SAAAPM

SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

2017 ANNUAL MEETING SYLLABUS

November 3-4, 2017

Swissôtel Chicago • Chicago, IL

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

American Society of Anesthesiologists®

SAAAPM

SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Program Information

Target Audience

This meeting is designed for anesthesiologists in Chair, Core Program, Subspecialty Program Director and Program Administrator positions. Members may invite physician and non-physician guests for whom separate registration rates are available. The program is designed to present and discuss areas of topical interest to attendees in keeping with our collective attempt to improve academic department's structure, function and the educational programs associated with academic learning.

About This Meeting

Topics for this meeting were selected by various methods. Suggestions for topics were derived from evaluations of the 2016 and other previous Annual Meetings, Council members, the membership at large and reviews of the published literature with the highest impact on the anesthesia specialty. These suggestions were discussed by our authorities in the field of anesthesia education or previous meetings.

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

This Meeting Will Provide:

- Institutional resources to support the educational, research and clinical missions essential to the day to day management of a successful academic anesthesiology department.
- Solutions to challenges in educating the next generation of trainees on issues of interpersonal communication skills, professionalism and systems-based practice.
- Ideas to design new modalities to incentivize their faculty to become best performers in fulfilling the educational and/or research missions of a successful anesthesiology department.

Registration

The registration fee for the SAAAPM 2017 Annual Meeting includes the course syllabus, all educational presentations, continental breakfasts, coffee breaks and Friday reception. There is a separate fee for lunches. Registrations that are either faxed, mailed, or made via the Web site to the SAAAPM office must be received by October 4, 2017. After October 4, 2017, late registration fees will be applied. Your registration fee is separate from the departmental dues that must be paid each year. Please include your ASA membership number with your registration to claim CME credits.

ACCME Accreditation and Designation Statements

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

The American Society of Anesthesiologists designates this live activity for a maximum of 13 *AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Commercial Support Acknowledgement

The CME activity is not supported by any educational grants.

Disclaimer

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

Disclosure Policy

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

Special Needs

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

Cancellation Policy

Cancellation of a meeting registration must be submitted in writing and will be accepted up until October 4, 2017. Your refund, less a $100 administrative fee will be sent after the conclusion of the meeting. Refunds will be determined by date written cancellation is received at the SAAAPM office in Milwaukee, Wisconsin.

Overall Learning Objectives

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

- Analyze future trends in anesthesiology manpower and training and apply these to their own situations and departmental models.
- Identify ways to mentor faculty and promote department culture change.
- Evaluate educational tools and methods available in training anesthesiology residents at their institution.

Faculty Disclosures

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

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Magdalena Anitescu, MD, PhD	Medtronic	Other Material Support
	Boston Scientific	Other Material Support
Aranya Bagchi, MBBS	Lung pacer Medical, Inc	Consulting Fees
Talmage D. Egan, MD	Medvis	Ownership; Royalties
	The Medicines Company	Consulting Fees
	Paion Pharmaceuticals	Consulting Fees
Robert R. Gaiser, MD, MSEd	The American Board of Anesthesiology	Other Material Support
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Andrew B. Leibowitz, MD	Merck	Spouse/Partner; Equity Position
	Novartis	Spouse/ Partner; Salary; Equity Positions; Stock Options
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All others, including editor, authors, reviewers and staff for the SAAAPM 2017 Annual Meeting reported they have no relevant relationship(s) with commercial interest(s).
See the SAAAPM Guidebook app for the most recent list of faculty disclosures.

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guidebook & Claiming CME Credit

Guidebook Mobile App

The SAAAPM 2017 Annual Meeting has gone mobile using Guidebook!

We strongly encourage you to download our mobile guide to enhance your experience at the SAAAPM 2017 Annual Meeting. You'll be able to plan your day with a personalized schedule and download all the meeting materials from your handheld device.

The app is compatible with iPhones, iPads, and Android devices. Windows Phone 7 and Blackberry users can access the same information via our mobile site at https://guidebook.com/g/saaapm2017.

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Please note: You must claim your credits for this meeting by December 31, 2017. You will NOT be able to claim credits after this date.

Please follow these directions to access the course, claim your CME credits, complete the program evaluation(s) and print your CME certificate(s):

1. Log in to the ASA Education Center at: http://education.asahq.org/

   If you have accessed the ASA Education Center for a previous meeting, please use your existing ASA username and password.

   If you have not previously accessed the ASA Education Center, you will soon receive an e-mail from the ASA Education Center with log-in instructions.
2. Once you have logged on to the ASA Education Center homepage, click the tab that says "MY LEARNING" and select "MY ENROLLMENTS" to view the link to the SAAAPM 2017 Annual Meeting.
3. Select the link to access the course evaluation and claim credit.
4. To retrieve a username or password, enter your email address at: https://www.asahq.org/member-center/forgot-password

Note: Physicians should claim only credit commensurate with the extent of their participation.

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SAVE THE DATE

2018 Annual Meeting
November 2-3, 2018
Swissôtel Chicago • Chicago, Illinois

Friday, November 3 *All AAAC presentations held in Zurich ABC unless otherwise noted.*

7:00 – 8:00am **Continental Breakfast *(Zurich Pre-Function)***

Morning Session

8:00 – 10:00am	**Skills for Success as a Department Chair** *Moderator: Ronald G. Pearl, MD, PhD*
8:00 – 8:20am	**Negotiation Skills: How to Get What You Need and Want** Daniel S. Talmor, MD, MPH
8:20 – 8:40am	**Leadership Skills: How to Motivate Others to Follow Your Lead** David A. Zvara, MD
8:40 – 9:00am	**Interviewing Skills: How to Identify the Best Talent for the Job** Aman Mahajan, MD, PhD
9:00 – 9:20am	**Counseling Skills: How to Deal with the Problem Employee** Jane C.K. Fitch, MD
9:20 – 9:40am	**Delegation Skills: How to Delegate and Still Sleep Soundly at Night** C. Michael Crowder, MD, PhD
9:40 – 10:00am	**Q&A**
10:00 – 10:30am	**Break *(Zurich Pre-Function)***
10:30 – 12:00pm	**Mistakes Made; Lessons Learned** *Moderator: Ronald G. Pearl, MD, PhD*
10:30 – 10:42am	Andrew D. Friedrich, MD
10:42 – 10:54am	Gerald Manecke, MD
10:54 – 11:06am	Talal W. Khan, MD, MBA
11:06 – 11:18am	Gordon Morewood, MD, MBA, FASE
11:18 – 11:30am	Scott Segal, MD, MHCM
11:30 – 12:00pm	**Q&A/Panel Discussion**
12:00 – 1:15pm	**Optional Box Lunch** *($10 Fee – RSVP Required)*

Afternoon Session

1:15 – 5:00pm	**All Chair Session** *Moderator: Peter Rock, MD, MBA, FCCM*
1:15 – 1:30 pm	**Introduction of All New and Interim Chairs**
1:30 – 1:50pm	**The Chair as Mentor and Departmental Mentoring Processes** George F. Rich, MD, PhD
1:50 – 2:10pm	**How Chairs Can Recognize and Develop Leaders** W. Scott Jellish, MD, PhD
2:10 – 2:30pm	**The Annual Faculty Review** Timothy E. Morey, MD
2:30 – 2:50pm	**How Chairs Can Manage Culture Change: Perspectives from a New and Experienced Chair** Douglas R. Bacon, MD, MA John F. Butterworth, IV, MD
2:50 – 3:00pm	**Q&A**
3:00 – 3:15pm	**Break *(Zurich Pre-Function)***
3:15 – 3:50pm	**Perfect Storm** Charles W. Whitten, MD
3:50 – 4:10pm	**Defining the Roles and Expectations of Division Chiefs and Vice-Chairs** Warren S. Sandberg, MD, PhD
4:10 – 4:30pm	**Lessons Learned from Mergers of Community Practices With an Academic Department** Andrew B. Leibowitz, MD
4:30– 4:50pm	**Defining Anesthesia Services in a Value-Based Era** Laureen L. Hill, MD, MBA
4:50 – 5:00pm	**Q&A**
5:00 – 5:30pm	**AAAC Business Meeting**
5:30 – 7:30pm	**SAAAPM Reception (Zurich Pre-Function)**

Friday, November 3 *All AACPD presentations held in Zurich EFG unless otherwise noted.*

7:00 – 8:00am **Continental Breakfast *(Zurich Pre-Function)***

Morning Session

8:00 – 9:30am	**New Common Program Requirements Panel** *Moderator: Christopher E. Swide, MD*
8:00 – 8:25am	**Physician Wellness, Moving Beyond the Burnout Conversation** Greg Ozark, MD, FAAP, FACP
8:25 – 8:50am	**Quality and Safety** Daniel Rubin, MD
8:50 – 9:15am	**Point of Care Ultrasound** Robina Matyal, MD
9:15 – 9:30am	**Q&A**
9:30 – 10:00am	**Associate Program Director Panel** *Moderator: Manuel C. Pardo, Jr, MD* Jack C. Buckley, MD Kristina Sullivan, MD
10:00 – 10:30am	**Break *(Zurich Pre-Function)***
10:30 – 12:00pm	**Evolving Trends in Anesthesia: Implications for PD's** *Moderator: Joy L. Hawkins, MD*
10:30 – 11:00am	**Preparing Residents for the OSCE Exams** Robert S. Isaak, DO
11:00 – 11:30am	**An Academic Medicine Rotation** Harendra Arora, MD
11:30 – 11:40am	**The RRC: From Idea to Program Requirement** Robert R. Gaiser, MD, MSEd
11:40 – 11:45am	**Survey Results: Teaching Practice Management** Joy L. Hawkins, MD
11:45 – 12:00pm	**Q&A**

12:00 – 1:30pm **Optional Box Lunch** *($10 Fee – RSVP Required)*

Afternoon Session

12:15 – 1:00pm	**AACPD Business Meeting**
1:00 – 1:30pm	**AACPD Meet & Greet / Open Discussion**
1:30 – 3:00 pm	**Technology in Anesthesia Education Panel** *Moderator: John D. Mitchell, MD*
1:30 – 1:35pm	**Brief Scope and Introduction** John D. Mitchell, MD
1:35 – 2:15pm	**Survey Results and Resident Perspectives** Heather C. Nixon, MD + Residents
2:15 – 2:45pm	**Program Director Perspective on Integrating Multiple Tech Tools** Catherine Barden, MD
2:45 – 3:00pm	**Q&A**
3:00 – 3:30 pm	**Break (Zurich Pre-Function)**
3:30 – 5:00pm	**Everything You Always Wanted to Know About Other Programs…** Michael Wiisanen, MD Timothy R. Long, MD
5:30 – 7:30pm	**SAAAPM Reception *(Zurich Pre-Function)***

Friday, November 3 *All AASPD presentations held in Zurich D unless otherwise noted.*

7:00 – 8:00am **Continental Breakfast *(Zurich Pre-Function)***

Morning Session

8:00 – 8:15am **Welcome and Announcements**

8:15 – 9:00am **Defining How Faculty Are Qualified to Teach Point of Care Ultra Sound? Should We and Methods.**
Moderator: Magdalena Anitescu, MD, PhD

