HANDOUT

AASPD
Association of Anesthesiology Subspecialty Program Directors

# Quality Improvement in Real Life Anesthesia Practice: What Our Trainees Need to Know

Richard P. Dutton, M.D., M.B.A.

11/11/2016
8:15am – 8:40am

# QUALITY IMPROVEMENT IN REAL-LIFE ANESTHESIA PRACTICE: WHAT TRAINEES NEED TO KNOW

Richard P. Dutton, MD MBA
Chief Quality Officer
US Anesthesia Partners

## Disclosure

- I am a shareholder in US Anesthesia Partners
  - *Houston, Dallas, Denver, Orlando*
- I have no investment in companies providing healthcare goods
- I am not paid by any other company
- I work clinically at Baylor University Medical Center, Dallas
  - *Not a university hospital!*
  - *Large community hospital: Level 1 trauma, cardiac, transplant*
- I am motivated to improve patient care

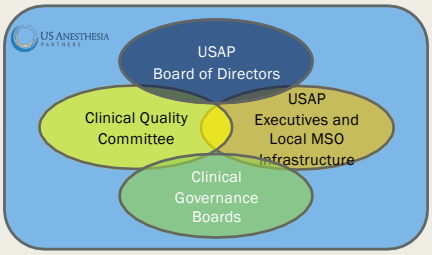
## Learning Objectives

- Recognize what a large group practice looks like in 2016
  - *Size and scope*
  - *Personnel*
- Understand why quality is a competitive advantage
  - *Regulatory requirements*
  - *Hospital partnerships*
- Learn what will be expected of a new-grad resident

## US Anesthesia Partners

- A true partnership -- member groups buy in
- The largest physician-owned company in the world
- Deep penetration in selected markets
- Physicians own all clinical governance
  - *Hiring, firing, staffing, schedules, compensation*
- Supported by the corporate umbrella
  - *Contracts, coding, billing, HR, malpractice, legal, compliance, information technology, QUALITY*

## Physician Governance - Collaborative Environment




## USAP Personnel Census

## Quality Improvement as a Competitive Advantage

- We want to take the best care of our patients
- We want our professionals to know their status
- We want to work with our hospital partners
- We want to work with payers
  - *CMS (measures and regulatory reporting)*
  - *Commercial insurance contracts*
- We want to create the right future

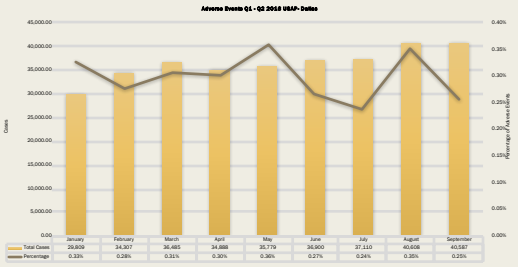
## USAP Quality: What I Ask For

- Outcomes capture from every case
- Patient satisfaction measurement in every practice
- Incident capture and review
- Participation in hospital quality programs
- Successful PQRS reporting
- Sharing best practices

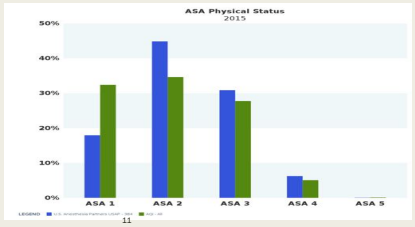
## Outcomes Capture

- Every case, every day
- Electronic form, linked to billing ticket
- Measure elements established annually by CQC
- Options:
  - *USAP Internal ("e-bluesheet"; South Texas, Orlando)*
  - *MD Cloud (North Texas)*
  - *Medaxian (Colorado)*

## Cases and Adverse Events




## Patient Demographics

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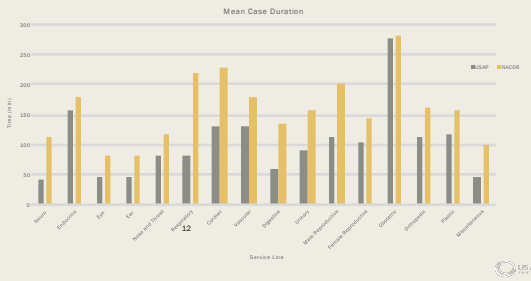
## Practice Efficiency

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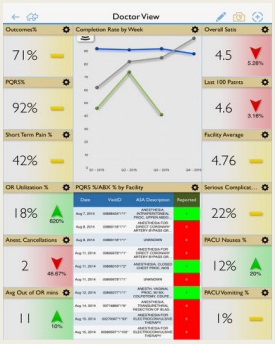
## Outcomes – 155,000 Cases in 2015

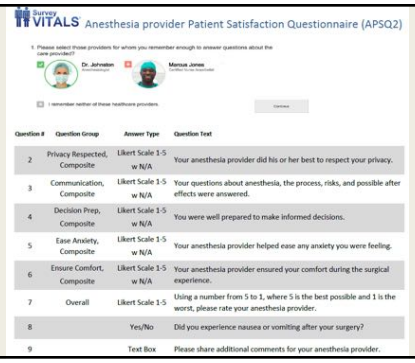
| Outcome | N | Rate | NACOR |
|---|---|---|---|
| Adverse Drug Reaction | 19 | 0.012% | 0.019% |
| Anaphylaxis | 2 | 0.001% | 0.006% |
| Aspiration | 15 | 0.010% | 0.024% |
| Cardiac Arrest | 20 | 0.013% | 0.075% |
| Case Cancellation | 52 | 0.033% | 0.063% |
| Death | 5 | 0.003% | 0.037% |
| Eye Injury | 21 | 0.014% | 0.005% |
| PONV | 169 | 0.109% | 3.010% |
| Post-Dural Puncture Headache | 9 | 0.006% | 0.031% |
| Neurologic Deficit | 3 | 0.002% | 0.020% |
| Reintubation | 30 | 0.019% | 0.060% |
| Respiratory Arrest | 7 | 0.005% | 0.007% |
| Unplanned Admission | 14 | 0.009% | 0.094% |
| Unplanned ICU Upgrade | 34 | 0.022% | 0.115% |

## Dashboards




## Drill Down

# Patient Satisfaction



Survey VITALS Anesthesia provider Patient Satisfaction Questionnaire (APSQ2)

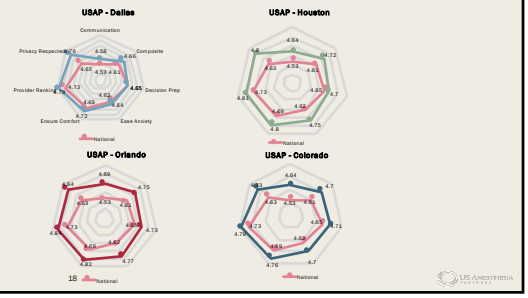
1. Please select those providers for whom you remember enough to answer questions about the care provided?

Dr. Johnston — Marcus Jones

I remember neither of these healthcare providers.

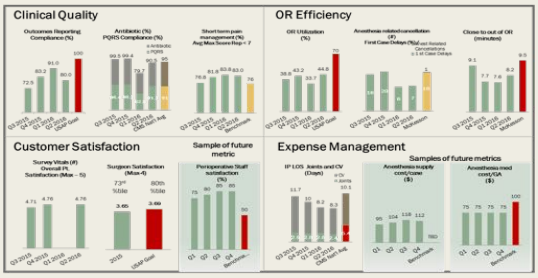
| Question # | Question Group | Answer Type | Question Text |
|---|---|---|---|
| 2 | Privacy Respected, Composite | Likert Scale 1-5 w N/A | Your anesthesia provider did his or her best to respect your privacy. |
| 3 | Communication, Composite | Likert Scale 1-5 w N/A | Your questions about anesthesia, the process, risks, and possible after effects were answered. |
| 4 | Decision Prep, Composite | Likert Scale 1-5 w N/A | You were well prepared to make informed decisions. |
| 5 | Ease Anxiety, Composite | Likert Scale 1-5 w N/A | Your anesthesia provider helped ease any anxiety you were feeling. |
| 6 | Ensure Comfort, Composite | Likert Scale 1-5 w N/A | Your anesthesia provider ensured your comfort during the surgical experience. |
| 7 | Overall | Likert Scale 1-5 | Using a number from 5 to 1, where 5 is the best possible and 1 is the worst, please rate your anesthesia provider. |
| 8 | | Yes/No | Did you experience nausea or vomiting after your surgery? |
| 9 | | Text Box | Please share additional comments for your anesthesia provider. |

## Patient Satisfaction

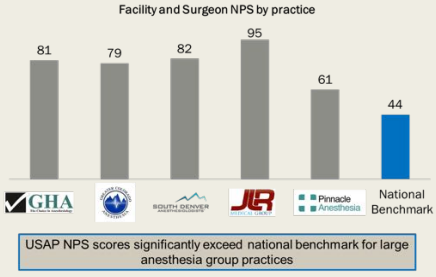


# Hospital Partnership

## Scorecards

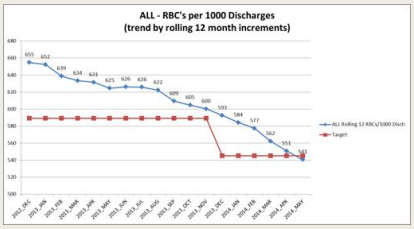



## Other Customers

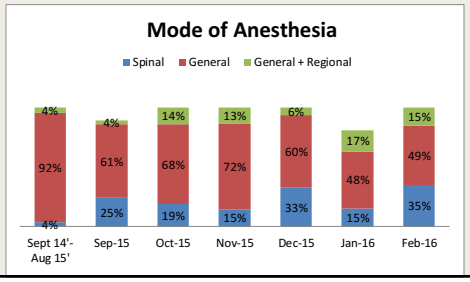



USAP NPS scores significantly exceed national benchmark for large anesthesia group practices

## Patient Blood Management




## Same Day Joint Surgery (BUMC)




## Perioperative Surgical Home Scorecard

| Pilot (Sept. 14'-Aug. 15') from Baseline (July 13'-Dec. 13') | Total Hip Replacement | Total Knee Replacement | Hip Fracture |
|---|---|---|---|
| LOS | Decreased 16.55% | Decreased 17.38% | Increased 4.98% |
| Direct Cost | Decreased 8.79% | Decreased 3.48% | Decreased 4.68% |
| 30 day Readmissions | Decreased 28.35% | | Decreased 44.96% |
| Pre-op education (Joint class attendance) | Increased 137.5% | | N/A |
| PACU (Recovery room) time | Increased 8.73% | Increased 4.18% | Decreased 6.83% |
| Patient Satisfaction | Increased by 2.4% | | |
| Blood transfusion utilization post-operatively | Decreased by 49% | Decreased 64.74% | Decreased 24.25% |
| One Day Joint Patients | Increased by 340% | Increased by 325% | N/A |

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# Regulatory Reporting

## "Pay for Performance"

- Federal programs to promote quality over quantity
  - *Based on measuring outcomes*
  - *Payment incentives and penalties*
  - *Public reporting*
- Today:
  - *Physician Quality Reporting System*
  - *Value Based Modifier*
  - *Meaningful Use*
- Applies to our reimbursement for traditional Medicare cases (but drives requirements for all payers)
- **Major change coming in 2019**

## Quality and Resource Use Report (Texas)


## Quality and Resource Use Report (Texas)

| | | Your TIN | | | | All TINs in Peer Group | |
|---|---|---|---|---|---|---|---|
| Measure Identification Number(s) | Measure Name | Number of Eligible Cases | Performance Rate | Standardized Performance Score | Included in Domain Score? | Benchmark (National Mean) | Standard Deviation |
| 76 | Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections | 13,288 | 99.93% | 0.66 | Yes | 84.20% | 23.98 |
| 145 | Radiology: Exposure Time Reported for Procedures Using Fluoroscopy | 2 | 100.00% | 0.89 | No | 77.92% | 24.88 |
| 193 | Perioperative Temperature Management | 391,246 | 99.68% | 0.62 | Yes | 93.11% | 10.68 |
| AQI 6 | Immediate Perioperative Cardiac Arrest Rate | 615,580 | 0.03% | — | No | — | — |
| AQI 7 | Immediate Perioperative Mortality Rate | 622,998 | 0.01% | — | No | — | — |
| AQI 8 | PACU Reintubation Rate | 526,275 | 1.69% | — | No | — | — |
| AQI 10 | Composite Procedural Safety for Central Line Placement | 90,675 | 99.69% | — | No | — | — |
| AQI 12 | Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics | 466,048 | 63.57% | — | No | — | — |
| AQI 13 | Perioperative Temperature Management | 428,630 | 55.74% | — | No | — | — |
| AQI 14 | Preoperative Use of Aspirin for Patients with Drug-Eluting Coronary Stents | 598,337 | 99.40% | — | No | — | — |
| AQI 15 | Surgical Safety Checklist - Applicable Safety Checks Completed Before Induction of Anesthesia | 600,750 | 99.85% | — | No | — | — |
| AQI 17 | Corneal Injury Diagnosed in the Post-Anesthesia Care Unit/Recovery Area After Anesthesia Care | 296,003 | 99.99% | — | No | — | — |

## MACRA – Specific Actions

- Push data capture/transmission/analysis/reporting
  - *Demographics*
  - *Patient Centered Clinical Outcomes*
  - *Cost accounting*
- Participate in measure design discussions
- Launch some trial balloons (e.g. Pre-op Assessment, PSH, joint replacement bundles)
  - *Coordination of care experiments*
  - *Novel payment mechanisms*
- Submit ABA Part IV or ABMS Portfolio applications
- Understand meaningful use requirements
- Negotiate against downside risks

## Questions? Contact Me!

richard.dutton@usap.com

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Association of Anesthesiology Subspecialty Program Directors

# Tapping Into Hospital Wide Projects

Colleen Koch, M.D., M.S., M.B.A., F.A.C.C.

11/11/2016
8:40am – 9:05am

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# Quality Improvement and Safety: *Tapping into Hospital-wide Projects*

**Colleen Koch, MD, MS, MBA**
**Professor and Chair**
**Department of Anesthesiology and Critical Care Medicine**
**Johns Hopkins Medicine**

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## No Conflicts of Interest to Report

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## Objectives

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- Describe why it is important to engage trainees in hospital-wide quality and patient safety initiatives.
- Recognize the importance of implementing a structured educational framework for basic quality and safety core competencies.
- Integrate ideas and employ tools from examples provided on process improvement, quality and safety into your unique work environment.

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## Top Ten Reasons

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### Hospital

- Hospitals become safer places
- Bottom up approaches work best
- Residents are on the front-line of the hospital
- Improved patient outcomes and employee engagement
- Prevent near misses from becoming sentinel events

### Resident

- Learn and practice team-based skills
- Knowledge gain
- Collaboration and communication
- Doable with almost immediate return
- Benefit from doing the right thing for the patients and families

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## Getting Started: *A Framework for Meaningful Work*

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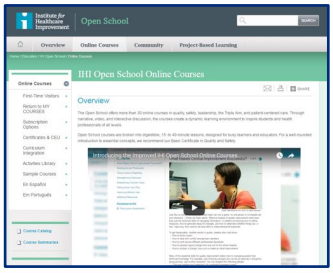


To: ACCM <ACCM@jhmi.edu>
**Subject:** IHI Open School Learning Opportunities

Hi ACCM,

As one of our Education and Patient- and Family-Centered Care strategic initiatives, all members of ACCM can access these essential training tools on safety, improvement, patient experience, leadership, etc. and also enter the IHI educational community of more than 250,000 learners.

Please find the instructions on how to log on to IHI Open School attached along with the course descriptions. Feel free to let me know if you have any questions.

Happy learning!

## Getting Started: *A Framework for Meaningful Work*

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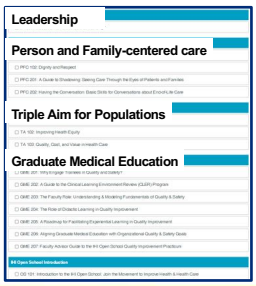

## Getting Started:
## *A Framework for Meaningful Work*

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**QI 103: Testing and Measuring Changes with PDSA Cycles**

In this course, we'll take you through basic concepts you need to know to run successful PDSA (Plan-Do-Study-Act) cycles in a clinical setting.

First, we'll teach you how to plan and conduct small-scale tests of change. We'll discuss how you can establish a helpful set of measures and how to design a data collection plan that facilitates rapid learning, using techniques such as sampling.

Next, we'll focus on studying the data you've collected, and we'll explain why a run chart is such a valuable tool at this stage of the process.

Finally, we'll show you how to act on your learning, possibly by increasing the size or scope of your next test cycle.

