of in-person meetings

7

Giving up pandemic reality

- Social distance, masks and virtual meetings

8

For an improved, mask optional one

9

What continues

- Encourage programs to keep in match
- Virtual interview for foreseeable future
- Ensure competence upon graduation: PD review case log
- Supportive and networking for job finding
- Expand fellowship education on telemedicine.

10

ACGME vs NRMP

- ACGME: 111 programs
- NRMP: 109 programs,
- % programs in match: 98%

11

Pain Medicine Fellowship-2019 Program Requirements

- Multidisciplinary fellowship
- Base specialties
  - Anesthesiology
  - Physical Medicine and Rehabilitation
  - Neurology
  - Psychiatry
- Other specialties can apply: ED, pediatrics, radiology, etc
- 1 Fellowship Program per institution no longer required

12

CONCLUSIONS

- Consistent, high competitive fellowship 15% applicants not matching
- Steady state of the match, now the 9th year.
- Advantages/Disadvantages

- Applicants:
  - Apply/interview widely,
  - Fear of no match
  - Virtual interviews
  - Extracurricular activities to serve the application best possible
- Program directors
  - Many applications/Time consuming
  - No objective data
  - Short Time of the interview
  - Virtual at times difficult
- Programs
  - Potential more
  - Quality of Education
  - Institutional resources
  - Few programs created since new req

Building a community of pain PD with similar aspirations for their incoming trainees

THE UNIVERSITY OF CHICAGO MEDICINE 13

13

THANK YOU FOR LISTENING!

THE UNIVERSITY OF CHICAGO MEDICINE 14

14

HANDOUT

AASPD

Updates from the Subspecialties: Pediatric Anesthesiology

Concetta Lupa, MD

Friday, November 11
1:30 PM – 2:15 PM

Pediatric Anesthesia Updates

Concetta Lupa, MD
November 2022
Chicago, IL

1

PAPDA WEBSITE

2

PAPDA Board of Directors

3

Meetings

All Members:
- SPA Winter (aka Spring)
- SAAAPM Fall

GME Program Task Force Recommendations
ABA Timing of Applied Exam - update- Pediatric Cardiac Update
Discussion of Match NRMP vs SF-
Virtual vs In person Interviews Lim and Lau (10 min)
Match Data

Special Education Session: Dr. William McDade- Diversity in GME
- Monthly to BiMonthly meetings virtually with the board

4

Topics addressed this year

- Implementing a Social Media presence
- ABA Applied Exam Process
- Fellowship Graduation Survey
- Discussions addressing core curriculum development
- Discussion of GME Taskforce recommendations
- PAPDA Board Member involved in CCAS Taskforce
- Meeting planning
- THE MATCH

5

Follow us!

Facebook:	Twitter:	Instagram:
PAPDASocialMedia	PAPDA_Social	papda_social

6

Program goals include:

- Creating extramural opportunities for networking, collaborating and sponsorship
- Expanding the community of practice in pediatric anesthesia
- Increasing academic activity to improve promotion and retention rates for junior faculty
- Assisting the transition of fellows from trainees to engaged and productive faculty
- Promoting gender equity and URM individuals in pediatric anesthesia

Types of Exchanges include:

- In Person Faculty
- In Person Fellow/Faculty
- Virtual Faculty
- Virtual Fellow/Faculty

ViSiPAP

- Exchanges are especially designed for junior faculty nearing promotion and fellows with an interest in academic medicine. Fellow/faculty exchanges provide additional mentorship opportunities.

7

Fellowship Graduation Survey

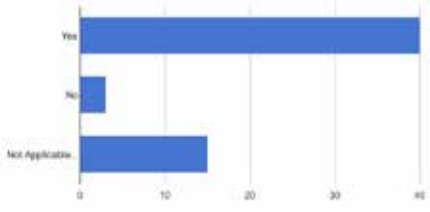
- Distributed to all Pediatric Anesthesia Fellows in June 2022
- N= 54 responses
- Lots of data here that is broad
- Will focus on some key points

8

Which of the following best reflects the reason you ENROLLED IN a pediatric anesthesiology fellowship?

9

Were you able to get the type of job you wanted following fellowship (patient population, practice setting, geographic location)?



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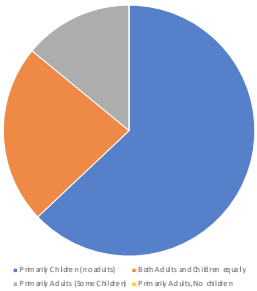
Jobs after fellowship

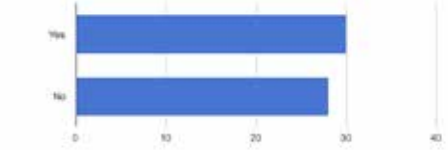


11

At any point during your training, did you ever consider additional training (12 months) to become a pediatric cardiac anesthesiologist?

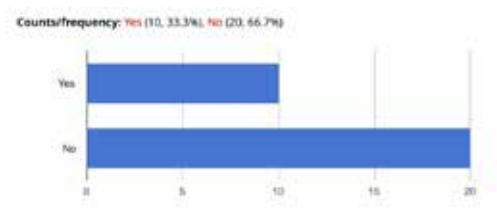
Total Count (N)	Missing*	Unique
58	0 (0.0%)	2

Counts/frequency: Yes (30, 51.7%), No (28, 48.3%)



12

Will you be doing an additional 12 months of training in pediatric cardiac anesthesiology?



13

GME Task Force - Implementation

14

GME Task Force - Implementation

- Scholarship Oversight Committee
  - **All fellows must conduct or be substantially involved in a scholarly project relevant to the subspecialty that is suitable for publication**
  - SOC determines *what counts*

15

GME Task Force - Implementation

- Standardizing a curriculum for Non-Clinical Domains
- Likely will be placed on Open Anesthesia

• Quality Improvement	• Communication Skills
• Patient Safety	• Medical Education
• Research Methods	• Practice Management
• Leadership Skills	• Supervision

16

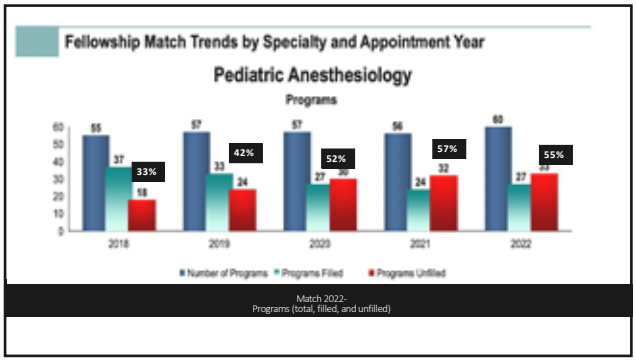
GME Task Force - Implementation

- Revise Case Logs
- Out of Date (minimum neonates for fellowship is 15!)
- Task force working on this

17

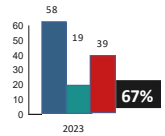
THE MATCH

18



19

Trends in Programs Filling, NRMP data
2013-Present
Pediatric Anesthesiology



Program Status	Percent of PGMs %
Filled	33%
Unfilled	67%
Zero (0) Fellows matched	35%

20

Pediatric Anesthesiology
ERAS Data

2017	2018	2019	2020	2021	2022
211	211	199	211	194	173

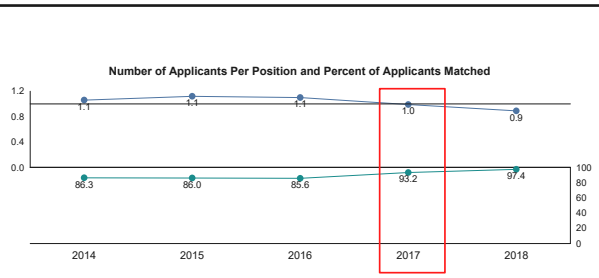
21

Number of positions

22

Number of applicants, matched and unmatched

23



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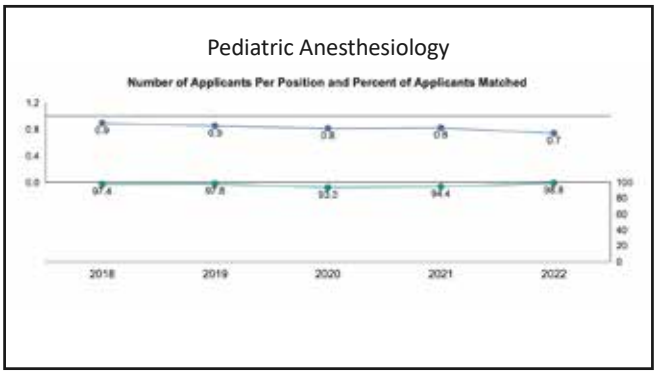
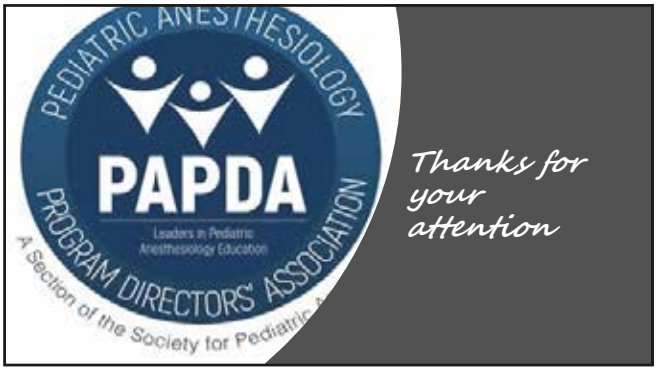

Pediatric Anesthesiology
Number of Applicants Per Position and Percent of Applicants Matched
2018
2019
2020
2021
2022

25

26


PEDIATRIC ANESTHESIOLOGY
PAPDA
Leaders in Pediatric Anesthesiology Education
PROGRAM DIRECTORS' ASSOCIATION
A Section of the Society for Pediatric
Thanks for your attention

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HANDOUT

AASPD

Updates from the Subspecialties: ACTA

Douglas C. Shook, MD, FASE

Friday, November 11
1:30 PM – 2:15 PM

HANDOUT

AASPD

Updates from the Subspecialties: OB Anesthesia

Andrea Traynor, MD

Friday, November 11
1:30 PM – 2:15 PM

HANDOUT

AASPD

Updates from the Subspecialties: Pediatric Cardiac Anesthesiology

Stephanie N. Grant, MD

Friday, November 11
1:30 PM – 2:15 PM

Updates from the Subspecialties:

Pediatric Cardiac Anesthesiology

Stephanie N. Grant, MD, FAAP
Assistant Professor of Anesthesiology and Pediatrics
Program Director, Pediatric Cardiac Anesthesiology Fellowship
Emory University/Children's Healthcare of Atlanta

1

- No financial disclosures

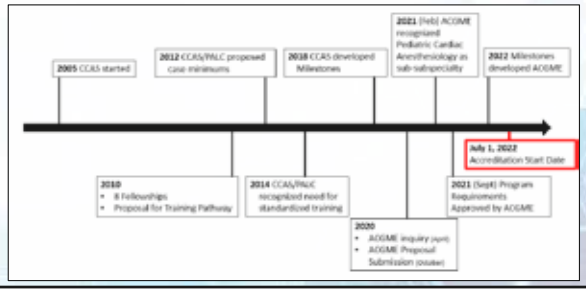
2

Learning Objectives

- Development of Pediatric Anesthesiology as an ACGME subspecialty
- Fellowship Eligibility
- Clinical Experience
- PALC/CCAS Task Force to address national shortage of Pediatric Cardiac Anesthesiologists

3

Evolution of Pediatric Cardiac Anesthesiology



4

Pediatric Cardiac Anesthesiology Program Requirements and Milestones Working Group

Sentharam Suresh, MD	Working Group Chair
Aditee Ambardekar, MD, MSEd	Review Committee Chair
Nina Deutsch, MD	Subject Matter Expert
Laura Edgar, EdD, CAE*,†,‡	ACGME Vice President, Milestones Development
Stephanie Grant, MD*	Subject Matter Expert
Cheryl Gross, MA, CAE*,†	ACGME Executive Director, Review Committee for Anesthesiology
Thomas McLoughlin, MD	Review Committee Member
Viviane Nasr, MD MPH	Subject Matter Expert
Mark Stafford-Smith, MD	Review Committee Member

Nasr VG, et al.. Anesth Analg. 2022

5

Pediatric Cardiac Anesthesiology Fellowships

23 non-ACGME Fellowships

6 ACGME Fellowships
- **Accreditation Start Date: 7/1/22**

Program Code - Name	Program Director
[3470740001] University of Colorado School of Medicine Program	Megan Aberle, MD
[3471254001] Emory University School of Medicine Program	Stephanie N. Grant, MD
[3471660001] McGaw Medical Center of Northwestern University Program	Erin L. Ivy, MD, MSci
[3471754001] Indiana University School of Medicine Program	Maria K. Ahmad, MD
[3472004001] Cincinnati Children's Hospital Medical Center Program	Jennifer Lah, DO
[3474064001] Baylor College of Medicine Program	Pramod M. Trivedi, MD

6

Fellow Eligibility Criteria

III.A.1.b)	Prior to appointment in the program, fellows must have successfully completed a residency program in anesthesiology that satisfies the requirements in III.A.1., and: (Core)
III.A.1.b).(1)	a fellowship program in pediatric anesthesiology that satisfies the requirements in III.A.1.; or, (Core)
III.A.1.b).(2)	a fellowship in adult cardiothoracic anesthesiology that satisfies the requirements in III.A.1. (Core)
III.A.1.b).(2).(a)	Fellows entering from adult cardiothoracic anesthesiology should have taken a minimum of one month of pediatric anesthesiology during the adult cardiothoracic anesthesiology fellowship. (Core)

ACGME Program Requirements for Graduate Medical Education in Pediatric Cardiac Anesthesiology. 2021

7

Curriculum Organization and Fellow Experiences

Block	1	2	3	4	5	6	7	8	9	10	11	12
Site	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1
Rotation Name	Clinical Anesthesia[1]									ICU	Elective[2]	Elective

Notes
1 - Clinical Anesthesia - includes intraoperative management of patients with congenital heart disease in the operating room, catheterization and electrophysiology lab, and diagnostic imaging sites
2 - Elective rotations include Echocardiography (2 weeks), Perfusion (2 weeks), Echocardiography Bootcamp (2 weeks), and Research (2-4 weeks)

8

Case Requirements

	Minimum number
CPB cases	**100** (≥ 50 Fellow as Primary Anesthesia Provider)
HLHS procedures	3
Other Neonatal Procedures	3
TGA procedures (Arterial Switch)	3
Repair of CAVC, TOF, VSD, ASD	20
Glenn	5
Fontan	4
Valvular lesion procedures	20
Palliative Shunt	1
Aortic coarctation - off bypass	3
PDA repair (surgical or Cath lab)	3
Vascular Ring	2
Heart Transplant or VAD	1
Cath Lab - Diagnostic	20
Cath Lab - Interventional	25
EP Procedures	10
Medical Imaging	10
Central Venous Line	30
Arterial Line	30

9

National Shortage of Pediatric Cardiac Anesthesiologists

PALC/CCAS Pediatric Cardiac Anesthesia Task Force

Developed with Goal to:

1. Increase the number of Pediatric Cardiac Anesthesiologists
2. Increase the number of Expert Pediatric Anesthesiologists in Moderate/Severe Congenital Heart Disease

PALC = Pediatric Anesthesia Leadership Council
CCAS = Congenital Cardiac Anesthesia Society

10

National Shortage of Pediatric Cardiac Anesthesiologists

PALC/CCAS Pediatric Cardiac Anesthesia Task Force

Subgroups
- Education
- Workforce
- Working Conditions
- Career Advancement
- Compensation

Surveys to Key Groups
- Division Leaders of Pediatric Cardiac Anesthesiology Divisions
- Program Directors of Pediatric Cardiac Anesthesiology Fellowships
- Graduates of Pediatric Cardiac Anesthesiology Fellowships in last 10 years
- CCAS members/Pediatric Cardiac Anesthesiologists
- 2022 Fellow Graduates of Pediatric Anesthesiology, PAPDA Survey Inclusion of Questions

11

Program Directors Survey - Taskforce

Preliminary Results

1. Are you interested in the development of a standardized curriculum with centralized lectures available to cover core topics in pediatric cardiac anesthesiology for your fellows?

	#/14	%
Yes	11	79
No	1	7
Maybe	2	14

2. Are you interested in the development of a standardized evaluation tool?

	#/11	%
Daily Evaluation of Fellow	5	45.5
Rotational Evaluation of Fellow	9	82
Fellow Evaluation of Faculty	9	82
Fellow Evaluation of Rotation	9	82
Fellow Evaluation of Program	11	100
Faculty Evaluation of Program	9	82
Not Interested	3 (out of 14)	21

12

Pediatric Cardiac Anesthesiology Program Directors' Group

- Committee supported by the Congenital Cardiac Anesthesia Society (CCAS)
- Program Directors of Pediatric Cardiac Anesthesiology Fellowships

13

Evolution of Accredited Pediatric Cardiac Anesthesiology Fellowship Training in the United States: A step in the right direction

Viviane G. Nasr, MD MPH[1]; Aditee Ambardekar, MD, MSEd[2]; Stephanie Grant, MD[3]; Laura Edgar, EdD, CAE[4]; Cheryl Gross, MA, CAE[5]; Thomas Mcloughlin, MD[6]; Mark Stafford-Smith, MD[7]; Santhanam Suresh, MD[8]; Nina Deutsch, MD[9]

ANESTHESIA & ANALGESIA

Accepted: September 22, 2022. Not yet published.

14

Thank you!

Please contact me with any questions.

stephanie.grant@emory.edu

@SGrantMD

15

HANDOUT

AAPAE

Introduction / Welcome / Business Meeting

Moderator: Faye Haggar, EdD

Friday, November 11
8:00 AM – 8:15 AM

HANDOUT

Keynote Speaker

Amy Miller Juve, MEd, EdD

Friday, November 11
8:15 AM – 9:00 AM

You can do it!

Leveraging intentional change theory to get what you want from your career (and life)

Amy Miller Juve, EdD, MEd
Professor
Vice Chair, Education
Oregon Health & Science University

1

Let's begin!

Are you ready?

2

3

4

Ideal Self

What do you want to be? Short and long term what is the vision you have for yourself: dreams, aspirations, sense of purpose. Not how or what but why. How do you want others to see you?

1. Write down 3 different visions for yourself

2. Share one of those visions with your neighbor

5

Real Self

Define your real self. Use tools, performance assessments, informal notes from colleagues. Identify your strengths and gaps. Do not just rely on how you "feel".

6

Learning Agenda

1. Use SMART or WOOP
2. Identify obstacles and potential solutions
3. Think outside of the box
4. Create a plan for accountability

Action 1

Action 2

Action 3

Action 4

7

8

Experiment and Practice

9

Trusting Relationships

Confide in them, find a coach or mentor, broaden your community, develop trust.

10

Bonus: coach others through their journey

01	02	03	04
Ask good questions	Spot the opportunity	Start with positivity	Keep people moving forward

Boyatzis, Smith, Van Oosten, 2019

11

Take home

1. You have the power and tools to change/chart your path
2. Use Intentional Change Theory to realize your dreams and aspirations
3. Frame your agenda in the positive
4. Help others

12

13

HANDOUT

Snap Talks

Moderators: Fei Chen, PhD, MEd & Amy N. DiLorenzo, MA, PhD

Friday, November 11
9:00 AM – 10:00 AM

HANDOUT

Snap Talks: Are Our Trainees Checked Out? Let's Check-In! A Low Stakes, Systematic Approach to Checking In On Trainees' Progression

Rachel Moquin, MA, EdD

Friday, November 11
9:00 AM – 9:15 AM

Snap Talk: Are Our Trainees Checked Out? Let's Check-In! A Low Stakes, Systematic Approach to Checking In On Trainees' Progression

Rachel Moquin, EdD
Assistant Professor, Director of Learning and Development
Washington University School of Medicine in St. Louis
Department of Anesthesiology

Objectives

- Participants will be able to…
  - Recognize the value of proactive communication with trainees
  - Identify one possible system for routinely reaching out to check on trainees to gather information about their needs and progress
  - Reflect on how they might develop a system for use with their trainees

Why Check In?

"Sense of belonging" → retention and persistence (Hoffman et al, 2002)

Connection → well-being → resilience → flourishing (Noble & McGrath,2012)

Loneliness, lack of support → burnout (Eris & Barut, 2020)

Generally "low awareness and little take-up of institutional support services" (Dhillon, McGowan, & Wang, 2008)

"Help avoidance" and resistance to seeking help prevalent in medical field (Chew-Graham, Rogers, & Yassin, 2003)

An Approach

Residents receive a 3-question survey once per month

Option to complete anonymously

'Schedule send' is my friend!

Which best describes you right now?
I'm great!
I'm ok.
I'm not great, but I'm making it.
I could use a check-in.

If you'd like a check-in, is there a specific topic or person you'd like to connect with?

What could you do to help yourself right now?

List of well-being and wellness resources from GME, ACGME, and Department with links

Next Steps

Responses are reviewed and aggregate data is shared with residency leadership

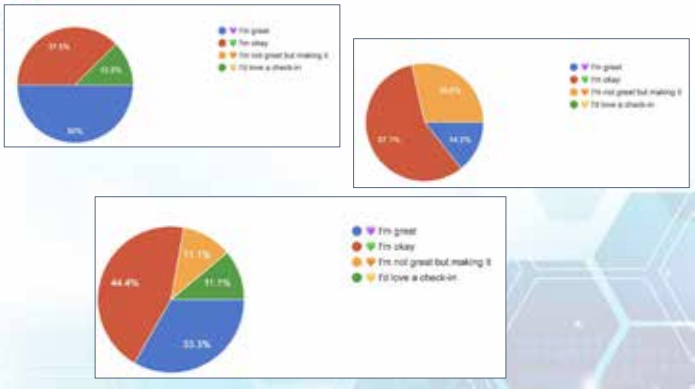
Follow-up with individuals as needed

- Email from me generally checking in
- Email connection to specific person re: need or topic
- Connection to specific resources

Benefits and limitations

- High-level snapshot of how residents are doing at that point in time
- Residents don't have to proactively reach out if they have a need
- Addressing concerns and providing support before issues escalate
- Individualize support
- Residents encouraged to think about their own wellbeing

- Optional to participate; unclear if we are missing people
- Not every need is "solvable"
- Difficult to identify the ideal person/people to review these
- Rarely: confidentiality vs. safety?



Check-In Example Responses

On my time off, I'm often too exhausted from the stress of the week being a new CA1. I think I would like some resources or directions regarding ways to be mindful and utilize my time off to its potential. I have previously spoken with our BJH psychologist/counselor but the hours available often did not work with my available schedule as a resident.

As a resident I would love some free/discounted access to mindfulness/meditation resources such as books or an online program/app. I know that there are some classes available online on the wellness website but again often times do not work with resident work hours

Quitting residency

I think I'm getting nervous about finding time/motivation to study. I know the ITE and basic exams will come up quicker than I expect. Wouldn't mind discussing this!