8:15 – 8:35am Santhanam Suresh, MD, FAAP

8:35 – 8:55am James P. Rathmell, MD

8:55 – 9:00am **Q&A**

9:00 – 10:00am **Developing Ultrasound Curriculum Across and Specific to the Subspecialties**
Moderator: Mark Stafford-Smith, MD, CM, FRCPC, FASE

9:00 – 9:25am Kevin C. Thornton, MD

9:25 – 9:50am Aranya Bagchi, MBBS

9:50 – 10:00am **Q&A**

10:00 – 10:30am **Break *(Zurich Pre-Function)***

10:30 – 12:00pm **Teaching Business of Medicine and Leadership Development**
Moderator: John Eck, MD

10:30 – 10:55am **Teaching Practice Management in Fellowship**
Jennifer E. Hofer, MD

10:55 – 11:20am **Preparing a Fellow for Academic Practice**
Gary J. Brenner, MD, PhD

11:20 – 11:45am **Preparing a Fellow for Private Practice**
Neal H. Cohen, MD, MPH, MS

11:45 – 12:00pm **Q&A**

Afternoon Session

12:00 – 1:30pm **Optional Box Lunch and Roundtable Discussion** *($10 Fee – RSVP Required)*

Topic 1: Quality Assurance/Patient Safety Data for Research Projects
Moderator: Charles W. Brock, MD

1:30 – 3:00pm **Updates from the Subspecialties**
Moderator: Charles W. Brock, MD

1:30 – 1:40pm **Regional Anesthesiology and Acute Pain Medicine**
Edward R. Mariano, MD, MAS

1:40 – 1:50pm **Critical Care Medicine**
Nicholas Sadovnikoff, MD

1:50 – 2:00pm **Pain Medicine**
Magdalena Anitescu, MD, PhD

2:00 – 2:10pm **Pediatric Anesthesiology**
Susan R. Staudt, MD, MSEd

2:10 – 2:20pm **ACTA**
Mark Stafford-Smith, MD, CM, FRCPC, FASE

2:20 – 2:30pm **OB Anesthesia**
Rebecca D. Minehart, MD, MSHPEd

2:30 – 2:45pm **Discussion on Uniform Fellowship Start Dates**

2:45 – 3:00pm **Group Discussion: Q&A**

3:00 – 3:20pm **AASPD Business Meeting**

3:20 – 3:45pm **Break *(Zurich Pre-Function)***

3:45 – 5:30pm **Subspecialty Breakout Sessions**

- **Adult Cardiothoracic (Vevey 1)**
  Mark Stafford-Smith, MD, CM, FRCPC, FASE
- **Critical Care Medicine (Vevy 2)**
  Nicholas Sadovnikoff, MD
- **Obstetric (Vevey 4)**
  Rebecca D. Minehart, MD, MSHPEd
- **Pain Medicine (Zurich D)**
  Scott A. Brancolini, MD, MPH
  Timothy Furnish, MD
  Glenn E. Woodworth, MD
- **Pediatric (Vevey 3)**

5:30 – 7:30pm **SAAAPM Reception *(Zurich Pre-Function)***

Friday, November 3 *All AAPAE presentations held in St. Gallen unless otherwise noted.*

FRIDAY, NOVEMBER 3

7:00 – 8:00am **Continental Breakfast *(Zurich Pre-Function)***

Morning Session

8:00 – 8:30am **Welcome**
Amy Miller Juve, EdD, MEd

8:30 – 10:00am **CCC/Milestones**
Moderator: Leslie Coker Fowler, MEd

8:30 – 8:55am **Just Say No! Developing Assessment Tools Beyond the Milestone Progression**
Lara Zisblatt, EdD, MA, PMME
Mandi Mizuta, MA

8:55 – 9:00am **Q&A**

9:00 – 9:25am **Data Overload: Best Practices for Reporting Assessment Data to the CCC**
Elisabeth Anne Hudson, BS
Kristin A. Johnson, MS
Faye Haggar, EdS

9:25 – 9:30am **Q&A**

9:30 – 10:00am **Roundtables: Sharing Practices Across Institutions**

10:00 – 10:30am **Break *(Zurich Pre-Function)***

10:30 – 12:00pm **Wellness**
Moderator: Amy N. DiLorenzo, MA

10:30 – 11:00am **Time for Wellness: Current Physician Wellness Models Within Our Programs and Institutions**
Janine Roberts, BS, C-TAGME

11:00 – 11:50am **Place Your Own Oxygen Mask Before Helping Others! Crowdsourcing and Small Group Activity: Barriers to Our Own Wellness**
Facilitator: Amy Miller Juve, EdD, MEd

11:50 – 12:00pm **Guiding Zen**
Vuslat E. Willey, MS

Lunch Program

12:00 – 1:30 pm *($10 Fee – RSVP Required)*
Mentorship program and how to become TAGME tables during lunch

1:30 – 3:00pm **Roundtables/Networking**

Topics:

- **Cardiac/critical care fellowships**
- **Pediatric/obstetric fellowships**
- **Pain/regional fellowships**
- **Non-physician educators**
- **Large residency programs**
- **Small residency programs**
- **TAGME Certified people**

3:00 – 3:30pm **Break *(Zurich Pre-Function)***

3:30 – 5:00pm **Joint Session with AACPD *(Zurich EFG)***

5:30 – 7:30pm **SAAAPM Reception *(Zurich Pre-Function)***

7:00 – 9:00pm **AAPAE Member Social**
Location:
Lizzie McNeill's Irish Pub
400 N McClurg Court
Chicago, IL 60611
Hosted Desserts, Cash Bar Available – Your RSVP is requested.

SATURDAY SCHEDULE CONTINUES ON NEXT PAGE

Saturday, November 4 *All AAPAE presentations held in St. Gallen unless otherwise noted.*

SATURDAY, NOVEMBER 4

6:30 – 7:00am	**Continental Breakfast *(Zurich Pre-Function)***
7:00 – 9:15am	**Choose 1**
	Joint Session with SAAAPM: Annual Updates *(Zurich)*
	-or-
	Educators Track – Roundtable Discussions *Moderator: Lara Zisblatt, EdD, MA, PMME* **Topics:** • **Role within Department/Institution** • **Current Scholarly Projects and Partnerships** • **Career Trajectory for Non-Physician Educator** • **Relationship with Program Administrators and Directors**
9:15 – 9:45am	**Break and Switch Rooms *(To: St. Gallen)***
9:45 – 10:15am	**ABA Updates and Q&A** James P. Rathmell, MD
10:15 – 10:45am	**ACGME Updates and Q&A** Anne Gravel Sullivan, PhD
10:45 – 12:00pm	**Partnering for Success** Moderator: Amy N. DiLorenzo, MA
10:45 – 11:15am	**Partnering with your GME office** Jennifer T. Kuttenberg, BA Ann M. Baker
11:15 – 11:45am	**Partnering with Your Program Evaluation Committee to Ensure a Robust Program Review** Christopher Zell, MS
11:45 – 12:00pm	**Q&A**
12:00 – 1:00pm	**Optional Box Lunch** *($10 Fee – RSVP Required)* **AAPAE Business Meeting (St. Gallen)**
1:00 – 2:30pm	**Afternoon Session – Join SAAAPM**
2:30pm	**EVENT ENDS**

Saturday, November 4 *All SAAAPM presentations held in Zurich unless otherwise noted.*

6:30 – 7:00am Continental Breakfast *(Zurich Pre-Function)*

Morning Session

7:00 – 9:30am	**Annual Updates** *Moderator: Jeffrey R. Kirsch, MD*
7:00 – 7:15am	**ASA Update** Linda J. Mason, MD
7:15 – 7:20am	**Q&A**
7:20 – 7:40am	**RRC Update** Robert R. Gaiser, MD, MSEd Anne Gravel Sullivan, PhD
7:40 – 7:50am	**Q&A**
7:50 – 8:20am	**ABA Update** James P. Rathmell, MD
8:20 – 8:30am	**Q&A**
8:30 – 8:50am	**ABA ITE Update** David O. Warner, MD
8:50 – 8:55am	**Q&A**
8:55 – 9:20am	**Break *(Zurich Pre-Function)***
9:20 – 9:30am	**Academic Caucus Update** Jeffrey R. Kirsch, MD
9:30 – 11:30am	**Morning Session** *Moderator: Jeffrey R. Kirsch, MD*
9:30 – 10:30am	**Improving Your Bottom Line to Support Research & Education**
9:30 – 9:50am	**Professional Citizenship** Jeffrey Scott Plagenhoef, MD
9:50 – 10:10am	**Philanthropic Creativity for Anesthesiology Departments** James Boyle Aaron Conley, EdD
10:10 – 10:30am	**The Duke Experience** Joseph P. Mathew, MD, MHSc, MBA
10:30 – 11:20am	**Entrepreneurship in Anesthesiology**
10:30 – 10:50am	**The Utah Experience** Talmage D. Egan, MD
10:50 – 11:10am	**Should Anesthesiology Innovators Work Under the University Umbrella or Start Their Own Company and Logistics for Taking the Best Approach** Douglas Eric Raines, MD
11:10 – 11:20am	**Q&A**
11:20 – 11:55am	**Funding Sources for Education Research**
11:20 – 11:35am	**FAER** James C. Eisenach, MD
11:35 – 11:50am	**IARS** Beverley Orser, MD, PhD, FRCPC
11:50 – 11:55am	**Q&A**
11:55 – 12:45pm	**Optional Box Lunch** *($10 Fee – RSVP Required)*
12:45 – 1:00pm	**SAAAPM Business Meeting**
1:00 – 2:30pm	**Afternoon Session** *Moderator: Jeanine P. Wiener-Kronish, MD*
1:00 – 1:30pm	**Mentoring Faculty Members: Gender Differences are Important** F. Kayser Enneking, MD
1:30 – 2:00pm	**Value in Anesthesiology** **How to Survive in the World of Value** Michael H. Wall, MD, FCCM
2:00 – 2:30pm	**Finding the Best Fellowship Applicants** **Debate: Required Documentation for Fellowship Applicants** Michael L. Ault, MD, FCCP, FCCM Christopher E. Swide, MD
2:30pm	**EVENT ENDS**

HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

Negotiation Skills: How to Get What You Need and Want

Daniel S. Talmor, MD, MPH

11/03/2017
8:00am – 8:20am

Negotiation Skills: How to Get What You Need and Want

Daniel S. Talmor, MD, MPH

HUMAN FIRST

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Disclosures

- Research funding
  - NHLBI
  - Gordon and Betty Moore Foundation
- Advisor
  - Hamilton Medical
  - Intensix
  - Faron

DEFINE THE PROBLEM

Background

- Over the recent years the scope of the department has expanded significantly
- At the same time the department has been effectively operating with a negative margin for the last two years
- The DACCPM does not have a structured agreement with the hospital.