**Estimated Time of Completion:** 1 hour 15 minutes

**Lessons**

**Lesson 1:** How to Define Measures and Collect Data

**Lesson 2:** How to Use Data for Improvement

**Lesson 3:** How to Build Your Degree of Belief over Time

**Course Objectives**

After completing this course, you will be able to:

1. Describe how to establish and track measures of improvement during the "plan" and "do" phase of PDSA.
2. Explain how to learn from data during the "study" phase of PDSA.
3. Explain how to increase the size and scope of subsequent test cycles based on what you're learning during the "act" phase of PDSA.

**PS 103: Human Factors and Safety**

This course is an introduction to the field of human factors: how to incorporate knowledge of human behavior in the design of safe systems.

You'll explore case studies to analyze the human factors issues involved in health care situations. And you'll learn how to use human factors principles to design safer systems of care -- including the most effective strategies to prevent errors and mitigate their effects.

Finally, you'll learn how technology can reduce errors -- even as, in some cases, it can introduce new opportunities for errors.

**Estimated Time of Completion:** 1 hour

**Lessons**

**Lesson 1:** Understanding the Science of Human Factors

**Lesson 2:** Changes Based on Human Factors Design Principles

**Lesson 3:** Using Technology to Mitigate the Impact of Error

**Course Objectives**

After completing this course, you will be able to:

1. Explain how human factors principles apply to health care.
2. Describe how changes to processes can mitigate the effects of factors that contribute to error.
3. Define simplification, standardization, constraints, forcing functions, and redundancies.
4. Discuss the risks and benefits of using technology to improve patient safety.

## Getting Started:
## *A Framework for Meaningful Work*

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**PS 104: Teamwork and Communication in a Culture of Safety**

Effective teamwork and communication are critical parts of the design of safe systems. In this course, you'll learn what makes an effective team through case studies from health care and elsewhere. You'll analyze the effects of individual behavior for promoting teamwork, communication, and a culture safety. Finally, you'll learn several essential communication tools, such as briefings, SBAR, and critical language.

**Estimated Time of Completion:** 1 hour 15 minutes

**Lessons**

**Lesson 1:** Why Are Teamwork and Communication Important?

**Lesson 2:** How Can You Contribute to a Culture of Safety?

**Lesson 3:** Basic Tools and Techniques for Effective Communication

**Course Objectives**

After completing this course, you will be able to:

1. Explain why effective teamwork is essential for promoting patient safety.
2. Define a culture of safety and discuss the features of a strong safety culture.
3. Identify four behaviors anyone can use to promote teamwork, communication, and a culture of safety.
4. Use structured communication techniques to improve communication within health care.

**TA 103: Quality, Cost, and Value in Health Care**

This course will provide you with an overview of value in health care. We'll start by distinguishing between cost and value, and understanding how both of these concepts relate to quality. We'll introduce you to the growing problem of health care spending, as well as the health care practitioner's role in managing these costs. Finally, we'll explain how to identify and overcome barriers to providing high-value, cost-effective care.

**Estimated Time of Completion:** 45 minutes

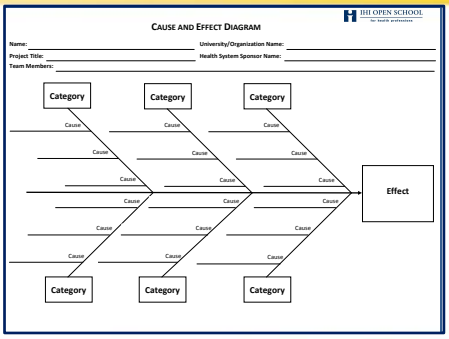
**Lessons**

**Lesson 1:** Quality, Cost, and Value in Health Care

**Course Objectives**

After completing this course, you will be able to:

1. Explain the potential harm of low-value tests and procedures.
2. Distinguish between cost and value in health care.
3. Define resource stewardship in health care.
4. Describe the ethical case for resource stewardship in health care.
5. Identify common barriers to resource stewardship and enablers of inappropriate resource use.

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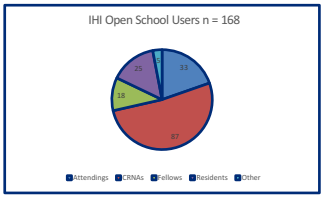


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## Getting Started:
## *Tracking Progress*

**Quick Stats**

**2,082** Courses Completed
**1,853.75** Credit Hours Collected

**Certificates Earned:**
- **71** Basic Certificate in Quality & Safety
- **42** Faculty Development - IHI Open School
- **73** Patient Safety - IHI Open School
- **79** Quality Improvement - IHI Open School

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## The Value of High Performance Teams

### Pyramid of Errors in Health Care

**Opportunities for learning:**
- **Complexity**
- **Interconnected**
- **Tight coupling**
- **Randomness**

**HP Teams as an Intervention**

**DEATH**
1

**PATIENT HARM**
5-10/death

**CLOSE CALLS**
caught at last 25-100/Injured pt.

**SLIPS/MISTAKES –**
discovered / corrected 125-1000/close call

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**Practical Example**

## Anesthesia Fellowship Initiative

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# Why are we doing this?

## The ACGME and You:

- As part of the ACGME program requirements for Graduate Medical Education in the area of Systems-based Practice Competency trainees
- "*Must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal heath care." "Trainees must work in inter-professional teams to enhance patient safety and improve patient care quality and participate in identifying system errors and implementing potential system solutions.*"

## Learner benefit:

- Gain practical experience in quality improvement, which is valued by educational systems and future employers.
- Work closely with faculty members with quality improvement knowledge and skills.
- Improve care in an area of interest.
- Leadership competencies.
- Operational efficiencies.

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## Quality and Patient Safety Project Report

**Project Title**:

**Team Members**:

**What are we trying to accomplish?**

**Background**: Why this topic is important to improve our processes-of-care and ultimately our patients' outcomes. You can reference the real-world case scenario to highlight the importance to patient quality and safety as well as cite literature on the topic. (1 page)

**Aim Statement**: A clear statement that includes the problem to be addressed that clearly justifies the need for improvement or a new process of care tool you are intending to evaluate.

**Interventions or changes to be tested**: Identify what interventions in care or items you intend to test/implement/ or evaluate.

**How do we know that a change is an improvement?**

**Outcomes or factors to be measured**: Choose/identify/ and define each variables you intend to measure or processes to be evaluated. Determine how you will measure it (is it something already collected in our electronic health system databases? Do you need an evaluation form with a series of questions to evaluate success of your improvement (i.e., turn-around time for blood product ordering or laboratory testing % success in identifying and documenting comorbid illness in preoperative evaluations, etc)?

## Practicum Summary Report at Project Completion

**Project Title**:

**Staff Mentor**:

**Team Members**:

**Aim of Project**:

**Planned changes that were tested/ evaluated**:

**What were your predictions**?

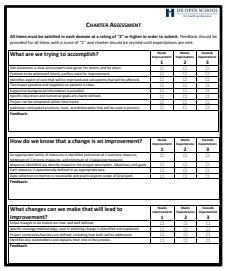
**What were your results**? (Use of graphics)

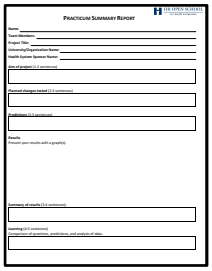
**Summary of results**:

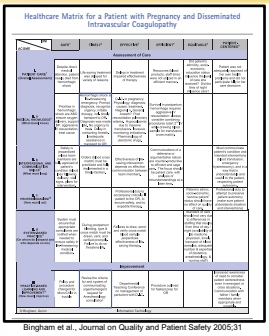
**Impact on processes-of-care or the health system**:

**Conclusion/s**:

**Reflections/Discussions**: (discuss the factors that promoted the success of the project and that were barriers to success. What did you learn from doing this project? What are your reflections on the role of the team?)







Bingham et al., Journal on Quality and Patient Safety 2005;31

**Healthcare Matrix**

Linking all six competencies (ACGME) with IOM aims for improvement with the goal to make readily apparent the linkage between competencies and outcomes.

## Fellow Team Projects

- **Operating Room Hand-offs**
- **OSA Management**
- **Massive Transfusion Protocol**
- **Jehovah Witness Perioperative Flow Plan**
- **Reduction in Phlebotomy Volume in CVICU**

## Surgical Fellow Team Project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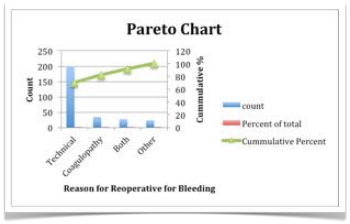
## Reason for Reoperation for Bleeding

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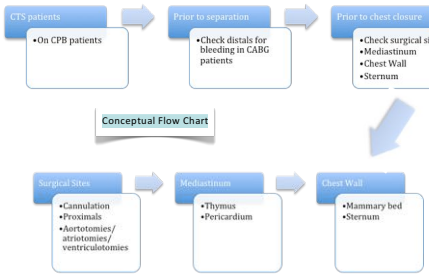
***Prior to Sternal Wires:***

☑ Surgical Sites
- ☐ Cannulation sites
- ☐ Proximals/ distals
- ☐ Aortotomies/ atriotomies/ ventriculotomies

☑ Mediastinum
- ☐ Thymus
- ☐ Pericardium

☑ Chest Wall
- ☐ Mammary bed

☑ Sternum

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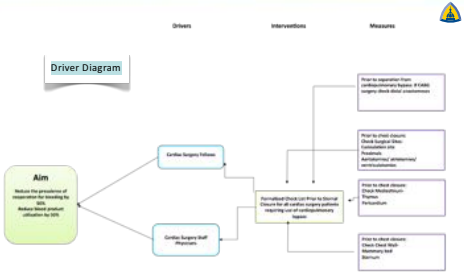


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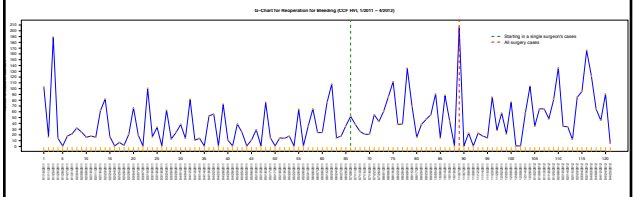
## G Chart for Reoperation for Bleeding



JOHNS HOPKINS MEDICINE

**CARDIOTHORACIC SURGICAL EDUCATION AND TRAINING**

## Process improvement in cardiac surgery: Development and implementation of a reoperation for bleeding checklist

Gabriel Loor, MD,[a] Alessandro Vivacqua, MD,[a] Joseph F. Sabik III, MD,[a] Liang Li, PhD,[b] Eric D. Hixson, PhD, MBA,[c] Eugene H. Blackstone, MD,[a,b] and Colleen G. Koch, MD, MS, MBA[d,e]

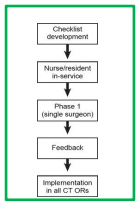
**Objective:** High-performing health care organizations differentiate themselves by focusing on continuous process improvement initiatives aimed at enhancing patient outcomes. Reoperation for bleeding is an event associated with considerable morbidity risk. Hence, our primary objective was to develop and implement a formal operative checklist to reduce technical reasons for postoperative bleeding.

**Methods:** From January 1, 2011, through June 30, 2012, 5812 cardiac surgical procedures were performed at Cleveland Clinic (Cleveland, OH). A multidisciplinary team developed a simple, easy-to-perform hemostasis checklist based on the most common sites of bleeding. An extensive educational in-service was performed before limited, then universal, checklist implementation. Geometric charts were used to track the number of cases between consecutive reoperations for bleeding. We compared these before (phase 0) and after the first limited implementation phase (phase 1) and the universal implementation phase (phase 2) of the checklist.

**Results:** The average number of cases between consecutive reoperations for bleeding increased from 32 in phase 0 to 53 in both phase 1 ($P = .002$) and phase 2 ($P = .01$).

**Conclusions:** A substantial reduction in reoperation for bleeding cases followed implementation of a formalized hemostasis checklist. Our findings underscore the important influence of memory aids that focus attention on surgical techniques to improve patient outcomes in a complex, operative work environment. (J Thorac Cardiovasc Surg 2013;146:1028-32)

*Journal of Thoracic and Cardiovascular Surgery 2013;146:1028*




JOHNS HOPKINS MEDICINE

## Process Improvement in Thoracic Donor Organ Procurement: Implementation of a Donor Assessment Checklist

Gabriel Loor, MD, Sara J. Shumway, MD, Kenneth R. McCurry, MD, Suresh Keshavamurthy, MD, Syed Hussain, MD, Garry D. Weide, DO, John R. Spratt, MD, Mazin Al Salihi, MD, PhD, and Colleen G. Koch, MD, MS

Division of Cardiothoracic Surgery, University of Minnesota Medical Center Minneapolis, Minnesota; Heart and Vascular Institute, Department of Thoracic and Cardiovascular Surgery, Cleveland Clinic, Cleveland, Ohio; and Division of Cardiothoracic Surgery, Department of Surgery, Emory University School of Medicine, Atlanta, Georgia

*Annals of Thoracic Surgery in press 2016*

**BEFORE SKIN INCISION**

- ❑ Consent for donation
- ❑ Blood type x's 2 (match)
- ❑ Brain death note x's 2
- ❑ Serologies
- ❑ Supplies

*Lung*

- ❑ CXR/ CT
- ❑ Bronch
- ❑ Vent (FiO2 100%, PEEP 5), ABG
- ❑ Limit IV fluids

*Heart*

- ❑ Echo
- ❑ Cath
- ❑ ECG
- ❑ Pressors

**BEFORE RETRIEVAL**

*Lungs*

- ❑ Nodules
- ❑ Selective ABG for singles
- ❑ Atelectasis, recoil
- ❑ Contusions, consolidation, edema

*Heart*

- ❑ Pericardial effusion
- ❑ Contractility (RV, LV)
- ❑ Coronary calcification
- ❑ Aortic calcification


JOHNS HOPKINS MEDICINE

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HANDOUT

AASPD
Association of Anesthesiology Subspecialty Program Directors

# Using the FORCE to Teach Quality, Safety & Value

Vineet M. Arora, M.D., M.A.P.P.

11/11/2016
9:05am – 9:30am

# Using the Force to Teach Quality, Safety, & Value in Academic Health Centers

VINEET ARORA MD MAPP
SOCIETY OF ACADEMIC ANESTHESIOLOGY ASSOCIATIONS
NOVEMBER 11, 2016

## Disclosures

Royalties from textbook *Understanding Value-Based Care*

Grant to support *Teaching Value & Choosing Wisely ® Challenge*

Grant support from NHLBI R25HL116372-01A1

## Objectives

To describe a conceptual framework for how to align medical education and the health system to improve the value of care provided by trainees

To share how to "Use the FORCE" to engage trainees to improve quality, safety, and value

## Merging Health System & Education Siloes

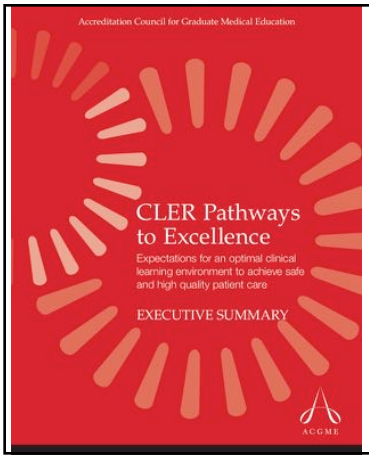

Merging the Health System and Education Silos to Better Educate Future Physicians

- Bridging leaders
- Engage frontline
- Go for win-win

Gupta & Arora 2015

## Clinical Learning Environment Review (CLER Program)


Focus is on alignment at the GME-hospital leadership level to coordinate the 6 focus areas




**Clinical Learning Environment Review**

QI Pathway 1: *Residents/fellows receive experiential training in..* ***overuse in diagnosis or treatment of patients***

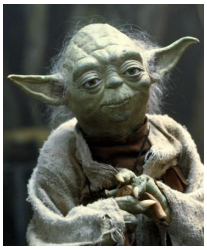

## IM Program Directors Perceptions

| Perceptions of Cost-Conscious Care | % Agree |
|---|---|
| GME has a responsibility to curtail costs of care | 85 |
| **Majority of faculty who work with residents model cost-conscious care** | **47** |
| Residents are prepared to incorporate value & costs into medical decisions | 43 |
| Residents in our program have access to information about costs of tests & procedures | 22 |

APDIM
Association of Program Directors in Internal Medicine

## Hidden Curriculum

- imbalanced focus on identifying rare cases
- sins of omission > sins of commission
- misperception that considering cost is not aligned with patient interests



***You must unlearn what you have learned! --Yoda***

## What is the Force?

*"It's an energy field created by all living things. It surrounds us and penetrates us; it binds the galaxy together."*