Can we meet to review my study plan?

I'm procrastinating… can you send me emails to remind me to be studying?

Need to talk to someone about burnout. I'm frustrated about my schedule.

I don't know who but I need someone to check in.

I'm not sure about fellowship vs. private practice. Could you ask my mentor to reach out?

What could you do for yourself?

Start exercising more!

Eat healthier. After particularly long or stressful day I've been eating more candy/junk food and drinking a beer or two which I normally don't do. I will look to find a replacement to these bad habits with some other stress relief comfort.

Take a nap

Exercise more often

Need to be able to get home on time more :(

Focus on one positive thing daily. Overall I could be more content with what I have instead of focusing on what I don't have

A little more sleep would be good

Making dedicated time to study and making a doctor's appointment.

I'm actually feeling better than last month. OB really helped and now on peds. Hard to be sad around cute children.

I should call my mom.

Get off this rotation!

I should make time this weekend to see some friends.

Make a vet appointment for my dog.

References

Hoffman, M., Richmond, J., Morrow, J., & Salomone, K. (2002). Investigating "Sense of Belonging" in First-Year College Students. Journal of College Student Retention: Research, Theory & Practice, 4(3), 227–256.

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Chew-Graham, C.A., Rogers, A. and Yassin, N. (2003), 'I wouldn't want it on my CV or their records': medical students' experiences of help-seeking for mental health problems. Medical Education, 37: 873-880.

HANDOUT

Snap Talks: Resident Wellness Development: A Coordinator's Perspective

Megan Souter, BA, C-TAGME

Friday, November 11
9:15 AM – 9:30 AM

Resident Wellness Development: A Coordinator's Perspective

Megan Souter, BA, C-TAGME

1

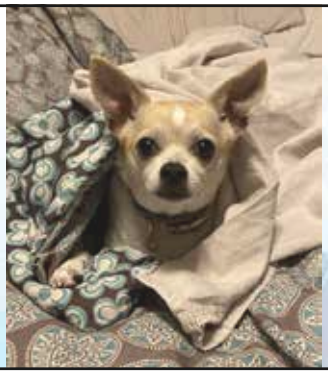
Learning Objectives:

- Upon completion, you will be able to
  - Define what wellness is in a residency setting
  - List steps for building and implementing a wellness program for residents
  - Incorporate small, inexpensive wellness activities into your program

2

Hi – I'm Megan.

3



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- Been a part of GME for 3 ½ years
- Started as an Assistant Program Coordinator
- Transitioned to Program Coordinator in April 2022

5

University of Kansas SOM – Wichita Anesthesiology Residency Program

- 4 – year community-based program
- Work with Ascension Via Christi St. Francis Hospital and Wesley Medical Center (HCA)
- 20 Squirrels

6

University of Kansas SOM – Wichita Anesthesiology Residency Program

- 4 – year community-based program
- Work with Ascension Via Christi St. Francis Hospital and Wesley Medical Center (HCA)
- 20 Residents

7

University of Kansas SOM – Wichita Anesthesiology Residency Program

- 4 – year community-based program
- Work with Ascension Via Christi St. Francis Hospital and Wesley Medical Center (HCA)
- 20 Residents
- Located in the Air Capital of the World – Wichita, Kansas

8

In the Beginning…

- 2019 – Wellness was starting to be the "buzz" word in GME
- Started asking questions like:
  - What is wellness?
  - As a program, what are we doing well?
  - Are there areas we could improve?

9

Wellness is…

10

- Annual Resident Retreat (Social Wellness)
- Paperwork Day (Emotional Wellness)
- Chief Rounds (Social Wellness)
- Card for Major Life Events (Emotional Wellness)
- Protected Study Time in the Afternoon (Intellectual Wellness)

We could do more!!! But what??

11

- Blasting Out Life Events
- Celebrating Birthdays
- Finding local speakers who discussed
  - Resilience
  - Stress Management
  - Financials as a Physician
- Faculty Involvement:
  - "The White Coat Investor" Book
  - Hot Yoga

12

Wellness now…

- April 2022 – Wellness is a common discussion in GME
- Started looking into wellness again
- Asking some of the same questions:
  - What are we doing well?
  - Are there areas we could improve?

Are we providing our residents the wellness tools to succeed not only in residency, but in life after residency?

13

Wellness Program:

- 3-year program
  - Completed during the CA years
- Focusing on 4 areas of wellness
- 2 lectures/activities for each of the 4-focus areas
  - For a total of 8 lectures/activities per CA year

14

- **Emotional/Intellectual Wellness**
  - Resilience, Stress Management, Conflict Resolution, Communication Skills, Test/Board Prep Skills, Work/Life Balance, Time Management Skills, Etc.
- **Physical Wellness**
  - Creating Healthy Eating Habits, How to Create Your Own Workout Routine, Hot Yoga, Gym Access, 5k/Half Marathon Race Teams, Cooking Classes, Etc.
- **Social Wellness**
  - Volunteering in the Community, Family Events, Golf Tournament with Attendings, The Amazing Race – Resident Style, Etc.
- **Financial Wellness**
  - Finances as a Resident, Student Loan Management/Loan Repayment Strategies, Overall Money Management, Investment Opportunities, Etc.

15

But what if….?

16

- Be a Facilitator
- Be a Safe Place
- Find Easy/Inexpensive Ways to Highlight Residents

- Look for Resources Within Your Department and Community
- Survey Your Residents
- Have Fun

17

18

19

HANDOUT

Snap Talks: Institutional Racism – What Is This? And How Does It Affect Your Trainees?

Rena Gresh, C-TAGME, GC-MedEd

Friday, November 11
9:30 AM – 9:45 AM

Institutional Racism:

What is this?

And how does it affect your trainees?

Rena Gresh, C-TAGME
Education Coordinator
University of Rochester
Department of Anesthesiology and Perioperative Medicine

Medicine of the Highest Order

1

Trigger Warning

Trigger topics: Racism, Slavery, Human Experimentation

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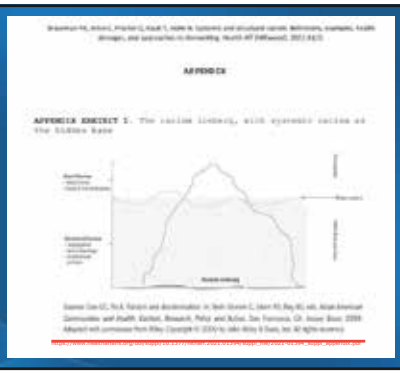

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Institutional Racism


Systemic **Structural** **Ingrained**

Medicine of the Highest Order

4

"Systemic racism is so embedded in systems that it often is assumed to reflect the natural, inevitable order of things."

Braveman, P. A. et al. (2022, February)

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5

Origins of today's Institutional Racism

2022

1520 First documented enslaved persons voyage to North America

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6

Atlantic Slave Trade

Image source: https://www.washingtonpost.com/history/2019/04/29/she-was-captured-enslaved-years-ago-now-angela-symbolizes-brutal-history/ Graphics by Lauren Tierney and Armand Emamdjomeh. Map and chart data sourced from

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7

Origins of today's Institutional Racism

1520 — 2022

1700 20,000 enslaved people in North American with 20,000 more arriving annually

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Origins of today's Institutional Racism

1520 — 1700 — 2022

1776
- Revolutionary War
- 550,000 chattel slaves in North America (20% of USA population)

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Origins of today's Institutional Racism

1520 — 1700 — 1776 — 2022

1807 Slave importation legally prohibited

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Origins of today's Institutional Racism

1520 — 1700 — 1776 — 1807 — 2022

1835 Barnum's Displays

1810 "Hottentot Venus"

1906 Bronx Zoo Monkey House Display

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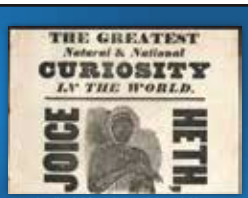

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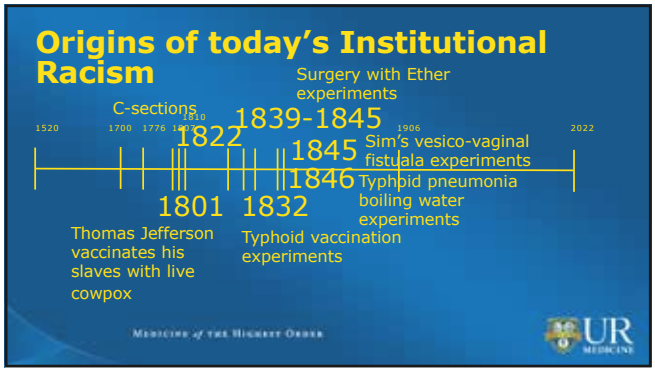

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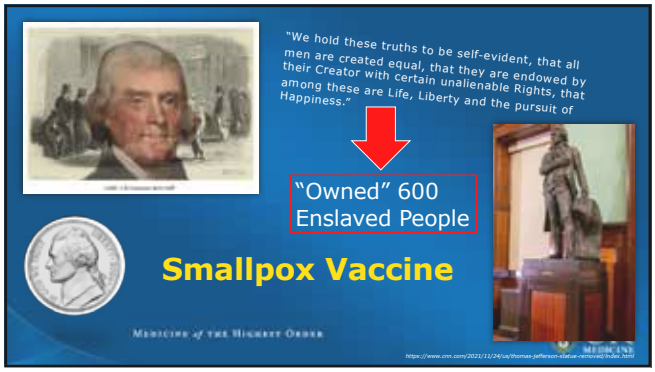

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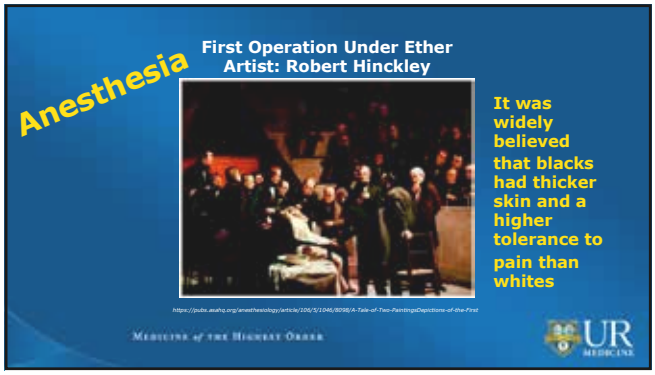

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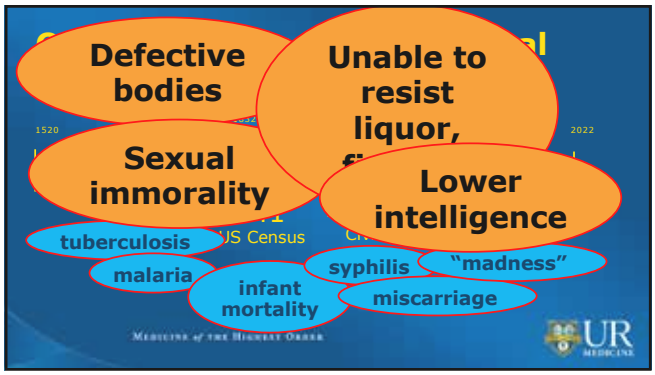

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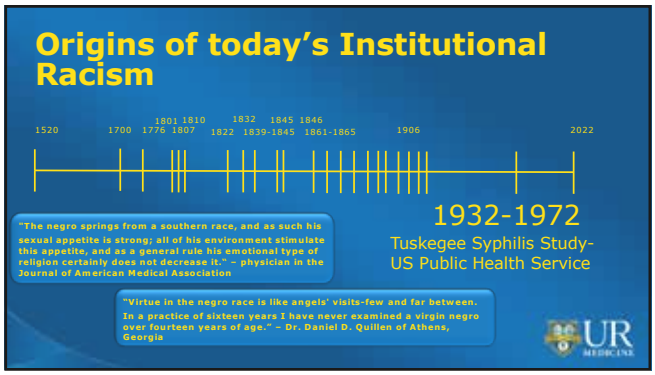

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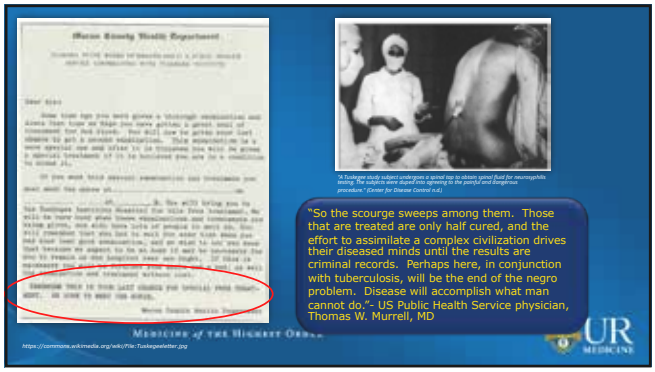

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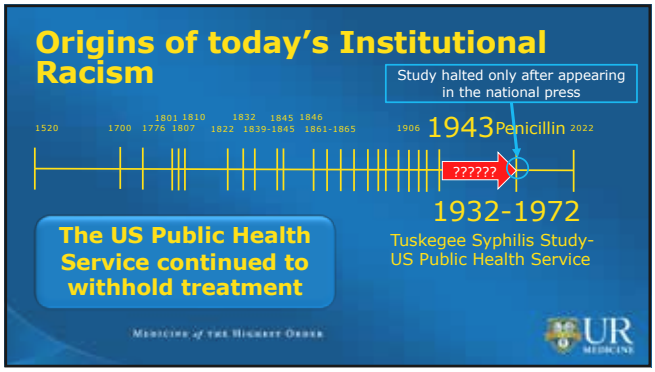

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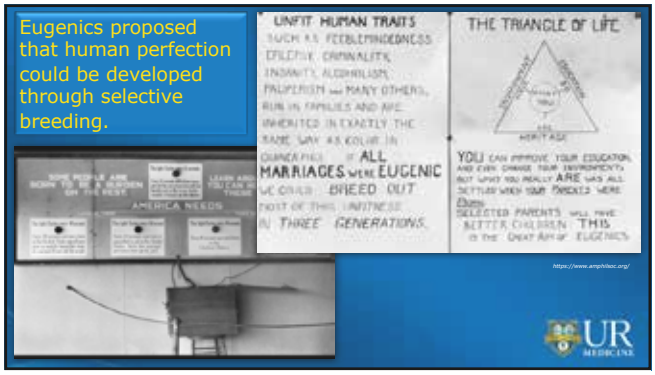

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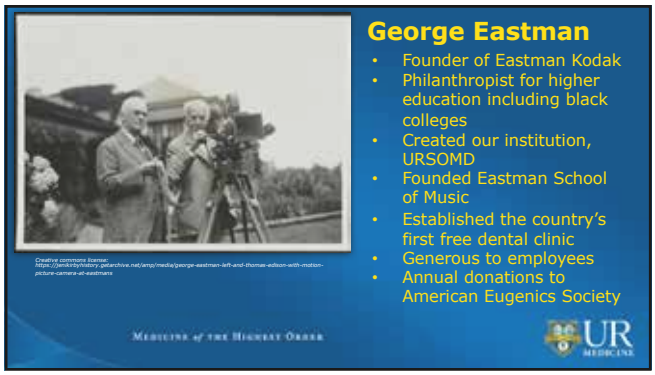

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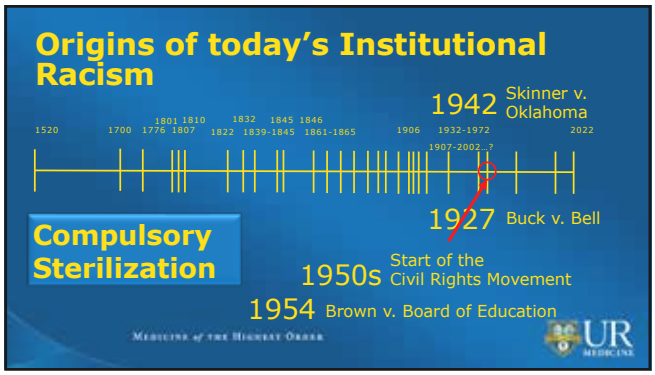

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Skinner v. Oklahoma
Desegregation

Fannie Lou Hamer & Mississippi Appendectomies

Creative Commons License: https://www.womenshistory.org/education-resources/biographies/fannie-lou-hamer

Medicine of the Highest Order

25

https://www.aeihs.org/eugenics-and-the-modern-conservative-movement/

Medicine of the Highest Order

26

Origins of today's Institutional Racism

1520 | 1700 | 1776 1801 1807 1810 | 1822 1832 | 1839-1845 1845 1846 | 1861-1865 | 1906 | 1907-2002...? 1927 1932-1972 1942 1954 | 2022

1929
Margaret Sanger

Forced Contraception

Medicine of the Highest Order

27

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Margaret Sanger

- Endorsed the 1927 Buck v. Bell decision
- Toppled Comstock laws against contraceptive distribution
- Quoted W.E.B. Du Bois, the founder of the National Association for the Advancement of Colored People, **"The mass of ignorant Negroes still breed carelessly and disastrously, so that the increase among Negroes, even more than the increase among whites, is from that portion of the population least intelligent and fit, and least able to rear their children properly."**
- Supported development of birth control pill
- Founder of Planned Parenthood
- Formed Birth Control Federation of America and the Negro Project, the latter bringing "family planning centers" to predominately black areas while seeking the best way of reducing black populations by promoting eugenic principles.
  - In 1972, 40% of blacks surveyed by the American Journal of Public Health believed birth-control clinics were a ploy to eradicate blacks

Birth Control Pill

Medicine of the Highest Order

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Origins of today's Institutional Racism

1520 | 1700 | 1776 1801 1807 1810 | 1822 1832 | 1839-1845 1845 1846 | 1861-1865 | 1906 | 1907-2002...? 1927 1929 1932-1972 1942 1954 | 2022

1942-1945
Manhattan Project

Medicine of the Highest Order

29

Manhattan Project

Purpose: Non-consensual experiments to determine the amount of radiation US soldiers could withstand in the case of nuclear war.

Creative Commons License: https://garystockbridge627.getarchive.net/amp/media/plutonium-ring-7b7f73

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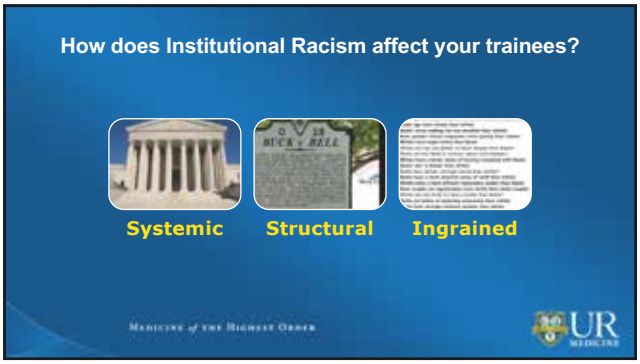
How does Institutional Racism affect your trainees?
Systemic
Structural
Ingrained
UR

31


Courage
Adversity
Diligence
UR

32


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Snap Talk: Institutional Racism – What Is This? And How Does It Affect Your Trainees?

Presenter

Rena Gresh, C-TAGME
Education Coordinator
University of Rochester
Department of Anesthesiology & Perioperative Medicine
Rena_Gresh@URMC.Rochester.edu

Goal

Coordinators and administrators play an integral role in trainees' professional development. Understanding the historical roots of racism within our country and the long lasting impacts on medicine and medical education, coordinators will gain comfort in facilitating conversations and guiding crucial interactions with trainees.

Learning Objectives

1. Upon completion of this SNAP talk, participants will be able to define institutional racism.
2. Upon completion of this SNAP talk, participants will be able to identify institutional racism within their own communities.
3. Upon completion of this SNAP talk, participants will understand how the history of the United States has contributed towards modern era's institutional racism.
4. Upon completion of this SNAP talk, participants will be able to evaluate the impact of institutional racism on their trainees.

HANDOUT

Snap Talks: GroundHog Day: A Yearly Cycle of Graduate Medical Education Administrative Work

Jannot Ross

Friday, November 11
9:45 AM – 10:00 AM

A Yearly Cycle of Graduate Medical Education Administrative Work

It's Groundhogs Day!

1

About me

- Jannot Ross, Director of Education for Anesthesia and Perioperative Care, University of California San Francisco
- 20 years experience working in Graduate Medical Education
- 6 years experience working in Anesthesia Education
- Groundhogs Day maybe one of my favorite movies.

2

Disclosures

I have no conflicts of interest.

3

Learning Objectives

- Understand the yearly cycle of ACGME Trainee Programs
- Understand the complexity of GME administrative work
- Have fun!

4

When poll is active, respond at **pollev.com/jjr**
Text **JJR** to **22333** once to join

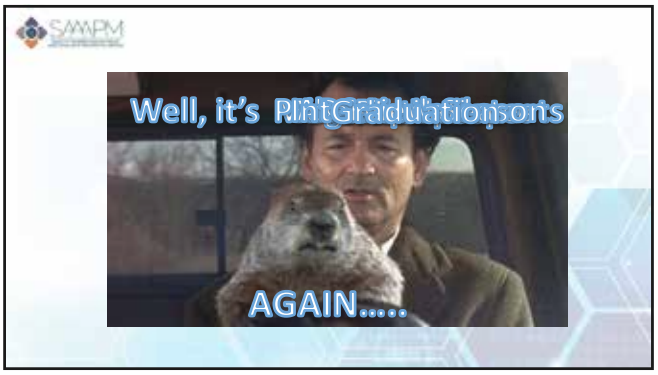
How long have you been in your position?

5 or more years
3 years
1- 2 years
This is my first year!
None of the above

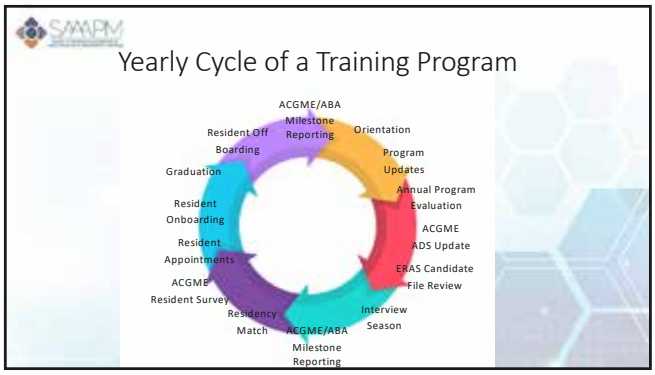
Powered by Poll Everywhere

5

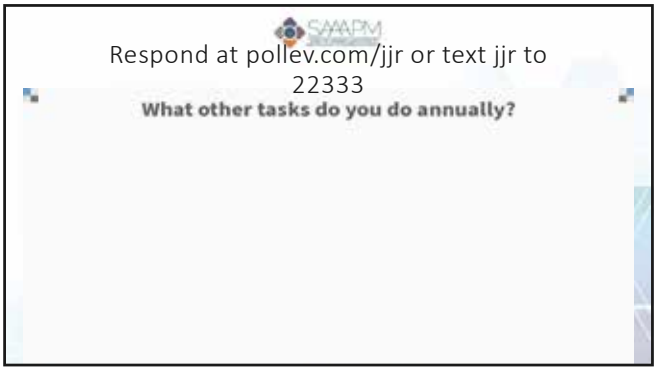
6


Well, it's that time of year
AGAIN.....