Scope of Practice

- 55 Anesthetizing locations
  - 42 BIDMC (avg)
  - 8 Milton
  - 5 Needham
- 4-5 ICUs per day
- 3 MDs in OB
- 10 Pain MDs in 6 locations
- PAT

Budget FY18

FY18 Budget Review – Financial Snapshot
Department: Anesthesia
As of: July 19, 2017

Harvard Medical School

	FY18 Budget	FY17 Forecast *	Var. Fav / (Unfav)	FY17 Budget	Var. Fav / (Unfav)
Net Patient Service Revenue	$ 43,284,489	$ 39,705,518	$ 3,578,971	$ 43,229,050	$ 55,439
Contract Settlements	-	99,238	(99,238)	-	-
Research Revenue	525,519	791,346	(265,827)	746,160	(220,641)
Funds Flow	8,160,473	7,829,070	331,403	7,558,984	601,489
Other Operating Revenue	2,772,803	2,858,877	(86,074)	2,469,617	303,187
TOTAL OPERATING REVENUE	**$ 54,743,284**	**$ 51,293,882**	**$ 3,449,402**	**$ 54,017,531**	**$ 725,753**
Salaries and Benefits	$ 53,160,510	$ 47,896,778	$ (5,263,732)	$ 46,724,358	$ (6,436,152)
Professional Liability Insurance	787,043	708,746	(78,297)	697,721	(89,322)
Contract Labor	180,000	228,026	48,026	175,000	(5,000)
Other Physician Related Expenses	1,373,460	1,227,771	(145,689)	1,157,819	(215,641)
Purchased Services	317,846	58,967	(258,879)	149,500	(168,346)
General Office Expenses	464,048	412,224	(51,824)	462,074	(1,974)
Other Operating Expenses	4,363,280	4,049,917	(313,362)	4,205,830	(157,450)
Depreciation and Amortization	73,801	87,377	13,576	90,792	16,991
TOTAL OPERATING EXPENSES	**$ 60,719,989**	**$ 54,669,807**	**$ (6,050,182)**	**$ 53,663,094**	**$ (7,056,894)**
NET INCOME/(LOSS) FROM OPERATIONS	**$ (5,976,705)**	**$ (3,375,925)**	**$ (2,600,780)**	**$ 354,436**	**$ (6,331,141)**
2% Margin Target	1,094,866	1,025,878		1,080,351	
Variance to 2% Margin Target	(7,071,570)	(4,401,803)		(725,914)	

DO YOUR HOMEWORK

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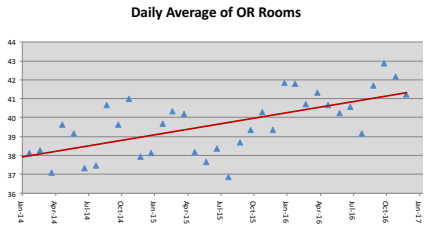
We Are Busier Than Ever



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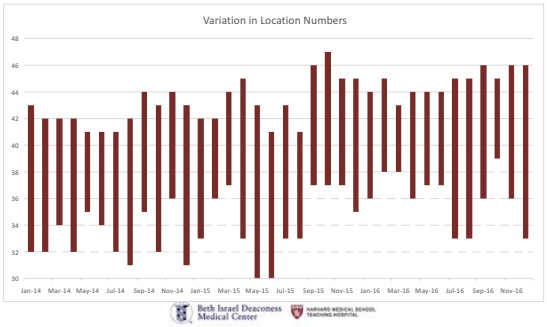
Wide Variation in Locations



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ORs are Substantially Behind Budget

Changes in Reimbursement for GI

- The departments structural deficit has been hidden by strong GI anesthesia revenue.
- HP is now denying non-indicated anesthesia care
- GI denials have increased substantially. Now over $1,000,000 in lost revenue

	GPSR	100% NPSR	75% Approved on Appeal	50% Approved on Appeal	25% Approved on Appeal
Practice: HMFP	$ 594,000	$ 463,212	$ 115,803	$ 231,606	$ 347,409
Practice: HVMA	$ 335,573	$ 261,686	$ 65,422	$ 130,843	$ 196,265
Practice: MILTON	$ 377,813	$ 294,626	$ 73,656	$ 147,312	$ 220,969
Practice: NEEDHAM	$ 12,613	$ 9,836	$ 2,459	$ 4,918	$ 7,377
Total Risk	$ 1,320,000	$ 1,029,360	$ 257,340	$ 514,680	$ 772,020

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Requests for New Services

	EP	TAVR
Current room/days per week	8	2
Current annual days	416	104
Cases per room/day	1.40	2.09
Annual Cases	584	217
Total Annual Revenue	**$ 704,973**	**$ 165,881**
Avg. Daily Revenue per Room	**$ 1,695**	**$ 1,595**
Anesthesia cost per day	$ 2,663	$ 2,663
Anesthesia net expense per room/day	**($ 968)**	**($ 1,068)**
Anesthesia annual net expense	**($ 402,688)**	**($ 111,071)**

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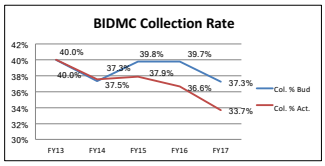
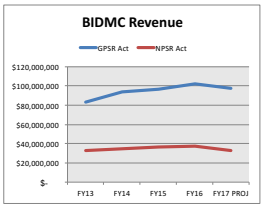
Deterioration in Collection Rate





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MAKE SURE YOUR OWN HOUSE IS IN ORDER

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Anesthesia Staffing Model

44 OR Locations
81.4 FTE

ORs	Staff	
17	11	special locations (1:1, GI w/ CRNA) (estimate)
14	7	double cover rooms (estimate)
13	13	single cover (estimate)
	4	ICU
	2	OB
	1	ICU float/ PACU
	1	PAT
	2	Floor Managers
	2	Regiona/APS
	3	In-House Call
	13	Pain Center
	59	**TOTAL STAFF CLINICAL @ BIDMC**
	4	post call
	15	lecture/meeting/vacation/LOA
	9	administrative/academic
	87	**STAFF REQUIRED**
5	2	Needham
8	3	Milton
	92	**REQUIRED STAFF FOR ALL ASSIGNMENTS**

80 Residents and Fellows

25 + 12 CRNA FTEs

Current deficit:
10.2 FTEs MD
1 FTE CRNA

Anesthesia Salaries vs. Benchmark SAAA Northeast Area 2016

		n	Mean	75%	50%	25%
Instructor		19				
	Low Paid		$242,120	$280,000	$255,703	$195,987
	Low BID					
	High Paid		$344,283	$384,029	$347,035	$297,550
	High BID					
	Mean BID		$280,527			
Assistant		25				
	Low Paid		$252,566	$316,032	$270,000	$210,348
	Low BID					
	High Paid		$455,435	$512,864	$449,620	$394,753
	High BID					
	Mean BID		$343,130			
Associate		25				
	Low Paid		$308,172	$347,500	$303,434	$272,052
	Low BID					
	High Paid		$477,964	$538,201	$477,867	$399,879
	High BID					
	Mean BID		$424,502			

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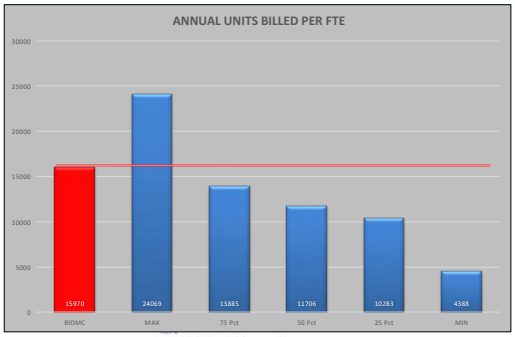
Productivity



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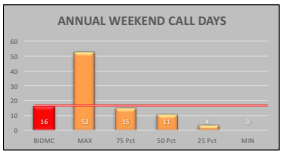

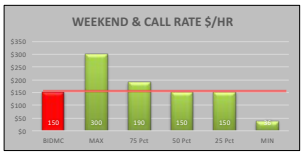

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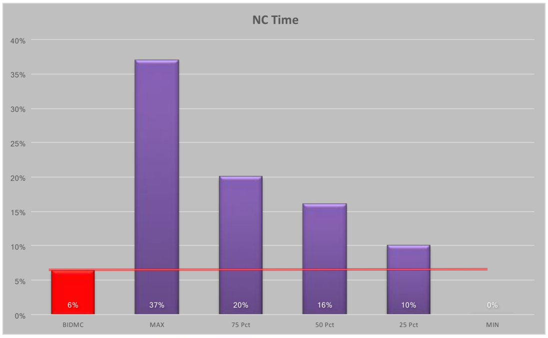

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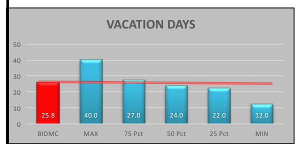
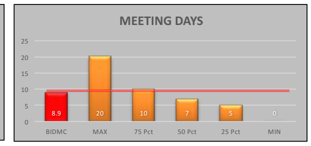
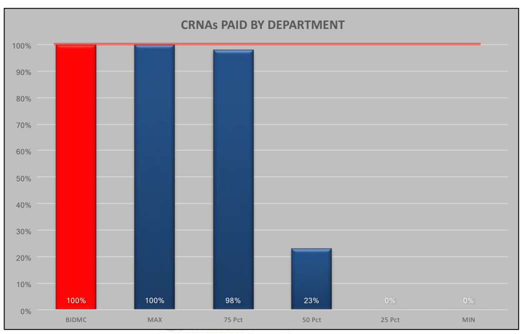




CRNAs



Next Steps- Improve Revenue Cycle

- Rev-cycle review completed
- Interim rev cycle manager in place

	DEBIT BALANCE AGING - SUMMARY BY FINANCIAL CLASS								
FINANCIAL CLASS	0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 150 Days	151 - 180 Days	181- 365 Days	Over 365 Days	Total
MEDICARE	$ 1,959,423	$ 356,696	$ 275,982	$ 303,971	$ 413,476	$ 345,618	$ 1,367,080	$ 74,442	$ 5,096,687
TUFTS	$ 342,268	$ 139,779	$ 124,235	$ 38,135	$ 60,623	$ 22,508	$ 162,682	$ 148,554	$ 1,038,785
COMMERCIAL	$ 968,757	$ 412,982	$ 228,914	$ 216,034	$ 132,801	$ 110,099	$ 678,743	$ 743,625	$ 3,491,955
HARVARD PILGRIM	$ 712,908	$ 360,093	$ 213,272	$ 55,908	$ 30,464	$ 17,331	$ 78,833	$ 58,023	$ 1,526,831
BLUE SHIELD	$ 882,290	$ 206,181	$ 61,825	$ 60,609	$ 60,105	$ 60,894	$ 172,623	$ 55,533	$ 1,560,061
HMO OTHERS	$ 976,847	$ 452,042	$ 70,749	$ 58,484	$ 71,690	$ 38,082	$ 120,564	$ 152,750	$ 1,941,207
HMO BLUE	$ 612,439	$ 339,785	$ 14,947	$ 18,126	$ 14,661	$ 10,019	$ 26,811	$ 33,281	$ 1,070,069
TUFTS SECURE HORIZ(	$ 172,367	$ 66,417	$ 59,587	$ 66,903	$ 78,936	$ 20,720	$ 177,828	$ 142,701	$ 785,459
MEDICAID	$ 384,453	$ 147,106	$ 12,571	$ 19,923	$ 18,128	$ 16,411	$ 44,471	$ 30,687	$ 673,748
WORKERS COMP	$ 87,687	$ 45,320	$ 27,176	$ 17,648	$ 26,215	$ 9,467	$ 59,458	$ 79,879	$ 352,850
COSMETICS	$ 35,750	$ 49,720	$ 33,440	$ -	$ 14,630	$ 9,460	$ 34,010	$ 5,113	$ 182,123
FREE CARE	$ 8,690	$ 15,615	$ 9,452	$ 7,402	$ 5,000	$ -	$ 32,997	$ 2,206	$ 81,362
AUTO LIABILITY	$ 16,409	$ 15,152	$ 8,619	$ 12,692	$ 1,870	$ 8,430	$ 5,761	$ 5,405	$ 74,338
CHAMPUS	$ 29,071	$ 6,724	$ 2,050	$ 2,530	$ 5,714	$ 8,887	$ 25,689	$ 37,242	$ 117,907
SELF PAY - NO INS	$ 39,537	$ 36,287	$ 40,811	$ 27,242	$ 13,589	$ 4,991	$ 19,160	$ 780	$ 182,397
SELF PAY AFTER INS	$ 38,131	$ 111,824	$ 78,557	$ 57,717	$ 52,138	$ 48,733	$ 150,247	$ 92,714	$ 630,060
Total	$ 7,267,028	$ 2,761,721	$ 1,262,186	$ 963,324	$ 1,000,039	$ 731,649	$ 3,156,958	$ 1,662,934	$ 18,805,838
	$11,290,935 60.0%			$1,963,363 10.4%		$5,551,540 30%			
Number of Accounts	14,780			3,573		9,588			