*--Obi Wan Kenobi*

## Ways to Use the Force to Teach Value

- Cultivate "situational awareness"
- Find the right champions
- Observe & understand cultural norms
- Embed "nudges" to promote the right thing
- Redesign the system

## Situational Awareness

**Situational awareness** = mindfulness of pt environment
- E.g. surgical timeout
- Reduces likelihood of medical errors

**Simulation** promotes situational awareness
- Hands-on training
- Risk-free environment for learning


**Do incoming interns have situational awareness as it relates to low value care practices?**

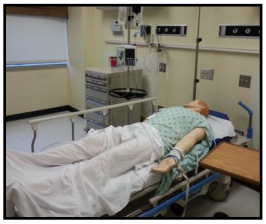
## The "Horror Room"

GME Orientation Boot Camp: 125 incoming interns

Inpatient simulation
- 55 y/o male, pneumonia, C. diff (+)
- Mock door chart

12 hazards of hospitalization
- 8 - patient safety
- 4 - low-value (overuse)

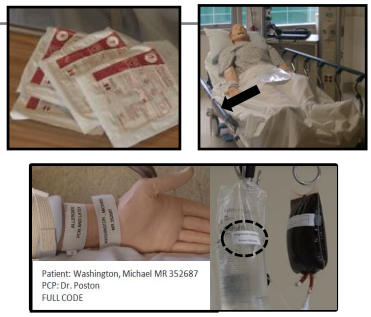
Assessment form
- List hazards identified
- Prior training



Farnan et al. BMJ Qual Saf 2015

## Safety Hazards in Horror Room

| SAFETY HAZARDS |
|---|
| No hand hygiene |
| Latex allergy |
| Bed rail down |
| Wrong name/wrong patient |
| No isolation precautions |
| Penicillin allergy |
| Wrong medication |
| No VTE prophylaxis |




AHRQ Agency for Healthcare Research and Quality

Medicare.gov | Hospital Compare
The Official U.S. Government Site for Medicare

## Low Value Hazards in Horror Room

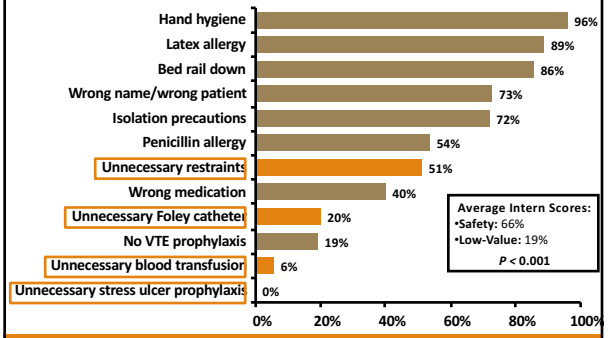
| LOW-VALUE HAZARD |
|---|
| Unnecessary restraints |
| Unnecessary Foley catheter (CAUTI risk) |
| Unnecessary blood transfusion |
| Unnecessary stress ulcer prophylaxis |

Patient is continuing a course of antibiotics for his pneumonia. He also has a history of HTN and DM2, well controlled on current regimen. Patient's home medications have been continued **with the addition of a PPI for stress ulcer prophylaxis**.

Choosing Wisely
An initiative of the ABIM Foundation

## % of Interns who Identified Hazards

*N* = 125

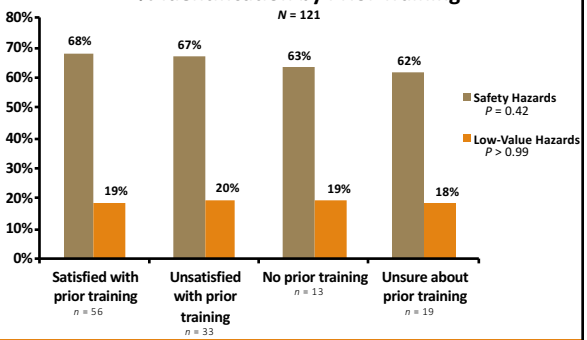



**Average Intern Scores:**
- **Safety:** 66%
- **Low-Value:** 19%

*P* < 0.001

## % Identification by Prior Training

*N* = 121




## Intern Feedback & Follow-Up

*I will [now] inherently approach every patient room "looking" for issues*

*Wish I had done this earlier in my career!*

*Really fun way to emphasize the importance of safety & value*

**One month into internship:**

- **69%** more aware of how to identify hospital hazards as a result of the Horror Room (*N* = 119)
- **52%** had taken action to reduce a hazard included in the simulation (*N* = 119)

## Ways to Use the Force to Teach Value

- Cultivate "situational awareness"
- Find the right champions
- Observe & understand cultural norms
- Embed "nudges" to promote the right thing
- Redesign the system

THE UNIVERSITY OF CHICAGO MEDICINE & BIOLOGICAL SCIENCES

*safety, effectiveness, efficiency, timeliness, patient-centeredness, equitability*

**The Office of Clinical Effectiveness**

Home | Scholarship | Quality Symposium | Innovations Grant | Choosing Wisely Challenge | Slogan Competition | Calendar

**Choosing Wisely Challenge at University of Chicago Medicine**
**Bright Ideas due April 1, 2015**

Around the world, the capabilities of modern medicine are being delivered inside of health systems with staggering complexity. Too often this complexity contributes to avoidable harm and unsustainable cost. Moreover, clinicians rarely have the support necessary to deliver **value**–defined as the best possible care at the lowest possible cost.

To help address this gap, and mirroring the Costs of Care (an American nonprofit) and the ABIM Foundation, the University of Chicago Medicine is launching the inaugural *Choosing Wisely®* Challenge. We want to identify the most promising bright ideas that can be successfully implemented here at the medical center.

challenge is open to Residents and Fellows of any program and to any employee of the University of Chicago

Challenge co-sponsored by GME & CQO Office (Michael Howell MD)

COSTS of CARE


COST Framework for Value Improvement: Skip the Drips

| | Interventions | Description | Skip the Drips |
|---|---|---|---|
| C | Culture | Valuing cost-consciousness and resource stewardship at the individual and team level | Subspecialty faculty champions recruited to email peers |
| O | Oversight | Requiring accountability for cost-conscious decision-making at a peer and organizational level | Pharmacy receives a monthly audit of PPI drips ordered and why |
| S | Systems Change | Creating systems to make cost-conscious decisions using institutional policy, decision-support tools, and clinical guidelines | Epic now requires indications for PPI drips when ordering |
| T | Training | Providing knowledge & skills clinicians need to make cost-conscious decisions | "Brochures" on Skip the Drips shared in workrooms & at morning report |

Levy et al. Acad Med 2014

THE UNIVERSITY OF CHICAGO

**Choosing Wisely Challenge**
**SKIP THE DRIPS**

Improve meaningful use of continuous infusions to improve value of care

**PPI FOR UPPER GI BLEED**

- Goals
  - ✓ Improve survival from life threatening GI bleed
  - ✓ Avoid complications such as C diff
  - ✓ Improve likelihood of successful endoscopy
- Recommend
  - ✓ Pre-endoscopy: reserve PPI drip for suspected high risk upper GI bleeds.
  - ✓ Post-endoscopy:
    - **All PPIs should be discontinued unless endoscopy identifies ulcers or erosions**
    - Continuous IV PPI can be used for ulcers with high-risk lesions

Dr. Gautham Reddy, GI Fellowship Program Director

Special thanks to UCM Office of Clinical Effectiveness, led by Michael Howell, MD.

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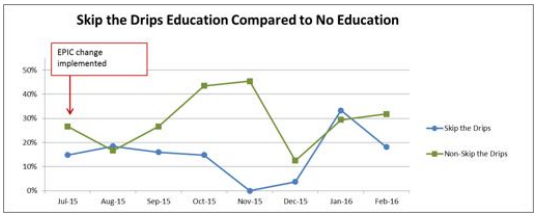
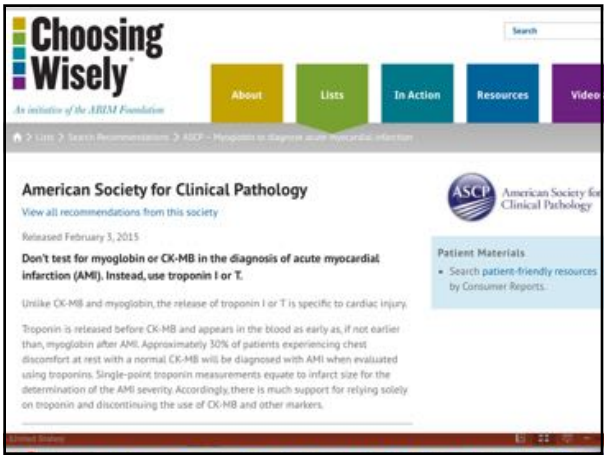
## Inappropriate PPI Orders by "Skip the Drips" Education



## Ways to Use the Force to Teach Value

- Cultivate "situational awareness"
- Find the right champions
- Observe & understand cultural norms
- Embed "nudges" to promote the right thing
- Redesign the system




## Ordering Wisely

- **Don't order CKMB to diagnose AMI**
- Don't order serum folate in workup of anemia
- Don't "pan-lab" for rheumatology
- Don't "pan-lab" for thyroid tests

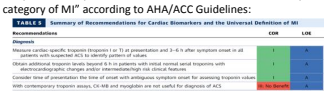
Courtesy Matt Modes PGY3

Ordering Wisely

*An educational initiative to improve value*

### Cardiac Biomarkers

-Troponin is the preferred biomarker "overall and for each specific category of MI" according to AHA/ACC Guidelines:




-Reviews of 30,000 patients from the CRUSADE Trial and 10,000 patients from the GRACE Registry have shown routine use of CK-MB rarely adds prognostic value to Troponin alone

-Health systems (Mayo, Mass Gen, Brigham, Hopkins-Bayview, and others) have taken steps to reduce volume of CK-MB testing

-Troponin rises earlier than CK-MB. Troponin is more specific than CK-MB in CKD and ESRD

***RECOMMENDATIONS:***

(1) If concern for ACS, initially check Troponin only.
(2) If Troponin is negative, there is no role for CK-MB.
(3) If Troponin is positive (either acutely or at baseline) and concern for infarction or reinfarction, recommend serial Troponins (q 3-6 hrs). CK-MB may aid in diagnosis and/or prognosis in certain clinical circumstances, such as reinfarction (consider lab-adding to screening Troponin).

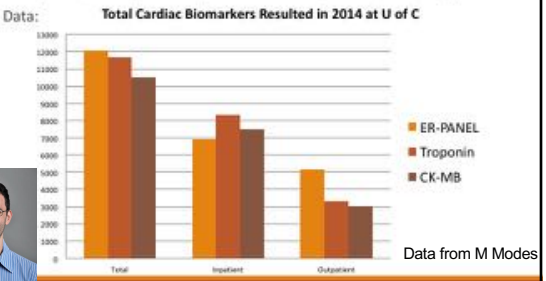
## Data from UChicago

**Are we outliers?**

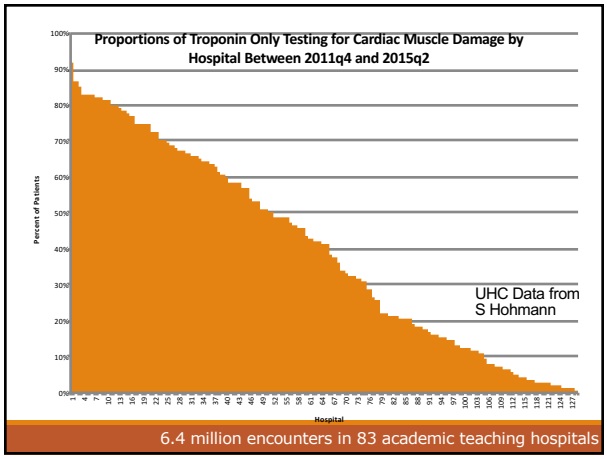
Ways to order Cardiac Biomarkers

- Troponin; CK-MB (inc Total CK); ER Cardiac Panel (Total CK, CK-MB, Trop)

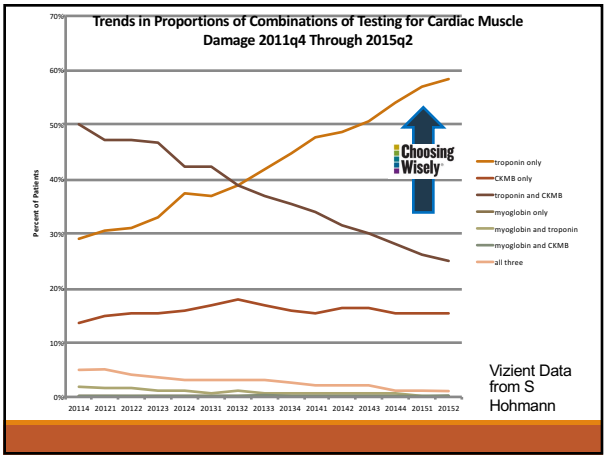
Data:




Data from M Modes

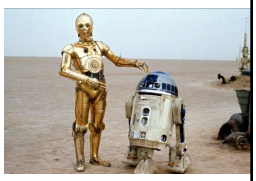



6.4 million encounters in 83 academic teaching hospitals



## Ways to Use the Force to Teach Value

- Cultivate "situational awareness"
- Recruit the right champions
- Understand the culture you work in
- Embed "nudges" to promote the right thing
- Redesign the system



## "FLIP" For Discharge

- Combines 4 SHM Choosing Wisely Recommendations
- "FLIP"
- Foley (1)
- Labs (routine daily) (5)
- Indications for Telemetry (4)
- Prophylaxis- Inappropriate GI Prophylaxis (2)

Choosing Wisely

Society of Hospital Medicine – Adult Hospital Medicine

shm

Five Things Physicians and Patients Should Question

1. Don't place, or leave in place, urinary catheters for incontinence or convenience or monitoring of output for non-critically ill patients (acceptable indications: critical illness, obstruction, hospice, perioperatively for <2 days for urologic procedures; use weights instead to monitor diuresis).
2. Don't prescribe medications for stress ulcer prophylaxis to medical inpatients unless at high risk for GI complications.
3. Avoid transfusions of red blood cells for arbitrary hemoglobin or hematocrit thresholds and in the absence of symptoms of active coronary disease, heart failure or stroke.
4. Don't order continuous telemetry monitoring outside of the ICU without using a protocol that governs continuation.
5. Don't perform repetitive CBC and chemistry testing in the face of clinical and lab stability.

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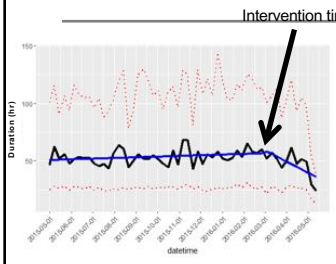
## FLIP for discharge

Charlies Wray, PGY4

*Clicking on the Check mark will take your directly to the Manage Orders Screen

## Telemetry Order Duration




$$y = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \beta_3 x_3$$

| Coefficients: | Estimate | Std. Error | Pr(>\|t\|) |
|---|---|---|---|
| B0 | 50.57 | 2.05 | <0.001 |
| B1 | 0.13 | 0.07 | 0.09 |
| B2 | 4.02 | 4.77 | 0.4 |
| B3 | -2.37 | 0.64 | <0.001 |

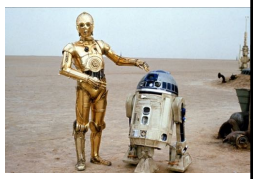
B0 = pre-intervention intercept
B1 = pre-intervention slope
B2 = intervention intercept change
B3 = intervention slope

courtesy John Fahrenbach, Center for Healthcare D
Science & Innovation

## Ways to Use the Force to Teach Value

F
O
R
C
E

- Find the right champions
- Observe & understand the cultural norms
- Redesign the system
- Cultivate "situational awareness"
- Embed "nudges" to promote the right thing



## Lessons for Jedi to Teach Value

- You must unlearn what you have learned.
- Use the FORCE.
- Do or do not. There is no try.
- Stay on target.

# Acknowledgements


- Horror Room
  - Jeanne Farnan, Kathleen Wiest, Kristen Hirsch, Barry Kamin, Mike Simon, Ellen Byrne
- Skip the Drips
  - Nikhil Bassi, Andy Levy, Sarah Sokol, Emmanuel Colonel, Anand Gopalswami, Gautham Reddy, Ellen Byrne, Michael Howell, Heather Limper
- Clinic Handoff
  - Amber Pincavage, Julie Oyler, Wei Wei Lee, Laura Ruth Venable, Megan Prochaska, Marcus Dahlstrom
- Ordering Wisely
  - Matt Modes, Sam Anderson, Andy Davis, Micah Prochaska, Sam Hohmann (UHC)
- SIESTA
  - Nimit Desai, Jay Balachandran, Ambrosio, Mary Ann Francisco, Cindy LaFond, Jeanne Farnan, Babak Mokhlesi, Kristen Knutson, Sam Anderson, Bill Marzack, Dawn Kohl, Ed Leung, David Meltzer, Bill Marzack, Jacqueline Ramos
  - Funding from NIA & NHLBI

HANDOUT

AASPD
Association of Anesthesiology Subspecialty Program Directors

# Report from the RRC: What are They Looking for From Fellows & From Faculty in Scholarly Activity

Andrew J. Patterson, M.D., Ph.D.