7


Yearly Cycle of a Training Program
ACGME/ABA Milestone Reporting
Orientation
Program Updates
Annual Program Evaluation
ACGME ADS Update
ERAS Candidate File Review
Interview Season
ACGME/ABA Milestone Reporting
Residency Match
ACGME Resident Survey
Resident Appointments
Resident Onboarding
Graduation
Resident Off Boarding

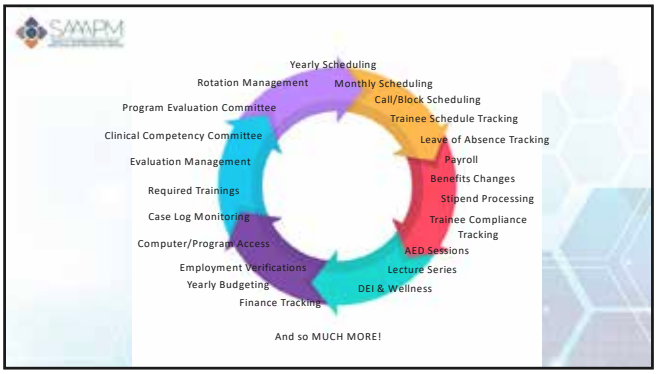
8


Respond at pollev.com/jjr or text jjr to 22333
What other tasks do you do annually?

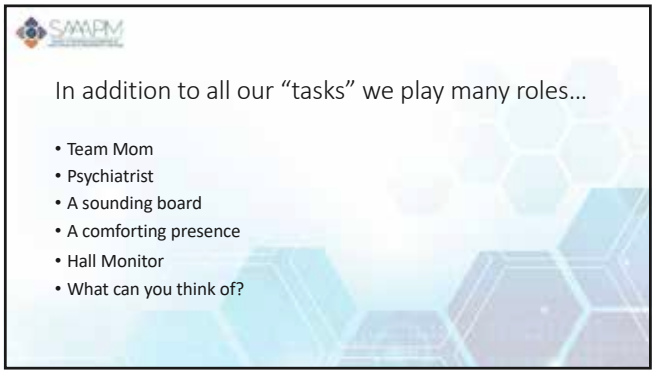
9


DIDN'T WE DO THIS YESTERDAY?
#GroundhogDay

10


Yearly Scheduling
Monthly Scheduling
Call/Block Scheduling
Trainee Schedule Tracking
Leave of Absence Tracking
Payroll
Benefits Changes
Stipend Processing
Trainee Compliance Tracking
AED Sessions
Lecture Series
DEI & Wellness
Finance Tracking
Yearly Budgeting
Employment Verifications
Computer/Program Access
Case Log Monitoring
Required Trainings
Evaluation Management
Clinical Competency Committee
Program Evaluation Committee
Rotation Management
And so MUCH MORE!

11


In addition to all our "tasks" we play many roles…
• Team Mom
• Psychiatrist
• A sounding board
• A comforting presence
• Hall Monitor
• What can you think of?

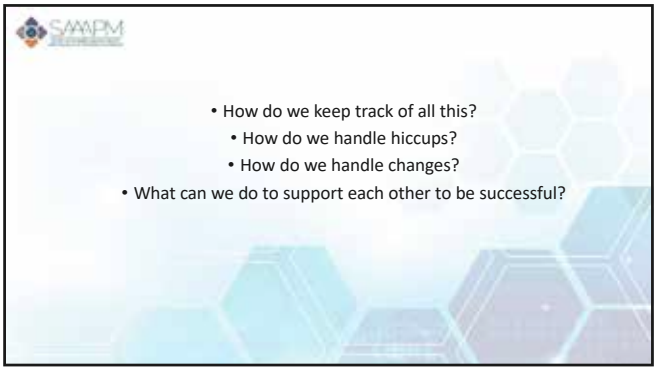
12


What other roles do we play?

13


I GET A FEELING
WE HAVE BEEN HERE BEFORE

14


• How do we keep track of all this?
• How do we handle hiccups?
• How do we handle changes?
• What can we do to support each other to be successful?

15


Questions?

16

HANDOUT

AAPAE Community of Practice

Moderators: Lara Zisblatt, EdD, MA, PMME & Faye Haggar, EdD

Friday, November 11
10:15 AM – 11:15 AM

Sense of Community
AAPAE Annual Meeting

Faye Haggar, EdD
Lara Zisblatt, EdD

1

Why is community important?

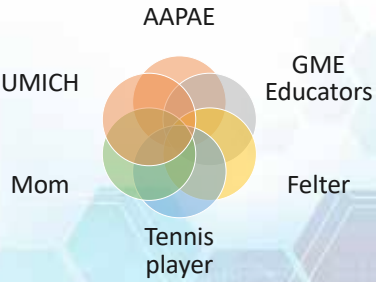
- Promote mental,
- Physical, and social well-being
- Productivity in the workplace
- Feelings of job satisfaction and fulfillment

Helliwell JF, Putnam RD. The social context of well-being. *Philos Trans R Soc Lond B Biol Sci*. 2004;359(1449):1435-46.

Chavis DM, Pretty GM. Sense of community: advances in measurement and application. *J Community Psychol*. 1999;27(6):635-42.

2

What are your communities?



3

What communities can you help build?

- Yours!!!
- For residents, faculty, staff

4

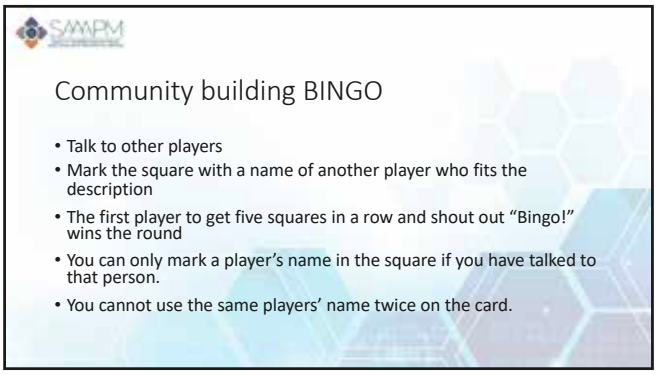
How to build community

- Reinforcement of Needs
  - *Get my needs met, share needs*
- Membership
  - *Community is part of my identity, I spend time with this community*
- Influence
  - *Community can solve problems, I can influence my community*
- Shared Emotional Connection
  - *Care about each other, celebrate together*

5

Time to play!!!

6


Community building BINGO
• Talk to other players
• Mark the square with a name of another player who fits the description
• The first player to get five squares in a row and shout out "Bingo!" wins the round
• You can only mark a player's name in the square if you have talked to that person.
• You cannot use the same players' name twice on the card.

7


Evaluation

8

HANDOUT

Justice, Equity, Diversity & Inclusion (JEDI) Panel

Moderator: Lucine Torosian, BS

Friday, November 11
11:15 AM – 11:45 AM

HANDOUT

Justice, Equity, Diversity & Inclusion (JEDI) Panel: Why Diversity, Equity and Inclusion Matters: Living Our Values

Kimberly J. Ward, MBA

Friday, November 11
11:15 AM – 11:25 AM

Why Diversity, Equity and Inclusion Matters: Living Our Values

Kimberly J. Ward
DEI Administrative Specialist and DEI Lead
Michigan Medicine
Department of Anesthesiology

1

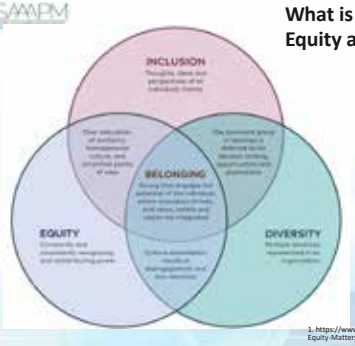
What Are DEI Values?

Equity,
Inclusion,
and **Dignity** for all

What does diversity mean as a value?

2

What is the point of Diversity, Equity and Inclusion (DEI)?



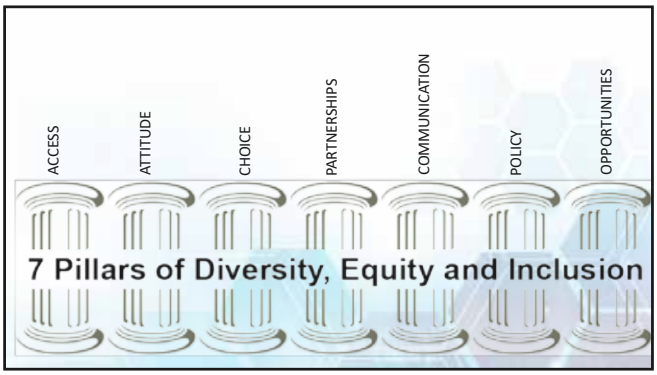
1. https://www.acgme.org/what-we-do/diversity-equity-and-inclusion/ACGME-Equity-Matters/

3

FOUR CORE VALUES OF DIVERSITY, EQUITY, AND INCLUSION

2. DEI Leadership in Psychiatry recommends needed guideline Valerie A. Canady 26March 2021 Recommendations to support diversity, equity and inclusion leadership should include financial, structural and administrative practices https://onlinelibrary.wiley.com/doi/10.1002/mhw.32738

4



5

ACCESS
Access explores the importance of a welcoming environment and the habits that create it.

ATTITUDE
Attitude looks at how willing people are to embrace inclusion and diversity and to take meaningful action.

CHOICE
Choice is all about finding out what options people want and how **they want to get involved.**

PARTNERSHIPS
Partnerships looks at how individual and organizational relationships are formed and how effective they are.

COMMUNICATION
Communication examines the way we let people know about the options to get involved and about the culture.

POLICY
Policy considers how an organization commits to and takes responsibility for inclusion.

OPPORTUNITIES
Opportunity explores what options are available for people from disadvantaged backgrounds.

6

"All Learners…"benefit from seeing themselves mirrored in the front of the classroom."

Diverse representation and inclusive learning environments provide inspiration and aspiration and help students believe, 'I can be there, or I can achieve through thoughtful leadership in the profession I choose."

Nancy Aebersold, founder and executive director of the Higher Education Recruitment Consortium (HERC). https://www.wiche.edu/resources/recruiting-retaining-talented-diverse-faculty-its-all-about-community/

7

8

Citations

1. https://www.acgme.org/what-we-do/diversity-equity-and-inclusion/ACGME-Equity-Matters/
2. *2. DEI Leadership in Psychiatry recommends needed guideline Valarie A. Canady 26March 2021 Recommendations to support diversity, equity and inclusion leadership should include financial, structural and administration practices.* https://onlinelibrary.wiley.com/doi/10.1002/mhw.32738
3. Nancy Aebersold, founder and executive director of the Higher Education Recruitment Consortium (HERC). https://www.wiche.edu/resources/recruiting-retaining-talented-diverse-faculty-its-all-about-community/
4. Kimberly J Ward Word Cloud Generator

9

HANDOUT

Justice, Equity, Diversity & Inclusion (JEDI) Panel: Challenges and Solutions to Safe Reporting

Erin Wood, MS, C-TAGME

Friday, November 11
11:25 AM – 11:35 AM

Challenges & Solutions to Safe Reporting

Erin Wood, MS, C-TAGME
Coordinator Education Development
Washington University School of Medicine in St. Louis

1

Who am I?

- Program coordinator; Washington University School of Medicine
- 4 Years
- Graduated 60 residents, another 80 in training

Questions? Reach me at:
Erin.wood@wustl.edu

2

What is Reporting?

#1 - Feedback

Helpful information or criticism that is given to someone to say what can be done to improve a performance, product, etc.

- The Britannica Dictionary

#2 - Reporting

Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing concerns.

- ACGME Common Program Requirements

3

Things Heard in My Office

4

Things Heard in My Office

"I heard one of the faculty making really racist comments to another team member in the breakroom, and they knew I was nearby. I don't feel safe around them anymore."

"I don't want to become a target"

5

Things Heard in My Office

"My attending grabbed me to reposition my body for a technique I was struggling with, without any warning. I really startled me, and I feel super uncomfortable around them now."

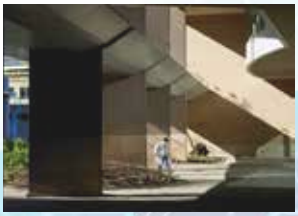
"No one else has a problem with it. I don't want to say something and accidently damage their career…or mine."

6

Things Heard in My Office

"Oh, Dr. X? They're always condescending and verbally abusive to the trainees."

"Dr. X has been here forever – no one is going to do anything about it, so why bother?"



7

Effective Reporting…How?

8

Step One: Identify the Problem

Started with a Goal: To work towards a safe, enjoyable work environment for ALL staff.

Scope: Our Department

Responsibility: Lies with us – anyone in a role of leadership or authority in the department.

9

Step Two: Check for Existing Solutions

WashU Med

SAFE

Supporting a Fair Environment

- A university-wide, safe reporting system
- Reports go to a review committee who reviews, responds
- Portal allows anonymous reporting, and to receive follow-up anonymously

10

Step Three: Adapt and Build New Solutions

PIA SAFE

Peers in Anesthesiology Supporting a Fair Environment

Peer-based program to help address concerns about negative behaviors, conflicts, and microaggressions experienced by members of the department.

11

Step 4: Implementation - PIA Safe

Department Role	# Champions
Chair	1
Vice Chair	4
Division Chief	2
Faculty	12
CRNA	3
RN	1
Trainee	10
Non-Clinical Support Staff	4
Total =	37

PIA Safe Champions are trained in:

1. Listening skills & navigating difficult conversations
2. Bystander & feedback training
3. Recognizing and addressing microaggressions, bias, etc.
4. Recognizing and verbalizing positive behavior to reinforce expectations

12

Step Five: Keep Investing in Systems!

Ample Reminders: Systems Exist!

- Both SAFE & PIA SAFE are on our website – easily accessible
- Fliers with QR codes EVERYWHERE
- Verbal Reminders at All Resident Meetings
- Creative Communication

Invest in the Process

- Maintain reporting platform
- Continue training people, and supporting those already trained
- Report on progress! People need to know change is happening.

13

It takes a village…

14

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

15

HANDOUT

Justice, Equity, Diversity & Inclusion (JEDI) Panel: Strategies for Increasing Diversity and Supporting URM Trainees

Marisa E. Hernandez-Morgan, MD, MPP

Friday, November 11
11:35 AM – 11:45 AM

Strategies for Increasing Diversity and Supporting URM Trainees

Marisa Hernandez-Morgan, MD, MPP
AAPAE November 11, 2022

1

Outline

- Strategies for Increasing Diversity in Residency Programs
- The URM resident experience
- How to support URM trainees

2

Strategies for Increasing Diversity in Residency Programs

- Diversity oriented recruitment strategies
  - Preparing faculty and residents for recruitment
    - Implicit bias training for program leadership, recruitment committee members and interviewers
  - Holistic review
  - Strategic visibility on interview day
    - Plan for continued mentorship

3

What does this mean for current trainees?

- Recognize that the burden of increasing diversity often falls disproportionately on URM residents and faculty

4

Minority Tax

- Minority Tax
  - Encompasses disparities in the areas of isolation, mentorship, diversity efforts, and clinical assignments
- Gratitude tax
  - Feeling of obligation that URM physicians have to the academic institution and to future generations of URMs for being given the opportunity to be a physician

5

Resident Experience

- Isolation
- Support Systems and Community
- Expectations
- Imposter Syndrome
- Microaggressions and bias

6

- "You don't want to give anyone a reason to think that you are not up to par. You always want to be better. It's not the same if your peers are better. Not allowing anyone to say or think that you are less than what you actually are capable of because of your race. I have always had high expectations of myself…because of this added pressure."
- I think [city] is kind of isolating…and so when we go to restaurants or out to do whatever we don't see a lot of… UiM and that is why my husband and I will not stay here…we don't want to feel isolated. We don't want our kids to feel isolated.
- …If we had like a support system, somebody that we can fall back on, yes people say we should be accepted, but we do face discrimination. But if you had someone at the higher level that you can talk to that puts checks in place and can help you, you don't feel like you are just out there on your own…"
- "To have mentorship from someone of a similar background…you can have good rapport with your colleagues, but if you can't see someone who has made it through that journey and represents that similar background to your own, then I think that's part of what's needed for under represented residents in general."

Harris R et al. J Grad Med Educ. 2021

7

Table 3. Total Number of Resident Physicians in Program Year 1 Positions and in Postgraduate Year 1 (PGY-1) Positions on Duty as of December 31, 2020, in ACGME-Accredited Programs and in Combined Specialty Programs

Specialty/subspecialty	Total No. of residents[a]	No. of residents in program year 1 position[a]	No. of residents in PGY-1 positions[b]	
			With prior US GME	Without prior US GME
Allergy and immunology	316	252	0	0
Anesthesiology	6388	1514	123	1167
Adult cardiothoracic anesthesiology	200	180	0	0
Clinical informatics	1	0	0	0
Critical care medicine	204	178	0	0
Obstetric anesthesiology	42	42	0	0
Pediatric anesthesiology	166	164	0	0
Regional anesthesiology and acute pain medicine	74	74	0	0

Brotherton S, Etzel S. JAMA. 2021

8

Table 8. Race and Ethnicity of Resident Physicians in ACGME-Accredited and in Combined Specialty Graduate Medical Education (GME) Programs on Duty as of December 31, 2020, by Specialty

Specialty/subspecialty	No. of resident physicians[a,b]								
	American Indian/ Alaska Native	Asian	Black	Hispanic ethnicity	Native Hawaiian/ Pacific Islander	White	Multiracial	Other/ unknown	Total
Allergy and immunology	0	105	7	27	2	138	12	52	316
Anesthesiology	13	1606	146	514	6	3387	249	581	6388
Adult cardiothoracic anesthesiology	0	32	7	12	2	108	1	50	200
Clinical informatics	0	0	0	0	0	1	0	0	1
Critical care medicine	1	34	9	17	1	107	0	52	204
Obstetric anesthesiology	1	6	2	1	0	21	1	12	42
Pediatric anesthesiology	0	30	5	16	1	88	0	62	166
Regional anesthesiology and acute pain medicine	0	13	5	3	1	35	2	18	74

Brotherton S, Etzel S. JAMA. 2021

9

How do we support URM trainees

- Support mechanisms, confidential peer reporting and counseling
- Mentorship
  - Early and ongoing
  - URM faculty and other trainees
  - Single mentor may not be enough
- Department and institutional commitment to creation of an inclusive and equitable learning environment
  - Commitment to anti-racism

10

References

- Crites K, Johnson J, Scott N, Shanks A. Increasing Diversity in Residency Training Programs. Cureus. 2022;14(6):e25962.
- Brotherton S, Etzel S. Graduate Medical Education, 2020-2021. JAMA. 2021;326(11):1088-1110.
- Yemane L, Omoruyi E. Underrepresented in medicine in graduate medical education: Historical trends, bias, and recruitment practices. Curr Probl Pediatr Adolesc Health Care. 2021;51(10):101088.
- Harris R, Covington K, Colford C, Denizard-Thompson N, Contarino M, Evans K, Zaas A, Kraemer MS, McNeill D. Focusing on Diversity: A Regional Internal Medicine Residency Viewpoint on Underrepresented Minority Support, Retention, and Mentoring. J Grad Med Educ. 2021 Apr;13(2):181-188.
- Gathers C, Mateo CM, Sox C. Implementing and Assessing a Resident Diversity Council to Address the Need for a Diverse Clinical Workforce. JAMA Netw Open. 2022 Oct 3;5(10):e2238240.
- Butler PD, Fowler JC, Meer E, Rosen JM, Reyes JM, Berns JS. A Blueprint for Increasing Ethnic and Racial Diversity in U.S. Residency Training Programs. Acad Med. 2022;97(11):1632-1636.
- Campbell, Kendall M. MD; Rodríguez, José E. MD. Addressing the Minority Tax: Perspectives From Two Diversity Leaders on Building Minority Faculty Success in Academic Medicine. Academic Medicine. 2019.94(12):1854-1857.

11

HANDOUT

AAPAE Lunch Round Tables Table 1: Managing Multiple Programs

Lucine Torosian, BS

Friday, November 11
12:20 PM – 1:00 PM

HANDOUT

AAPAE Lunch Round Tables Table 2: Work - Life Balance During COVID

Lara Zisblatt, EdD, MA, PMME

Friday, November 11
12:20 PM – 1:00 PM

The Journal of Education in Perioperative Medicine

Original Research

Improving Administrator and Educator Sense of Community in Anesthesiology Graduate Medical Education

Lara Zisblatt, EdD, MA
Leslie Coker Fowler, MEd
Amy DiLorenzo, MA
Debi Stabler, MEd
Aleda M. Leis, MS
Amy Miller Juve, EdD, MEd

Introduction

The Accreditation Council for Graduate Medical Education (ACGME) has made a call to action. Through the changes in the Common Program Requirements, the ACGME has made it clear that they are committed to overtly addressing physician well-being for individuals in graduate medical education (GME).[1] With the ACGME increasing its focus on the wellness of residents and fellows, there has also been a call for improving the wellness of administrators of GME.[2] Preliminary studies about program coordinators' wellness have demonstrated issues with coordinators being undersupported and overworked.[3,4] The argument is that improving the learning environment, requires programs to advocate for the wellness of all members of that environment, including faculty, nurses, and administrative staff.

Administrators and educators in GME can often be isolated in performing all the duties necessary to the management and development of residency and fellowship programs. While they may have connections to other administrators or educators in their institutions, the requirements and work environment of each specialty make it difficult to develop working relationships with those from other specialties. GME programs may only have 1 or 2 administrators working for a department; further, only a handful of departments across the country employ an educator. This leaves many administrators and educators to work in relative isolation. More than any other factors, research has shown that social capital, connectedness, and a sense of community promote mental, physical, and social well-being, as well as productivity in the workplace and feelings of job satisfaction and fulfillment.[5,6] While the ACGME does host program coordinator sessions during its annual meeting and has introduced specialty-specific new coordinator workshops, they do not have a mechanism for continued, ongoing interactions among coordinators.

In April 2015, the Society of Academic Associations of Anesthesiology & Perioperative Medicine (SAAAPM) council agreed to support the formation of Association of Anesthesiology Program Administrators and Educators (AAPAE) for a 3-year trial period. At that time, there were no anesthesiology-specific organizations that promoted and supported educators and administrators of residency and fellowship programs. Members of the AAPAE include both administrators, those who are program coordinators, administrative directors, and other managers of GME programs, and educators, who are non-physicians who provide support and guidance. These individuals are involved in anesthesiology residency or fellowship training programs at academic medical centers where the departments are members of SAAAPM. The SAAAPM includes 4 different associations for Department Chairs, Residency Program Directors, Fellowship Program Directors, and the newly formed AAPAE. Membership dues are paid at the department level, and any number of members can be added with no additional cost.