Third Party Financial Class Based upon Primary Payer
Self Pay Financial Class Based Upon Having No Primary Payer Assigned
Aging Based on Charge Entry Date

Next Steps- Renegotiate contracts with sites

- Methodology
  - Cost + 4% margin
  - Excess revenue split 50-50
- BID Milton
  - 50% recovery of this years loss
  - Agreed upon methodology going forward
- BID Needham
  - Negotiating

KNOW YOUR BOTTOM LINE
(THIS IS WHAT THEY PAY YOU FOR)

Proposed Service Levels

- 40 Locations at BIDMC- Will need to reduce block
- Eliminate funding for PAT nurses
- Reduce service for EP- Urgent cases only
- Reduce service levels for GI- Force appropriate triage

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NEGOTIATE A PATH FORWARD

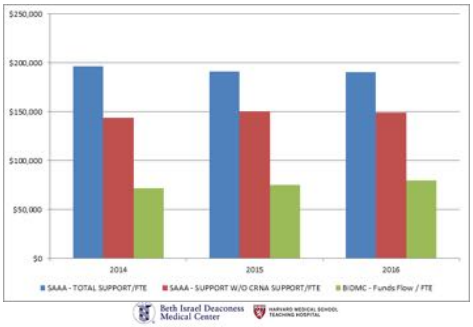
Beth Israel Deaconess Medical Center

Next Steps- Develop sustainable service agreement with BIDMC

- Current Funds Flow Model
  - Negotiated ad hoc
  - Largely tied to services (call, admin positions etc)
  - Supplemented by "contingency"
  - Does not take into account market forces
  - Not separated by service or location
  - CRNAs are paid by the department

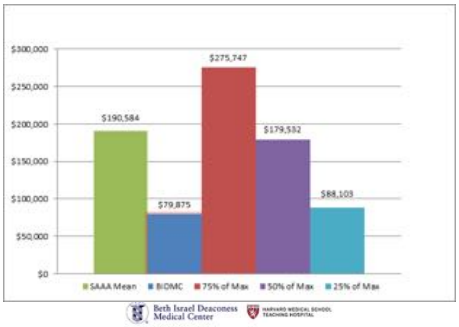
Beth Israel Deaconess Medical Center

Funds Flow vs. National Benchmarks



Beth Israel Deaconess Medical Center

Funds Flow vs. National Benchmarks



Beth Israel Deaconess Medical Center

STAY FRIENDS

Beth Israel Deaconess Medical Center

HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

Leadership Skills: How to Motivate Others to Follow Your Lead

David A. Zvara, MD

11/03/2017
8:20am – 8:40am

Vision, Strategy and Motivation:
How to get others to follow your lead

David A. Zvara, M.D.
COO UNC Faculty Practice
Professor and Chair, Anesthesiology
University of North Carolina *at* Chapel Hill
SAAAPM April 2017

Congratulations! You're the Chair! Maybe this is a position you've always wanted or perhaps this is a position you've never imagined for yourself. Nonetheless, here you are: Chair, CEO of a medium sized company with millions in revenues and dozens of employees. Your Dean looks to you to articulate the departmental vision and come up with a strategy to get there. What is implied is that you will motivate your people to higher levels of performance, greater efficiencies, better care, greater access, 24-7-365 seamless coverage, while contributing to the education and research mission *and all under budget and in the black.* Problem is leading people is difficult even under ideal conditions and we all know that health care in 2017 is far from perfect. Leadership is about getting results. That's why you were hired and if you can't deliver, the bitter truth is that you will be replaced. So how do you get your people to follow you when the problems are so complex, the path so uncertain and the future so unsure?

Vision

I'm betting your hospital or medical school has a Vision, Values and Mission statement. Find it. You can adapt the System Vision to your department easily. Similarly, it is generally easy to imagine any number of "vision" statements to include being "the preferred" medical location delivering "the best care" that's "affordable, accessible and outcome driven." Unfortunately, it is remarkably easy to create an empty slogan with which all can agree but lacks true buy in. What is imperative as a departmental leader is that you must provide a compelling vision of the future that aspirational, attainable and professionally motivating *for each person in your department.* Your people must feel like they are a part of something bigger than themselves, an organization in which they can be a proud member and one in which they can achieve milestones of professional growth. Without these elements, no cliché vision statement will ever work. Your vision must provide a realistic pathway to get your people where they dream they can be.

Strategy

We all know you eat an elephant one bite at a time. Managing your department is no different. Casting a compelling vision of the future in the absence of a realistic strategy (pathway) to achieve this vision is an empty exercise. Nothing will happen and your faculty will soon see the futility of following you and the hollowness of their

efforts. Simply stated, they'll check out physically or mentally: no vision, no strategy; no people, no department. Easy.

When discussing strategy, I always try to frame any proposition using SMART goals. SMART goals can be applied to an individual, a division or the entire department. A SMART goal is:

SPECIFIC – The objective is clearly defined in as precise a way as possible. For example, stating that I want to lose weight might be specific, but stating that I want to lose 5-pounds is better. Be specific.

MEASUREABLE – If you can't measure it, you can't change it or manage it. If implementing your vision cannot be quantified in measureable units, change the goals!

ATTAINABLE – If you really want to fail at something, set a vision that is unattainable. For example, an institution with no history nor current NIH funding is unlikely to be "#1 in research" anytime soon.

RELEVANT – Is the goal relevant to your overall objective? Is it consistent with your vision? You'd be surprised at the number of activities we all engage in that simply are irrelevant! Or, maybe not….

TIME BOUND – This is the one most leaders over look at their own peril. Everything you do should have a time stamp associated with it so that you can MEASURE progress and post RESULTS.

Motivation

General Eisenhower once said "Leadership means getting people to do what you want done because they want to do it." Do your people follow you? Are they motivated to follow your stated vision and employ your (SMART) strategy? How do you know and more importantly, what can you do if you suspect not? Fortunately, leadership (and motivation) is a skill like any other than can be learned and practiced. Naturally gifted leaders can lose their people, and the most unlikely among us can generate almost mystical loyalty. How in the world does this happen?

In my 25 years in academic medicine and in my eleven years as a Chair, I've seen the full range of leaders from the truly exceptional to those who flame out soon after a heralded appointment. You have, too. In nearly every case, success or failure are unrelated to knowledge and almost entirely dependent on the leader's interpersonal skills and ability to cultivate relationships, establish trust and communicate clearly with others. You were selected for Chair based on your past accomplishments, but as the best-selling book by Marshall Goldsmith states, *what got you here won't get you there.* So, what can you do to enhance your opportunity for success as a Chair? How can you motivate others follow?

Ten Tips to Motivate Others

1) **Attitude is everything.** I've heard it said that "We can teach you our product but we can't teach you *Attitude*." This is universally true, and the attitude you

bring to work each day will define the relationships you develop and the interactions you have as a leader. You know this is true. You've seen it, right? You don't want to be around someone with a bad attitude any more than the next person, but have you thought about how you are projecting *your* attitude*?* Leadership can be surprisingly physically challenging and certainly emotionally draining. Get ready for it, and remember that despite all the demands placed on you, the one thing you own, and you own alone, is your attitude. Bring a good one to work and you will find people anxious and willing to help you and follow you. Adopt a bad attitude and you will find yourself charging up the hill alone.

2) **Use your Body.** Here's a staggering fact: 60% of your communicated message comes from your body language. Thirty percent from your facial expressions and only 10% of your intended message are the actual words coming out of your mouth! Think about that. In thinking about those around you whom you admire, respect and look up to, how do they communicate? Is it that their words are so thoughtful and motivating, or is there more? Of course, there is more. To motivate others, you need to communicate a leader's message that engenders *trust.* Dress right. Stand tall. Be aware of your body language. Practice active listening with an attentive facial expression, and (least of all!) choose the right words when trying to communicate a motivating message.
3) **Earn your keep.** Remember this: There are no special deals for the Chair. Sure, your job is distinctly different from everyone else in the department and you need time to attend meetings, prepare budgets, tackle HR disputes and the like. But what you are not entitled to is a different set of rules. Different job, different job description? Sure. Special rules for you? No way. You should go where assigned on your clinical days, put in vacation like everyone else, and pull your share of unpleasant assignments. If people perceive that you are cut a special deal, they will resent your position. If your people see you pulling your fair share, going the extra mile, they will respect you. There's a reason why great Generals ensure their troops eat before they do. Learn this lesson.
4) **Don't criticize, condemn or complain.** This goes hand in hand with #3 above. If you want to be an effective leader that others will follow, you need people on your side because *they choose to be on your side.* Fear and intimidation have limited roles in leadership, but far and away, influence (leadership) stems from respect, trust and likability. I've said to others, "I'm not your friend; I'm your Boss." But that doesn't mean that I am not friendly, approachable, fair and open minded, empathetic, sincere and authentic. A successful leader truly cares about their people. These qualities must be genuine. You can't fake empathy, for example. One sure way to lose your people is to criticize, condemn or complain. These are the opposite qualities of empathy, respect and caring.
5) **Embrace the rule of 85/15.** Your professional success rests on the rule of 85/15. This rule asserts that 15% of your professional success depends on your factual knowledge and a shocking <u>85</u>% of your success depends on the relationships you build with others. Think about it – you didn't get to your leadership position by being dumb! But your technical skills do not translate

into people following you. How many professional and collegiate coaches get fired every year because their teams can't win? Are the teams failing because the coach doesn't know their X's and O's? Of course not. They fail because the chemistry required to win is not there. At this stage of your career, it is less about knowledge (knowledge is assumed) and more about building teams, motivating others and developing meaningful winning relationships. The good news is that anyone can learn the skills of relationship building. This is a skill like any other and it can be learned, so…