11/11/2016
10:30am – 10:55am

# Scholarly Activity: What the ACGME's RRC is Looking for from Faculty & from Fellows

Andrew J. Patterson, M.D., Ph.D.

**Objectives**

1. At the conclusion of this presentation, attendees will be able to describe the RRC expectations for scholarship for Anesthesiology faculty.
2. At the conclusion of this presentation, attendees will be able to describe the RRC expectations for scholarship for Anesthesiology fellows.

**Disclosures**

Andrew J. Patterson, M.D., Ph.D. is a member of the ACGME RRC for Anesthesiology. He is a former Fellowship Program Director for Anesthesiology Critical Care Medicine at Stanford University. He is currently the Executive Vice-Chair and Larson Professor of Anesthesiology at the University of Nebraska Medical Center in Omaha.

**The Rules: Faculty Expectations**

Core Programs

II.B.5 The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

5a. The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

5b. Some members of the faculty should also demonstrate scholarship by one or more of the following:
(1) Peer-reviewed funding.
(2) Publication of original research or review articles in peer reviewed journals or chapters in textbooks.
(3) Publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings.
(4) Participation in national committees or educational organizations.

5e. If the program is unable to fulfill one aspect of this requirement, the curriculum must include educational activities for the residents in the deficient component.[1]

Fellowship Programs

Program requirement variations do exist, but the intent is similar for all Anesthesiology fellowship programs.

Anesthesiology Critical Care Medicine

II.B.6. Each faculty member participating in the fellowship must demonstrate ongoing academic achievements appropriate to anesthesiology critical care medicine, including publications, the development of the educational program, or the conduct of research.[2]

Obstetric Anesthesiology

II.B.5. Physician faculty members must demonstrate ongoing academic achievements appropriate to the subspecialty, including at least one of the following: publications, the development of education programs, or the conduct of research.[3]

Adult Cardiothoracic Anesthesiology

II.B.9. Faculty members must maintain an active role in scholarly pursuits pertaining to cardiothoracic anesthesiology, as evidenced by involvement in education and scholarship that pertains to the care of adult cardiothoracic patients.[4]

**The Rules: Fellow Expectations**

Program requirement variations do exist, but the intent is similar for all Anesthesiology fellowship programs.

Anesthesiology Critical Care Medicine

IV.B.1. The program must provide instruction in the fundamentals of research design and conduct, and the implementation and presentation of data.
IV.B.2. During the program, fellows must participate in at least one clinical or other research project related to critical care medicine.

a. Results of each project must be disseminated through publication or presentation at local, regional, national, or international meetings.[2]

Obstetric Anesthesiology

IV.B.1. Each fellow should conduct or be substantially involved in a scholarly project related to the subspecialty which leads to both presentation at a national meeting and publication.

a. Fellows must have a faculty mentor overseeing the project.[3]

Adult Cardiothoracic Anesthesiology

IV.B.1. All fellows must complete a scholarly project.

a. The results of such projects must be disseminated through a variety of means, including publication or presentation at local, regional, national, or international meetings.[4]

**The Reality: Citations related to scholarly activity are the most common citations from the ACGME's RRC for Anesthesiology.**

**The Reality: Finding Faculty to Mentor One Year Clinical Fellows for Substantive Scholarly Projects is Challenging.**

1. Clinical demands at many institutions limit the amount of time faculty are provided for scholarly activities.
2. Clinical productivity is sometimes financially rewarded more than academic productivity.
3. Junior faculty are sometimes saddled with considerable debt from college and medical school and are sometimes under pressure to focus on resolution of financial obligations rather than scholarly work, especially in areas of the country where the cost of living is high.
4. The types of projects that are rewarded with grants (particularly NIH grants) and high profile publications frequently are not the types of projects that one year fellows can participate in due to time limitations, call obligations, and lack of technical training or facility with data analysis and scientific writing. Consequently, faculty who include one year fellows in substantive projects may put themselves at risk for moving their projects along too slowly. Faculty may also anger post docs and other research personnel who perform much of the "heavy lifting" for their projects by allowing clinical fellows to present data at meetings or including them on manuscripts for which these individuals have played minor roles.
5. Some institutions that have or are seeking fellowship training programs do not have the infrastructure for substantive scholarly projects.
6. Effective faculty mentors for scholarly projects are sometimes difficult to find, particularly for small subspecialty groups and divisions

**The Reality: One Year Clinical Fellowships present unique challenges.**

1. Substantive scholarly projects often take more than one year to complete (let alone present and/or publish).
2. One year clinical fellows have a short time to master the clinical skills germane to their Anesthesiology subspecialties. Some fellows need to focus more than others on clinical elements in order to master them.
3. In some cases, fellows must prepare for ABA subspecialty board examinations or an NBE examination. Preparing for these examinations is time consuming.
4. Fellows have to find jobs during their one year of fellowship training, which necessitates travel and days off for interviews.
5. One year clinical fellows in the Anesthesiology subspecialties are pulled in many directions simultaneously and may find it difficult to engage in a scholarly project in meaningful ways.

**Suggestions**

1. Band together. Take advantage of economies of scale by creating **consortia** that allow fellows and faculty in all the member programs to meet the ACGME requirements.
2. Develop scholarly **programs** that fellows can participate in sequentially rather than having each fellow invent a new project from scratch.
3. Focus fellows on short, "doable" elements of scholarly endeavor rather than encouraging them to take on ambitious stand-alone projects.
4. Contact your ACGME RRC Executive Director (Anne Gravel Sullivan, Ph.D.) to discuss your plans and your concerns.
5. Get the information for your fellows' scholarly projects into the ACGME Accreditation Data System (ADS) by June 28th so the information is available to the RRC reviewers during the fall reviews.

**References**

[1] Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Anesthesiology. Effective: July 1, 2016. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/040_anesthesiology_2016.pdf
[2] Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Anesthesiology Critical Care. Effective: July 1, 2016. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/045_critical_care_anes_2016_1-YR.pdf
[3] Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Obstetric Anesthesiology. Effective: July 1, 2016. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/043_obstetric_anesth_2016_1-YR.pdf
[4] Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Adult Cardiothoracic Anesthesiology. Effective: July 1, 2016. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/041_adult_cardiothoracic_anes_2016_1-YR.pdf

HANDOUT

AASPD
Association of Anesthesiology Subspecialty Program Directors

# Scholarship: How to Best Leverage Big Department Infrastructure

Maya Jalbout Hastie, M.D.

11/11/2016
10:55am – 11:20am

Columbia University Medical Center

# Scholarship: how to best leverage big department infrastructure

**Maya Jalbout Hastie, MD**
Associate Professor of Anesthesiology
Associate Fellowship Director, ACTA
Columbia University Medical Center

*Discover. Educate. Care. Lead.*

## Objectives

Definitions and review of terms

Goals and examples of scholarship

Strengths and weaknesses of big programs

Fellows' motivation



| | Description | Role of Fellow | Role of Program | Outcome |
|---|---|---|---|---|
| ACTA | Scholarly project | Completion | | Dissemination – *variety of means* |
| CCM | Clinical or research project | Participation | Instruction in research design, conduct, analysis and interpretation of data | Dissemination – *publication or presentation* |
| Obstetrics | Scholarly project | Conduct or substantially involved | Faculty mentor | Presentation *and* publication |
| Pediatrics | Scholarly project | Completion | Instruction in research design, conduct, analysis and interpretation of data | Dissemination – *variety of means* |
| Pain | Scholarly activity | Participate | • Basic principles of research, and their application to patient care<br>• Allocate educational resources to facilitate | |

**Specialty-specific references for DIOs: Resident/Fellow Scholarly Activity**. (June 2016). **ACGME**. Retrieved from *https://www.acgme.org/Portals/0/PDFs/Specialty-specific%20Requirement%20Topics/DIO-Scholarly_Activity_Resident-Fellow.pdf*



## Defining scholarship

What it is NOT:

- Committees
- Journal clubs
- Lectures



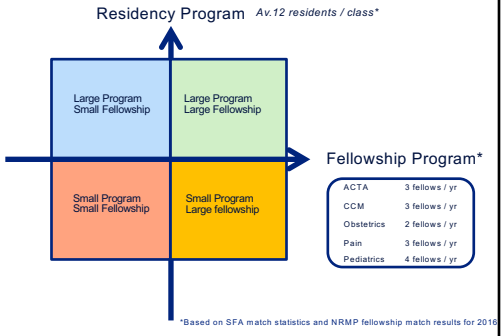
## Defining Scholarship

| | | |
|---|---|---|
| Discovery | Advancing knowledge | Research resulting in publication / abstract |
| Integration | Synthesizing knowledge | Case reports / studies |
| Application | Applying existing knowledge | Protocols and panels |
| Education | Disseminating existing knowledge | Curriculum design / Grand rounds |

Grady, E. et al. *Defining Scholarly Activity in Graduate Medical Education*. JGME Dec, 2012



## Defining "big"



## Goals of a scholarship program

- Making the fellowship year count
- Recruitment strategy
- Prepare for academic career
- Prepare next generation of leaders in our specialty

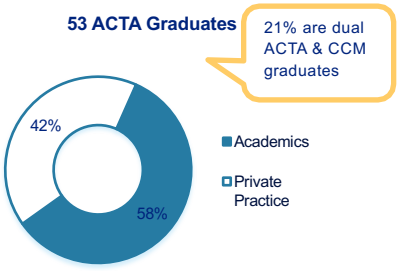


## ACTA Scholarly Tracks

| | Skills | Faculty Mentor | Outcome |
|---|---|---|---|
| **Research** | Biostatistics; Turning research ideas to projects; Designing research protocols; submitting IRB protocols; collecting data | | Approved IRB protocol / abstract / pilot study |
| **Clinical / TEE** | TEE quality improvement; Clinical management protocols; | | Echo rounds / TEE conference case presentation / Grand Rounds presentation |
| **Patient Safety QI** | Identifying system's problems, participating in RCA | | PS/QI project |
| **Education** | Learning theories; curriculum design; instrument design; education research | | Simulation scenarios / OSCE development / Educational research project |



## Graduates of ACTA@CUMC – 2008 to 2016






## Scholarship: Big Program Strengths

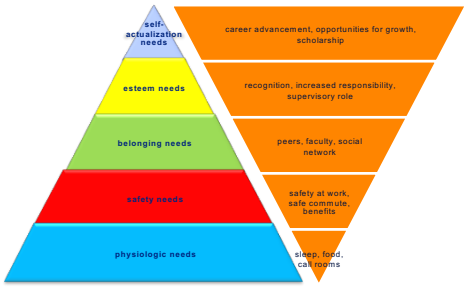
| Planning Phase | Implementation Phase | Dissemination Phase |
|---|---|---|
| • Mentorship<br>• Research / Education curriculum<br>• Research infrastructure<br>• Administrative infrastructure | • Flexible scheduling<br>• Dedicated protected time<br>• Clinical exposure | • Financial support<br>• Protected meeting time<br>• Sponsorship |



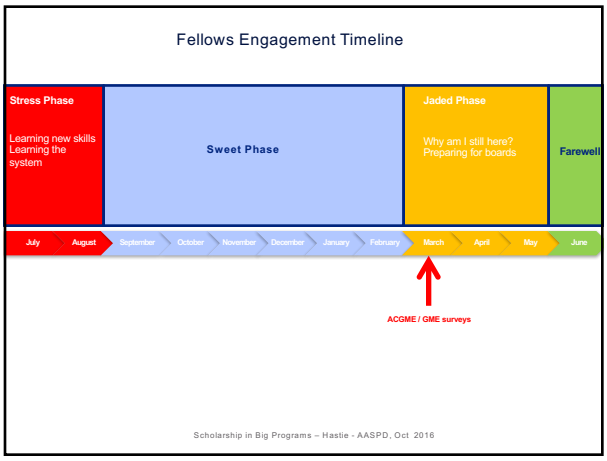
- Busy clinical schedule
- Monochromatic view
- Depersonalized



## Motivation theory – *Maslow's hierarchy of needs*




Adapted from Daft, R. L., Marcic, D. (2014). *Building Management Skills : An Action-First Approach.* (First Ed.) Mason, OH: South-Western Cengage Learning




## References

Specialty-specific references for DIOs: Resident/Fellow Scholarly Activity. (June 2016). ACGME. Retrieved from *https://www.acgme.org/Portals/0/PDFs/Specialty-specific%20Requirement%20Topics/DIO-Scholarly_Activity_Resident-Fellow.pdf*

Grady, E. et al. *Defining Scholarly Activity in Graduate Medical Education*. JGME Dec, 2012

Daft, R. L., Marcic, D. (2014). *Building Management Skills : An Action-First Approach.* (First Ed.) Mason, OH: South-Western Cengage Learning

Scholarship in Big Programs – Hastie - AASPD, Oct 2016

HANDOUT

AASPD
Association of Anesthesiology Subspecialty Program Directors

# How to Do Scholarship in Smaller Departments

Magdalena Anitescu, M.D.

11/11/2016
11:20am – 11:45am

THE UNIVERSITY OF CHICAGO MEDICINE

# How to do scholarship in smaller departments

Magdalena Anitescu, MD, PhD, Associate Professor
Chief, Section of Pain Management
Program Director, Multidisciplinary Pain Medicine
University of Chicago Medicine
Department of Anesthesia and Critical Care

## Conflict of interest

- Educational Grant Medtronic for fellows education

## Objectives

- Define academic scholarship
- Describe forms of scholarship
- Identify fellows opportunities to participate in scholarly projects
- Describe program director role in mentoring fellows' scholarly activity



## Outline

- The academic scholar and the school of medicine
- Fellows perspective of scholarly activity
- Program director perspective of scholarly activity



## Academic scholarship-Inside Out

### Feelings

- Fear
- Joy
- Sad
- Anger
- Disgust

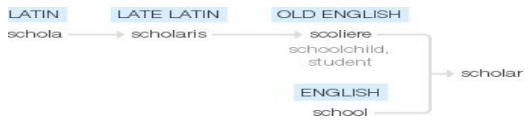
### How you see it

- A Job
- A state of mind, a vocation
- A necessary thing
- An awful thing
- Everyday frustration



## Scholar-definition through time

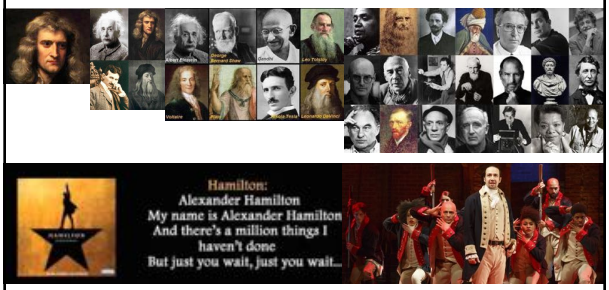
- In ancient times: one who goes to school, a pupil
- Modern: the **expert**, **specialist in a certain field**, a **distinguished academic**, a highly educated person with an aptitude for study
- Synonym: academic, intellectual, savant






## The pressure-our contribution

- Are all of us geniuses in our own way?



## The modern scholar

SINCE COLONIAL TIMES, the American professoriate has responded to mandates both from within the academy and beyond. First came teaching, then service, and finally, the challenge of research. In more recent years, faculty have been asked to blend these three traditions, but despite this idealized expectation, a wide gap now exists between the myth and the reality of academic life. Almost all colleges pay lip service to the trilogy of teaching, research, and service, but when it comes to making judgments about professional performance, the three rarely are assigned equal merit.

1990: a new definition of scholarly activity: beyond "teaching versus research" debate and that the familiar and honorable term "scholarship" be given a broader meaning



Ernest L. Boyer Scholarship reconsidered, Priorities of the professoriate. A Special Report *Princeton, NJ: Carnegie Foundation for the Advancement of Teaching* (1990).



## In the new context: Proposal

- Four entities
  - Scholarship of discovery
  - Scholarship of integration
  - Scholarship of application
  - Scholarship of teaching
- Challenges
  - How does the scholar maintain excellence in their work
  - Many high education institutions were willing to adopt but the question of assessment arose.



## Noble, broad, modern…sustainable?

- 2 question arose quickly
  - What is the meaning of "scholarship of teaching"
  - How the quality of scholarship shall be measured

To give the four kinds of scholarly activities the weight that each deserves, they all must be held to the same standards of scholarly performance. The paradox is this: In order to recognize discovery, integration, application, and teaching as legitimate forms of scholarship, the academy must evaluate them by a set of standards that capture and acknowledge what they share as scholarly acts.