The AAPAE's main goal was to create a community for administrators and educators to help them develop professional connections, share ideas, and support each other in their work for GME programs. The literature on Sense of Community reported by McMillan[7] and Chavis[6] was used as an underlining theoretical framework to help design appropriate interventions. Interventions were meant to include the major domains of Sense of Community, including affirming and meeting the needs of the group, recognizing and celebrating membership, allowing members to actively participate in all aspects of the community, and fostering emotional connections through sharing of experiences.[7] This study was developed to determine if interventions designed to create feelings of connection were effective in augmenting a sense of community among the members of this newly formed association.

Materials and Methods

Intervention

In 2014, two authors (A.M.J., D.S.) developed a survey to assess the need for a program administrator association within anesthesiology. They sent their survey to all 124 program anesthesiology coordinators listed on the Fellowship and Residency Electronic Interactive Database Access (FREIDA) website via SurveyMonkey.com. Out of the 124 coordinators who received the survey, 76 (61%) responded. Of those respondents, 67 (89%) said they were interested in becoming members of a national

continued on next page

continued from previous page

anesthesiology program administrator organization. Furthermore, all comments received were in support of creating a national administrator organization. These data, along with a proposal for the creation of the group, was submitted to the SAAAPM, and in April 2015, the AAPAE was formed.

After its creation, over a 2-year period, the AAPAE implemented a series of interventions that were meant to foster a sense of community. This included development of a leadership structure, inclusion of a track for administrators and educators in the annual national SAAAPM meeting, a coaching program, a Facebook group for sharing information and asking questions, distribution of pins with the AAPAE logo, and social gatherings for AAPAE members at national conferences. Announcements about the creation of the AAPAE, as well as updates about its work, are included in the monthly emails distributed to all SAAAPM members.

The leadership structure of AAPAE mirrors that of the other 3 SAAAPM associations and includes 8 council positions: President, President-Elect, Secretary, Past-President, and four other council members in charge of the Coaching Program, Membership, Marketing, and Assessment. Council members are elected by AAPAE members to vacant seats each year for a 2-year term prior to the national meeting in November. All members are eligible to run for council positions via self-nomination or peer nomination.

The SAAAPM and its associations have an annual 2-day meeting in November. Each association meets individually for the first day of the conference, with all associations meeting together for the second day. From 2016-2018, the AAPAE-specific meeting included sessions such as analyzing data for the clinical competency committee, creating wellness programs, and developing the annual program evaluations. The group was split into special interest roundtables and included icebreakers, which allowed the membership to interact in both formal and informal settings to develop professional and personal relationships. Lapel pins with the AAPAE logo were distributed during the meeting to augment feelings of membership and belonging. In addition, the AAPAE held social events at the SAAAPM annual meeting, the American Society of Anesthesiology annual meeting, and the ACGME annual meeting.

The coaching program is a voluntary program that matches more experienced professionals with novice members. The private Facebook group was created to allow all AAPAE members to ask questions, share experiences, and offer advice. In addition, there is an AAPAE specific section in the SAAAPM monthly newsletter that is emailed to all members.

All of the previously described interventions were designed to help members interact, create connections, share resources, and network with other professionals doing similar work so that they could call on the community for help and support.

Survey

In February 2016 and again in January 2018, using the validated, 24-item Sense of Community Index version 2 (SCI-2),[2] AAPAE council surveyed its members to elicit responses about their sense of community within AAPAE. The SCI-2 is the most popular empirical measure of sense of community in community psychology, and while the theoretical foundation and factorial structure of concepts included in studying sense of community are still under investigation, this index remains the standard tool for measuring a sense of community for a specific group, whether that be a neighborhood, virtual community, or workplace environment.[8] The goal of the survey was to determine if the association was successful in building collegiality and community among our members 2 years after its creation. The survey includes a total score that assesses the sense of community overall and within 4 separate categories: reinforcement of needs, influence, membership, and shared emotional connection.[9]

Continuous data were assessed for normality using a Kolmogorov-Smirnov test. Comparisons between pretests and posttests were made using Mann-Whitney *U* tests. SAS version 9.3 (SAS Institute, Cary, NC) was used for all statistical analysis. A *P* value < .05 was considered statistically significant for all analyses conducted.

This study received approval by Vanderbilt Institutional Review Board (#172017).

Results

Association Growth and Development

Annual membership for the AAPAE grew from 169 members in 2016 to 211 members in 2017, a 25% increase. In 2016 and 2017, 94% and 93% of SAAAPM departments, respectively, had at least 1 administrator or educator registered as a member of AAPAE. Based on the titles submitted in the application for membership in 2016, the AAPAE included 111 coordinators, 41 general administrators, 8 administrative directors, and 9 educators. In 2017, membership included 123 coordinators, 50 general administrators, 11 administrative directors, 10 educators, and 17 who did not disclose a title. Since its inception, there have been 10 different council members, which included a combination of educators and administrators. The AAPAE hosted 73 members at the 2016 SAAAPM annual meeting and 95 members at the 2017 SAAAPM annual meeting, a 30% increase in attendance. The coaching program included 16 pairs that have been voluntarily matched based on their positions within their institutions and their areas of interest or expertise.

As of March 2018, the Facebook group had 123 members. Members write posts about topics such as how to draft alumni surveys, ideas for interview season, how to collect information about scholarly activity, and the new ACGME common program requirements. In addition, members share their experiences, such as proctoring the anesthesiology In-Training Exam and preparing for the Training Administrators of Graduate Medical Education (TAGME) certification exam.

Survey on Sense of Community

Seventy-four members (44% of 2016 membership) took the survey in February 2016, and 87 members (42% of 2017 membership) took the survey in January 2018. There was an increase of the sense of community between the pretest and posttest scores for all subscales and the total sum score ($P < .001$ for all). The reinforcement of need subscale increased by a median of 4.5 points (IQR: 7.5 to 12.0). The influence subscale increased by a median of 4 points (IQR: 7.0 to 11.0). The membership subscale increased by a median of 3.5 points

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(IQR: 8.5 to 12.0), and the shared emotional connection subscale increased by a median of 3.0 points (IQR: 7.0 to 10.0). The total sum score increased a median of 11.5 points from a median of 27.5 (IQR: 17.0 to 39.0) to 39.0 (IQR: 27.0 to 53.0). Results from the total sum score and subscales are presented in Table 1.

A total of 10/24 (42%) individual items had improvement postintervention. Table 2 shows the responses for all items of the SCI-2 preintervention and postintervention and what questions had significantly different scores preintervention versus postintervention. The most significant changes were seen in the items: "When I have a problem, I can talk about it with members of this community"; "This community has been successful in getting the needs of its members met"; "I have influence over what this community is like"; "This community has good leaders"; "If there is a problem in this community, members can get it solved"; and "This community has symbols and expressions of membership such as clothes, signs, art, architecture, logos, landmarks, and flags that people can recognize" ($P = < .001$).

Discussion

Anesthesiology administrators and educators often work in relative professional isolation within their own institutions. Creating community can allow these individuals to connect with others across the country who share similar professional roles, interests, and issues. A combination of web-based (e.g., Facebook, email) and face-to-face (e.g., annual meeting, social gatherings) interactions allowed the AAPAE to successfully instill a sense of community among its members through an intentional facilitated effort over a 2-year period. While some may view the interventions to create a sense of community as necessary steps in establishing a new organization, reporting the details of this organization's accomplishments could guide others who seek to do the same. An increase in sense of community for a new organization cannot be assumed as the natural effect of creating a new organization—especially in this case, in which it is possible for administrators or educators to be added to the group without any action on their part.

Some factors contributed to the early success of the AAPAE: First, the SAAAPM is a group of associations for different stakeholders in academic anesthesiology. While it was started as an organization for department chairs, it opened its membership to core and subspecialty program directors, paving the way for the administrators and educators to propose the creation of an association for themselves. Second, since the membership fees are solicited department by department, AAPAE membership does not require additional funding, aside from registration fees associated with the annual meeting.

Some barriers to the success of the group included program directors concerns about attending the annual meeting during interview season, which may have prevented some AAPAE members from attending the annual meeting. Also, registration fees, travel, and lodging expenses to attend the meeting may be a real barrier to attendance. In addition, membership in the organization is not individual, so there might be some administrators or educators who are interested in membership but their departments are not members of SAAAPM. Further, some chairs and program directors are unaware of the AAPAE or do not see its value and therefore have not added administrators or educators from their departments to the membership group.

Through the development of the association, many administrators and educators were able to connect to other professionals who face similar challenges and opportunities. The group has been able to share their experiences and build a community that can support them in their own development. While the connection of the creation of this community to any improvement in wellness of its members is purely theoretical, the significant increases in the sense of community is the first step associating the development of such organizations to improvement in well-being.

There are limitations to this study: While a large percentage of the membership took the surveys, members who feel a sense of community may be more likely to complete the survey. The survey was anonymous, so there was no way to know if an individual's sense of community changed as a result of the interventions. There was also no way to know what interventions actually improved members' sense of community. In addition, it is possible that the creation of a new organization in itself would impact a sense of community. Without a control group of members who did not receive the interventions, there is no way to know if the interventions had more of an impact on the sense of community.

Future directions may include repeating the survey to see the long-term impact of the interventions and investigating whether building a sense of community is helpful in recruitment and retention of anesthesiology administrators and educators. The connection between individual wellness and membership to the community could be investigated. In addition, establishment of this community may serve a model for other specialties. Finally, a qualitative study could be conducted that would interview members of the community and may further explain and define if, how, and why organizations such as ours impact members' wellness.

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This work should be attributed to Department of Anesthesiology, University of Michigan Health System Funding: This study was funded internally through each department of the authors.

Abstract

Background: Research has shown that, more than any other factors, social capital, connectedness, and a sense of community promote mental, physical, and social well-being, as well as productivity in the workplace and feelings of job satisfaction and fulfillment. In April 2015, the Society of Academic Associations of Anesthesiology & Perioperative Medicine (SAAAPM) agreed to support the formation of the Association of Anesthesiology Program Administrators and Educators (AAPAE) to promote collaboration and collegiality among administrators and educators of anesthesiology residency and fellowship programs. This study was designed to determine if a series of interventions were able to promote a sense of community among administrators and educators of anesthesiology residency and fellowship programs.

Methods: From February 2016 to January 2018, the AAPAE implemented a series of interventions designed to foster a sense of community. These interventions included the development of a leadership structure, a coaching program, a Facebook group, distribution of pins with the AAPAE logo, social gatherings for members, as well as the creation of a dedicated track for administrators and educators during the SAAAPM annual meeting. In 2016 and again in 2018, using the validated, 24-item Sense of Community Index version 2 (SCI-2) with a score range of 0-72, AAPAE surveyed its members to assess their sense of community. Continuous data were assessed for normality using a Kolmogorov-Smirnov test. Comparisons between pretests and posttests were made using Mann-Whitney U tests.

Results: Seventy-four of 169 (44%) and 87 of 211 (42%) members took the survey in February 2016 and January 2018, respectively. The total sum score measuring the sense of community increased 11.5 points from a median of 27.5 (IQR: 17.0 to 39.0) to 39.0 (IQR: 27.0 to 53.0, $P < .001$). This shows a significant increase in the average sense of community of AAPAE members.

Conclusions: A combination of web-based and face-to-face interactions allowed the AAPAE to successfully cultivate a sense of community among its members.

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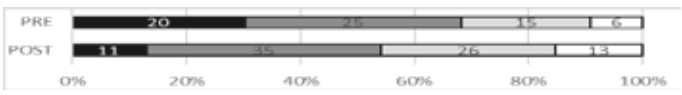
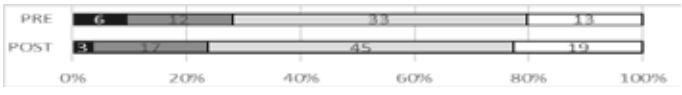
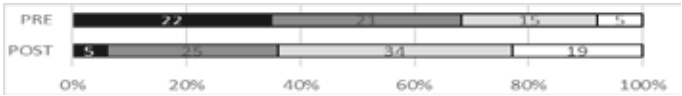
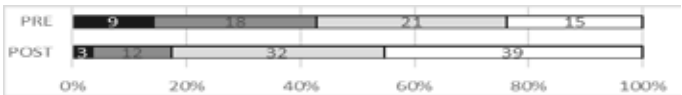
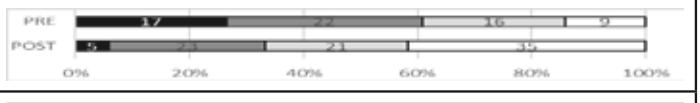
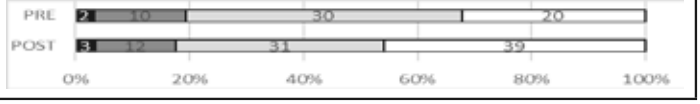
Figures

Table 1. *Results of Presurvey and Postsurvey Using the SCI-2 to Assess Intervention Impact on AAPAE Members' Sense of Community*

SCI-2 Subcategories and Total Score	Preintervention, February 2016 (N=74)	Postintervention, January 2018 (N=87)	*P* Value
Subscale—Influence *(Max score 18)*	7.0 [4.0 to 12.0]	11.0 [8.0 to 15.0]	<0.001
Subscale—Membership *(Max score 18)*	8.5 [4.0 to 12.0]	12.0 [9.0 to 16.0]	<0.001
Subscale—Reinforcement of Needs *(Max score18)*	7.5 [4.0 to 12.0]	12.0 [9.0 to 16.0]	<0.001
Subscale—Shared Emotional Connection *(Max score 18)*	7.0 [3.0 to 11.0]	10.0 [7.0 to 14.0]	<0.001
Total Score *(Max score 72)*	27.5 [17.0 to 39.0]	39.0 [27.0 to 53.0]	<0.001

Data are presented as medians with 25th and 75th percentiles

Table 2. *Presurvey and Postsurvey Using the SCI-2 Responses to All Questions*

SCI-2 Responses by Item	Scale 0 = Not at All 1 = Somewhat 2 = Mostly 3 = Completely
Reinforcement of Needs	
1. I get important needs of mine met because I am part of this community.	
2. Community members and I value the same things.	
3. This community has been successful in getting the needs of its members met.* (*P*=<.001)	
4. Being a member of this community makes me feel good.* (*P*=.003)	
5. When I have a problem, I can talk about it with members of this community.* (*P*=<.001)	
6. People in this community have similar needs, priorities, and goals.	

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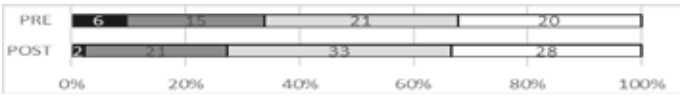
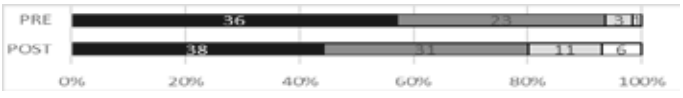
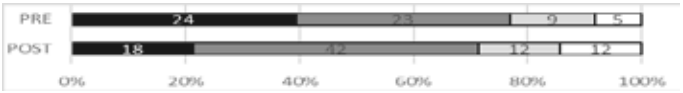
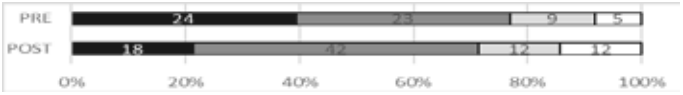
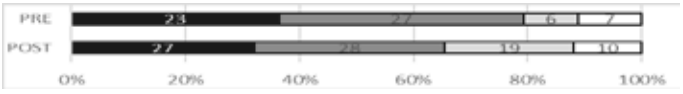
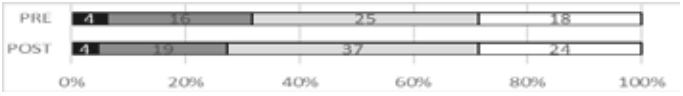
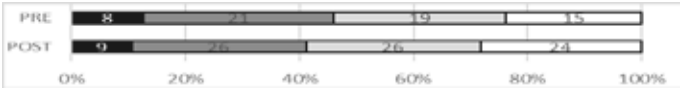
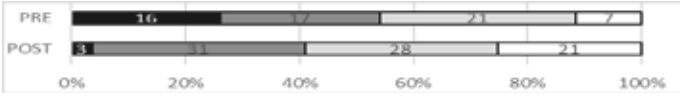
Figures *continued*

Table 2 cont. *Presurvey and Postsurvey Using the SCI-2 Responses to All Questions*

Membership	
7. I can trust people in this community.	
8. I can recognize most of the members of this community.* (*P*=.002)	
9. Most community members know me.	
10. This community has symbols and expressions of membership such as clothes, signs, art, architecture, logos, landmarks, and flags that people can recognize.* (*P*=<.001)	
11. I put a lot of time and effort into being part of this community.	
12. Being a member of this community is a part of my identity.	
Influence	
13. Fitting into this community is important to me.	
14. This community can influence other communities.	
15. I care about what other community members think of me.	
16. I have influence over what this community is like.* (*P*=<.001)	
17. If there is a problem in this community, members can get it solved.* (*P*=<.001)	

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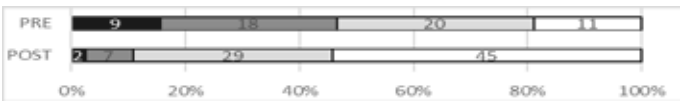
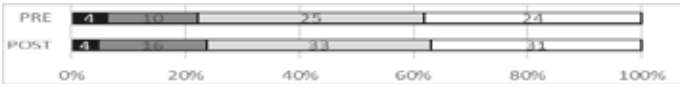
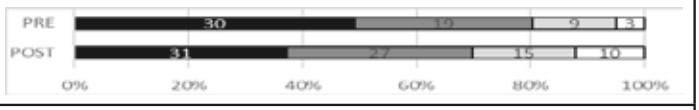
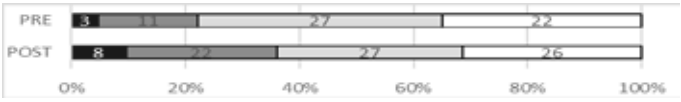
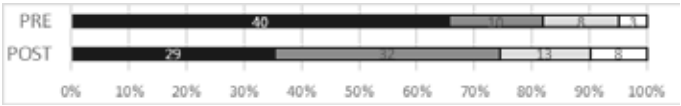
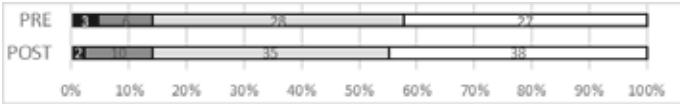
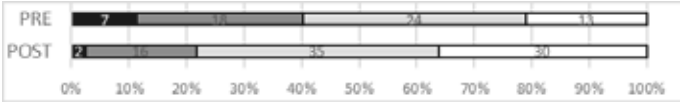
Figures *continued*

Table 2 cont. *Presurvey and Postsurvey Using the SCI-2 Responses to All Questions*

18. This community has good leaders.* (*P*=<.001)	
Shared Emotional Connection	
19. It is very important to me to be a part of this community.	
20. I am with other community members a lot and enjoy being with them.	
21. I expect to be a part of this community for a long time.	
22. Members of this community have shared important events together, such as holidays, celebrations, or disasters.* (*P*=.003)	
23. I feel hopeful about the future of this community.	
24. Members of this community care about each other.* (*P*=<.033)	

**Indicates statistically significant results.*

HANDOUT

AAPAE Lunch Round Tables Table 3: How to Get Started with Ed Research

Ashley Grantham, MA, PhD

Friday, November 11
12:20 PM – 1:00 PM

HANDOUT

AAPAE Lunch Round Tables Table 4: Step-By-Step How to Write an Abstract/Poster

Fei Chen, PhD, MEd

Friday, November 11
12:20 PM – 1:00 PM

HANDOUT

AAPAE Lunch Round Tables Table 5: Dealing with difficult personalities at work

Amy N. DiLorenzo, MA, PhD
Rossela Martinez

Friday, November 11
12:20 PM – 1:00 PM

HANDOUT

SAAAPM Business Meeting

Saturday, November 12
7:30 AM – 8:00 AM

HANDOUT

Introduction / Welcome

Michael C. Lewis, MD, FASA

Saturday, November 12
8:00 AM – 8:10 AM

HANDOUT

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

ASA Update

Ronald L. Harter, MD

Saturday, November 12
8:10 AM – 8:30 AM

ASA and SAAAPM: Partnering for a Better Future

Ronald L. Harter, MD, FASA | President-Elect
November 12, 2022

American Society of Anesthesiologists

asahq.org

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Disclosures & Objectives

- Nothing to disclose (although I am a recovering academic anesthesiology chair)
- Participants will learn:
  - How ASA is leveraging its resources to address the academic mission, especially in science and discovery
  - How ASA is working with residents, residency program directors, and early-career members to engage them in the specialty and Society

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2

Special "Thank You" to SAAAPM Leadership

Michael C. Lewis, MD, FASA
President & ASA Delegate

Tong J. (TJ) Gan, MD, MBA, MHS, FRCA, FASA
President-Elect & ASA Alternate Delegate

Cynthia Wong, MD
Secretary/ Treasurer

Peter Rock, MD, MBA, FCCM
Past President

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Special "Thank You" to SAAAPM Leadership

- AACPD President: Timothy R. Long, MD, FASA
- AASPC President: Magdalena Anitescu, MD, PhD, FASA
- AAPAE President: Faye Haggar, EdD
- Council Members: Jeffrey S. Berger, MD, MBA, FASA; Stephanie B. Jones, MD; Cynthia A. Lien, MD, FASA; K.A. Kelly McQueen, MD, MPH, FASA; B. Scott Segal, MD, MHCM
- AACPD Representatives: Charles A. Napolitano, MD, PhD, FASA; Jed Wolpaw, MD, MEd
- AASPD Representatives: Mark Stafford-Smith, MD; John Eck, MD
- AAPAE Representatives: Lara Zisblatt, EdD, MA, PMME; Malin Cannon, MEd, C-TAGME
- CFAS Alternate: Julie L. Huffmyer, MD

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4

We are ASA: Leaders in Patient Safety

Mission: Advancing the practice and securing the future

Vision: A world leader improving health through innovation in quality and safety

Values: Patient safety, physician-led care and scientific discovery

Strategic Pillars

1. Advocacy
2. Quality & Practice Advancement
3. Educational Resources
4. Member Engagement
5. Leadership & Professional Development
6. Research & Scientific Discovery
7. Stewardship of the Society & Specialty

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5

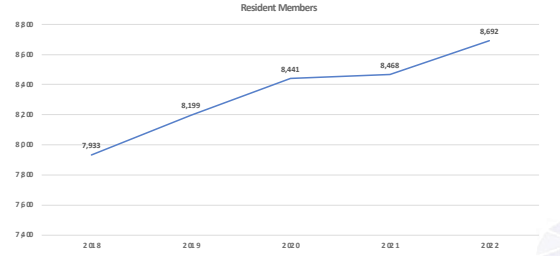
Resident and Medical Student Engagement

American Society of Anesthesiologists

asahq.org

6

Resident Membership



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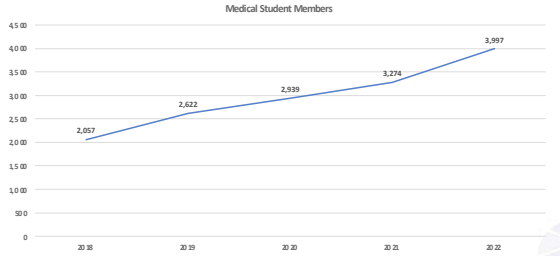
Medical Student Membership