6) **Read something!** If you believe in the rule of 85/15 and you concede that nurturing relationships is a skill like any other, why wouldn't you study some tried and true techniques? There are many great books on the market but to me, one stands out above all the rest: *How to Win Friends and Influence People* by Dale Carnegie published in 1936. Get it, read it, and learn from it. You can thank me later. Motivational leaders study the art of leadership. Make it a habit to read 4 books a year (one a quarter) on self-improvement and leadership. Realize as you do this that 2/3 of any given book will fall flat for you, but 1/3 will speak to you. And, this 1/3 will change from year to year as your challenges and life journey unfolds. Keep reading.
7) **Learn to Deal with Conflict.** Leadership is conflict. The sooner you learn the techniques of effective conflict resolution, the better. For a simple starter, I suggest *What to do when conflict happens* by Eric Harvey and Steve Ventura found at *Walkthetalk.com.* This book is quick, easy and it will help you. Learning how to deal with conflict constructively and you will be light years ahead in this game (and mentally healthier, too!). As the boss, you must be impartial, open-minded and a stickler for policy. Don't play favorites. Listen before acting. Don't avoid conflict, it won't go away by itself. Your people will respect you for being fair and firm.
8) **Don't take it personally.** Criticism is your new travel mate. You will be challenged, judged, unfairly misquoted and harshly held to an impossible standard of perfection. Unfair? You bet. Roll with it. The reality is that you have chosen a a leadership position and this comes with the territory. You are working in the kitchen and it gets hot. So, learn from your mistakes and take criticisms constructively. Don't get down on yourself when things go poorly. If knocked down, pick yourself up, dust off, *learn something*, and move on.
9) **Put others first.** Transition to senior leadership is a huge step. Success isn't about you any longer; it is about how well your team performs. How well are your people doing? Do your faculty have the resources they need for success? Are they moving forward on the promotion ladder? Are your faculty receiving academic recognition in their specialty? How about in the hospital by the hospital president? How about by the surgeons? Failed leaders struggle in this last transition. Peter Drucker, a famous business thinker said, "Rank does not confer privilege or give power. It imposes responsibility." This new authority comes with a new set of responsibilities and the shocking secret is that most of the people around you want you to succeed in your position. Those around you are pulling for you. They want you to take the reins of this

new responsibility and lead. Leaders don't have all the answers, but they bring out the best in their teams for optimal success. Leaders put others first.

10) **Don't lose yourself.** I am continually amazed at the increasing pace and demands placed on all of us. The emails never stop, meetings swallow your free time, HR issues explode like IEDs. Each day you will leave work with a list of tasks left incomplete. The work demands are substantial and the emotional toll can be every bit as challenging. I've learned that one can literally work 20 hours a day *and will still be behind.* As crazy as that sounds, it's true. As a leader, you are running up the side a muddy hill, and as soon as you reach the top, all you see is the next hill yet to climb. To lead others, you must find a way to compartmentalize this work environment. Learn to decompress. Exercise. Eat healthfully. Engage with others outside of work. Play when you can. And always, cherish the ones you love and love you.

In thinking about how to motivate people to follow you as a leader, there are so many tips and tricks in addition to those principles listed above that this small essay can do no justice to the subject. In the edits for this submission I left out the power of delegation, the value of silence, the evils of hubris, and so many more. The one reality is that regardless of your natural leadership qualities, you will truly only be highly successful as a leader if you apply the techniques of leadership that motivate others to do what you want done because they want to do it. As a leader, you can make a real difference.

I know you can. I hope you will.

HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

Interviewing Skills: How to Identify the Best Talent for the Job

Aman Mahajan, MD, PhD

11/03/2017
8:40am – 9:00am

Interviewing Skills: How to Identify the Best Talent for the Job

Aman Mahajan, MD, PhD, MBA
Ronald L Katz Professor and Chair, Dept. of Anesthesiology
Professor of Anesthesiology and Bioengineering
Co-Director, UCLA Cardiac Arrhythmia Center &
Neurocardiology Research Center
UCLA Health System

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Finding the right people is the single biggest problem in our practice today.

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Most Important Chair Job

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The Selection Interview: Must be part of a larger recruitment and development system

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The Selection Interview: Must be part of a larger recruitment and development system

Job descriptions/competencies:

- Relevant reporting relationships
- Statement of the department's/team's objectives
- Details of responsibilities and duties (including teamwork)
- Specific performance expected (outcomes)
- How performance will be measured
- List of necessary competencies for the assignment

Recruiting, screening, interviewing, selection, and checking references

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Screening applicants: Better interviewing

Talk to as many people as possible on the telephone briefly to assess qualifications.

Ask them to write an e-mail explaining why they want the job
Ask for a resume and a specific "cover letter" email explaining why they want the job.

Talk to people even if no job is open, to hone skills, assess job market, and for public relations.

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Objectives of a selection interview:

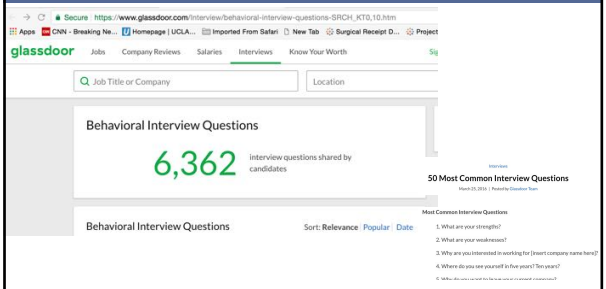
To assess competencies and skills that fit with the job situation

To identify past behavior as an indicator of future behavior

To assess cultural/values fit

To predict success in the job and with the organization

There's no such thing as a surprise interview question anymore



Preferably limit the "Gut Feel" strategy

	Description	Drawbacks
Gut Feel	A quick, personal judgment about a candidate, usually based on the interviewer's past hiring experiences (both good and bad)	- Low accuracy, particularly among less experienced managers - Lacks systematic collection and analysis of available candidate data - Difficult to align stakeholders - Can lead to early commitment to candidate and reluctance to change with new data

Choosing the correct interview technique

Traditional Interviews - resume based, direct questions, usually close-ended questions

Case based Interviews - a hypothetical situation, analytical skills, troubleshooting knowledge

Situational Interviews - more in-depth view of thought processes

Behavioral Interviews - recount a past experience so one can assess their likely future performance

Competency based Interviews - based on competencies required

Competencies and Traits to look for in the selection interview

1. Intelligence
   - Problem-solving
   - Practical
   - Creative
   - Emotional
2. Motivation
   - Ambition
   - Competitiveness
   - Goal orientation
   - Growth orientation
3. Past performance success
4. Job skills, knowledge, and experience
5. Positive self-image, confidence, and optimism
6. Emotional maturity, realism, and self-control
7. Integrity, honesty, and dependability
8. Empathy and social sensitivity
9. Energy and personal impact
10. Conscientiousness (work ethic)
11. Flexibility and adaptability
12. Chemistry and cultural fit
13. Persuasive
14. Efficient
15. Analytic skills
16. Attention to detail, careful
17. Persistence
18. Action oriented, proactive

A leadership candidate's ability to learn, adapt, and innovate.

Learning: "How would you continuously learn and maintain your expert status in your field (or in a particular technical area)."

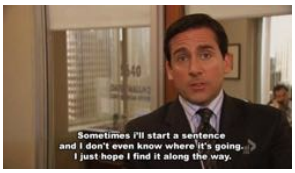
Agility: "Identify the steps or path you'd take to adapt when a dramatic unexpected change occurs in either your practice or stakeholder expectations."

Innovation: "Outline the steps you'd take to increase innovation among your team to respond to increased competition or new technologies."

Improving the Interviewing Technique

Don't talk too much.

This is the biggest mistake that most interviewers make.



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Improving the Interviewing Technique

Put candidates at ease, be friendly.

Probe for specific, detailed answers.

Lots of follow-up questions.

Ask situational questions.

Concentrate on past successes and skills, not on experience or education.

Do not respond to negatives – keep an open mind.

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Improving the Interviewing Technique

Look for strengths, not shortcomings.

Hire for strengths and skills.

Discover how they think, how they solve problems.

Find out why applicants want to *do (and* not *have)* the job

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This is the second biggest mistake people make.

Beware of halo effects (don't clone yourself).

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Biases with the selection interview

First impressions

Stereotyping

Situational influences

Interviewer differences

Tendency to be unstructured

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After the Interview

Tendency to forget

Tendency to remember only negatives

Pressure to hire

Interviewing order in which applicants appear

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Interview Evaluation Report

Interview Evaluation Report
Confidential

Candidate: _____ Position applying for: _____
□ Internal Candidate □ External Candidate

EVALUATION FACTORS:	1 Clearly Unacceptable	2 Marginally Acceptable	3 Satisfactory Acceptable	4 Very Good	5 Clearly Outstanding
General first impression: Appearance/Poise/Manner					
Knowledge of UCLA					
Related work experience/qualifications					
Knowledge of general work field					
Education					
Job interest/self motivation					
Apparent creative problem solving ability					
Reasoning/judgment ability					
Apparent ability to get along with people/team builder					
Financial management skills					
Attitude					
Initiative in conversation/enthusiasm/self expression					
Maturity					
Energy					
Goal oriented					
Values/character					
Final impression and overall evaluation					

Recommendation
Hire □ Continue Search □

Comments:

Interviewed and evaluated by: Date:

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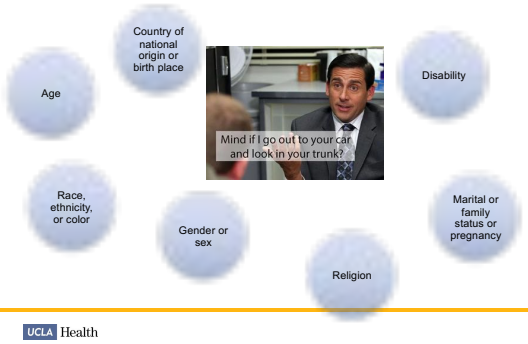
Questions that you cannot ask: Please don't do go there



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In case it is not clear, avoid these questions

- What arrangements are you able to make for child care while you work?
- How old are your children?
- What does your wife do for a living?
- Where did you live while you were growing up?
- Will you need personal time for particular religious holidays?
- Are you comfortable working for a female boss?
- Is a large disparity between your age and that of the position's coworkers a problem for you?
- How long do you plan to work until you retire?
- Have you experienced any serious illnesses in the past year?

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The Ultimate Hiring Rule

Everything else being relatively equal, always hire the smartest person.

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Who are the best people and where to find them

Develop a reputation for hiring, nurturing, and promoting diversity.

Recruit all the time.
- Ask "Who do you know who's talented?"
- Ask "Who's the hardest worker?"
- Ask "Who's the smartest worker?"

Develop a reputation for hiring smart people, *training* them, and promoting them.