Glassick, Charles E., Mary Taylor Huber, Gene I. Maeroff, and E. L. Boyer. *Scholarship assessed Evaluation of the professoriate*. San Francisco: Jossey-Bass, 1997.



## Measuring quality of the scholarly work

- Goals: "measuring the quality of scholarship" or "how excellence shall be sustained"
- How was it done
  - 51 granting agencies: **how would you decide which proposals to fund?**
  - 58 scholarly press directors: **what criteria do you use when selecting manuscripts for publication**?
  - 31 scholarly journal editors: **what do you tell referees to look for**?
- New publication:
  - 6 themes were derived, called "standards".



Glassick, Charles E., Mary Taylor Huber, Gene I. Maeroff, and E. L. Boyer. *Scholarship assessed Evaluation of the professoriate*. San Francisco: Jossey-Bass, 1997.



**Summary of Standards**[a,b,c,*]

*Clear Goals*

Does the scholar state the basic purpose of his or her work clearly? Does the scholar define objectives that are realistic and achievable? Does the scholar identify important questions in the field?

*Adequate Preparation*

Does the scholar show an understanding of existing scholarship in the field? Does the scholar bring the necessary skills to his or her work? Does the scholar bring together the resources necessary to move the project forward?

*Appropriate Methods*

Does the scholar use methods appropriate to the goals? Does the scholar apply effectively the methods selected? Does the scholar modify procedures in response to changing circumstances?

*Significant Results*

Does the scholar achieve the goals? Does the scholar's work add consequentially to the field? Does the scholar's work open additional areas for further exploration?

*Effective Presentation*

Does the scholar use a suitable style and effective organization to present his or her work? Does the scholar use appropriate forums for communicating the work to its intended audiences? Does the scholar present his or her message with clarity and integrity?

*Reflective Critique*

Does the scholar critically evaluate his or her own work? Does the scholar bring an appropriate breadth of evidence to his or her critique? Does the scholar use evaluation to improve the quality of future work?

*These six standards can be applied to all four forms of scholarship proposed by Boyer: the scholarship of discovery, of integration, of application, and of teaching. The standards were derived from the analysis of information collected in 1994 by Carnegie scholars from granting agencies, scholarly press directors, and scholarly journal editors.

## Clinical medicine

- Discrepancy between busy clinical work with unprotected time and research;
- 2 orphan children, not often recognized
  - **Integration**: making connections across disciplines-health outcomes, biomedical technologies and devices,
  - **Application**: translation of knowledge to new and practical applications (clinical guidelines, patient safety protocols)
- Framework to recognize integration and application entities-**Clinical scholarship**



Grogsby RK, Thorndyke L. Perspective: Recognizing and Rewarding Clinical Scholarship Acad Med. 2011; 86: 127-131

## Clinical Scholarship

- **Systematic observation and scientifically based methods to identify, describe and solve clinical problems**
- Offers potential for learning how to **improve clinical practice**
- Extends broadly **beyond the clinical arena**, encompass a patient or a health care system
- **Interdisciplinary**
- **Dissemination of knowledge** through presentation, consultation, use by others, applied leadership


Grogsby RK, Thorndyke L. Perspective: Recognizing and Rewarding Clinical Scholarship Acad Med. 2011; 86: 127-131


## So…scholarship comes in many shapes and forms…



## Fellows-happy to have matched their chosen fellowship…

- First day
  - Heavy clinic, orientation
  - By the way…write an IRB by tomorrow
  - …and by the end of the week write that case report
  - …and call the patients to schedule the stim
  - …while you submit your ASRA abstract




## The reality of the fellowship

- 1 year in most specialties unless research time is added for dedicated PhD, MS scientists
- Small fellowships can have an additional burden.
- The fellows challenge you…
  - I am tired
  - I want to go in private practice
  - I have no idea what research means?
  - I want to focus on becoming clinically excellent




## However…ACGME has requirements

Different text, same message:
Fellows need to do scholarly activity

| | | |
|---|---|---|
| **IV.B.** | **Fellows' Scholarly Activities** | |
| **IV.B.1.** | **The curriculum must advance fellows' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.** | (Core) |
| **IV.B.2.** | **Fellows should participate in scholarly activity.** | (Core) |
| **IV.B.3.** | **The sponsoring institution and program should allocate adequate educational resources to facilitate fellow involvement in scholarly activities.** | (Detail) |
| **IV.B.** | **Fellows' Scholarly Activities** | |
| IV.B.1. | The program must provide instruction in the fundamentals of research design and conduct, and the interpretation and presentation of data. | (Core) |
| IV.B.2. | Each fellow must complete a scholarly project, the results of which must be disseminated through a variety of means, including publication or presentation at local, regional, national, or international meetings. | (Core) |



## Scholarly work in small fellowship

- Good: Just 1 or 2 fellows to deal with
- Evil: If unmotivated…bad news
- Good: Less projects to complete
- Evil: Multiple commitments hard to complete
- Good: Not busy clinical, scholarly projects possible
- Evil: Busy clinical, no time for scholarly work

MAKE IT WORK!

## Fellows' thirst for knowledge does exist

- Generation of highly educated digitally native physicians
- Reserved at times
- Duty vs. save the world
- A little play for their attention
- And certainly teach by example



## How can we motivate our fellows?
### KNOW THEM!

- **Involve the fellows**: explain why do you do what you do, the vision
- **Emphasize the greater good**: how can you help others, patients, colleagues by disseminating your scholarly work
- **Give responsibilities** and leadership opportunities
- **Give feed back** and encouragement
- **Flexibility** in work hours at the scholarly project-work from home
- **Provide educational opportunities** and developments on the topic-conferences



## What scholarly project can fellows complete?

TABLE 2 PROPOSED BASELINE RUBRIC FOR ALL ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME) RESIDENCY REVIEW COMMITTEES (RRCs)

| Component of Scholarship | Examples | Assessment Criteria |
|---|---|---|
| Discovery = advancing knowledge | Published paper<br>Work resulting in abstract | All 4 components of scholarship should be present when looking at the sum of the core faculty members' work<br>Each resident should be exposed to each of the 4 components of scholarship and should complete at least one scholarly activity during the residency training period<br>More stringent requirements may be instituted by the specialty-specific RRC as needed |
| Integration = synthesizing knowledge | Case studies or reports<br>Patient education projects | |
| Application = applying existing knowledge | Participation in national guideline panels<br>Participation in professional societies | |
| Teaching = disseminating current medical knowledge | Preparing and delivering lecture(s)<br>Curriculum development<br>Development of web-based modules, etc | |

- Similarly with faculty standards, fellows should be evaluated based on Boyer's 4 entities of scholarship.
- Involve fellows in the scholarship of teaching where they can become involved with their peers, patients, etc.



## How is the scholarly work quantified?

Metrics for Scholarly Activity

| Position | Pass | Fail | Commendation |
|---|---|---|---|
| Residents* | 1 point/resident | <1 point/resident | ≥ 1.5 points/resident on average |
| Fellows* | 1 point/fellow | <1 point/fellow | ≥ 1.5 points/fellow on average |
| Faculty (FTE)# | Average 2 pts/faculty member | Average < 2 pts/faculty member | Average ≥ 1.5 pts/faculty member |

* One point given per publication (print-i.e. article, case report, chapter, or electronic- i.e. ACR case in point) or local, regional or national presentation/poster or electronic exhibit over the length of the program

# One point given for documented activity in each of the following activities over the length of the review cycle

Grants
Publications
Selected chapters, text books
Presentation at local, regional or national meeting
Education related service on national committees



## Scholarship work demystified

- Highly selective process for fellowship, supposedly dedicated, smart and with appropriate work ethic
- Expectations
  - Excellence in clinical care: **easy to attain** due to volume
  - Excellence in scholarly work**: hard to atta**in due to time constraints
- Solutions
  - Lecture every day,
  - Attending database case reports of challenging cases-prepare
  - QA projects
  - Regional meetings presentations



## It is on YOU to find solutions…

- **Academic days, administrative days** (chief fellows) roughly 1-2 per month (1 every other week sometimes)
- **Play detective**: your rationale for the case to be presented, investigate the course, discuss other options.
- **Be available**: find cases, listen to fellows suggestions, guide do not destroy.
- **Be altruistic**: collaborate on book chapters, research projects

## How do we do it?

- One grand rounds presentation,
- One abstract (research/case report) submission and presentation at national meetings
- One presentation at the institutional multidisciplinary meeting
- One presentation at the collaborative case conferences
  - Chicago Pain summit **AND** Collaborative case conference
- One QA project
- Attend and present at the institutional pain boards
  - Spine board **OR** Oncology pain **OR** Comprehensive pain conference **OR** Bone health meeting



## Similar and different approach

AGAIN…ON YOU

- "Abstract presentation in Fellow Complex Case Session at Annual Society of Cardiovascular Anesthesiologists Meeting"
- "One "writing project". Usually a Case Report or Case Conference for the Journal of Cardiothoracic and Vascular Anesthesia".
- "I usually have the IRB proposal written up and approved so they can hit the ground running on day 1. Then towards the end of their year I have the fellow write up the IRB proposal and get the project approved for the next fellow."



## Create an Intellectual stimulating place

- Start them early;
  - Gradual responsibility: case report as CA1 to paper writing during fellowship
  - Fellows involved in medical student research, combine efforts: fellows/residents
  - Book chapters early, correct them in fellowship
- Helpful!
  - A good fellowship coordinator-share resources with core PD
  - Ask your colleagues institutionally or at meetings
  - Create an academic environment for the fellows: readings, discussions, journal clubs,



## Long lasting connections with your fellows…some advise

- **Set same expectation for your section faculty** to present at grand rounds and at the national meetings
- **You and faculty aim to always improve**: research, clinical, educational and service.
- **Networking**: get involved with colleagues from other institutions and meet alumni at meetings, social media
- Introduce the scholarly work to fellows in a non-assuming way: **be gentle not forceful**
- Expect the best, deal with the worst

THEY DO WHAT THEY SEE!

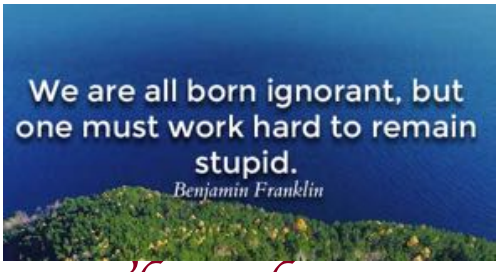


## Conclusions

- Scholarship has more dimensions: **discovery, application, integration and teaching**
- Fellows scholarly activity is rated every year
- Fellows scholarship can be performed in various ways; research is only one component
- **Be engaged** with the fellows as it is a small family by now
- Make a difference, lead by example and be flexible in listening to your trainees: **guide do not destroy**

Scholarly work in small fellowships: **Blessing or Curse**






*Thank you*

HANDOUT

AASPD
Association of Anesthesiology Subspecialty Program Directors

# Regional Anesthesia Update

Santhanam Suresh, M.D., F.A.A.P.

11/11/2016
1:30pm – 1:40pm

Ann & Robert H. Lurie Children's Hospital of Chicago

# Regional Anesthesia Fellowship Update

Santhanam Suresh MD
Arthur C. King Professor & Chair
Department of Pediatric Anesthesiology
Ann & Robert H. Lurie Children's Hospital of Chicago
Professor of Anesthesiology & Pediatrics
Northwestern University Feinberg School of Medicine
Chicago, IL



## Regional Anesthesiology and Acute Pain Medicine

- History of Regional Anesthesia Fellowships
  - Early 1980's
    - Virginia Mason Medical Center
      - Daniel Moore, MD
    - Brigham and Women's Hospital
      - Benjamin Covino, MD, PhD
    - Others
      - Duke
      - Hospital for Special Surgery/Cornell
      - Mayo Clinic
      - McGill University
      - St. Luke's/Roosevelt/Columbia
      - University of Alberta
      - University of Florida
      - University of Manitoba
      - University of Texas/Houston
      - University of Toronto



## Regional Anesthesiology and Acute Pain Medicine

- Currently (2016)……
  - **62 RAAPM fellowships in the US**
  - **8 RAAPM fellowships in Canada**
  - **133 positions available in the US**
  - **17 positions available in Canada**



## Regional Anesthesiology and Acute Pain Medicine

Directors of Regional Anesthesia Fellowship Training

- History
- Membership
- Function
- Initiatives

Meetings Sponsored by HSS



## Group Initiatives

- Development of Guidelines
- Curriculum Development
- ACGME Accreditation
- Information Repository
- Knowledge Sharing



## ACGME Accreditation

- Pro's
  - Consistency in the curriculum
  - Rigorous review process
  - Potential subspecialty certification
  - Recruiting tool
  - Legitimacy
- Con's
  - Restrictions in the curriculum
  - ACGME hours regulations
  - Faculty practice ineligibility
  - Loss of autonomy

Adapted from Current Opinion Anesth 20:572-575

## Regional Anesthesiology and Acute Pain Medicine

Ann & Robert H. Lurie Children's Hospital of Chicago

- Proposal for new Subspecialty submitted to ACGME December 2013 by Boards of ASRA and AAPM
- Exploratory Committee formed in May 2014
- Subcommittee to develop Program Requirements met from June 2015-June 2016
- Fellowship approved at September 23-25, 2016 Board of Directors meeting
- Applications online October 4th

## Regional Anesthesiology and Acute Pain Medicine

Ann & Robert H. Lurie Children's Hospital of Chicago

- Common Application in ADS must be initiated by DIO
- Sub-specialty Application on specialty page (Word format)
- **New Application Deadlines:**

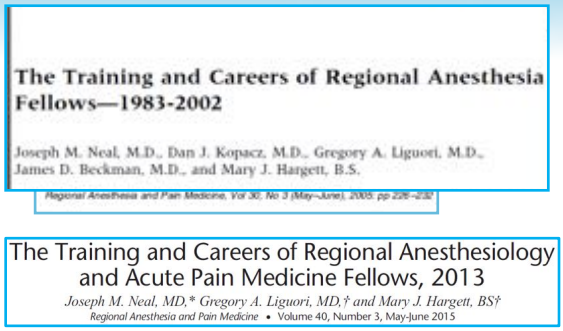
March 26-27, 2017 RC meeting-- December 2, 2016

- September 2017 RC meeting -- June 2, 2017 (approx.)
- Contact Anne Gravel Sullivan or Sonia Sangha with any questions.

## Information Repository

Ann & Robert H. Lurie Children's Hospital of Chicago

- ASRA Website Fellowship Directory
- E-mail list of all graduates of regional anesthesia fellowship programs
  - Approx 500 graduated fellows
- What this list allows us to determine……where are they now and what they are doing!



The Training and Careers of Regional Anesthesia Fellows—1983-2002

Joseph M. Neal, M.D., Dan J. Kopacz, M.D., Gregory A. Liguori, M.D., James D. Beckman, M.D., and Mary J. Hargett, B.S.