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8

Anesthesia Toolbox

- **Fast Numbers**:
  - Over 15,000 Users
  - Over 100 Residency Programs
  - Over 1,000 Content Resources
  - Over 2,500 Quizbank Questions
- Supports **curriculum development** including rare and difficult topics
- Provides **diverse learning formats** to engage Gen Z and millennial learners
- **Case management guides** for learners and faculty including both surgical and anesthesia considerations

Join the Anesthesia Toolbox community today: **asahq.org/toolbox**

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9

Resident and Medical Student Educational Offerings

- Residents in a Room podcast series
- Online Grand Rounds modules
- Resident career development curriculum
- Medical student career development resources and video interviews
- Resident and medical student educational tracks at ANESTHESIOLOGY Annual Meeting; Resident Track at ASA ADVANCE

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10

Medical Student Resources

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11

Resident and Fellow Resources

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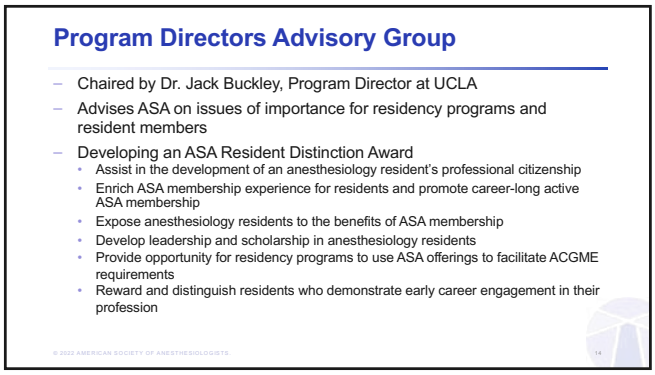

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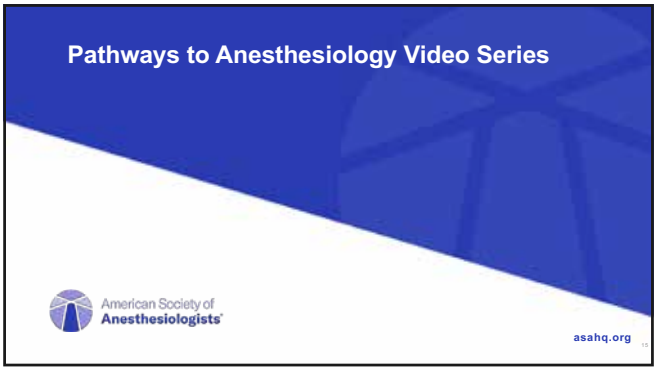

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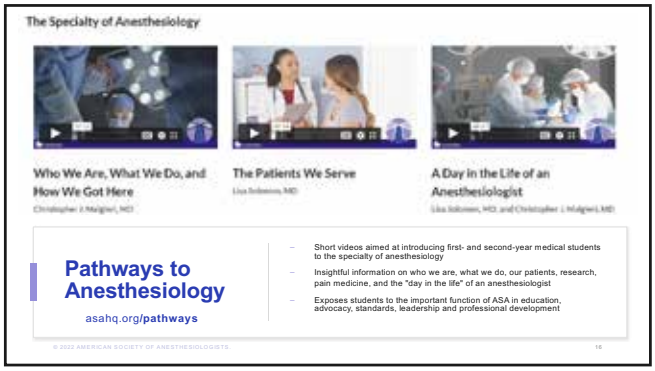

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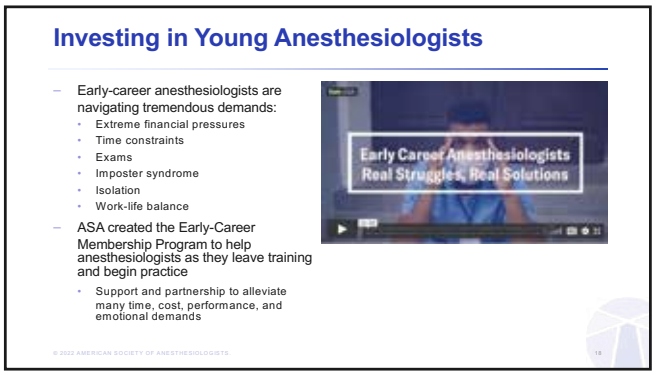

18

Zero Complexity. 100% Value.

Value-priced at **just $299**, the Early-Career Membership Program offers:

- 3 years of ASA membership as they begin practice
  - One-time payment, in first year after completion of residency or fellowship training
- Free yearly clinical resources:
  - ACE
  - Summaries of Emerging Evidence (SEE)
  - Fundamentals of Patient Safety
  - ANESTHESIOLOGY Refresher Course Lecture Summaries
  - Curated, targeted recorded sessions:
    - 10 sessions from ANESTHESIOLOGY® annual meeting
    - 5 sessions from ASA® ADVANCE: The Business of Anesthesiology Meeting
- One free registration to each event:
  - ASA ADVANCE
  - ANESTHESIOLOGY annual meeting
- **Program valued at $4,638 for ASA members**

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19

Early-Career Education Package 2023

- Included in the value bundle are ASA's highly regarded education products
- 158 CMEs available
- Courses updated automatically each year of the program

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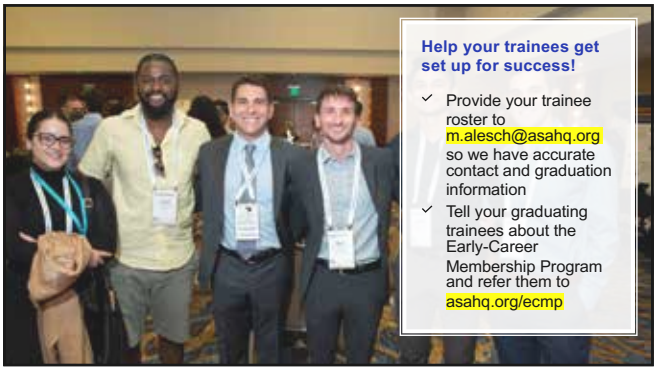

Help your trainees get set up for success!

- ✓ Provide your trainee roster to m.alesch@asahq.org so we have accurate contact and graduation information
- ✓ Tell your graduating trainees about the Early-Career Membership Program and refer them to asahq.org/ecmp

21

Education

American Society of Anesthesiologists

asahq.org

22

ASA Education Portfolio - 300+ Offerings!

- **Anesthesia SimSTAT:** Powerful, realistic online simulation training
- **ACE:** Reinforce and refresh fundamental knowledge
- **Summaries of Emerging Evidence (SEE):** Key insights from 30+ journals worldwide
- **Fundamentals of Patient Safety:** Fresh review of core concepts
- **NEW:** Patient Safety Highlights, QI Activities, Patient Safety Updates
- **Simulation Education Network:** ASA-endorsed sim centers deliver experiential training around the country.
- **Online CME courses**

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23

Questions?

American Society of Anesthesiologists

asahq.org

24

HANDOUT

FAER Update

James Eisenach, MS, MD

Saturday, November 12
8:30 AM – 8:40 AM

FAER Update

James C. Eisenach, MD
FAER President

1

FAER
Foundation for Anesthesia Education and Research

To develop the next generation of physician investigators

2

Medical **S**tudent **A**nesthesia **R**esearch **F**ellowship
- Expanded to include T35, more students
- Living and travel stipends increased
- More virtual programming and resources

Day for New Researchers at Anesthesiology Mtg

Interactions with MD, PhD student organizations

Exploring partnerships with departments

Students

3

4

PARTNERSHIPS FOR LEADERSHIP DEVELOPMENT

NAM Fellowships

for Health Science Scholars

50 years NATIONAL ACADEMY of MEDICINE

5

Working groups

- Pathways
- Trial infrastructure
- A.I. in clinic & research

Anesthesia Research Council

Developed in collaboration with: American Society of Anesthesiologists · International Anesthesia Research Society · FAER

6

7

HANDOUT

Global Health

Moderator: Warren S. Sandberg, MD, PhD

Saturday, November 12
8:55 AM – 10:15 AM

HANDOUT

Global Health: Introduction

Warren S. Sandberg, MD, PhD

Saturday, November 12
8:55 AM – 9:00 AM

HANDOUT

Global Health: Presentation 1 - Role of Global Health in Your Department: Vice-Chair of Education Perspective

Dawn Dillman, MD

Saturday, November 12
9:00 AM – 9:20 AM

Global Anesthesia

The Vice-Chair for Education Perspective

Dawn Dillman, MD November 11, 2022

1

Conflicts

- No pertinent conflicts

2

Objectives

- Discuss the role of the Vice-Chair for Education
- Discuss how the Vice-Chair can support Global Anesthesia Initiatives and Global Anesthesia is relevant to the Vice-Chair of Anesthesia role

3

Vice Chair for Education in Anesthesiology

What do they do?

- Not well-described
- Not universal
- Somewhere between the chair and general faculty

Brownfield E, et al. Academic Medicine: August 2012 - Volume 87 - Issue 8 - p 1041-1045

4

Vice Chair for Education

Twelve Roles to Provide a Framework for Success

- Teacher
- Leader
- Mentorship
- Sponsor
- Cheerleader
- Collaborator
- Faculty Developer
- Networker
- Manager & Recruiter
- Emotional Intelligence
- Negotiator
- Strategic Planner

Catanzano TM, et al. Academic Radiology Volume 28, Issue 7, July 2021, Pages 1010-1017

5

And where does Global Health fit in to these roles?

6

Networker

- In institution
- Community
- External

7

Teacher

- May or may not be on trips
- Create opportunities for sharing
- Professional Identity Formation

8

Cheerleader

- Meaning
- Purpose
- Autonomy
- Celebrating wins

9

Leader

- Priority setting
- Vision communicating
- Innovating

10

Negotiator

How can we do this

- Resources
  - Financial
    - How much & from where
  - Persons hours
    - Who goes & how counted

11

Recruiter

- Residents
- Fellows
- AA/CRNAs
- Faculty

12

Mentor

- For new PDs
  - GMEC
  - ABA
  - MOU

13

Vice Chair for Education

Twelve Roles to Provide a Framework for Success

- Teacher
- Leader
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- Cheerleader
- Collaborator
- Faculty Developer
- Networker
- Manager & Recruiter
- Emotional Intelligence
- Negotiator
- Strategic Planner

Colanzano TM, et al. Academic Radiology Volume 28, Issue 7, July 2021, Pages 1010-1017

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Thank you!

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HANDOUT

Global Health: Presentation 2 - Role of Global Health in Your Department: Program Director Perspective

Brian J. Gelfand, MD

Saturday, November 12
9:20 AM – 9:40 AM

Role of Global Health in your Department: Program Director Perspective

Brian J. Gelfand, M.D.
Vice-Chair, Educational Affairs
Vanderbilt University Medical Center

VANDERBILT HEALTH

1

- No disclosures or industry sponsorship that influences this presentation

2

Learning Objectives:

- Defining the structure of Vanderbilt International Anesthesia and programs
- Incorporation of global health initiatives and education into residency curriculum
- Establishment of committed leadership development tracks in the global health space during residency

3

4

Why is this essential and should be an integral part of your residency curriculum?

- 5 billion people without access to safe surgical and anesthetic care
- 143 Million annual unmet surgical needs
- In 2010 16.9 Million lives lost from conditions requiring surgical intervention

Lancet Commission on Global Surgery 2015, Lancet

5

- 55% Regional Hospitals in 8 African countries have no anesthesia machine
- >70% ORs SSA have no pulse oximeter
- In 28 District Hospitals in Zambia, 35% did not have a laryngoscope.
- Nigeria 60% District Hospitals and 75% Regional Hospitals have no equipment to maintain a pediatric airway

6

Postoperative Outcomes

African Surgical Outcomes Study

- 11,000 patients in 25 countries
- Postoperative complications – **18.2%**
- 30-day mortality – **2.1%** (Lower ASA-50.3% ASA 1)
- Young age (38.5 years)

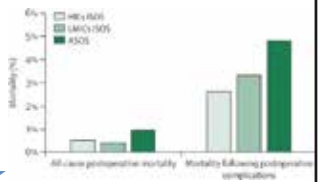


Figure 3. Surgical mortality following elective surgery in HICs, LMICs, and African countries

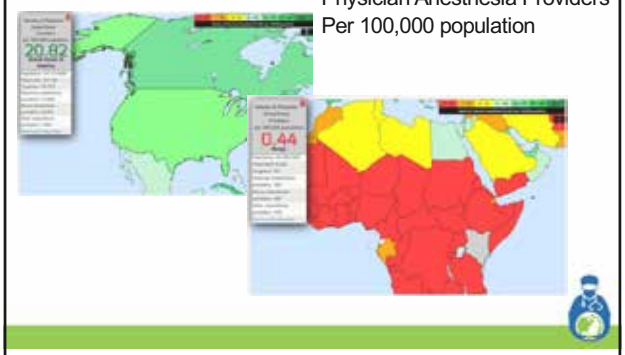
HICs=high-income countries. ISOS=International Surgical Outcomes Study. LMICs=low-middle income countries. ASOS=African Surgical Outcomes Study.

Biccard et al. Lancet 2018

7

VANDERBILT HEALTH

Physician Anesthesia Providers
Per 100,000 population



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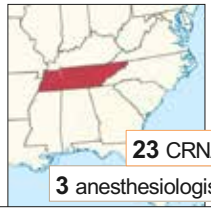
If Tennessee was in East Africa…

Ethiopia population - 99 million

51 anesthesiologists

350 CRNAs



23 CRNAs

3 anesthesiologists

TN population - 6.5 million

9

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VIA

- Multiple innovative projects across 15 LMIC
- Long established partnerships with educational-capacity building
- International advocacy
- Research
- Promote health and support healthcare infrastructure of regions in need

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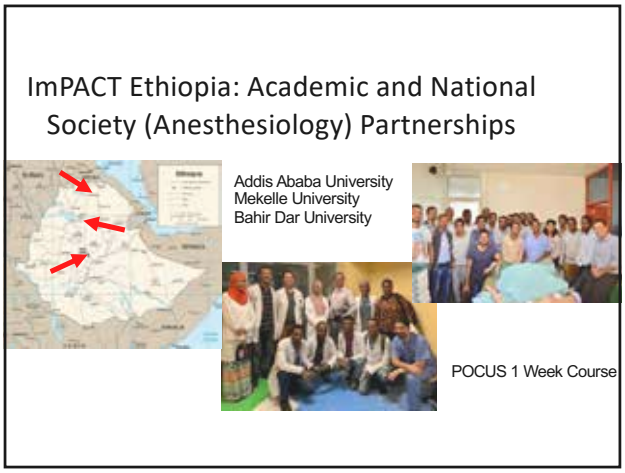

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VANDERBILT HEALTH

Mobile Obstetric Simulation Training (MOST)

Multidisciplinary teams | High-fidelity simulation training
On-site (including rural hospitals) | Local leadership and mentorship

IMPACT AFRICA

Team Training

21

Quality Assessment: Program and Trainees with External Examiners (Mentoring)

- Practical Examinations: Pre-operative Assessment, General Anesthesia,
- Regional Anesthesia (spinal)

22

Cultural Awareness in Clinical Care and Education

23

PRIME

Preparing Residents for International Medical Experiences

- VUMC Departments of Anesthesiology, Surgery, and Obstetrics

Credit: D

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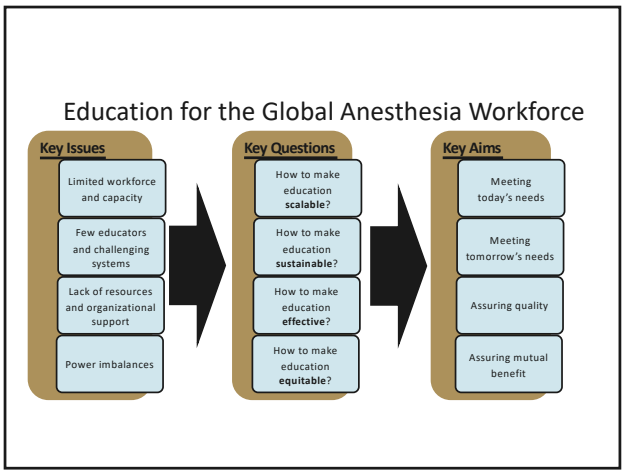

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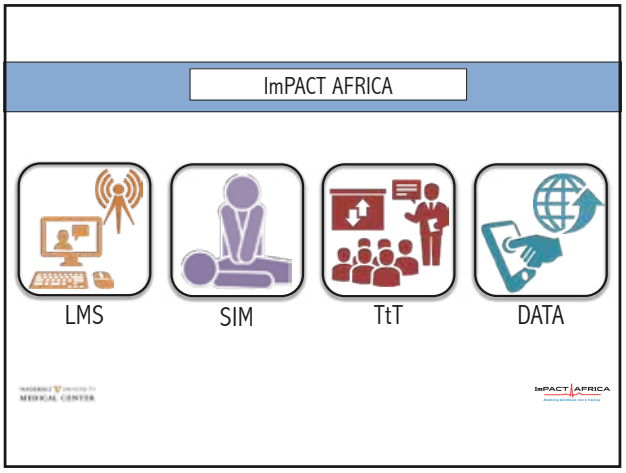

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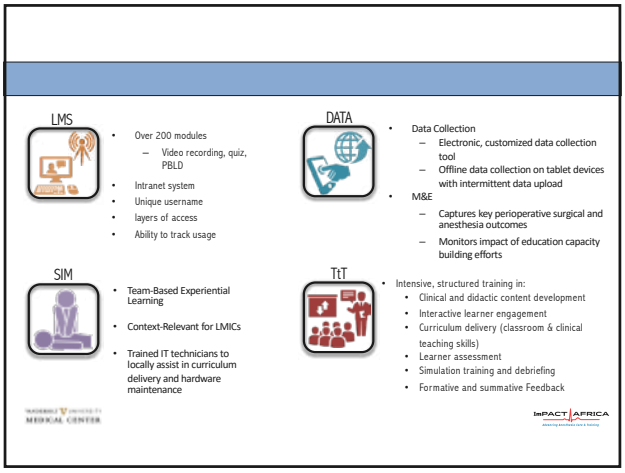

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Leadership with Vision and Commitment
VANDERBILT HEALTH

31


Bidirectional Benefit in Academic Partnerships

32

33


THANK
YOU

34

HANDOUT

Global Health: Presentation 3 - Role of Global Health in Your Department: Chair's Perspective

Daniel Talmor, MD, MPH

Saturday, November 12
9:40 AM – 10:00 AM

HANDOUT

Re-Engagement with Residents and Faculty

Moderator: Lara Zisblatt, EdD, MA, PMME

Saturday, November 12
10:45 AM – 11:45 AM

HANDOUT

Re-Engagement with Residents and Faculty: Introduction

Lara Zisblatt, EdD, MA, PMME

Saturday, November 12
10:45 AM – 10:50 AM

HANDOUT

Re-Engagement with Residents and Faculty: Presentation 1

Shelley Brickson, MA, PhD

Saturday, November 12
10:50 AM – 11:20 AM

Engaging Members Through Organizational Value Creation

Shelley Brickson
UIC BUSINESS

1

Big picture arguments about engagement

- Members are more engaged when:
  - They receive various forms of value
  - They understand the value proposition of:
    - Their organization
    - Their own actions
- Leaders can do a LOT to enhance engagement!

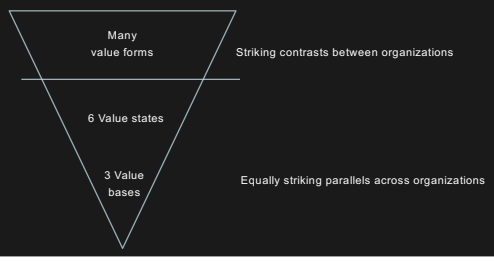
2

PART 1

ORGANIZATIONAL VALUE AND VALUE CREATION

3

What kinds of value do members derive from org membership? Is there underlying dimensionality?



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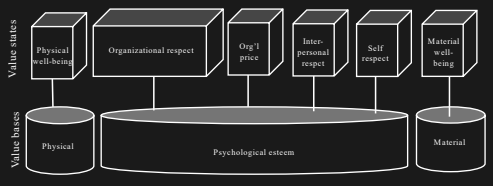
Underlying dimensionality – Common value bases

5

Underlying dimensionality – Common value bases and states



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Value is co-created in relationship practices.
Relationship practices reside at different levels.
Practices at different levels generate different value states.