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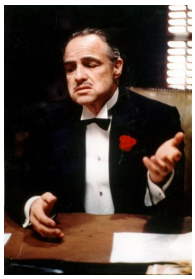
Referrals are the best source for excellent candidates
- From current employees
- From industry/network contacts
- From friends



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UCLA | DEPARTMENT OF
ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

Counseling Skills: How to Deal with the Problem Employee

Jane C.K. Fitch, MD

11/03/2017
9:00am – 9:20am

BLIND SPOT

JANE C.K. FITCH, MD
J.L. PLEWES PROFESSOR & CHAIR, OU
PRESIDENT, SAAA 2012-2014, & ASA 2014

HOW THEY DISRUPT

- DISRUPTING MEETINGS
- NONCOMPLIANCE WITH POLICIES
- HOSTILE ENVIRONMENT
- BREACH OF CONFIDENTIALITY
- UNDERMINING PROFESSIONAL REPUTATION

WHAT THEY DISRUPT

- DISRUPT HOSPITAL OPERATIONS
- AFFECT ABILITY OF OTHER TO DO THEIR JOBS
- CREATE HOSTILE WORK ENVIRONMENT

WHAT THEY DISRUPT (CON'T)

- INTERFERE WITH ABILITY TO PRACTICE COMPETENTLY
- ADVERSELY AFFECTS COMMUNITY'S CONFIDENCE IN HOSPITAL'S ABILITY TO PROVIDE QUALITY CARE

DESCRIPTORS

- TROUBLESOME, TROUBLEMAKING
- UNRULY, DISORDERLY
- UPSETTING
- DISTURBING, DISTRACTING

EXAMPLES

- PERSONAL, IRRELEVANT ATTACKS – VERBAL OR PHYSICAL
- IMPERTINENT/INAPPROPRIATE COMMENTS MADE IN MED RECORD
- CRITICISM THAT INTIMIDATES, UNDERMINES, BELITTLES, IMPLIES STUPIDITY OR INCOMPETENCE
- REFUSAL TO ACCEPT ASSIGNMENTS OR PARTICIPATE APPROPRIATELY

SAYINGS

- ZERO TOLERANCE
- BEST PREDICTOR OF FUTURE BEHAVIOR IS PAST BEHAVIOR
- STOP THEM AT THE DOOR

DRIVING FORCES

- FUNDAMENTAL CHANGES IN MEDICINE THAT FRUSTRATE PHYSICIANS
- INCREASE FREQUENCY & SIZE OF LAWSUITS RAISE THE STAKES
- INCREASING DIVERSITY
  - CULTURAL BIAS VS DISRUPTIVE BEHAVIOR

BOTTOM RUNG

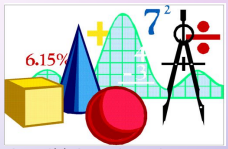
- APPOINT EXCELLENT PHYSICIANS
  - ASK – PHYSICIAN, REFERENCES, NPDB/FSMB, INTERNET/SOCIAL MEDIA
  - EVALUATE RED FLAGS
  - PERSONAL INTERVIEW
  - QUALIFIED APPOINTMENT

NEXT STEP

- SET & COMMUNICATE EXPECTATIONS
  - BYLAWS, CODE OF CONDUCT POLICY
  - EXPECTATION FOR PROFESSIONALISM & MATURITY
  - CULTIVATE BUY-IN TO EXPECTATIONS

NEXT STEP

- MEASURE ACTUAL PERFORMANCE
  - COLLECT PERFORMANCE DATA
  - TRACK & TREND HURDLES
  - TOOLS – IR, COMPLAINTS, SURVEYS, QUESTIONNAIRES
  - ENCOURAGE REPORTING
  - NON-RETALIATION POLICY



NEXT STEP

- PROVIDE PERIODIC, TIMELY FEEDBACK
  - BOTH POS & NEG
  - MOST IMPROVEMENT WHEN POS:NEG = 5:1
  - DENIAL
  - PRAISE IN PUBLIC, CHASTISE IN PRIVATE
  - WRITTEN FEEDBACK, F2F (ESP FOR NEG)

NEXT STEP

- PROVIDE PERIODIC, TIMELY FEEDBACK (CON'T)
  - GROUND RULES
    - VALIDATE COMPLAINT
    - PRIVATE F2F
    - FREQ – 3 OR 6 MONTHS, AT LEAST Q 2 YRS
    - TIMELY

NEXT STEP

- MANAGE POOR PERFORMANCE
  - SERIES OF ESCALATING INTERVENTIONS

- COLLEGIAL DISCUSSION – ACTION PLAN
- LESS COLLEGIAL – REVISE AP
- MONOLOGUE, NOT DIALOGUE
- DOC IN THE BOX

TOP RUNG

- TAKE CORRECTIVE ACTION
  - RECOMMENDATIONS
  - FAIR HEARING
  - FILE WITH NPDB/SMLB
  - IMMUNITY UNDER HCQIA

ENCOUNTER

- REFERENCE ROLE
- ID BEHAVIOR/INCIDENT
- REFER TO EXPECTATIONS/POLICY
- INVITE THEIR SIDE OF THE STORY
- DEFLECT EXCUSES/JUSTIFICATIONS

ENCOUNTER (CON'T)

- REFER TO DATA
- FOCUS ON BEHAVIOR, NOT PERSON
- CLARIFY NONRETALIATION
- TIME LIMITED (20 MIN OR LESS)
- CLOSE WITH NEXT STEPS & DOCUMENTATION

GOALS

- ESTABLISH A POSITIVE BEHAVIOR

HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

Delegation Skills: How to Delegate and Still Sleep Soundly at Night

C. Michael Crowder, MD, PhD

11/03/2017
9:20am – 9:40am

Delegation Skills: How to Delegate and Still Sleep Soundly at Night

Mike Crowder, M.D., Ph.D.

The Allan J. Treuer Endowed Professor and Chair
Department of Anesthesiology and Pain Medicine
Adjunct Professor of Genome Sciences
University of Washington School of Medicine

UW Medicine | HEALTH SYSTEM
ANESTHESIOLOGY & PAIN MEDICINE

Delegation Skills: How to Delegate so that You Can Sleep Soundly at Night

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I have no conflicts of interest

Learning Objectives

- After completion of this learning activity, the participant should be able to describe **why** delegation is essential to success as a leader
- After completion of this learning activity, the participant should be able to determine **what** to delegate
- After completion of this learning activity, the participant should be able to identify to **whom** to delegate
- After completion of this learning activity, the participant should be able to describe **how** to delegate

Bibliography

The Busy Manager's Guide to Delegation
Richard A. Luecke, Perry McIntosh
American Management Association
New York, New York

Delegation and Supervision
Brian Tracy
American Management Association
New York, New York

Case Scenario

You are a new chair of a large department. You are trying to redesign your research track in your residency program. You have a strong scientific background, current NIH funding, and experience helping with designing a successful residency research track at your former department.

Approach 1: Handle it personally. After all, it's your initiative and you are perfectly qualified for the job.

Approach 2: Give the job to another experienced, accomplished, clinician scientist, who has less administrative duties than you.

Why?

- Too much to do and not enough time to do it
- You can't be an expert at everything
- As a leader, you need to focus on strategy and management
- Delegation develops your faculty

What?

- Does this task absolutely require your unique knowledge, skills, or authority?
  - Is there someone else who can, even if training is needed, do the job?
  - Hiring, firing, annual reviews of direct reports, discipline DO require you
- How mission critical is the job?
- Will the job develop and provide satisfaction to one or more of your faculty?
  - Don't always/only delegate dirty/boring work
- Consider expense/benefit balance sheet?
  - Probability/Consequence of failure
  - Time invested versus time saved
    - One time job versus recurring

Who?

- Who has the essential skills/traits for the job?
- Who would benefit from doing/completing the job?
  - Career advancement
  - Learn the most/expand capabilities
  - Improve her/his own work environment
- Who has interest in the job?
- Who has the bandwidth?
  - Avoid giving everything to the same few people
- Who is close to the job?

How?

- Get buy in from the delegate
  - Explain the value to the institution/department/individual
- Communicate to other faculty
- Determine precisely the desired outcome (Your job)
- Precisely define the approach/means to the outcome (Primarily delegate's job)
  - Personnel, tools, resources, budget
  - Steps
  - Timeline
- Define the skill sets needed
  - Develop a training/education plan, if needed
  - Include others if necessary

How?

- Delegate whole tasks, if possible
  - Give full authority and decision making for the tasks
  - Don't undermine/micromanage
- Have well-defined and agreed upon checkpoints and a monitoring plan
  - Define intermediate deliverables with deadlines
  - Refine approach, add or take away resources
  - Provide encouragement, coaching, and constructive feedback
- Evaluate and recognize the finished product
  - Did it achieve the desired outcome(s) – Fully completed and at a high quality
  - Was it done on time and within budget
  - Does the delegate feel that they achieved the outcome and was it worthwhile
  - Give direct, specific, fact-based feedback to the delegate
  - Recognize personally and publically the accomplishments and successes

Troubleshooting

- The best person for the job says no
- A faculty, who shouldn't, says yes
- The delegate tries to hand the job back to you
- Delegate really isn't up to the job
- Primary delegate can't/won't lead
- Team can't work together

Case Scenario

You are a new chair of a large department. You are trying to redesign your research track in your residency program. You have a strong scientific background, current NIH funding, and experience helping with designing a successful residency research track at your former department.

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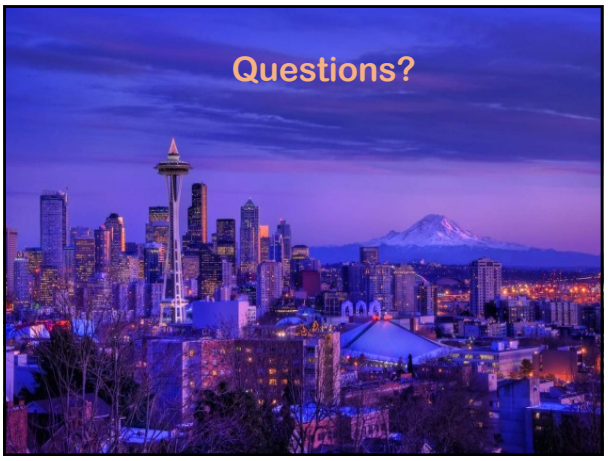


HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

Mistakes Made; Lessons Learned

Andrew D. Friedrich, MD

11/03/2017
10:30am – 10:42am

The Impaired Physician: Lessons for Chairs

Andrew Friedrich, MD
Department of Anesthesiology
University of Cincinnati

Case Scenario

- A few weeks before starting your new role as chair, your predecessor (Interim Chairman) informs you that, several months ago, he received multiple complaints about a senior faculty member in the department
- The complaints raised suspicion of possible alcohol abuse, and the Interim Chairman contacted both Human Resources and the Chief of Staff Office
- A formal meeting occurred with the faculty member, Interim Chairman and Chief of Staff
- The faculty member adamantly denied alcohol abuse, but was given a formal written warning for his behavior

The Complaints to the Interim Chair

Signs of physician impairment

Deteriorating personal hygiene
Increased absence from professional functions or duties
Emotional lability
Appearing sleep-deprived
Increased professional errors (eg, prescriptions, dictations, clinical judgment)
Not responding to pages or telephone calls
Decreased concern for patient well-being
Citing unexplained 'personal problems' to mask deficits in concentration or patient care

Current Psychiatry 2011; 10: 67-71

Case Scenario, Continued…

- You assume your new role in July, and hear no formal complaints about the faculty member
- In December, the same complaints resurface: lack of availability, frequent call-offs from work, smell of alcohol, concern of impaired medical judgment, and not completing his required documentation
- Around the same time, the Chief of Staff contacts you to ask about the status of this physician, and whether the previous investigation could be considered closed
- What should you do? What are your options?