Regional Anesthesia and Pain Medicine, Vol 30, No 3 (May–June), 2005: pp 226–232

The Training and Careers of Regional Anesthesiology and Acute Pain Medicine Fellows, 2013

*Joseph M. Neal, MD,* Gregory A. Liguori, MD,† and Mary J. Hargett, BS†*

*Regional Anesthesia and Pain Medicine* • Volume 40, Number 3, May-June 2015

## Survey

Ann & Robert H. Lurie Children's Hospital of Chicago

- 12 programs surveyed
- Programs were contacted and asked for their graduate fellow information
- 77/176 (44%) responded
- 54/77 (70%) were from 2 institutions (VMMC, BWH)
- 47/77 (61%) of respondents were from academic practices

Regional Anesthesia and Pain Medicine, Vol 30, No 3 (May–June), 2005: pp 226–232

## New 2013 Survey

Ann & Robert H. Lurie Children's Hospital of Chicago

- Alumni from 47 programs surveyed
- 201/341* (59%) responded

*371 Surveys Sent

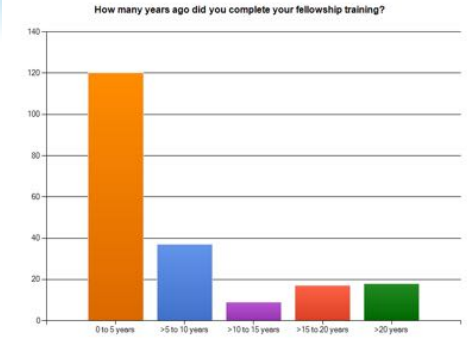
- 28 Bounced Back
- 2 Opted Out of Survey

Regional Anesthesia and Pain Medicine, Vol 30, No 3 (May–June), 2005: pp 226–232

Ann & Robert H. Lurie Children's Hospital of Chicago

## "Demographics" of Fellowships in Regional Anesthesia and Acute Pain Medicine

| | 2002 (US/Canada) | 2012 (US/Canada) |
|---|---|---|
| Number of programs | 16 (12/4) | 47 (39/8) |
| States with Fellowships | 7 | 25 |
| Cum. Fellows trained | 176 | 430 |
| Average number/year | 9 | 30 |

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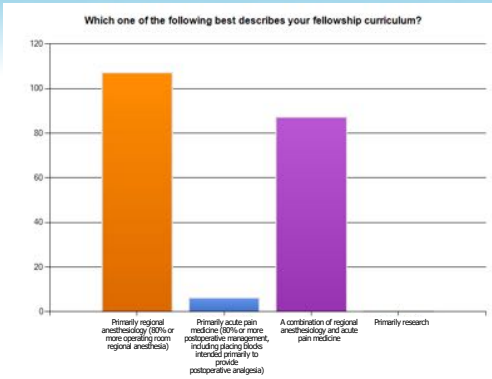
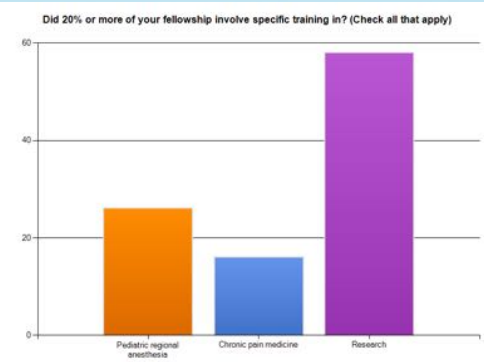
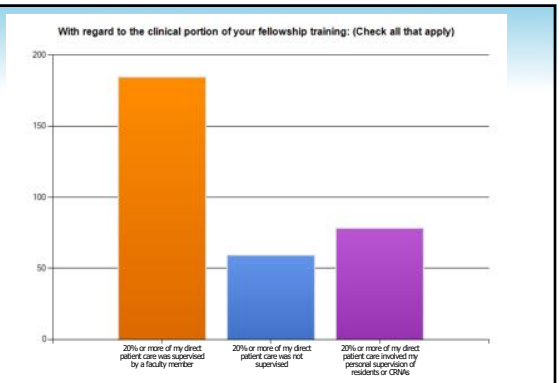
## Fellowship Training……Then

## Fellowship Training……Now




## Where are our graduate fellows practicing?

Ann & Robert H. Lurie Children's Hospital of Chicago

| | 2002 | 2012 |
|---|---|---|
| Academic Practice | 49% | 53% |
| Private Practice | 43% | 23% |
| "Hybrid" Practice | 8% | 24% |

## Adequacy of Skills

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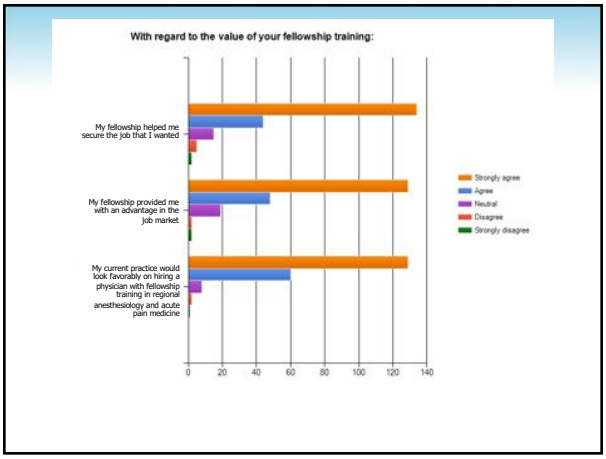



## How are our graduate fellows "staying current"?

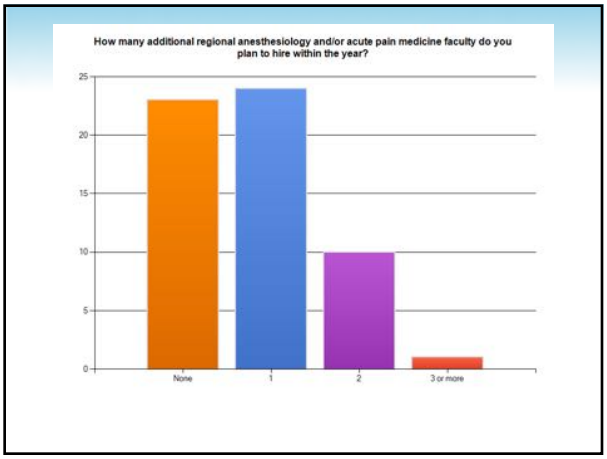
Ann & Robert H. Lurie Children's Hospital of Chicago

| | 2002 | 2012 |
|---|---|---|
| Members of ASRA | 73% | 79% |
| Read RA Literature | 92% | 78% (RAPM) |

## Academic Chairs Survey

Ann & Robert H. Lurie Children's Hospital of Chicago

| | 2002 (61) | 2012 (58) |
|---|---|---|
| Additional RA faculty needed | 2 (±2) | 1 (±1) |

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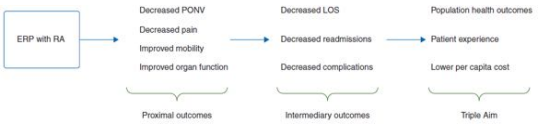
## What is it worth?

- 58 studies
  - 37 RCT, 1 non-Rct
  - All inpatient, 55 elective

Impact of including regional anaesthesia in enhanced recovery protocols: a scoping review
D. I. McIsaac[1,2,3], E. T. Gole[1] and C. J. L. McCartney[1,2,3,*]
British Journal of Anaesthesia, 115 (5): 686–696 (2015)




- Of all studies, X% found..
  - 58% significant improvement in pain
  - 28% improved PONV outcomes
  - 46% mobility improved
  - 52% improved GI function
  - 42% shorter LOS
  - 5% lower readmissions
  - 27% decrease in adverse events
  - Consistent signal towards improved economic outcomes with RA included in ERPs
    - Need more value based outcomes!

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## Pain and Cost Saving Case Study

**TABLE 3.** PACU-Associated Outcomes in Pediatric Patients Undergoing ACL Repair

| Variable | Control (n = 39) | Nerve Block (n = 115) | P |
|---|---|---|---|
| PACU phase I stay, min | 87 ± 37 | 82 ± 27 | 0.373 |
| PACU phase II stay, min | 192 ± 101 | 145 ± 76 | 0.013* |
| PACU opioids, mg/kg | 0.125 ± 0.098 | 0.051 ± 0.060 | <0.001* |
| PACU antiemetic use | 6 (15%) | 7 (6%) | 0.071† |
| PACU acetaminophen | 31 (80%) | 55 (48%) | 0.006* |
| PACU ketorolac | 4 (10%) | 9 (8%) | 0.638 |
| UHA | 7 (18%) | 8 (7%) | 0.045* |

Regional Anesthesia Is Cost-Effective in Preventing Unanticipated Hospital Admission in Pediatric Patients Having Anterior Cruciate Ligament Reconstruction
Regional Anesthesia and Pain Medicine • Volume 41, Number 4, July-August 2016

**TABLE 4.** Peripheral Nerve Block Costs and Savings

| | No Ambulatory Pump | | Ambulatory Pump | |
|---|---|---|---|---|
| | PNB in OR | PNB in Block Room | PNB in OR | PNB in Block Room |
| Itemized cost | | | | |
| Disposable supplies w/B/U | $55.27 | $55.27 | $294.14 | $294.14 |
| a) Consult | $47.01 | $47.01 | $47.01 | $47.01 |
| b) Single-shot FNB | $75.82 | $75.82 | | |
| c) Catheter FNB | | | $82.39 | $82.39 |
| d) Single-shot SNB | $74.81 | $74.81 | $74.81 | $74.81 |
| PNB in OR | $60.00 | | $127.50 | |
| Added induction time | 4 min | | 9 min | |
| Subtotal costs | $312.91 | $252.91 | $625.85 | $498.35 |
| Savings | | | | |
| PNB in block room | | ($75.00) | | ($75.00) |
| UHA* | ($263.81) | ($263.81) | ($263.81) | ($263.81) |
| PACU 2 stay† | ($158.39) | ($158.39) | ($158.39) | ($158.39) |
| Pharmacy | ($5.71) | ($5.71) | ($5.71) | ($5.71) |
| Subtotal savings | ($427.91) | ($502.91) | ($427.91) | ($502.91) |
| Total cost savings‡ | $115.00 | $250.00 | ($197.94) | $4.56 |

*UHA average added cost across all patients undergoing ACL without nerve block, $430.77; with nerve block, $166.96.
†PACU 2 stay average cost across all patients undergoing ACL without nerve block, $647.04; with nerve block, $488.65.
‡Sum of subtotal savings minus subtotal cost.
FNB indicates femoral nerve block; SNB, sciatic nerve block.

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## Areas for Growth


- Pediatrics
- Non-Surg Acute Pain
- Newer/Truncal Blocks
- Administrative Practice
- Research

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## Summary

- Growth
- Initiatives
- Competition and Prospects

HANDOUT

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Association of Anesthesiology Subspecialty Program Directors

# Critical Care Medicine Update

T. Miko Enomoto, M.D.

11/11/2016
1:40pm – 1:50pm

# AASPD Subspecialty Update: Critical Care

Miko Enomoto, MD
Oregon Health Sciences University

## Anesthesiology Critical Care Medicine

- 1985 ABMS approved ABA to issue certificates in Critical Care Medicine
- 1986 SOCCA formed
- 1986 ABA issued first board certification of special competence in CC
- 1988 ACGME accredited
- 2013 ABMS approved ABA/ABEM certification of EM physicians in ACCM

## Numbers

| | 2014 | 2015 | 2016 |
|---|---|---|---|
| APPLICANT DATA | | | |
| Applicant registrations | 196 | 189 | 194 |
| # Applicant Rank Lists Submitted | 147 | 148 | 153 |
| Matched Total | 127 | 137 | 149 |
| Unmatched Total | 20 | 11 | 4 |
| Applicant Matching % (Overall) | 86% | 93% | 97% |
| Total # of Withdrawals | 20 | 19 | 16 |
| PROGRAM DATA | | | |
| # Of Participating Programs | 47 | 49 | 52 |
| Positions Offered | 150 | 167 | 186 |
| Positions Filled | 127 | 137 | 149 |
| Unfilled Positions | 23 | 30 | 37 |

## Match Process

- SF Match
- Common Application Service: new this year
- Standardized LOR: not yet using
- Exceptions to the Match

## Match Timeline

| | Date |
|---|---|
| Applicant Registration Begins | November 1, 2016 |
| Rank List Submission Deadline | May 26, 2017 |
| Results Released to Programs | June 2, 2017 |
| Results Released to Applicants | June 2, 2017 |
| Post-match vacancies posted | June 5, 2017 |
| Fellowship Training Begins | July 2018 |

## Exceptions to the Match

- Requires agreement from applicant and program
- Exceptions
  - Active military service
  - Commitment > 1 yr
  - Outside US at time of application
  - Not eligible for ABA certification
  - 'Couples match'
  - Internal candidates

## Issues with the ACCM Match

- Exception Process

| | 2014 | 2015 | 2016 |
|---|---|---|---|
| Positions Offered | 150 | 167 | 187 |
| Exceptions | 31 | 36 | 56 |

  - Process
  - Fairness
  - Transparency
- Programs holding positions outside of match

## Subspecialty Organization

- SOCCA
  - Formally sponsored 2013
- PDs meet 3 times a year
  - SAAA/ AASPD
  - SCCM: Honolulu, January 21, 2017
  - SOCCA/IARS: Washington, DC, May 6, 2017

## Other Interests (?In Common)

- Discussion Board
- Common Competencies/ Collaboration
- Jobs in the Community & Academics
- Professional Development Opportunities for our PDs
- Critical Care Ultrasound

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# Pain Medicine Update

Gary J. Brenner, M.D., Ph.D.

11/11/2016
1:50pm – 2:00pm

## 2016 Pain Medicine Match

| Year | Programs | Positions | Filled | % not matched | %US Grad | US FMG | Osteo | Inter'l |
|---|---|---|---|---|---|---|---|---|
| 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 |

## 2016 Pain Medicine Certification Examination Pass Rates

| Board | Total Candidates | # Passed | Pass Rate | Total First time takers | # Passed the first time | First Time Pass Rate |
|---|---|---|---|---|---|---|
| ABA | 320 | 282 | 88% | 287 | 261 | 91% |
| ABEM | 1 | 0 | 0% | 1 | 0 | 0% |
| ABFM | 1 | 0 | 0% | 0 | - | - |
| ABPMR | 79 | 70 | 89% | 75 | 68 | 91% |
| ABPN | 17 | 15 | 88% | 16 | 15 | 94% |
| ABR | 1 | 1 | 100% | 1 | 1 | 100% |

## 2016 Pain Medicine Recertification Examination Pass Rates

| Board | Total Candidates | # Passed | Overall Pass Rate | Total First time takers | # Passed the first time | First Time Pass Rate |
|---|---|---|---|---|---|---|
| ABA | 381 | 272 | 71% | 319 | 233 | 73% |
| ABPMR | 99 | 72 | 73% | 78 | 60 | 77% |
| ABPN | 14 | 9 | 64% | 13 | 9 | 69% |

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Association of Anesthesiology Subspecialty Program Directors

# Pediatric Anesthesiology Update

Susan Staudt, M.D.

11/11/2016
2:00pm – 2:10pm

2016 Fellowship Annual Report PAPDA to AASPD and SAAC Boards
Prepared October 15, 2016
Susan Staudt, MD MSEd President
Pediatric Anesthesiology Program Directors Association

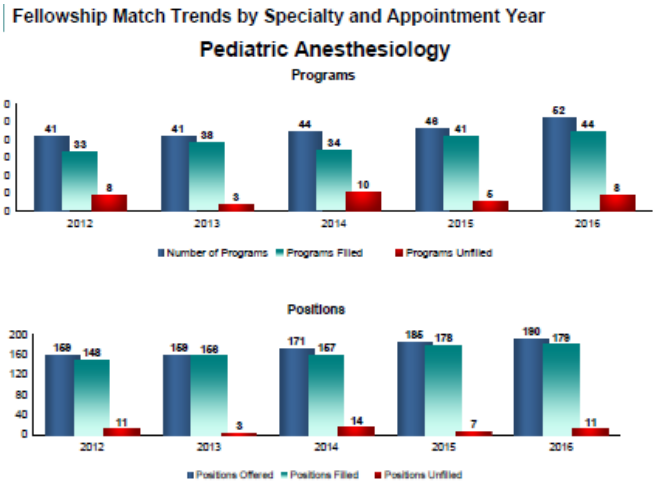
**Pediatric Anesthesiology Fellowships Metrics and Demographics ACGME Data (2015-16)**

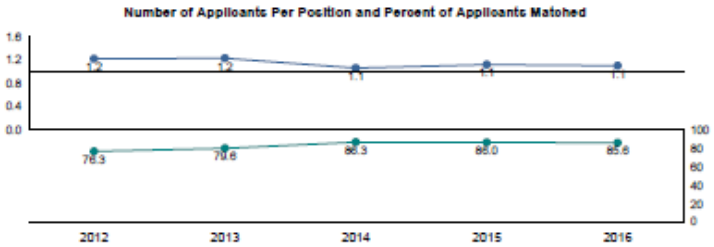
58 accredited acgme fellowships
250 ACGME approved positions (27 = 11% unfilled)
223 completed training AY 2015- 16
Overall subspecialty training growth rate 2008-2016 = 8.9% (approved positions growth rate 10 %)
Snapshots: **2008**- 43/130 **2011**- 46/185 **2016**- 58/223

NRMP Match 2016 for 2017 (NRMP data)

Match closed mid September
Contiguous with pain, OB (crit care and adult CV in June SF match)
53/58 programs in match 210 match positions- 193 filled /17 unfilled (vs 2016 52-190-11)

Prior Trends:




Comments re: NRMP Match:

1. Overall trend towards increased n of positions in match.
2. Continue to have out of match offers -in general are unpopular with PD's and trainees (including trainees who have accepted same (data from PAPDA surveys 2013-15)
3. Third year of common application migrating for 2017 to ERAS based
4. NEW for 2017-using ERAS for application process- (centralized **verified** LOR process, test scores , transcripts-training reports)-no longer application on SPA site? Fall action item-1/2 programs representing about 40% of positions have not activated ERAS as yet-? PD Education vs a decision to not participate? –will be PAPDA fall discussion/action item.
5. Looking Forward ? 2016-17 Agenda
    1. ? Match all in? --PAPDA –future discussion –
    2. ? Common calendar -unified match and application services for all anesthesia subspecialties? –we

Educational Initiatives:

1. ACGME and ABA Initiatives:
    A. Fellowship milestones under use and collection
    B. Case log was revised and streamlined-not ideal instrument but is significantly improved
    C. Dr Suresh to address PAPDA members/ hold Q and A at fall ASA PAPDA meeting (ABA and ACGME RRC rep)
2. Common Goals and Objectives-general fellowship G and O were approved over a year ago and are housed on SPA site
    A. Anticipate review/approval of critical care common goals/objectives at fall AASPD
    B. aim is to complete process for pain, congenital CV by spring 2017 SPA
3. Shared Evaluation Instruments and Curriculum Initiatives:
    A. Focus of discussion and action at fall SAAC-AASPD meeting-desired outcome will be on dissemination of and shared trialling/modification of existing "donated" peer made instruments with ultimate goal of selection of some for multiple institution collaborative use/modification. Ultimate goal is instrument validation . Current initiatives: 1-PACA practice exam is

under validation study at present; in use by over 10 fellowships 2-combined program anesthesia simulation/boot camps growing in size and popularity

4. Shared education materials
    A. SPA and PAPDA have agreed to contribute to the Anesthesia Toolbox.
    B. PAPDA members feel need to outreach to core faculty SPA members for materials creation and will volunteer to peer review/edit same –agenda item for recruiting curriculum development and organizing editors is on the PAPDA meeting agenda
    C. Milestones reports on graduates from ACGME programs will now be available to fellowships
    D. Professionalism train the trainers education-SPA has continued to support and endorse this PALC initiative. Spring SPA to include 2 workshops in this focus area-one to introduce the existing toolbox and the second to facilitate programs personal development of take home curriculum.