Level of relationship						
External	D	I	D	I	I	D
Employment	D	D	D	I	I	D
Interpersonal	D			D	D	

7

Leaders should ask themselves – and their people:

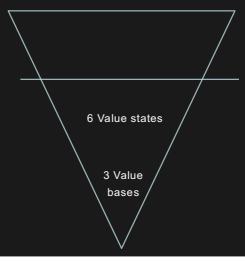
- Value
  - How much of these 6 value states are people receiving?
  - How are value states distributed across groups (e.g., hierarchical, functional, tenure, demographic)
- Practices
  - What kinds of specific practices do and can create value for our people at different levels?
  - What is the *quality* of relationships underlying these practices?
    - How much mutual engagement, respect, and trust (Dutton, 2003)

8

PART 2

THE IMPACT OF ORGANIZATIONAL IDENTITY ON VALUE AND VALUE CREATION

9



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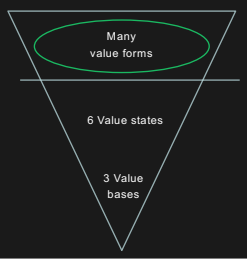
Org identity shapes the form that the 6 value states take.
It does this by shaping the nature of relationship practices that create value



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Organizational Identity Orientation (Typology not Classification)

(Brickson, 2005; 2007, 2013)

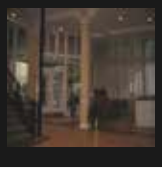
Org. Identity Orientation	Salient Org. Traits	Motivation *Vis-à-Vis* Stakeholders	Self-Evaluation Comparison
Individualistic	Those distinguishing it from others	Organization's self-interest	Inter-organizational comparison
Relational	Those connecting it dyadically	Particular other's interest	Role comparison
Collectivistic	Those connecting it to a larger whole	Greater collective's interest	Collective contribution, intergroup comparison

12

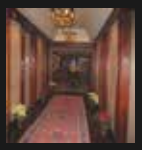
Law Firm Case Studies

Pure exemplars selected from larger sample of 53 firms

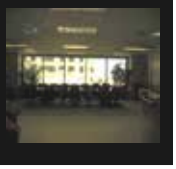
Individualistic firm
Litigation
External OI: Among the best at taking risks and winning tough cases
Internal OI: Enabling the excellence of top quality self-starters



Relational firm
General practice
External OI: Committed to the deep satisfaction of clients' specific needs
Internal OI: Ensuring that members are personally and professionally satisfied



Collectivistic firm
Public housing
External OI: Changing communities for the better
Internal OI: Advancing community and equality among membe3rs



13

Divergent Relationship Patterns

	Individualistic	Relational	Collectivistic
Employment Relationship Patterns • Decision mkg • Training • Socialization • Info flows • Benefits • Work tasks • Evaluation	• MP handles mundane, committees of one • Thrown in, experimentation • Circulation of (high) hours, "genteel feedback" on hours • Meetings minimized, happy hours • Push $ down, productivity + seniority • Organized chaos, early responsibility • 2X/year, candid, extensive #s	• Exec Com based on deep knowledge of all • Mentors • Expectation to live full life & care; no billables pressure • Personal info, on- & off-site events, emails about life • Exec Com based on lifestyle + personal needs • Long-tem files • Yearly, bidirectional, relat-focused	• Consensus • Topical groups • Minorities & staff teach others acceptable treatment; reduced but strict billables • On-site gatherings • 70% equal 30% compressed merit • Assign based on workload • Infrequent

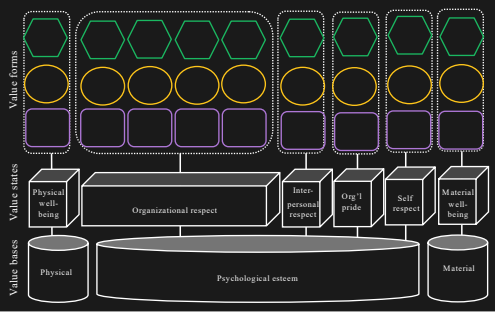
14

Divergent Relationship Patterns

	Individualistic	Relational	Collectivistic
Employment Relationship Patterns • Decision mkg • Training • Socialization • Info flows • Benefits • Work tasks • Evaluation	• MP handles mundane, committees of one • Thrown in, experimentation • Circulation of (high) hours, "genteel feedback" on hours • Meetings minimized, happy hours • Push $ down, productivity + seniority • Organized chaos, early responsibility • 2X/year, candid, extensive #s	• Exec Com based on deep knowledge of all • Mentors • Expectation to live full life & care; no billables pressure • Personal info, on- & off-site events, emails about life • Exec Com based on lifestyle + personal needs • Long-tem files • Yearly, bidirectional, relat-focused	• Consensus • Topical groups • Minorities & staff teach others acceptable treatment; reduced but strict billables • On-site gatherings • 70% equal 30% compressed merit • Assign based on workload • Infrequent

15

Common value bases and states; divergent forms



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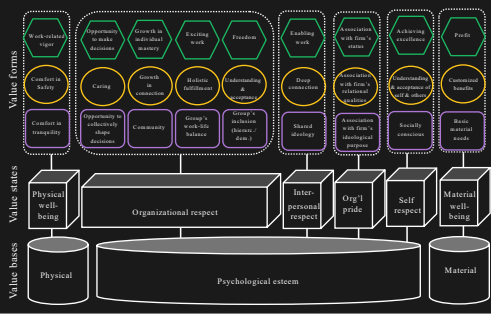
Common value bases and states; divergent forms



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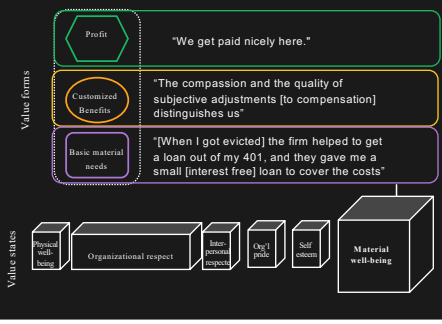
Differences by OIO – Distinct value forms



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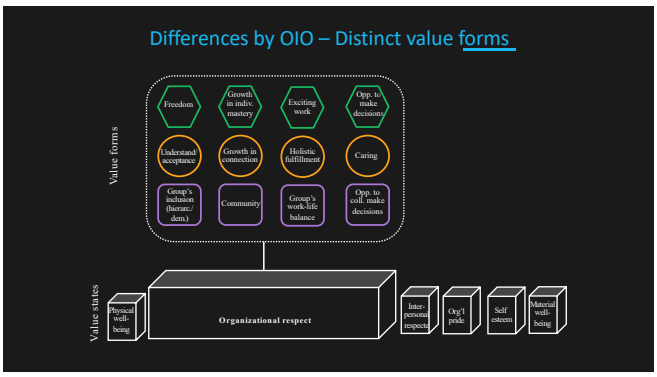

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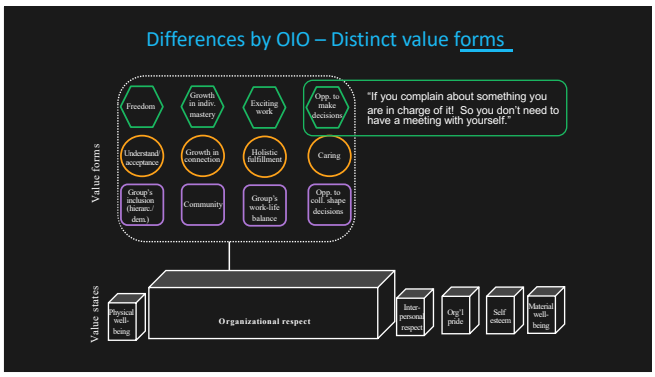

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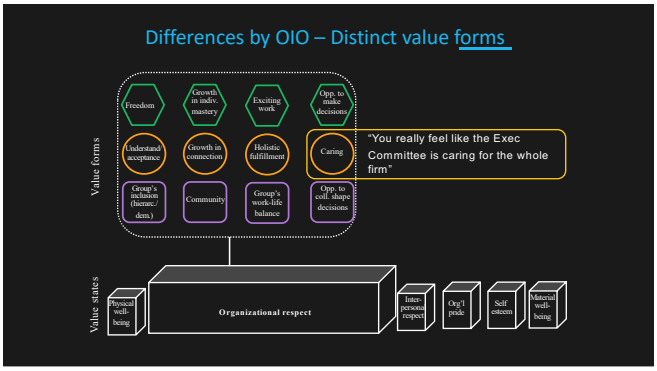

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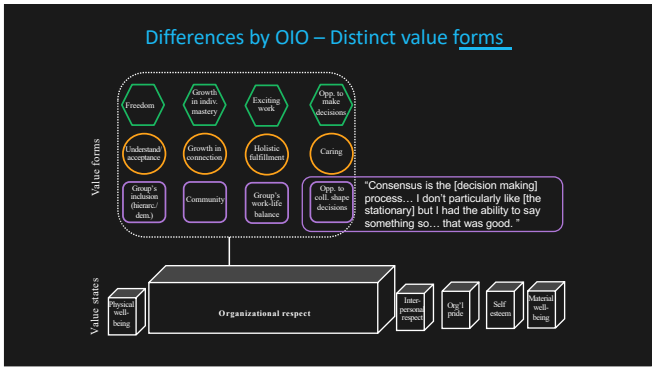

22

Leaders should:

- Reflect on / collaboratively crystalize
  - OIO(s)
  - Aspired value forms for each value state that align with OIO(s) (TRADE-OFFS)
- Examine org practices
  - Are they aligned with OIO and aspired value creation?
  - Do they maximize value creation (relationship quality, clarity, etc)?
- Communicate to members
  - Org's value proposition (actual and aspired; internal and external)
  - Their role in co-creating value
- Seek members (and external stakeholders) with aligned identity
  - They will find value in the value forms you are capable of creating
  - They will work hard to co-create ongoing cycles of value

23

HANDOUT

Re-Engagement with Residents and Faculty: Presentation 2

John D. Mitchell, MD
Nick Yeldo, MD

Saturday, November 12
11:20 AM – 11:40 AM

HENRY FORD HEALTH

(Re)Engagement: The Educational Program

Nicholas Yeldo, M.D.

1

OBJECTIVES

- To discuss the Organizational Identity Orientation of the Henry Ford Anesthesiology Residency
- To highlight values created within our relational organization/residency program.
- To discuss practical tips to improve relational organizational identity.

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2

I HAVE NO DISCLOSURES

HENRY FORD HEALTH

3

Engagement AND Reengagement

It's about

VALUE-CREATION

HENRY FORD HEALTH

4

Maslow's Hierarch of Needs

HENRY FORD HEALTH

5

Maslow's Hierarch of Needs // Value States

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6

Maslow's Hierarch of Needs ??

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7

Assessment and Creation of Value in Alignment with your Organizational Identity Orientation(OIO)

HENRY FORD HEALTH

8

9

Henry Ford Anesthesiology Residency OIO

R C

HENRY FORD HEALTH

10

How do WE create value in the Henry Ford Anesthesiology Residency Program that aligns with our **Relational (+Collectivistic)** OIO?

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11

VALUE FORMS: RELATIONAL OIO

How do we view our trainees and faculty?

- Humans not numbers
- Each journey looks different – Allowed to grow as an individual
- Nurturing not punitive. Caring.
- Connectedness – HFH as a whole.
- Safety is paramount
- You are creative, resourceful and whole – The answers are within you
- Faculty are integral – Let them know it. Happy faculty, happy trainees.

How do teach/train/develop?

- Strategic, meaningful Mentorship AND Coaching
- Agency – The PD is your agency
- Empowering and training teachers + empowering and developing leaders – HFH HIGH IMPACT Education
- Personal and Professional Development Courses

How do we all engage each other?

- Community – Dept and program level. Communities
- Create time and space to gather – Be intentional
- Present, visible leadership

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12

From: Yeldo, Nicholas S. <nyeldo1@hfhs.org>
Sent: Friday, January 21, 2022 11:19:11 AM
To: Anesthesiology Residents <AnesthesiaResidents@hfhs.org>
Cc: Chhina, Anoop <achhina1@hfhs.org>; Guruswamy, Jayakar <JGURUSW1@hfhs.org>; Bond, Beth <bbond2@hfhs.org>
Subject: I'm your agent

I've been thinking these last few days about how I can best promote the success of everyone around me. I'm obviously always trying to do this for you all, but I had a thought I wanted to share. When it comes to advancing your career, making a connection, finding a mentor, etc, etc, I am like your agent. I am here to make these things happen for you if you don't feel comfortable doing it yourself. I'm also someone who has a lot of connections and someone who is owed a lot out there. Its my pleasure to use these favors to help you. So, if you are trying to connect with someone and they aren't responding, or if you have your eye on some role or position or would like someone to mentor you, you should use me to help you. I am basically your agent, among other things. The same way professional athletes have agents to make deals and make sure they are getting what they need, I see myself in the same light.

Hope this makes sense.

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13

VALUE FORMS: Collectivistic OIO

- **Strong sense of common MISSION.**
  - **Mission above any one human = Shared Ideology.**
- **Safety net hospital in an underserved community.**
- **Commitment to DEIJ. History of civil rights activism.**
- **Consistent incorporation of resident feedback into future changes.**
  - **Short- and long-term goals**
  - **Small wins, big wins.**

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14

Program Leadership Should:

- **Reflect on / collaboratively crystalize / communicate OI**
  - **Recruitment Tool?**
- **Explore what kinds of practices do and can create value for our people at different levels?**
- **Work to communicate to trainees/educators the value of the overall enterprise internally and externally and the role that they play value creation.**

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15

Engagement AND Reengagement

Its about
VALUE-CREATION....

HENRY FORD HEALTH

16

THANK YOU!

HENRY FORD HEALTH

17

HANDOUT

The Wellbeing of an Anesthesia Department

Moderator: Amy E. Vinson, MD, FAAP

Saturday, November 12
12:15 PM – 1:15 PM

HANDOUT

The Wellbeing of an Anesthesia Department: Introduction

Amy E. Vinson, MD, FAAP

Saturday, November 12
12:15 PM – 12:20 PM

HANDOUT

The Wellbeing of an Anesthesia Department: Establishing Psychological Safety

Elizabeth W. Duggan, MD, MA

Saturday, November 12
12:20 PM – 12:35 PM

HANDOUT

The Wellbeing of an Anesthesia Department: Organizational of a Wellbeing initiative

Carol Ann Diachun, MD, MSEd

Saturday, November 12
12:35 PM – 12:50 PM

Organizational Well-being: Role of Leaders

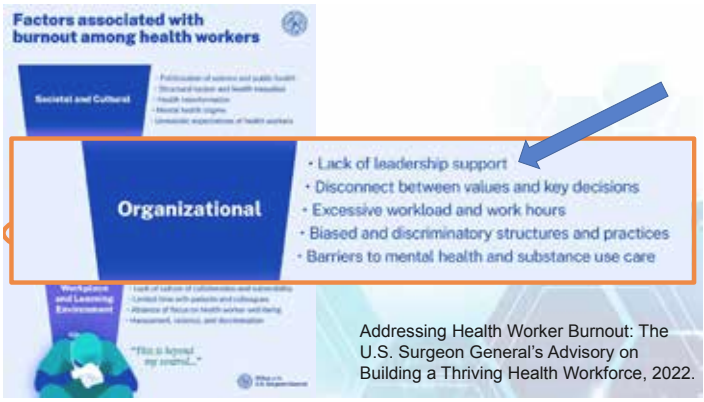
Carol Ann Diachun, MD, MSEd
Associate Dean for Educational Affairs
Associate Chair & Professor of Anesthesiology
Core Residency Program Director
University of Florida College of Medicine - Jacksonville

Disclosures

- Unfortunately, no financial disclosures.

Objectives

- Examine relationship of leadership behaviors and faculty well-being
- Review Wellness-Centered Leadership Model
- Describe Trust Behaviors essential to Wellness Centered Leadership



Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce, 2022.

Impact of leadership behaviour on physician well-being, burnout, professional fulfilment and intent to leave: a multicentre cross-sectional survey study

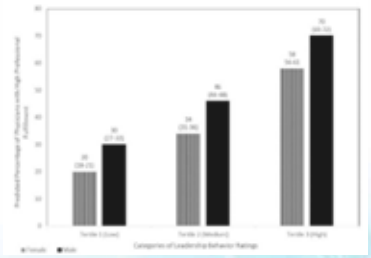
- Cross-sectional survey study at 11 healthcare organizations
- 5416 attending physicians responded (45% response rate, 50% female)
- Mayo Clinic Participatory Management Leadership Index categorized into tertiles
- Examined leadership behavior rating of supervisor on:
  - Professional fulfillment
  - Burnout
  - Intent to leave

Mayo Clinic Participatory Management Leadership Index

- Holds career development conversations with me
- Empowers me to do my job
- Encourages employees to suggest ideas for improvement
- Treats me with respect and dignity
- Provides helpful feedback and coaching on my performance
- Recognizes me for a job well done
- Keeps me informed about changes taking place at (name of organization)
- Encourages me to develop my talents and skills
- Overall, how satisfied are you with (name of immediate supervisor)

Shanafelt TD, Wang H, Leonard M, et al. *JAMA Netw Open*. 2021;4(2):e2035622.

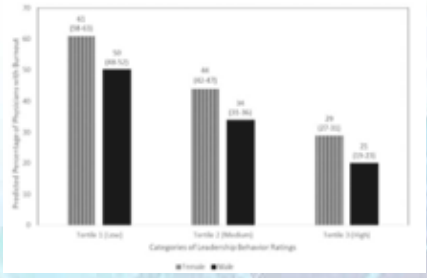
Professional Fulfillment



- Professional fulfillment increased with increasing tertiles of supervisor's leadership behavior rating
- (19%, 34%, 47%, p<0.001)
- Odds of professional fulfillment were 5.8 times higher (OR=5.8, 95% CI: 5.1 to 6.59) for physicians in the top tertile compared with those in the lowest tertile.

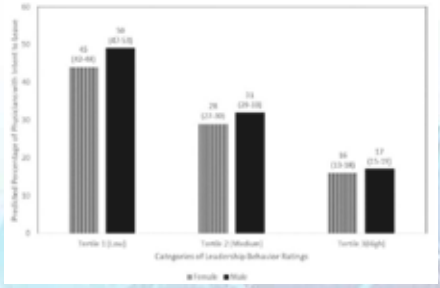
Burnout

- Physicians who rated their supervisor's leadership in upper tertiles relative to lower tertiles exhibited lower levels of burnout
- (18% vs 35% vs 47%, p<0.001)



Intent to Leave

- Physicians who rated their supervisor's leadership in upper tertiles relative to lower tertiles exhibited lower levels of intent to leave within 2 years
- (16% vs 24% vs 50% p<0.001)



"Physicians who are dissatisfied with their supervisor's ability to lead the team are the more likely to consider other opportunities"

Association of Burnout, Professional Fulfillment, and Self-care Practices of Physician Leaders With Their Independently Rated Leadership Effectiveness

- Survey study of 1285 physicians and physician leaders (60% response rate)
- Compared wellness of leaders with their leadership scores
- Each 1-point increase in the leaders' burnout score was associated with a 0.19-point decrement in their independent leadership behavior score
- Each 1-point increase in a leader's professional fulfillment score was associated with a 0.13-point higher leadership behavior score
- 9.8% of the variation in leaders' aggregate leadership behavior scores was associated with a leader's own degree of burnout.

JAMA Network Open. 2020;3(6):e207961. doi:10.1001/jamanetworkopen.2020.7961

Wellness-Centered Leadership: Equipping Health Care Leaders to Cultivate Physician Well-Being and Professional Fulfillment

Tait Shanafelt, MD, Mickey Trockel, MD, PhD, Ashleigh Rodriguez, MSN, MMM, APRN, and Dave Logan, PhD

Acad Med. 2021;96:641-651.

Foundation: Care about people always

Integrity	Respect	Empathy
Listen	Validate	Gratitude

Shanafelt, etal. *Acad Med*. 2021;96:641-651.

Cultivate Relationships

Ask their values
Nurture their talents
Seek input from team
Inform of organizational goals & needs
Cultivate team relationships
Communicate in both word & actions

Shanafelt, etal. *Acad Med*. 2021;96:641-651.

Inspire Change

Empower team
Provide flexibility
Align goals with intrinsic motivators:
Meaning, purpose, voice, values, input, control & professional development

Shanafelt, etal. *Acad Med*. 2021;96:641-651.

Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce, 2022.

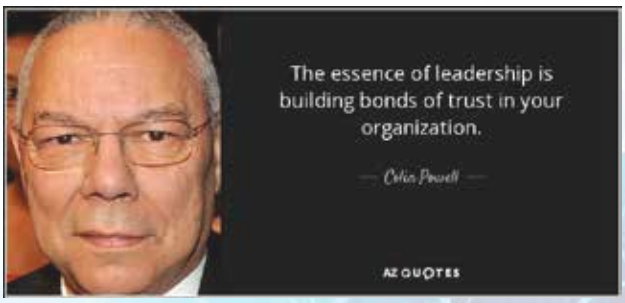
High Trust Behaviors

- Be honest. Tell the truth. Don't spin.
- Demonstrate Respect. Genuinely care for others.
- Create Transparency. Declare your intent. No hidden agendas.
- Right Wrongs. Apologize quickly.
- Show Loyalty. Give credit to others. Don't disclose others' private information.
- Deliver Results. Don't overpromise and underdeliver.

Speed of Trust, FranklinCovey.

- Get Better. Ask for and act on feedback on yourself.
- Confront Reality. Don't skirt the real issues. Acknowledge the unsaid.
- Clarify Expectations.
- Practice Accountability – yourself first, others second. Take responsibility for good and bad.
- Listen First. Don't presume you have all the answers.
- Keep Commitments. Say what you will do, then do what you say.

Speed of Trust, FranklinCovey.



SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

HANDOUT

The Wellbeing of an Anesthesia Department: Peer Support in Action

Bridget Pulos, MD

Saturday, November 12
12:50 PM – 1:05 PM

MAYO CLINIC

SAAAPM

PEER SUPPORT IN ACTION

ESTABLISHING A PEER SUPPORT PROGRAM

Bridget Pulos, MD

SAAAPM
Chicago, November 12, 2022

1

Disclosures

- None

2

Learning Objectives

- Describe why peer support is beneficial
- Identify barriers to creating a peer support program
- Illustrate strategies to build a successful peer support program

3

Second victim phenomenon

- Term was first defined by Dr. Albert Wu
  - First focus was on physicians after medical errors
- Expanded to include all health care providers who are involved in unanticipated adverse patient event, medical error and/or patient related injury
- Patients and their families considered 1st victims
- Involved medical professionals considered 2nd victims
- Organizations (and subsequent patients of affected medical professionals) considered 3rd victims

4

The impact of perioperative catastrophes on anesthesiologists: results of a national survey

- Surveyed 1200 randomly selected ASA members
- 659 completed the survey (56% response rate)

- 84% reported being involved in at least one unanticipated death or serious injury of a perioperative patient over the course of his/her career

5

The impact of perioperative catastrophes on anesthesiologists

- When asked about the emotional impact of "most memorable" perioperative catastrophe
  - >70% experienced guilt, anxiety, and re-living of the event
  - 88% required time to recover emotionally
  - 19% reported never fully recovering

  - 12% considered a career change

6

What is a "stressful event"?

- Unexpected patient outcome (death, intraop cardiac arrest, nerve injury, difficult airway, postop vision loss)
- Medication/system error
- Near miss event
- Anything that has emotional impact!

7

High risk for stressful events:

High risk work area
- OB
- Peds
- Critical Care
- Cardiac

High risk scenarios
- First death in the OR
- Failure to rescue cases
- Multiple patients with unexpected/adverse outcomes in short period of time
- Anything that "feels familiar"
- Stress of litigation
- Trainees

8

Common symptoms:

- Isolation
- Frustration
- Fear
- Grief
- Self-doubt/second-guessing
- Anger
- Preoccupation with the event
- Inability to concentrate
- Flashbacks
- Fatigue
- Sleep disturbance
- Rapid heart rate
- Muscle tension

9

After traumatic events:

- Talking with peers is the #1 desired intervention when someone is emotionally affected by adverse event

10

Anesthesia specific barriers to support

- Often there is not time for debriefing, formally or informally
- Time pressure to move on the next case
- Lack of physical space in proximity to the OR to reflect and pause
- Fear of litigation/ need for confidentiality
- Cultural barriers in the surgical environment ("culture of silence")

11

12

Culture change

- Culture of shame/blame → culture of psychological safety
- Culture of perfectionism → culture of growth mindset
- Culture of silence → culture of sharing, discussion, peer support

13

How to build a successful peer support program

- Get department/institutional leadership on board
- Form a program leadership team
- Decide who will be served by the program
- Recruit and train peer supporters
- Advertise to normalize
- Plan for ongoing training and resources

14

HELP Program: Healing Emotional Lives of Peers

- The HELP program is a peer support program for colleagues who experience emotional impacts after involvement in stressful or traumatic work-related events
- The goal of the HELP program is to assist colleagues who have been involved in such events return to a pre-event level of performance by use of trained peer supporters around the enterprise

15

HELP program provides:

- One on one peer support
- Provides a "safe-zone" to express emotions, thoughts, and reactions
- Assurance that this is a "normal reaction"
- Maintain confidentiality
- Referral to other resources as needed
  - Including information for family members

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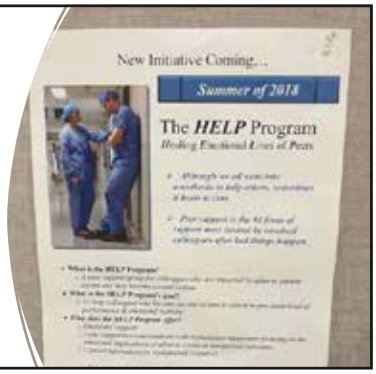
17

Advertise!