Reporting Impaired Physicians

Options for reporting impaired colleagues

Impairment in hospital-based physicians may be reported to the hospital's in-house impairment program, the hospital's chief of staff, or another appropriate supervisor (eg, a chief resident)
Impairment in physicians with office-based practices may be reported to hospitals where they have privileges or to the state's physician health program
Colleagues who continue to practice despite offers of assistance and referrals for treatment or for whom the above options are not available should be reported to the state licensing board

Current Psychiatry 2011; 10: 67-71

State medical board rules on reporting physician impairment: 3 examples

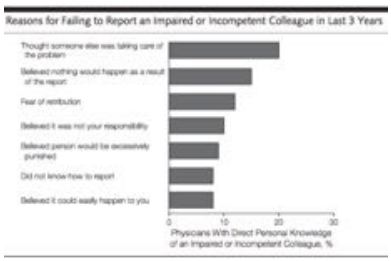
State	Rules
California[9]	California's Medical Practice Act contains no mandatory reporting requirement. 'However, … the Board clearly is concerned about physicians who potentially present a danger to their patients. Reporting an impaired colleague to the Medical Board will allow the Board to ensure adequate protections are in place so a colleague who requires assistance will not harm the public. The Board keeps the sources of complaint information confidential.'
Montana[10]	'[E]ach licensed physician … shall … report to the board any information … that appears to show that a physician is' impaired. However, '[i]nformation that relates to possible physical or mental impairment connected to [substance misuse or illness] may be reported to' Montana's physician rehabilitation program 'in lieu of reporting directly to the board.'
Ohio[11]	'Any Board licensee having knowledge' that a physician is impaired because of substance misuse 'is required … to report that information to the Board. … [H]owever, … the [impaired] physician's colleagues may be excused from reporting the physician's impairment … if the [impaired] physician has completed treatment with a Board approved treatment provider and maintained uninterrupted sobriety, and violated no other provisions of the Ohio Medical Practice Act.'

Current Psychiatry 2011; 10: 67-71

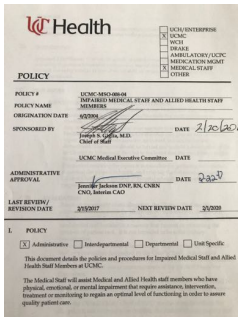
The Pros and Cons of Reporting

- Con: What if you're wrong?
  - Possibility of damaging the career of the physician
  - If falsely accused, physician could bring legal action
- Pro: Early identification
  - Will protect a greater number of patients from harm
  - Increased probability that the physician's health will benefit from earlier diagnosis and treatment

Why Reporting Doesn't Happen



What I Actually Did…


UC Health

POLICY

POLICY #: UCMC-MSO-000.01

POLICY NAME: IMPAIRED MEDICAL STAFF AND ALLIED HEALTH STAFF MEMBERS

ORIGINATION DATE: 6/2004

SPONSORED BY: Joseph A. Galla, M.D., Chief of Staff — DATE 2/20/20

UCMC Medical Executive Committee — DATE

ADMINISTRATIVE APPROVAL: Jennifer Jackson DNP, RN, CNRN, CNO, Interim CAO — DATE 2-20-20

LAST REVIEW/REVISION DATE: 2/15/2017 — NEXT REVIEW DATE: 2/1/2020

I. POLICY

[X] Administrative [ ] Interdepartmental [ ] Departmental [ ] Unit-Specific

This document details the policies and procedures for Impaired Medical Staff and Allied Health Staff Members at UCMC.

The Medical Staff will assist Medical and Allied Health staff members who have physical, emotional, or mental impairment that require assistance, intervention, treatment or monitoring to regain an optimal level of functioning in order to assure quality patient care.

The UCMC Policy

- The evaluation of the alleged impaired physician may be performed by either the Clinical Chief or by the Chief of Staff
  - The evaluation is confidential and focuses on protecting patient care
  - It is not intended to be a disciplinary investigation
- The Clinical Chief or Chief of Staff may recommend:
  - No action
  - Continued monitoring of practitioner
  - Advise the practitioner to initiate a voluntary therapeutic program
  - Require initiation of a voluntary therapeutic program
  - Request the practitioner to voluntarily restrict or resign privileges until satisfactory rehabilitative progress is demonstrated

Case Scenario, Continued…

- I met with the faculty member, with the Director of HR and the Chief of Staff in attendance. The physician again vehemently denied alcohol or drug use, but admitted to depression and a cervical spine problem
- The physician was strongly encouraged to take a medical leave of absence via FMLA, and was referred to the UC Employee Assistance Program for help
- The physician agreed to use FMLA, but postponed it by 6 weeks and declined to use the EAP
- After taking only 1 month of FMLA, the physician returned to work
- Two days after his return, I was called by several CRNAs who felt that his conduct threatened patient safety: not answering calls, mental status not normal, ill-appearing, etc.

Case Scenario, Continued…

- I called the AOD and had the physician removed from clinical duty
- I called the physician and demanded a meeting in my office
- Again, the physician denied substance abuse, insisting that his behavior was secondary to the effects of antidepressants
- The physician was given 2 options: termination, or return to FMLA with the promise to obtain appropriate treatment, and a requirement for fitness for duty evaluation prior to return
- The physician agreed to Option 2
- I contacted HR and the COS Office to assist with the process
- Six weeks after starting the second medical leave, the physician was admitted to the hospital with acute alcoholic liver failure, with a MELD of 40

Another Option: Physician Health Programs

Medical associations' official positions on reporting impairment

American Medical Association (Policy H-275.952)[2]	'Physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues.'
Federation of State Medical Boards[3]	Physician health programs have 'a primary commitment to [help] state medical boards … protect the public … [These] programs [should] demonstrate an ongoing track record of ensuring safety to the public and reveal deficiencies if they occur.'

Current Psychiatry 2011; 10: 67-71

Physician Health Programs

- Most states have PHPs
  - No national standards
  - Structure, size and quality of programs varies
- PHPs offer physicians a route to fulfilling their reporting obligations and receiving help for their condition, without the stigma of board sanction
- PHPs are typically separate from state medical boards
  - Generally administered by state medical societies
- The goal of PHPs is early detection of impairment
- PHPs have had good success: 75-90% of US physicians treated for substance abuse are licensed and working at 5 year follow-up

Table 3. Selected Characteristics and Outcomes of Anesthesiologists and Other Physicians in State Physician Health Programs for Substance Use Disorders, with Adjusted and Unadjusted Odds Ratios[a]

Characteristic/outcome	Anesthesiologists (n = 83)	Other physicians (n = 697)	Unadjusted univariate odds ratios OR (95% CI)	P	Adjusted multivariate odds ratios* OR (95% CI)	P
Gender						
Male	71 (86)	599 (86)	1.1 (0.6–2.0)	0.87	1.1 (0.5–2.0)	0.88
Primary drug of abuse						
Alcohol	23 (28)	361 (52)	0.4 (0.2–0.6)	<0.001	0.4 (0.2–0.6)	<0.001
Opioids	46 (55)	217 (32)	2.8 (1.7–4.4)	<0.001	2.9 (1.8–4.6)	<0.001
IV drug use history						
Yes	32 (41)	64 (10)	6.3 (3.8–10.7)	<0.001	5.7 (3.4–9.8)	<0.001
Number of substances						
Multiple	40 (48)	358 (51)	0.9 (0.6–1.4)	0.63	0.9 (0.6–1.4)	0.61
Prior treatment						
Yes	25 (30)	273 (39)	0.7 (0.4–1.1)	0.12	0.7 (0.4–1.1)	0.15
Enrollment status						
Mandatory	49 (59)	393 (57)	1.1 (0.7–1.8)	0.73	1.2 (0.8–2.0)	0.76
Positive drug test						
Yes	9 (11)	156 (23)	0.4 (0.2–0.9)	0.02	0.4 (0.2–0.8)	0.01
Reported to board						
Yes	15 (18)	140 (20)	0.9 (0.5–1.6)	0.77	0.8 (0.5–1.5)	0.72
Program status						
Completed contract	59 (71)	445 (64)	1.4 (0.9–2.3)	0.23	1.5 (0.9–2.5)	0.17
Contract extended	15 (18)	112 (16)	1.2 (0.6–2.1)	0.64	1.1 (0.6–2.1)	0.69
Failed to complete	9 (11)	140 (20)	0.5 (0.2–1.0)	0.05	0.5 (0.2–0.9)	0.05
Occupational status						
Licensed or practicing medicine	63 (76)	508 (73)	1.2 (0.7–2.0)	0.60	1.2 (0.7–2.1)	0.57
License revoked	6 (7)	78 (11)	0.6 (0.3–1.5)	0.35	0.6 (0.2–1.4)	0.28
Died	5 (6)	24 (3)	1.8 (0.7–4.8)	0.22	1.7 (0.6–4.7)	0.30

Anesth Analg 2009; 109: 891-6

Lessons Learned

- Be aware of the signs of physician impairment, and act immediately when they are recognized
- Expect your faculty member to deny the problem
- Do not act alone. Take advantage of institutional and state resources to help impaired physicians:
  - Human resources
  - Chief of Staff office
  - State Physician Health Program
- Your obligation is not just to the health of your patients; it is also to the health of your faculty member
- Managing this is not comfortable for anyone, but you must act decisively. Think of it as an act of tough love

HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

Mistakes Made; Lessons Learned

Gerald Manecke, MD

11/03/2017
10:42am – 10:54am

Relax and Socialize: A Confessional

Gerard Manecke, M.D.

Many of us have achieved success and been asked to serve as Department Chair because of our capacity for hard work, critical thinking skills, dedication, knowledge, “drive” and organizational acumen. Our heavy daily workload may discourage prioritization of the personal and social aspects of our leadership role. I, for one, am not one to seek out social situations. I enjoy problem solving, one-on-one teaching in the OR, reviewing journal submissions and other proposals (even budgets!), and other “solitary” work. I also enjoy the “vision” and “mission” aspects to meet the challenges of being an academic department in these challenging times. Departmenal or health system meetings, parties, weddings, funerals, and other social events often take a back seat to my “real work”.

I recently made a mistake, and it had to do with the social aspects of serving as Chair. This error reminded me of a general area in which I have “opportunities for improvement”.