Other-? Outreach and for discussion:

1. Set annual benchmarks for fellow attendance at minimum of one SPA or fall annual ASA meeting and track same? Membership drive to seek over 90% ASA and society membership?

2. Global health initiatives: ? PAPDA and SPA endorsements of short term global experiences for fellows in training?

**2016 PAPDA Board**:

Sam Yanofsky MD, MSEd, Past President
Susan Staudt MD MSEd, President (2016-18)
Franklyn Cladis , President –Elect (2016-18; 2018-20)
Justin Lockman, Secretary
Robert, Brislin, DO BOD Member
Debnath Chaterjee, MD BOD Member
Louise Furukawa, MD BOD Member

PAPDA Vision and mission Statements and goals summary - Established 2013:

Exemplary pediatric anesthesiology education and perioperative care for children worldwide

## Mission

The Pediatric Anesthesiology Program Directors Association (PAPDA) purpose is to promote advanced clinical training in perioperative care for pediatric patients by providing the highest quality education to future pediatric anesthesiologists with emphasis on clinical excellence, lifelong scholarship, professional development, personal wellness and career mentorship. THE PAPDA will become the primary source of regulatory and educational information for program directors in ACGME-approved pediatric anesthesiology fellowship programs.

## Goals

1. **Programs and Members:** support academic advancement and growth
2. **Education:** improve the quality of pediatric anesthesiology education through dissemination of best practices of medical education
3. **Outreach:** to advance pediatric anesthesiology through national and international education initiativ

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Association of Anesthesiology Subspecialty Program Directors

# ACTA Update

Mark Stafford-Smith, M.D., C.M., F.R.C.P.C., F.A.S.E.

11/11/2016
2:10pm – 2:20pm

# AASPD Panel: Update from the Subs: What have we learned & where are we going? : Adult Cardiothoracic Anesthesia (ACTA) Update

SAAA 2016 Annual Meeting, Chicago, IL
Mark Stafford Smith, MD, CM, FRCP(C)

The ACTA Fellowship was ACGME approved in 2007, but remains without a certification exam (see below). A summary of current topics and issues being discussed by the ACTA PDs and affecting the ACTA Fellowships are outlined below.

## ACTA Fellowship Match:

Four successful matches using SF Match have occurred since 2013 (see below). In the 2016 match there was a notable increase (~25%) in the number of ACTA applicants, relative to the previous 3 years. Sixty of sixty three ACGME-approved ACTA programs (95.3%), representing 199 of 207 (95.7%) total positions participated in the 2016 match. Many of the withdrawals each year have been attributable to individuals matching to a 2 year fellowship involving an ICU fellowship first, followed by an ACTA fellowship – this trend appears to be increasing. The ACTA Fellowship Directors continue to use a handful of identified situations (e.g., applicant from home program, 2-year program), to allow pre-match "agreements" documented through an SCA website tool, where PDs and applicants agree to rank each other to match – these have been occurring at a rate of approximately 40 per year. The content of the electronic application for the 2017 match has been updated to include ABA Basic, and COMLEX scores, and an optional photo (after interview acceptance).

| Adult Cardiothoracic Anesthesiology Fellowship | June 2013 | June 2014 | June 2015 | June 2016 |
|---|---|---|---|---|
| **APPLICANT DATA** | | | | |
| Applicant Registrations | 267 | 268 | 268 | 331 |
| # Applicant Rank Lists Submitted | 230 | 213 | 211 | 258 |
| Matched Total | 166 | 172 | 182 | 199 |
| Unmatched Total | 64 | 41 | 29 | 59 |
| Applicant Matching % (Overall) | 72% | 81% | 86% | 77% |
| Total # of Withdrawals | 9 | 21 | 14 | 25 |
| **PROGRAM DATA** | | | | |
| # of Participating Programs | 54 | 55 | 57 | 60 |
| Positions Offered | 168 | 174 | 183 | 199 |
| Positions Failed | 166 | 172 | 182 | 199 |
| Unfilled Positions | 2 | 2 | 1 | 0 |

Timelines for the upcoming June 2017 Match are as follows.

Timelines:

- Friday, Nov. 11, 2016 — Applicant registration begins
- Wednesday, Feb. 1, 2017 — CAS deadline (suggested)
- Monday, June 5, 2017 — Rank lists must be submitted by 12 PM (Pacific)
- Monday, June 19, 2017 — Match results available to programs/applicants
- Wednesday, June 21, 2017 — Vacancies listed on SF Match

## Fellow/Program Director Questionnaire:

Using the (generously offered) pediatric anesthesia fellowship questionnaire tool as a model, a task force (Shook/Ural/Augoustides) has edited and modified the document with input from PDs at the ASA meeting to be pertinent to the ACTA fellowship. The intention is to circulate the document to current (2016-17) fellows/PDs - timing still to be determined.

## ACGME Case Log:

The previously published version was intended for July 2016 roll out but was deemed inadequate and withdrawn. A task force (Sniecinski, Shook, Stafford Smith) generated a revised template developed with input from the PDs which was provided to the ACGME for formatting, and is currently in an advanced stage of development – the intention is that the tool can produce TEE printouts for TEE certification as well as provide a log for the Fellowship itself – hopefully this will be available for the July 2017 start date.

## Fellow Web Seminars:

A task force has been formed (Weitzel, Bottiger, Ahlgren, Stafford Smith) to investigate formats, technologies and tools for creating online media (videos, podcasts etc.), to complement the already-existing 15 presentations constituting the SCA fellowship lecture series, for use by ACTA fellowships through the SCA website. Two prototypes were developed, and reviewed by the PDs at the ASA PD meeting and were well received. Suggested topics and other ideas are currently being solicited from the PDs and others for further development of this initiative. The SCA Board is in support, and opportunities for the use of such educational resources beyond the Fellowships are being discussed.

## ACTA Fellowship Certification:

A strong perception of the PDs, voiced unanimously at the ASA meeting as on previous occasions, is that the demands of the TEE certification exam during the ACTA fellowship distract from a balanced learning experience. The belief is that a comprehensive certification exam covering all aspects of ACTA anesthesia would re-balance this disequilibrium. The ABA and other options are currently being explored as viable SCA-sponsored pathways towards such a certification exam.

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# OB Anesthesia Update

Elizabeth H. Ellinas, M.D.

11/11/2016
2:20pm – 2:30pm

# OB ANESTHESIA FELLOWSHIP UPDATE SESSION

LIBBY ELLINAS, MD
CHIEF OF OB ANESTHESIA
PROGRAM DIRECTOR OB ANESTHESIA FELLOWSHIP
ASSOCIATE DEAN FOR FACULTY AFFAIRS AND WOMEN'S LEADERSHIP
MEDICAL COLLEGE OF WISCONSIN

No disclosures.

**NRMP MATCH RESULTS OB ANESTHESIA**
OB Anesthesia has participated in its second NRMP Match.

**THIS YEAR'S MATCH (2016):**
Oct 5, 2016 for Fellows Entering July 2017:

**PROGRAMS:** No non-accredited OB Fellowship programs participated in the Match this year.
There are currently 31 ACGME accredited programs in OB Anesthesia.

- 26 participated in this year's Match with *at least one* of their positions, for a participation rate of 84% -- above the 75% NRMP suggested threshold for success.
- 11 programs that participated in the Match filled (42.3% of 26);
- 15 programs that participated in the Match have at least one position remaining unfilled. (57.7% of 26)

**POSITIONS:** There are 55 accredited positions in OB Anesthesia.

- 43 of those positions were available in the Match (78% of 55) – above the 75% NRMP suggested threshold for success.
- 12 positions filled outside the Match in accredited programs.
- 26 positions filled in the Match (60% of 43 in the match; 47% of 55 total accredited positions)
- 17 of the in-Match positions were unfilled. (40% of 43; 31% of 55)

**THE 2015 MATCH:** was quite similar.

**THOUGHTS REGARDING THE MATCH:**

- Continue participation
- Promote the specialty by emphasizing the ACOG levels of care and their emphasis on Fellowship-Trained Anesthesiologists for the higher levels.

**PLANS FOR STANDARDIZED FILLABLE FELLOWSHIP APPLICATION FORM**

- Approval from the Pediatric Anesthesiology Fellowship to use their form, with thanks to John Eck (creator of peds form), Susan Staudt, and the SPA BOD.
- SOAP Business Team will put on website with link
- Will use the form mostly unchanged except for the "Extended Questions."
    - Consider such questions as "If your department received $1million, how would you spend it, and why?"

- Impetus was that the time spent in person with candidates seems to be getting less and less.

**WEBINARS**

- We will have completed 4 years of monthly webinars in December 2020!
- Always 2nd Wednesday of month noon Pacific
- Speakers can use this on their CVs as a "invited national lecture."
- Programs can use these lectures (ACGME approval obtained) within their own curricula if a faculty member watches with the fellow, and discusses the supplementary papers attached to each lecture.
- Future plan is to try to obtain outside speakers (e.g. from Maternal-Fetal-Medicine/CCM/Cardiac, etc.), international speakers, or unusual topics for programs – e.g. Drug Abuse or Psychiatric Disorders in Pregnancy.

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# Critical Care Subspecialty Breakout

Ahmed M. Darwish, M.D.
T. Miko Enomoto, M.D.

11/11/2016
3:45pm – 5:30pm

SAAA / AASPD

Critical Care Breakout Session

Friday, November 11, 2016

3:45-5:30 pm

Miko Enomoto, Chair

Agenda

1. Welcome
2. ACCM Match
    a. Results of 2016 Match
    b. Common Application Service
    c. Timeline for 2017 Match
    d. Exception Process Updates
3. Group Governance
4. Task Force Updates
    a. Out Reach
    b. CAS/ Standardized Letter
    c. Critical Care Ultrasound
    d. Critical Care Anesthesiology Jobs
    e. SOCCA Interchange
5. Upcoming meetings
6. Teaching Communication Skills to Our Fellows, Silvia Perez Protto

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Association of Anesthesiology Subspecialty Program Directors

# OB Anesthesia Subspecialty Breakout

Elizabeth H. Ellinas, M.D.

11/11/2016
3:45pm – 5:30pm

# OB Anesthesia Fellowship Breakout Session


## LIBBY ELLINAS, MD

CHIEF OF OB ANESTHESIA
PD OB ANESTHESIA FELLOWSHIP
ASSOCIATE DEAN FOR FACULTY AFFAIRS AND WOMEN'S LEADERSHIP
MEDICAL COLLEGE OF WISCONSIN


No disclosures.

Discussion Topics:

1. Webinars – attendance, speakers, request suggestions for future changes
2. Common Application for OB Anesthesia – permission received from the Pediatric Fellowship to use their form, with thanks to Susan Staudt and John Eck.
3. Match results and discussion – please see info in OB Anesthesia Match Session
4. Other business as required.

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# Pain Medicine Subspecialty Breakout

Bryan C. Hoezler, M.D.

11/11/2016
3:45pm – 5:30pm

# Association of Pain Program Directors: 2016

Bryan Hoelzer M.D.
President-elect: Association of Pain Program Directors

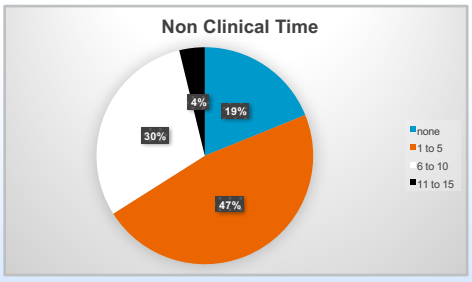
## Disclosures

- None

## Objectives

- Review the 2017 match
- Review the Pain Medicine ACGME Program requirements for Medical Knowledge competencies
- List the Medical Knowledge Competencies. IV.A.5.b) to IV.A.5.b).(4).(n)
- Identify area where Program Directors have weaknesses in their Curriculum
- Introduce the website content being developed by the APPD
- Simulation is Pain Fellowship training

| Year | Programs | Positions | Filled | % not matched | %US Grad | US FMG | Osteo | Inter'l |
|---|---|---|---|---|---|---|---|---|
| 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 |




## Future Directions of APPD?

- **Ranked as Very Important**
- Access to Educational Content (70%)

# Introducing a Pain Medicine Fellowship Educational Resource:

## The Association of Pain Program Directors' New Website

**Scott Brancolini, MD, MPH**

Assistant Professor
Program Director, Pain Medicine Fellowship
Board Member, APPD
University of Pittsburgh Medical Center
Department of Anesthesiology/Pain Medicine Division
SAAA – 11/11/16
AASPD Pain Medicine Fellowship Breakout Session

## ACGME Competencies

- Practice Based Learning and Improvement
- Systems Based Practice
- Professionalism
- Interpersonal Skill and Communication
- Patient Care
- **Medical Knowledge**

## Pain Medicine ACGME Medical Knowledge Competencies

- https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/530_pain_medicine_2016_1-YR.pdf

- **IV.A.5.b) Medical Knowledge**
- **Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.**

## Dear Colleagues, Don't Worry.

- I promise I will not read aloud all of the following items.
- Hang on for a few slides, my point is coming soon!