- Department newsletter
- Department Grand Rounds
- Surgical Services Safety & Quality conference
- Division meetings
- Posters
- Name badge holders



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Our Process

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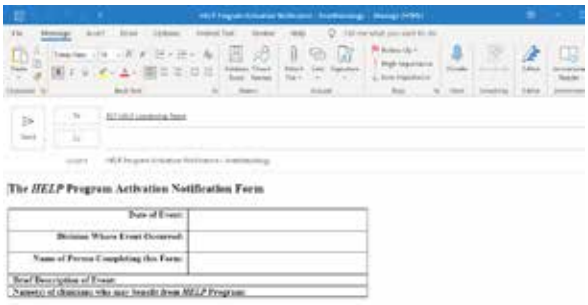

22

The *HELP* Program Activation Notification Form

Date of Event:	[redacted]
Division Where Event Occurred:	[redacted]
Name of Person Completing this Form:	Bridget Pules
Brief Description of Event: intrap op death, first time this has occurred for several members of the anesthesia team. I chatted with [redacted] on Saturday evening and checked in with them again today but I think would benefit from formal HELP follow-up. Thank you !	
Name(s) of clinicians who may benefit from *HELP* Program: [redacted]	

23

The *HELP* Program Activation Notification Form

Date of Event:	[redacted]
Division Where Event Occurred:	[redacted]
Name of Person Completing this Form:	[redacted]
Brief Description of Event: Infiltrated IV on pediatric patient resulting in fasciotomies	
Name(s) of clinicians who may benefit from *HELP* Program:	[redacted]

24

The *HELP* Program Activation Notification Form

Date of Event:	[redacted]
Division Where Event Occurred:	**OB anesthesia**
Name of Person Completing this Form:	[redacted]
Brief Description of Event: my Co-resident has been involved in several complicated and stressful OB cases for two days in a row. I am concerned he might feel overwhelmed and wanted to make sure he is doing fine and feel supported	
Name(s) of clinicians who may benefit from *HELP* Program:	[redacted]

25

What happens next?

- Once the HELP program activation is put in a TPS should reach out in the next 1-2 days
- It is completely up to potentially affected colleague if they would like to meet
- If support is declined at that time, the TPS will reach out again in 3-4 days
- If support is desired at a later time, affected colleague is encouraged to contact same TPS or put in self-activation

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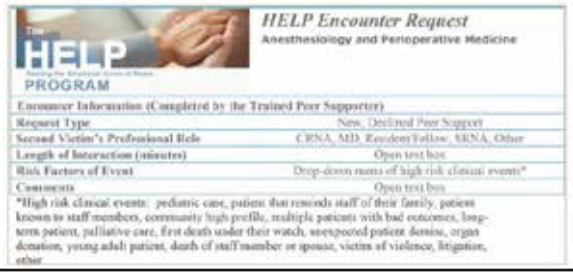
Encounter Form (completed by TPS)



HELP Encounter Request

Anesthesiology and Perioperative Medicine

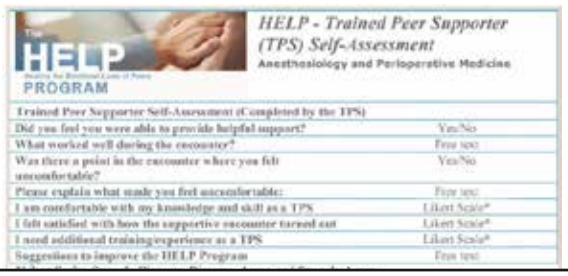
PROGRAM

Encounter Information (Completed by the Trained Peer Supporter)	
Request Type	New, Declined Peer Support
Second Victim's Professional Role	CRNA, MD, Resident/Fellow, SRNA, Other
Length of Interaction (minutes)	Open text box
Risk Factors of Event	Drop-down menu of high risk clinical events*
Comments	Open text box

*High risk clinical events: pediatric case, patient that reminds staff of their family, patient known to staff members, community high profile, multiple patients with bad outcomes, long-term patient, palliative care, first death under their watch, unexpected patient demise, organ donation, young adult patient, death of staff member or spouse, victim of violence, litigation, other.

27

Self-Assessment form (completed by TPS)



HELP - Trained Peer Supporter (TPS) Self-Assessment

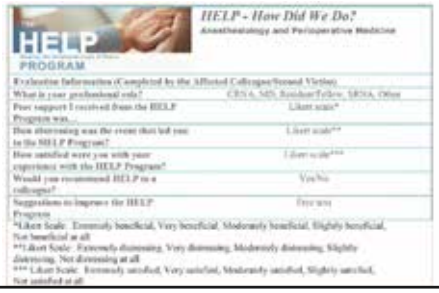
Anesthesiology and Perioperative Medicine

PROGRAM

Trained Peer Supporter Self-Assessment (Completed by the TPS)	
Did you feel you were able to provide helpful support?	Yes/No
What worked well during the encounter?	Free text
Was there a point in the encounter where you felt uncomfortable?	Yes/No
Please explain what made you feel uncomfortable:	Free text
I am comfortable with my knowledge and skill as a TPS	Likert Scale*
I felt satisfied with how the supportive encounter turned out	Likert Scale*
I need additional training/experience as a TPS	Likert Scale*
Suggestions to improve the HELP Program	Free text

28

Evaluation Form (completed by affected colleague)



HELP - How Did We Do?

Anesthesiology and Perioperative Medicine

PROGRAM

Evaluation Information (Completed by the Affected Colleague/Second Victim)	
What is your professional role?	CRNA, MD, Resident/Fellow, SRNA, Other
Peer support I received from the HELP Program was…	Likert scale*
How distressing was the event that led you to the HELP Program?	Likert scale**
How satisfied were you with your experience with the HELP Program?	Likert scale***
Would you recommend *HELP* to a colleague?	Yes/No
Suggestions to improve the HELP Program	Free text

*Likert Scale: Extremely beneficial, Very beneficial, Moderately beneficial, Slightly beneficial, Not beneficial at all

**Likert Scale: Extremely distressing, Very distressing, Moderately distressing, Slightly distressing, Not distressing at all

*** Likert Scale: Extremely satisfied, Very satisfied, Moderately satisfied, Slightly satisfied, Not satisfied at all

29

HELP activations in first 2 years:

Clinical event	Activations (N=91)*
Intraoperative Patient Demise	42
Pediatric patient	33
Intraoperative Cardiac Arrest	16
First death in the Operating Room	8
Multiple difficult events over short period of time	8
Prolonged resuscitation	8
Medication or System Error	5
Patient Known to Staff	4
Organ donation case	4
Violent Patient and/or Staff	4
Unanticipated difficult airway	3
Patient Situation Closely Resembles Someone in Personal Life	2
Intraoperative Awareness	2

*Each activation may be associated with more than one clinical event

30

The HELP program

- Began in our department in 2018
- In 2019, expanded to Mayo's children center and some community sites
- In March 2020, due to pandemic and increasing demand the program was expanded to the entire enterprise and is now housed within enterprise-wide well-being
- Currently over 600 trained peer supporters across the enterprise

31

In our department:

- Included in orientation for new residents
- Included in onboarding for new attendings
- Present updates to the program at Grand Rounds

32

AMA

Peer Support

Mitigating the Emotional Toll on Physicians

Jo Shapiro, MD, FACS
Associate Professor of Otolaryngology--Head and Neck Surgery, Harvard Medical School
Founder, Center for Professionalism and Peer Support, Brigham and Women's Hospital
Senior Faculty, Center for Medical Simulation, Boston, MA
Consultant, Massachusetts General Hospital

33

5 STEPS to build a peer support program

For more information on implementing a peer support program in your practice, visit:

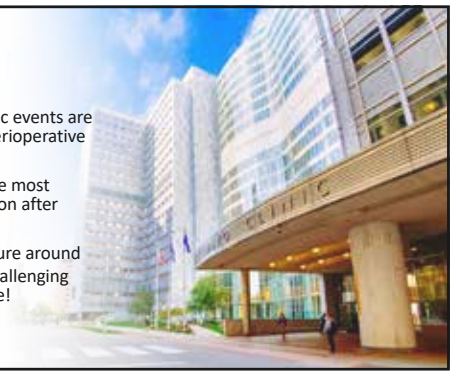
STEPSforward

https://edhub.ama-assn.org/steps-forward

34

Summary

- Stressful/traumatic events are common in the perioperative environment
- Peer support is the most desired intervention after stressful events
- Changing the culture around peer support is challenging but not impossible!



35

HANDOUT

Perioperative Medicine. What is Now and What is Next

Moderator: TJ Gan, MD, MBA, MHS, FRCA, FFARCS (IRE), Lic Ac

Saturday, November 12
1:15 PM – 2:30 PM

HANDOUT

Perioperative Medicine. What is Now and What is Next: Introduction

TJ Gan, MD, MBA, MHS, FRCA, FFARCS (IRE), Lic Ac

Saturday, November 12
1:15 PM – 1:20 PM

HANDOUT

Perioperative Medicine. What is Now and What is Next: The Vision and Value of Perioperative Medicine

Angela F. Edwards, MD, FASA

Saturday, November 12
1:20 PM – 1:40 PM

HANDOUT

Perioperative Medicine. What is Now and What is Next: Where Are We Now?: Opportunities and Barriers for Advancing Perioperative Medicine at the National and Institutional Level

Matthew D. McEvoy, MD

Saturday, November 12
1:40 PM – 1:50 PM

Where Are We Now?: Opportunities and Barriers for Advancing Perioperative Medicine at the National and Institutional Level

Matthew D. McEvoy, MD

matthew.d.mcevoy@vumc.org @mattmcevoymd

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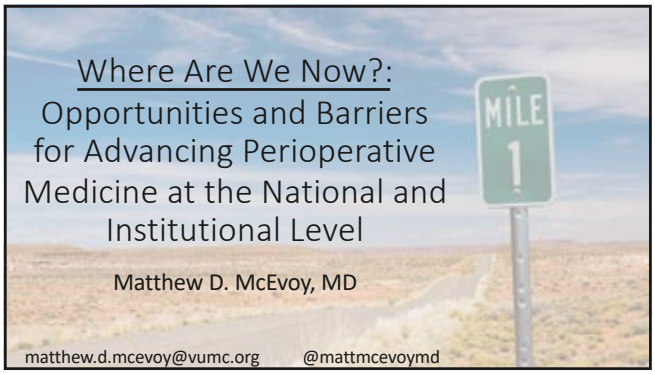


2

Disclosures

- Royaltiess from ASRA apps
- PeRLS (Perioperative Resuscitation and Life Support) Editorial Board for ASA
- President of ASER Perioperative Medicine
- I deeply believe Perioperative Medicine is one major part of the future of our specialty… but we have to actually practice it to teach it to practice it

3

Learning Objectives

By the end of this presentation, the learner should be able to:

- Describe the current state of Perioperative Medicine in the United States
- Discuss next steps for extending the impact of Anesthesiology within the subspecialty of Perioperative Medicine
- Describe how they could be a part of expanding the scope of Anesthesiologists to be Perioperative Physicians in the future

4

Who am I to talk about this?

5

My profile…

Professor of Anesthesiology and Surgery…	Practice anesthesia in the OR
Vice-Chair of Perioperative Medicine…	Oversee this area in our dept
Medical Director, VUMC Enhanced Recovery Programs…	Collaborate with teams/systems
Program Director, Perioperative Medicine Fellowship…	Teach this to residents/fellows
Medical Director, Hi-RiSE Preoperative Optimization Clinic…	Practice the medicine in clinic
Director, Perioperative Consult Service…	Practice the medicine in-hospital
Department of Anesthesiology…	I am on the same team as you!

6

What is Perioperative Medicine?

7

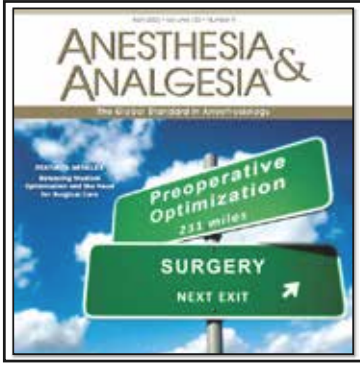
Perioperative medicine is a multidisciplinary subspeciality composed of practitioners who can effectively identify and meet the *complex medical needs of patients at particular risk from the adverse effects of surgical treatment*… from decision to post-discharge

Grocott MPW and Pearse RM, BJA;108: 723–6

8

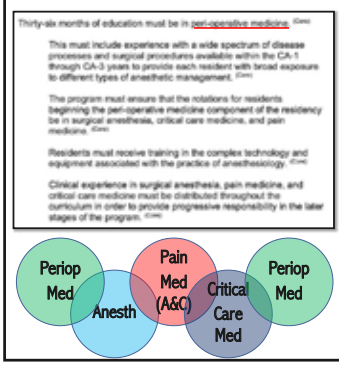
Where are we now?

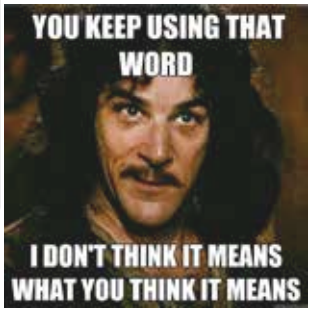
9



- Lots of editorials
- A number of name changes
  - SAAA → SAAAPM
- Dying of the Surgical Home
- Reduced training time in perioperative medicine
- Ambiguity over what 'perioperative medicine' actually means

10





11

Change Your Institutional Discussion to Change the National Discussion

12

Perioperative Physician/Leader: 2 Features

Improve Sick Systems of Care

13

Capacity Pillar: ERAS

VUMC ERP Score Card with Quarterly Reporting to Hospital Leadership

14

Capacity Pillar: CMI Adj. RLOS ERAS and No ERAS

FY23TD

		Case Counts	Avg. Discharge Orders in by 9:30AM	Avg. Discharged Before 11AM	CMI Adj. RLOS
FY 2022	ERAS	2,967	43.6%	21.9%	1.74
	SURGICAL	15,389	24.8%	14.8%	2.02
	MEDICAL	25,119	20.6%	13.6%	3.98
FY 2023	ERAS	924	44.9%	23.5%	1.71
	SURGICAL	4,689	25.2%	16.3%	2.02
	MEDICAL	7,557	22.7%	15.6%	4.10

ERAS Service Lines include Bariatrics, C-Section, Colorectal, Gynecology, Hernia, Hip Fracture, Soft Tissue Sarcoma, Total Joint Replacement, Urology (Cystectomy)

15

Capacity Pillar: FY 22 Readmission Rates ERAS vs No ERAS

Inpatient Surgical patients only

Avg 30d Readm: 6.2%

Avg 30d Readm: 9.4%

Avg 30d Readm: 10.8%

ERAS
Total # inpatients= 2,967
Avg Readmission RLOS = 4.51

Median Readmission RLOS = 3
Service Lines include Bariatrics, C-Section, Colorectal, Gynecology, Hernia, Hip Fracture, Soft Tissue Sarcoma, Total Joint Replacement, Urology (Cystectomy)

Non-ERAS (Surgical)
Total # inpatients= 15,389
Avg Readmission RLOS = 6.09

Median Readmission RLOS = 4

Non-ERAS (Medical)
Total # inpatients= 25,119
Avg Readmission RLOS = 6.96

Median Readmission RLOS = 4

16

Capacity Pillar: RLOS for Live ERAS Populations

	Prior Fiscal Year	Fiscal Year to Date	Prior Fiscal Quarter	Fiscal Quarter to Date
Distinct Encounters	1,595	1,043	366	77
CMI Adj. RLOS	1.73	1.71	1.73	1.41
Median RLOS	2.20	2.18	2.20	1.68
Average RLOS	2.75	2.73	2.73	2.00

ERAS Service Lines include Bariatrics, C-Section, Colorectal, Gynecology, Hernia, Hip Fracture, Soft Tissue Sarcoma, Total Joint Replacement, Urology (Cystectomy)

17

Capacity Pillar: RLOS & ERAS Pathway Compliance for Live ERAS Populations

Overall compliance continues to improve across service lines, allowing incremental LOS gains.

Monthly Avg RLOS & Overall Compliance Trend

Compliance with a formal ERAS pathway is inversely correlated with rLOS, as seen in our own data and in published evidence (with greatest gains in LOS associated with Compliance > 80-90%)

ERAS Service Lines include Bariatrics, C-Section, Colorectal, Gynecology, Hernia, Hip Fracture, Soft Tissue Sarcoma, Total Joint Replacement, Urology (Cystectomy)

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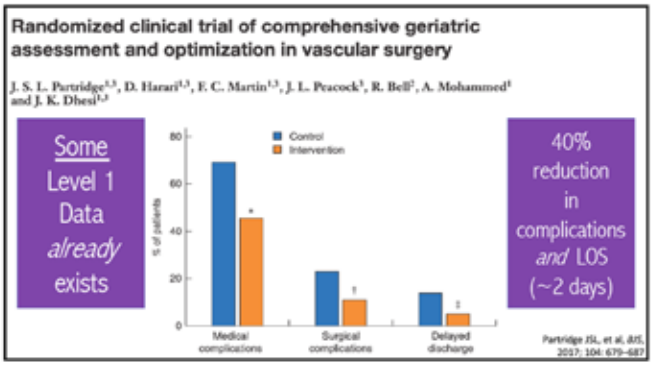

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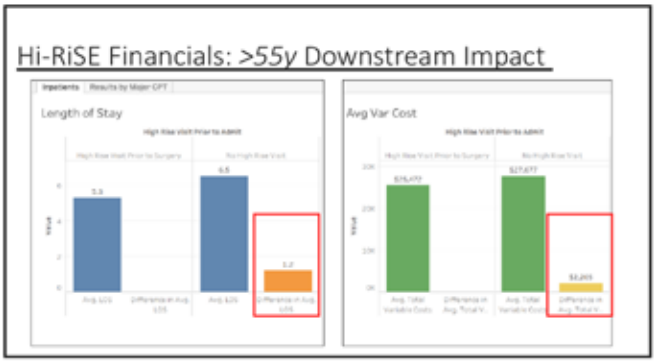

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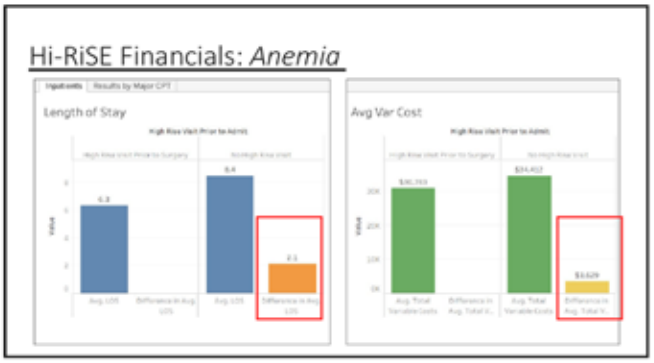

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Hi-RiSE Financials: *Malnutrition*

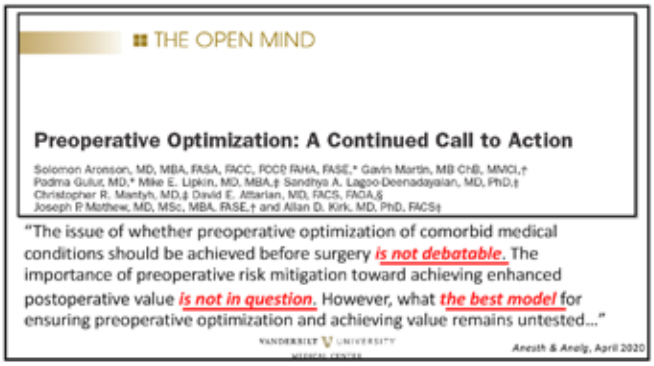
25

What is next?

26

Better data...

27



THE OPEN MIND

Preoperative Optimization: A Continued Call to Action

Solomon Aronson, MD, MBA, FASA, FACC, FCCP, FAHA, FASE,* Gavin Martin, MB ChB, MMCI,† Padma Gulur, MD,* Mike E. Lipkin, MD, MBA,‡ Sandhya A. Lagoo-Deenadayalan, MD, PhD,‡ Christopher R. Mantyh, MD,‡ David E. Attarian, MD, FACS, FACA,§ Joseph P. Mathew, MD, MSc, MBA, FASE,† and Allan D. Kirk, MD, PhD, FACS‡

"The issue of whether preoperative optimization of comorbid medical conditions should be achieved before surgery ***is not debatable.*** The importance of preoperative risk mitigation toward achieving enhanced postoperative value ***is not in question.*** However, what ***the best model*** for ensuring preoperative optimization and achieving value remains untested..."

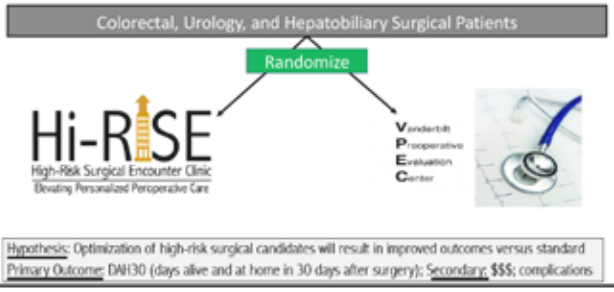
VANDERBILT UNIVERSITY MEDICAL CENTER

Anesth & Analg, April 2020

28

Caveat: Association, but what about causation?

Planning RCT launch for early 2023 (N ~950 pts)

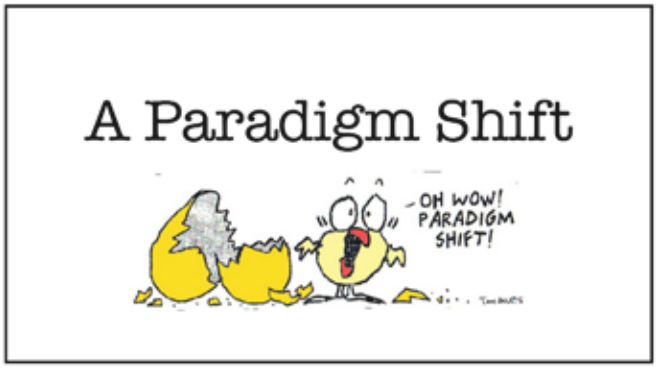


Hypothesis: Optimization of high-risk surgical candidates will result in improved outcomes versus standard
Primary Outcome: DAH30 (days alive and at home in 30 days after surgery); Secondary: $$$; complications

29

What is (urgently) needed (from the leaders in our specialty)?