## ACGME Pain Medicine Competencies

- IV.A.5.b).(1) assessment of pain
- IV.A.5.b).(1).(a) anatomy, physiology and pharmacology of pain transmission and modulation
- IV.A.5.b).(1).(b) natural history of various musculoskeletal pain disorders
- IV.A.5.b).(1).(c) general principles of pain evaluation and management including neurological exam, musculoskeletal exam, psychological assessment
- IV.A.5.b).(1).(d) indicators and interpretation of electro-diagnostic studies: X-Rays, MRI, CT, and clinical nerve function studies
- IV.A.5.b).(1).(e) pain measurement in humans, both experimental and clinical

## ACGME Pain Medicine Competencies

- IV.A.5.b).(1).(f) psychosocial aspects of pain, including cultural and cross-cultural considerations
- IV.A.5.b).(1).(g) taxonomy of pain syndromes
- IV.A.5.b).(1).(h) pain of spinal origin, including radicular pain, zygapophysial joint disease, and discogenic pain
- IV.A.5.b).(1).(i) myofascial pain
- IV.A.5.b).(1).(j) neuropathic pain

## ACGME Pain Medicine Competencies

- IV.A.5.b).(1).(k) headache and orofacial pain
- IV.A.5.b).(1).(l) rheumatological aspects of pain
- IV.A.5.b).(1).(m) complex regional pain syndrome
- IV.A.5.b).(1).(n) visceral pain
- IV.A.5.b).(1).(o) urogenital pain
- IV.A.5.b).(1).(p) cancer pain, including palliative and hospice care

## ACGME Pain Medicine Competencies

- IV.A.5.b).(1).(q) acute pain
- IV.A.5.b).(1).(r) frequent psychiatric and pain co-morbidities, which include substance-related mood, anxiety, somatoform, factitious, and personality disorders
- IV.A.5.b).(1).(s) the effects of pain medications on mental status
- IV.A.5.b).(1).(t) assessment of pain in special populations, including patients with ongoing substance abuse, the elderly, pediatric patients, pregnant women, the physically disabled, and the cognitively impaired
- IV.A.5.b).(1).(u) functional and disability assessment

## ACGME Pain Medicine Competencies

- IV.A.5.b).(2) treatment of pain
- IV.A.5.b).(2).(a) Drug Treatment I: opioids
- IV.A.5.b).(2).(b) Drug Treatment II: antipyretic analgesics
- IV.A.5.b).(2).(c) Drug Treatment III: antidepressants, anticonvulsants, and miscellaneous drugs
- IV.A.5.b).(2).(d) psychological and psychiatric approaches to treatment, including cognitive-behavioral therapy, psychosocial therapies and treatment of psychiatric illness
- IV.A.5.b).(2).(e) prescription drug detoxification concepts
- IV.A.5.b).(2).(f) functional and vocational rehabilitation
- IV.A.5.b).(2).(g) surgical approaches

## ACGME Pain Medicine Competencies

- IV.A.5.b).(2).(h) complementary and alternative treatments in pain management
- IV.A.5.b).(2).(i) treatments that comprise multidisciplinary cancer pain care
- IV.A.5.b).(2).(j) strategies to integrate pain management into the treatment model
- IV.A.5.b).(2).(k) hospice and multidimensional treatments that comprise palliative care; and
- IV.A.5.b).(2).(l) treatment of pain in pediatric patients
- IV.A.5.b).(3) general topics, research, and ethics; including

## ACGME Pain Medicine Competencies

- IV.A.5.b).(3).(a) epidemiology of pain
- IV.A.5.b).(3).(b) gender issues in pain
- IV.A.5.b).(3).(c) placebo response
- IV.A.5.b).(3).(d) multidisciplinary pain medicine
- IV.A.5.b).(3).(e) organization and management of a pain center
- IV.A.5.b).(3).(f) Continuing Quality Improvement, Utilization Review, and Program Evaluation
- IV.A.5.b).(3).(g) patient and provider safety

## ACGME Pain Medicine Competencies

- IV.A.5.b).(3).(h) designing, reporting, and interpreting clinical trials of treatment for pain
- IV.A.5.b).(3).(i) ethical standards in pain management and research
- IV.A.5.b).(3).(j) animal models of pain, ethics of animal experimentation
- IV.A.5.b).(4) interventional pain treatment, including
- IV.A.5.b).(4).(a) selection criteria for a broad range of interventions and an understanding of the risks and potential advantages of these interventions
- IV.A.5.b).(4).(b) airway management skills
- IV.A.5.b).(4).(c) sedation/analgesia

## ACGME Pain Medicine Competencies

- IV.A.5.b).(4).(d) fluoroscopic imaging and radiation safety
- IV.A.5.b).(4).(e) pharmacology of local anesthetics and other injectable medications, including radiographic contrast agents and steroid preparations
- IV.A.5.b).(4).(e).(i) This must include treatment of local anesthetic systemic toxicity
- IV.A.5.b).(4).(f) trigger point injections
- IV.A.5.b).(4).(g) peripheral and cranial nerve blocks and ablation
- IV.A.5.b).(4).(h) spinal injections including epidural injections: interlaminar, transforaminal, nerve root sheath injections, and zygapophysial joint injections

## ACGME Pain Medicine Competencies

- IV.A.5.b).(4).(i) discography and intradiscal/percutaneous disc treatments
- IV.A.5.b).(4).(j) joint and bursal injections, including sacroiliac, hip, knee, and shoulder joint injections
- IV.A.5.b).(4).(k) sympathetic ganglion blocks
- IV.A.5.b).(4).(l) epidural and intrathecal medication management
- IV.A.5.b).(4).(m) spinal cord stimulation
- IV.A.5.b).(4).(n) intrathecal drug administration systems

## THAT'S A LOT OF WORDS. THAT'S A LOT OF CONTENT.

- Wouldn't it be nice to not have to worry about this?
- We are here to help!

## The APPD Website

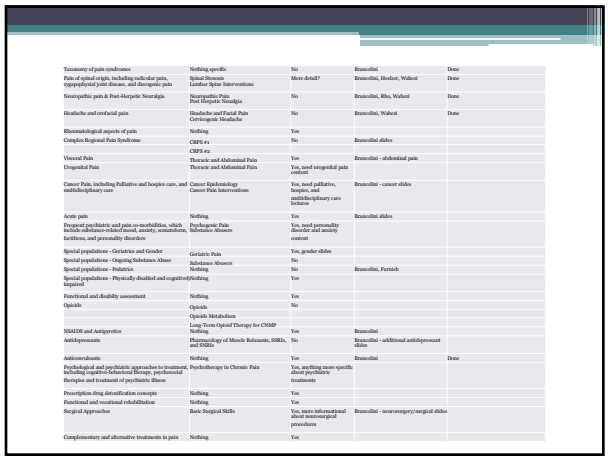
- http://www.appdhq.org/
- New educational content design
  - Lectures comprised to satisfy all ACGME Pain Medicine Medical Knowledge Competencies
  - Maximize fellow education
  - Eliminate concern for not fulfilling ACGME requirements for site visits
  - A joint national effort

## The APPD Website

- Thank you to all contributors.
- We request with your kind permission to use some of your slides for the new content.
- It's ok to say no.
- But your cooperation would be great appreciated!
- All credit will be given when your slides are used.

## Where we are…

| APPD Website Educational Content Upgrade Project 2016-2017 | | | | Key to content |
|---|---|---|---|---|
| | | | | Lecture completed |
| Scott Brancolini, MD,MPH, Program Director, Assistant Professor, UPMC Pain Medicine Fellowship | | | | No content |
| http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/330_pain_medicine_07012014_1-YR.pdf | | | | Started but lacking content |
| | | | | Blank - have full/partial content, not yet started |
| | | | | |
| # ACGME Medical Knowledge Competencies | Current Website Content | Content Needed? | Authors | Revision deadline |
| 1 Anatomy, physiology and pharmacology of pain transmission and modulation | Radiology of Cervical and Lumbar Spine | More detail? | Brancolini | Done |
| | Cervical Anatomy | | Hooker | |
| | Spinal Cord Stimulation | | Wahezi | |
| | Sympathetic Ganglion Blocks | | | |
| | Neuropathic Pain | | | |
| | Overview of Pharmacologic Treatment of Pain #1 | | | |
| | Overview of Pharmacologic Treatment of Pain #2 | | | |
| 2 Natural history of various musculoskeletal pain disorders, myofascial pain, and trigger point injections | Myofascial Pain | No | Argetsio, Argerio, Brancolini | Done |
| 3 General principles of pain evaluation and management including neurological exam, musculoskeletal exam, psychological assessment | Lumbar Spine Interventions | No | Brancolini, Wahezi | Done |
| 4 Indications and interpretation of electro-diagnostic studies: X-Rays, MRI, CT, and clinical nerve function studies | Radiology of Cervical and Lumbar Spine<br>Cervical Anatomy | More detail? | Brancolini, Wahezi | Done |
| 5 Pain measurement in animals and humans, both experimental and clinical, placebo response | Animal Models of Pain | Yes - for human models and placebo | Brancolini, Wahezi | Animal portion completed. |
| 6 Psychosocial aspects of pain, including cultural and cross-cultural considerations | Psychotherapy in Chronic Pain | Yes - regarding cultural and cross-cultural consideration | Brancolini, Pohlman | Psychotherapy portion completed. |



| | | | | |
|---|---|---|---|---|
| Taxonomy of pain syndromes | Nothing specific | No | Brancolini | Done |
| Pain of spinal origin, including radicular pain, zygapophyeal joint disease, and discogenic pain | Spinal Stenosis<br>Lumbar Spine Interventions | More detail? | Brancolini, Hoelzer, Waheed | Done |
| Neuropathic pain & Post-Herpetic Neuralgia | Neuropathic Pain<br>Post Herpetic Neuralgia | No | Brancolini, Rho, Waheed | Done |
| Headache and orofacial pain | Headache and Facial Pain<br>Cervicogenic Headache | No | Brancolini, Waheed | Done |
| Rheumatological aspects of pain | Nothing | Yes | | |
| Complex Regional Pain Syndrome | CRPS #1 | No | Brancolini slides | |
| | CRPS #2 | | | |
| Visceral Pain | Thoracic and Abdominal Pain | Yes | Brancolini - abdominal pain | |
| Urogenital Pain | Thoracic and Abdominal Pain | Yes, need urogenital pain content | | |
| Cancer Pain, including Palliative and hospice care, and multidisciplinary care | Cancer Epidemiology<br>Cancer Pain Interventions | Yes, need palliative, hospice, and multidisciplinary care lectures | Brancolini - cancer slides | |
| Acute pain | Nothing | Yes | Brancolini slides | |
| Frequent psychiatric and pain co-morbidities, which include substance-related mood, anxiety, somatoform, factitious, and personality disorders | Psychogenic Pain<br>Substance Abusers | Yes, need personality disorder and anxiety content | | |
| Special populations - Geriatrics and Gender | Geriatric Pain | Yes, gender slides | | |
| Special populations - Ongoing Substance Abuse | Substance Abusers | No | | |
| Special populations - Pediatrics | Nothing | No | Brancolini, Furnish | |
| Special populations - Physically disabled and cognitively impaired | Nothing | Yes | | |
| Functional and disability assessment | Nothing | Yes | | |
| Opioids | Opioids | No | | |
| | Opioids Metabolism | | | |
| | Long-Term Opioid Therapy for CNMP | | | |
| NSAIDS and Antipyretics | Nothing | Yes | Brancolini | |
| Antidepressants | Pharmacology of Muscle Relaxants, SSRIs, and SNRIs | No | Brancolini - additional antidepressant slides | |
| Anticonvulsants | Nothing | Yes | Brancolini | Done |
| Psychological and psychiatric approaches to treatment, including cognitive-behavioral therapy, psychosocial therapies and treatment of psychiatric illness | Psychotherapy in Chronic Pain | Yes, anything more specific about psychiatric treatments | | |
| Prescription drug detoxification concepts | Nothing | Yes | | |
| Functional and vocational rehabilitation | Nothing | Yes | | |
| Surgical Approaches | Basic Surgical Skills | Yes, more informational about neurosurgical procedures | Brancolini - neurosurgery/surgical slides | |
| Complementary and alternative treatments in pain | Nothing | Yes | | |

| | | | | |
|---|---|---|---|---|
| Organization and management of a pain center and multidisciplinary pain medicine | Nothing | Yes | | |
| Ethics: pain management, research, and animal experimentation | Nothing | Yes | | |
| | Radiology of Cervical and Lumbar Spine | | | |
| Fluoroscopic imaging and radiation safety | | Yes - radiation safety | Brancolini - fluoroscopy images | |
| | Cervical Spine Anatomy | | | |
| Local Anesthetics and treatment of toxicity | Nothing | Yes | Brancolini | Done |
| Radiographic contrast agents and steroid preparation | Nothing | Yes | Brancolini lecture | |
| Cranial nerve blocks and ablations | Nothing specific | Yes | Brancolini, Emerick lectures on ablation | |
| Spinal Injections (SIS, TFESI, Nerve root Sheath, Zygapophysial) | Lumbar Spine Interventions | Yes, TFESI, zygapophysial | Brancolini slides - facet | |
| Discography and intradiscal/percutaneous disc treatments | Complications of Interventional Pain Procedures | Yes, perc disc needed | Kent lecture | |
| Joint and bursal injections, including sacroiliac, hip, knee, and shoulder joint injections | Lumbar Spine Interventions | Yes, need hip, knee, shoulder details | | Done - More details welcomed |
| Sympathetic ganglion blocks | Sympathetic Ganglion Blocks | | | |
| | | No | | |
| Epidural and intrathecal medication management, intrathecal delivery systems | IDDS Part 1, IDDS Part 2, IDDS: Opioid Pharmacology, IDDS Troubleshooting | No | | |
| Spinal cord stimulation | Spinal Cord Stimulation | | | |
| | | No | | |

## The APPD Website Future

- Key word database
- Resources materials
- Videos of pain procedures
- Audio recorded lectures
- A way to build your CV for promotion
- Possible peer reviewed publication

## Thank you!

- Please contact me if you are interested
- Please refer to your handout

- brancolinisa@upmc.edu

MAYO CLINIC

## Simulation in Pain Medicine Training

Bryan Hoelzer M.D.

## Objectives

- Creating a positive learning environment
- Why do simulation
- Picking scenarios
- Set-up tips

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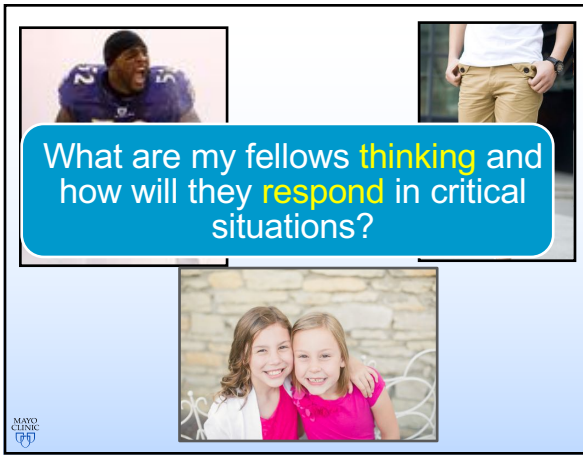
## Create the Right Environment

- Outline the positive benefits of the exercise
- Emphasize that the point is improvement NOT measurement
- Share the feelings you have had during simulation exercises

## Why do Simulation?




## Critical Skills Taught in Simulation

| | |
|---|---|
| Critical event recognition | Crisis management |
| Teamwork | Patient care handoffs |
| ACLS algorithm | Empathetic listening |
| Vital sign pattern recognition | Closed-loop communication |
| Communication skills | Group dynamics |

## Picking Scenarios

## Possible Simulation Scenarios

| | |
|---|---|
| Total spinal following a stellate ganglion injection | Pneumothorax following a stellate ganglion block |
| Seizure following a stellate ganglion injection | Bradycardia and Vasovagal reaction during a cervical injection |
| Seizure following a TAP block | Progressing epidural hematoma |
| Lost airway during sedation | Recognition of anterior spinal syndrome during a transforaminal injection |
| Pneumothorax following intercostal blocks | Inadvertent pocket fill during an intrathecal pump refill |
| Severe pain on injection | Non-compliant (moving) patient during injection |
| Equipment (fluoroscopy) failure during procedure | |

| Possible Difficult Conversation Scenarios | |
|---|---|
| Disclosing a wrong-sided procedure | Discussing a procedural complication with a patient or family member |
| Discussing end-of- life issues with a terminal patient | Utilizing a translator |
| Discontinuing opioid therapy in a combative patient | Discussing an unexpected finding during a toxicology screening |
| Patient consent | Neuritis following radiofrequency ablation |

## Scenario examples

- Tape

## Scenario Examples

- Wro

## Set up Tips

## Scenarios

- Base them on what makes you uncomfortable
  - Think about difficult situations you have encountered
- Keep them fairly simple
  - Try to focus on one concept

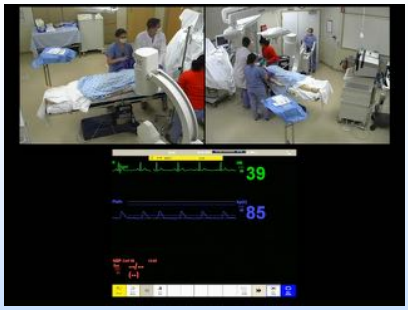
## Environment

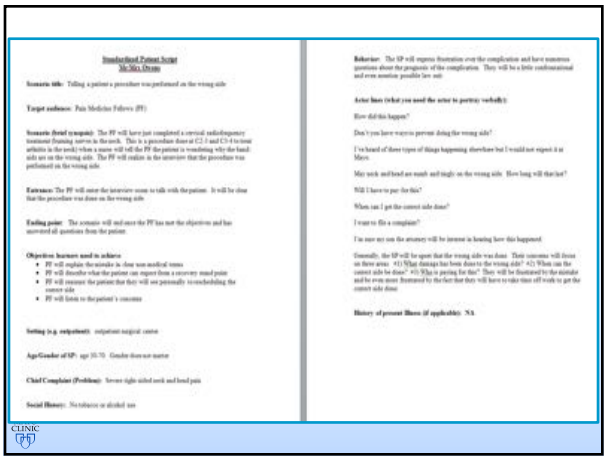
- Make it as close to the real thing as possible
- Don't over think the details
- Be a part of the scenario

## Debriefing

- Start with open ended questions
  - How did that feel?
  - What went well?
  - What was difficult?
- Let other learners provide feedback
  - Gives a team sense to the simulation
- Always find and emphasize the positives

## Simulation Room



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## Thank You!

Bryan Hoelzer M.D.
Mayo Clinic
Hoelzer.bryan@mayo.edu