30



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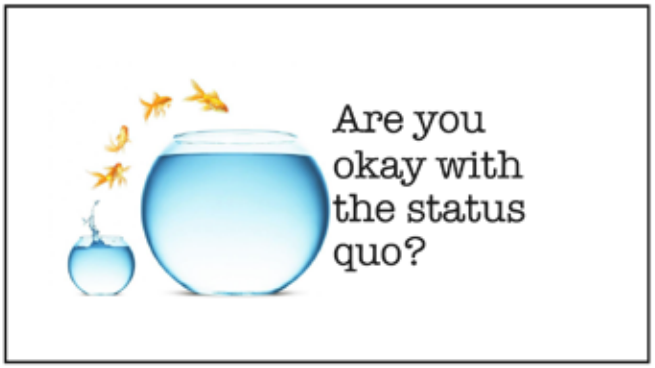

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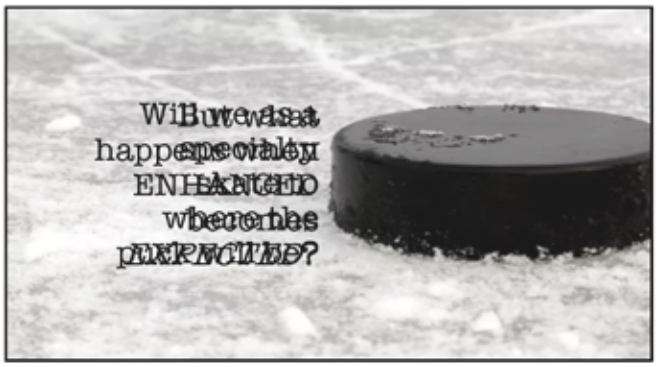

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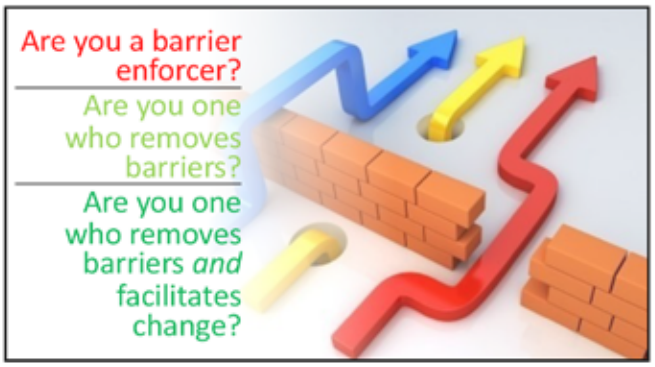

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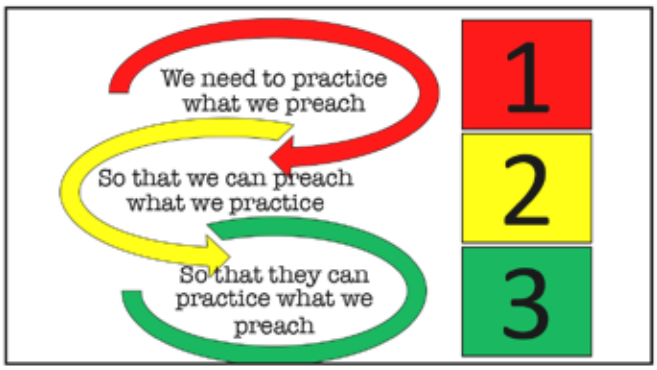

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36

Encourage Learning Now…

- For faculty and trainees

American Society of Anesthesiologists · IARS · ASER · SPAQI · Perioperative Medicine Summit · Vanderbilt Perioperative Medicine Seminar

37

Encourage Learning Now…

- For faculty and trainees
- For future perioperative physicians

38

Topic: ACGME Training Requirements for Anesthesiology

- Cardiac anesthesia → 2 months
- OB anesthesia → 2 months
- Pediatric anesthesia → 2 months
- Neuroanesthesia →
- Pain Medicine →
- Critical Care Medicine →

You can do a fellowship in all of these… and it is needed to practice this domain in any specialized manner

- Preoperative Medical Optimization (climbing the mountain) →
- Postoperative Inhospital Care (summiting the peak) →
- Post-acute Medical Care (descending the mountain) →

…and is more likely if you aren't prepared here

Most injury, disability, and death occurs here

39

In-Person Clinical Perioperative Medicine, Quality, and Safety Fellowships in the US

Vanderbilt University Medical Center · UW Medicine University of Washington Medical Center · UCIrvine · Washington University in St. Louis School of Medicine · Brigham Health Brigham and Women's Hospital · Wake Forest Baptist Medical Center · DukeHealth · Beth Israel Deaconess Medical Center · UC San Diego Health System · Tulane Health System · UCLA Health · Stanford Medicine · Michigan Medicine

40

You don't have to ask permission to take responsibility.

EDWIN CATMULL

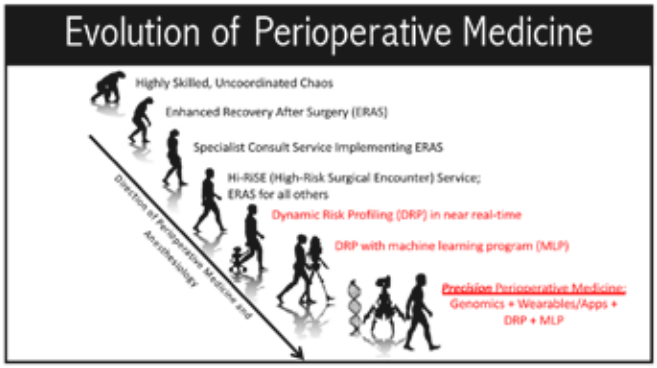
We should be collaborative with other specialties and invite them in, but we do not need to ask them for permission. Period.

41

Thank you!

matthew.d.mcevoy@vumc.org @mattmcevoymd

42


Evolution of Perioperative Medicine
Highly Skilled, Uncoordinated Chaos
Enhanced Recovery After Surgery (ERAS)
Specialist Consult Service Implementing ERAS
Hi-RISE (High-Risk Surgical Encounter) Service;
ERAS for all others
Dynamic Risk Profiling (DRP) in near real-time
DRP with machine learning program (MLP)
Precision Perioperative Medicine:
Genomics + Wearables/Apps +
DRP + MLP
Direction of Perioperative Medicine and Anesthesiology

43

HANDOUT

Perioperative Medicine. What is Now and What is Next: Training the Next Generation of Perioperative Physicians: A Close Up Look at Fellowship Training

Jenna D. Blitz, MDD, FASA, DFPM

Saturday, November 12
1:50 PM – 2:20 PM

Training the Next Generation of Perioperative Physicians:
A Close Up Look at Fellowship Training

Jeanna Blitz, MD, FASA, DFPM
Associate Professor of Anesthesiology, Duke University
Director, Preoperative Anesthesia and Surgical Screening Clinic
Director, Perioperative Medicine Fellowship

1

Disclosure

President, Society for Perioperative Assessment and Quality Improvement

www.spaqi.org

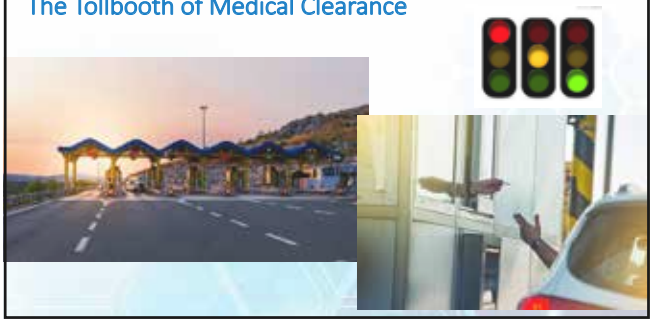
2

Objectives

- Delineate the key tenets of Perioperative Medicine (POM)
- Define the skillset of the of POM specialist
- Review the current state of POM fellowship curriculum
- Highlight the gap between current and ideal state

3

The Tollbooth of Medical Clearance



4

Measure Value by Measuring Outcomes:

- **Health status achieved** or retained
- **Recovery Process**:
  - **Time to recovery**
  - **Barriers to recovery**
- **Sustainability of health**:
  - Recurrences
  - Long-term consequences of treatment
  - Long-term clinical and functional status

5

Achieving the Quintuple Aim

Outcomes driven models require an **"integrator"** who accepts responsibility for all of the aims

The IHI Triple Aim | IHI - Institute for Healthcare Improvement: www.ihi.org
The Quintuple Aim Image:
Accreditation Q-Tip: Quality Improvement at WCH | Women's College Hospital (womenscollegehospital.ca)

6


Health Outcomes
Health Factors
Policies & Programs
Magnan S. 2017 Social Determinants of Health 101 for Health Care: Five Plus Five. NAM Perspectives

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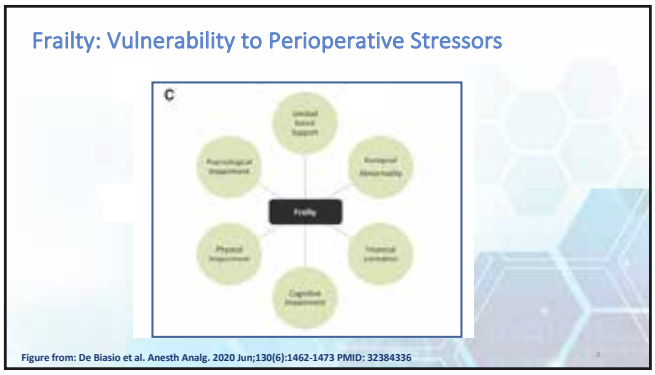
Frailty: Vulnerability to Perioperative Stressors
C
Frailty
Figure from: De Biasio et al. Anesth Analg. 2020 Jun;130(6):1462-1473 PMID: 32384336

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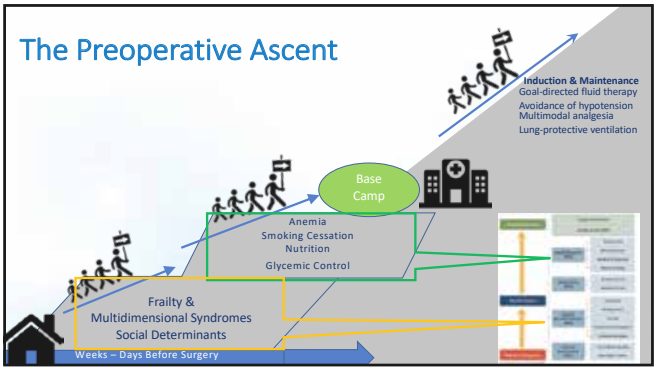
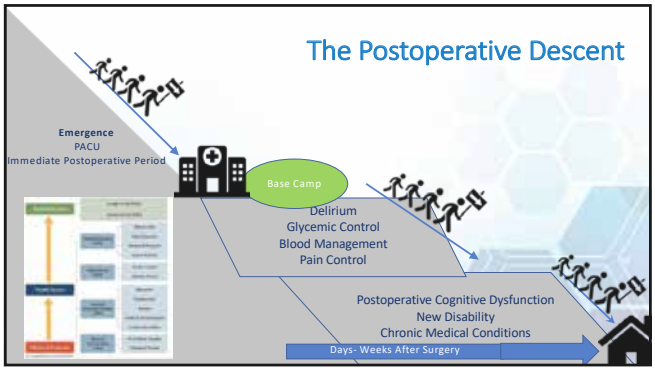
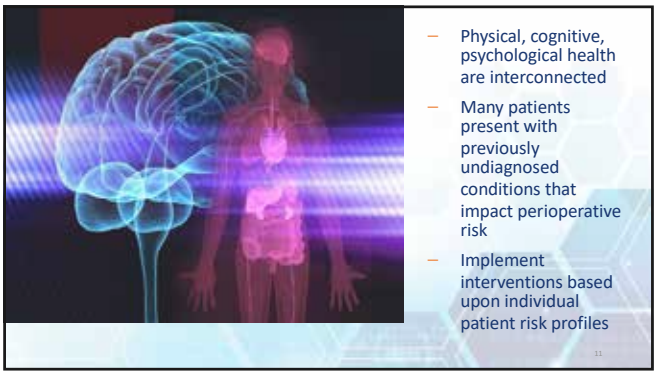

The Preoperative Ascent
Induction & Maintenance
Goal-directed fluid therapy
Avoidance of hypotension
Multimodal analgesia
Lung-protective ventilation
Base Camp
Anemia
Smoking Cessation
Nutrition
Glycemic Control
Frailty &
Multidimensional Syndromes
Social Determinants
Weeks – Days Before Surgery

9


The Postoperative Descent
Emergence
PACU
Immediate Postoperative Period
Base Camp
Delirium
Glycemic Control
Blood Management
Pain Control
Postoperative Cognitive Dysfunction
New Disability
Chronic Medical Conditions
Days- Weeks After Surgery

10


Physical, cognitive, psychological health are interconnected
Many patients present with previously undiagnosed conditions that impact perioperative risk
Implement interventions based upon individual patient risk profiles

11


Traveler, there is no path. The path is forged as you walk.
— Antonio Machado, Campos de Castilla.1
Rapidly adapt to challenges in a dynamic environment is critical to success:
Changing plans
Obscured paths
Anticipate obstacles

12

13

Population Health and the Perioperative Period

Ambulatory Anesthesia: The Innovating Edge of Perioperative Medicine?

- Optimization to improve candidacy for ambulatory surgery
- Patient's desire to avoid hospital based-location or admission
- Hospital's desire to maximize resource allocation
- Ability to improve health outcomes

14

The Tenets

1. POM exists in the continuum between diagnosis, surgery, and postoperative recovery
2. The proficient POM specialist is skilled in managing patient complexities throughout the entire perioperative continuum
3. The perioperative period requires different therapeutic targets and approaches to optimization of chronic conditions
4. Perioperative medicine is *both* the creation of safe, evidence-based pathways, *and* the act of guiding the patient through complex and nuanced decisions

15

The Tenets

5. Take a holistic approach to address all domains that impact vulnerability to perioperative stress
6. Aim to improve patients' perioperative outcomes and long-term health
7. Measure value by measuring outcomes: time and quality of recovery, impact upon long-term health
8. A nuanced appreciation of system resources within various surgical settings is critical to success

16

The Skillset of the POM Specialist

17

Prehabilitation

- Multidimensional syndromes are best addressed with multi-modal interventions
- 3 domains:
  - Functional Status
  - Nutrition
  - Psychological State
- Withstand the physical and psychological stress of the perioperative period

Norris CM et al. Anesthesia and Analgesia 2020 PMID 32384342; Kow AW. Ann Acad Med Singap. 2019. PMID: 31960020

18

Mobility, Functional Capacity, Cardiac Risk Assessment

- Functional status is an independent predictor of postoperative adverse events
- Wide variation in the degree of age-related changes to the respiratory and cardiovascular systems
- Mobility and gait speed assessments are important components

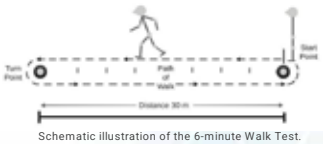
19

Chair Sit to Stand

Assessment 30-second Chair Stand (cdc.gov)
Last accessed Sept 2022

20

Gait Speed Tests



Schematic illustration of the 6-minute Walk Test.
V Benavent-Caballer.

21

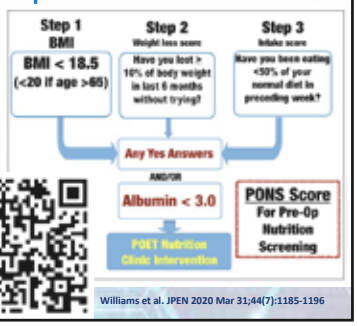
Feasibility and Rationale for Incorporating Frailty and Cognitive Screening Protocols in a Preoperative Anesthesia Clinic

Amini S. et al. Anesth Analg 2019 Sept; 129(3): 830-838

22

Nutrition Optimization

Precipitating Factors for Delirium in Hospitalized Elderly Persons
Predictive Model and Interrelationship With Baseline Vulnerability



Increased Risk:
- Delirium
- Length of Stay
- Readmission

Williams et al. JPEN 2020 Mar 31;44(7):1185-1196

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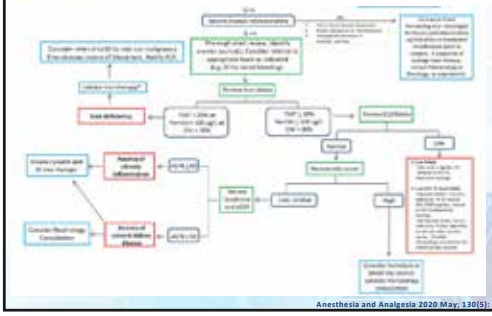
Anemia Management



Anesthesia and Analgesia 2020 May; 130(5): 1364-1380 PMID: 32167979

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Who Smokes?

Education Level	Prevalence
GED	43.0%
High school graduate	21.7%
Some college	19.7%
Associate degree	17.1%
Undergraduate degree	7.9%
Postgraduate degree	5.4%

Income Status	Prevalence
Below poverty level	26.3%
At or above poverty level	15.2%

Mental Health Conditions:

- 40% of men and 34% of women with a mental health condition smoke
- 31% of all cigarettes are smoked by adults with a mental health condition

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Anxiety and Depression

Preoperative anxiety predicted the incidence of postoperative delirium in patients undergoing total hip arthroplasty: a prospective cohort study

BMC Anesthesiol 2021. PMID: 33579195

Postoperative Delirium: Acute Change with Long-Term Implications

Anesthesia and Analgesia 2011. PMID: 21474660

Measures of Executive Function and Depression Identify Patients at Risk for Postoperative Delirium

Anesthesiology 2009. PMID: 19326494

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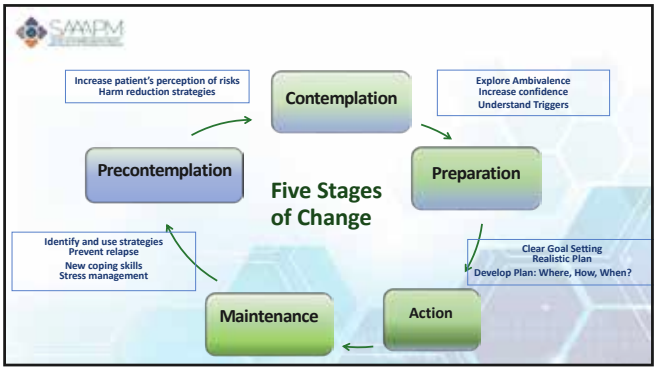

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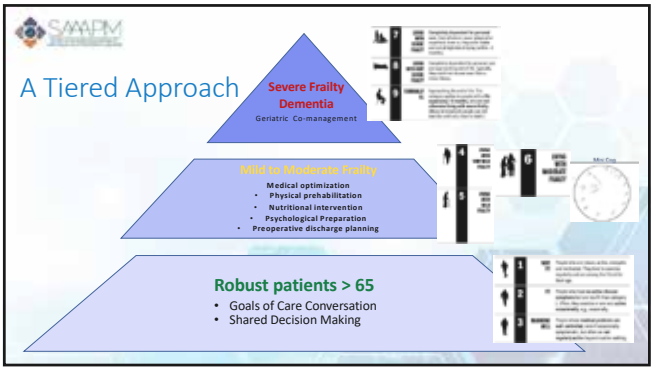
A Tiered Approach



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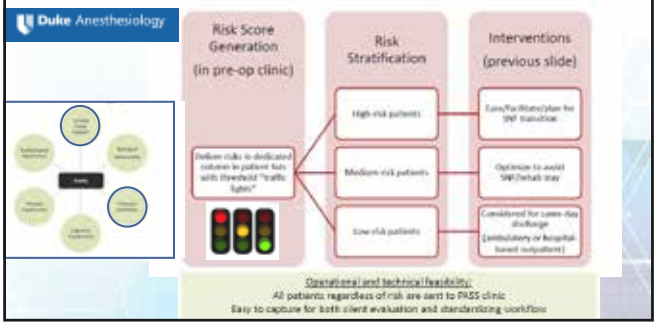
Preoperative Case Management Intervention



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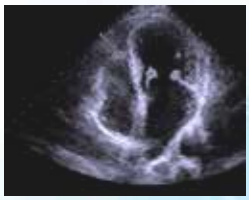
Role of diagnostic point-of-care ultrasound in preoperative optimization: a narrative review

PMID: 34686645



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Perspective
August 2015
JAMA Internal Medicine

Communication—The Most Challenging Procedure

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Ideal State of Fellowship Curriculum

Preoperative Clinic | Operating Room | PACU and Postop Floors

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ASA Ad Hoc Committee on Perioperative Medicine

- Most key systems-based and interdisciplinary concepts required for success are not included in current residency curriculum
- Multiple POM fellowships exist, but lack standardization
- **Aim: To develop and define a standardized set of competencies to be included in perioperative medicine (POM) fellowship training programs for anesthesiologists in the United States**

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Fellowship Workgroup Members

- Current Perioperative Medicine Fellowship Directors
- Former Fellows active in Perioperative Medicine
- Education Development and Research Expert
- National and International Experts in Perioperative Medicine
- Chairs of Academic Anesthesiology Departments
- ASA Leadership

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In-Person Clinical Perioperative Medicine, Quality, and Safety Fellowships in the US

Vanderbilt University Medical Center
UW Medicine University of Washington Medical Center
UCI Irvine
Washington University in St. Louis School of Medicine
Brigham Health Brigham and Women's Hospital
Wake Forest Baptist Medical Center
DukeHealth
Beth Israel Lahey Health Beth Israel Deaconess Medical Center
UC San Diego Health System
Tulane Health System
UCLA Health
Stanford Medicine
Michigan Medicine

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Consensus on Curriculum Elements

Preoperative Clinic → Operating Room → PACU and Postop Floors

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Next Steps

- Provide a reference document to align programs and standardize the definition of a fellowship trained POM physician
- Planned submission end of 2022
- Additional studies to determine the value and utility of the recommendations across different healthcare systems and practice environments
- Feedback re: barriers and facilitators of implementation at the departmental and institutional level

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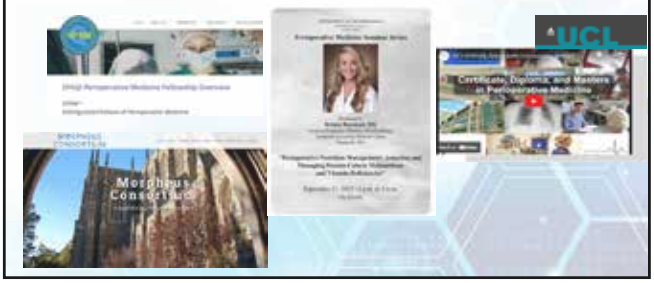
Non-Traditional Training Opportunities

- Preceptorships at various hospitals with strong POM programs



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Summary

- Support existing clinical fellowships by referring residents
- Create positions for POM specialists within your departments
- Leverage non-traditional training opportunities for anesthesiologists interested in POM
- Promote the value of a POM-trained anesthesiologist

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