I recently attended a beginning of the year “meet and greet” party for the incoming group of residents. It was a beautiful family gathering held at one of our faculty’s homes. All the residents, attendings, and families were smiling and having fun. The San Diego weather was wonderful, and there were games for the children, great food, drinks, and lively conversation. I showed up, smiled, introduced myself to a few new residents and their families, and made some “small talk” with other residents and faculty. It was all “OK”, but I confess was making this appearance primarily because it was my job to do so. One senior resident came up to me and said, “I brought my mother along today and I would like you to meet her-I’ve told her all about you and the Department and she would love to meet you”. I said that would be very nice and that I would stop by her table later to meet her. I spent much of the time looking at the clock, trying to determine the exact amount of time the Chairman should stay at this party. Finally, after speaking with a number of people and having lunch I decided to discretely leave. I made up the story to myself “They’ll have more fun without the stuffy Chair being here anyway”. I made such a direct line out the door and to the car that I completely forgot to stop by and see the resident and her mom. I was simply too anxious to quickly meet my social obligation and get out of there. I am disappointed in myself, both because I did not allow myself to relax and enjoy this event, and because I let one of our residents (and her mom) down.

Many young faculty and residents look up to us as models, including social ones. I under-appreciated the importance of taking time (at a departmental get-together) to sit with junior faculty and residents, meet family members at get-togethers and simply get to know those who serve the Department. I am generally perceived as being approachable and personable (I think), but I have

fallen short, at times, at promoting the important social, personal aspects of what we do. These things are extremely important for the Department, but are sometimes overlooked because of the day-to-day logistical tasks, as well as the various other initiatives and priorities. Some ideas that might help address this;

1. Create a Departmental Newsletter that includes social events, births, and other positive life events in the Department
2. Use social media for #1
3. Take a brief period at the beginning of departmental meetings to announce social events, births, birthdays, weddings, etc.
4. Recognize importance of attending weddings, funerals, and other events when invited. These things are every bit as important as our other tasks as Chairs.
5. Recognize the importance of social events as a means to support departmental morale.
6. Add your own…

Suggested Reading

Mets, Berend. (2016). Leadership in Academic Anesthesiology: Theories and Practice. International anesthesiology clinics. 54. 66-82.

HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

Mistakes Made; Lessons Learned

Talal W. Khan, MD, MBA

11/03/2017
10:54am – 11:06am

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Mistakes Made; Lessons Learned

Talal W. Khan, MD, MBA
Professor and Chair
University of Kansas Medical Center and Health System

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

University of Kansas Health System

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Department of Anesthesiology

- 82 Physician Anesthesiologists
- 35 Residents
- 4 fellows
- 107 CRNAs
- 48 SRNAs

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

….background

- In process of acquisition of outpatient hospital 7 ORs 19 IP beds
- Chair of Board of OP Hospital (Acquisition Target) – Anesthesiologist
- April 2012 – Interim Chair
- Transaction to be completed June 2012

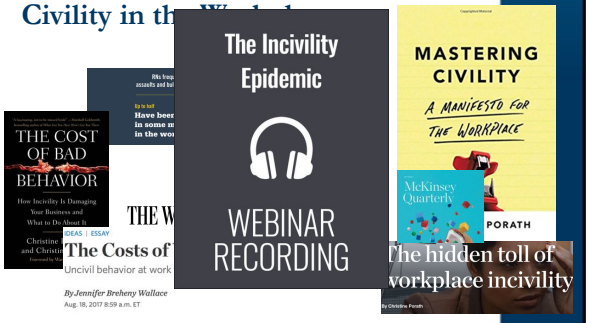
THE UNIVERSITY OF KANSAS HEALTH SYSTEM

The saga begins

- Unprofessional behavior
  - Colleagues, Nurses, Surgeons
- ?Compliance issues
- Undermining department policies
- Great interactions with hospital leadership!

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Civility in th



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The Incivility Continuum

Negative Behavior
- *Rude comments*
- *Insensitive actions*
- *Unintentional slights*
- *Complaining*
- *Gossip/rumors*
- *Cultural bias*
- *Crude jokes*
- *Profanity*

Verbal Aggression
- *Yelling / loud voice*
- *Belittling comments*
- *Intimidation / threats*
- *Discriminatory comments*
- *Cursing at someone*
- *Humiliation*

Physical Aggression
- *Assault / Battery*
- *Throwing objects*
- *Violent outbursts (e.g., hitting the wall)*
- *Inappropriate touching*
- *Harassment*

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Impact of Incivility in Healthcare

- Patient safety
- Quality of care
- ↓ morale, ↓ productivity, ↑ turnover
- Lawsuits, settlements
- Reduced profitability
- Negative organizational reputation
- Erosion of relationships
- Lack of engagement
- Increase in harm, errors, infections and costs

https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_24_June_2016.pdf

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Managing Challenging Personalities

- Avoid being dazzled by brilliance
- Political ramifications
- Dig Deep
- Direct Feedback
- Consequences
- Some people wont change
- DOCUMENT DOCUMENT DOCUMENT
- Isolate
- Distance/Distraction

Gallo. How to manage the toxic employee. HBR Oct 2016

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An Ounce of Prevention …

- Primary Prevention
  - Hire right – self-assessments, behavioral interviewing, 360 assessments, talk to references
- Secondary Prevention
  - Detect and intervene early
  - Education/coaching
- Tertiary Prevention
  - Separate and salvage
  - Document ongoing and clear communications and interventions

Brightman. How to overcome the 6 most toxic employee behaviors. Fast Company Dec 2013

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Interventions

- Collegial discussions
- Input from various stakeholders
- Intermittent feedback
- Formal warning with VP Periop Svcs and COO
- Official Warning Letter
- Joint meeting with hospital leadership

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Risk Mitigation

- Lawyers
- Severance
  - How much?
  - How?
  - In lieu of indemnification
- Political Ramifications
- Supportive coalition
- Advice and mentorship

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Mistakes Made

- Being forced to hire
- Ignorance – did not know what I did not know
  - Not realizing the impact on others i.e. morale, perception of leadership etc
- Arrogance – thought I could manage once hired
- Not completely aware of how hard I could/should push
- Left unaddressed for too long? 3 yrs
- Ignoring red flags – unprofessional interaction where there was a power differential

"Ultimately, you can't build credibility with coercive influence — you can think of it like bullying in the workplace." Lipkin Business Intelligence

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Lessons Learned

- Hire Right!
  - There is more to recruitment than talent alone
- Recognize and address the issue
- Play fair and engage
- Follow a deliberate process
- Keep key stakeholders involved and informed
- Negotiation/Conflict Management
- Managing up, down and across
- Document/Advice from legal
- …remember everyone is watching your every step!

HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

Mistakes Made; Lessons Learned

Gordon Morewood, MD, MBA, FASE

11/03/2017
11:06am – 11:18am

MISTAKES MADE; LESSONS LEARNED

GORDON MOREWOOD, MD, MBA, FASE
TEMPLE UNIVERSITY

I have no financial disclosures relating to the subject of this presentation.

One month prior to my appointment as interim Chair on April 3rd of 2015, the ACGME imposed a probationary accreditation status on the department's residency program. At the time of my appointment the department was in the crosshairs of the Dean's office, a poisonous atmosphere existed between the faculty and residents, several of the faculty were under investigation by the hospital GME Office and medical school Faculty Affairs Office for "abusive behavior" towards residents, the clinical service was understaffed by roughly 24% relative to the daily clinical commitments, and the average faculty compensation was bordering on the 4th quartile of the AAMC rankings.

On April 21st of 2016, 12 months later, the ACGME returned the department to full accreditation. In the intervening period the department's entire leadership structure had been reorganized, a 23% increase in the annual budget had been secured, only 2 faculty members left the department, 16 new faculty were hired, the anesthetic service at the health system's cancer center was successfully integrated into the department's responsibilities, and ambitious plans to expand the department's fellowships, chronic pain service, and critical care service were in place.

However, despite these successes I found that my family relationships had become unrecognizable, I was working either clinically or at my computer 18 or more hours a day 7 days each week, and I could barely cajole myself out of bed each morning. The deluge of emails, acute crises, and unfinished projects had nearly overwhelmed my stamina and desire to continue in the position. Although an outstanding leadership team had begun to form within the department, I had allowed the organizational strains to become entirely personal.

The most significant mistake in this instance was the failure to set aside enough time for self-preservation and to establish a regular pattern of disconnecting from the duties of the position. Although retrospective judgments are always somewhat suspect, it is likely that some efforts could have been deferred or delegated with little or no change in the most important endpoints.

Although there has not been a scientific study of the personality traits or behavioral patterns predominant amongst US anesthesiologists I believe that our specialty may be especially prone to this pattern of maladaptive behavior. This may be particularly true for those anesthesiologists already predisposed to accumulating administrative responsibilities over time. Unwavering personal accountability, meticulous attention to detail, and a strong tendency to defer personal needs in order to meet organizational goals are all hallmarks of a successful clinical anesthesiologist. However, in most institutions clinical workflows allow for periods free from professional responsibilities to allow such clinicians to rejuvenate. When applied to administrative tasks and taken to extreme in the context of the 24-7 organizational management structure of an academic medical system these traits can become self-destructive.

The important lesson learned, especially applicable to new Chairs or those entering a period of crisis, is: "Please put your own oxygen mask on first, before helping others."

HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

Mistakes Made; Lessons Learned

Scott Segal, MD, MHCM

11/03/2017
11:18am – 11:30am

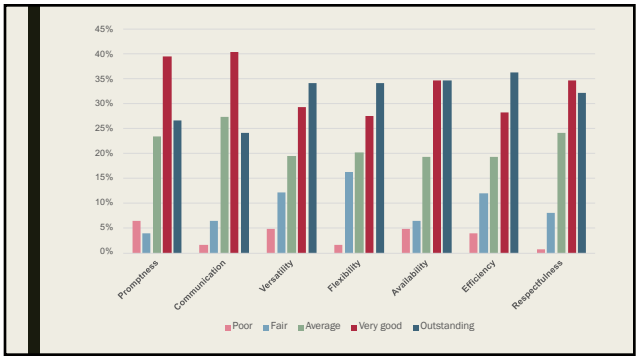
MY MISTAKE

Managing Change Poorly

Scott Segal, MD, MHCM

What I did

- Launched a faculty evaluation system to complement resident evaluations
- Included evaluation by clinical leadership
- One of 19 metrics for proposed faculty incentive compensation plan
- Vetted survey for face validity with clinical leadership
- ~One year later finally conducted surveys
- Statistical analysis showed excellent performance!



Multivariate

Correlations

	Availability	Timeliness	Pleasant
Availability	1.0000	0.9024	0.7558
Timeliness	0.9024	1.0000	0.7155
Pleasant	0.7558	0.7155	1.0000

There are 9 missing values. The correlations are estimated by REML method.

Principal Components / Factor Analysis

Principal Components: on Correlations

Number	Eigenvalue	Percent	20 40 60 80	Cum Percent	ChiSquare	DF	Prob>ChiSq
1	2.5853	86.175		86.175	967.323	1.418	<.0001*
2	0.3198	10.659		96.834	131.985	1.767	<.0001*
3	0.0950	3.166		100.000	0.000	.	.

Cronbach's α

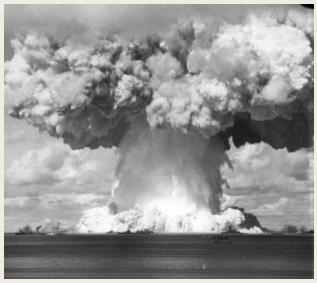
	α	-.8 -.6 -.4 -.2 0 .2 .4 .6 .8
Entire set	0.9191	

Excluded Col	α	-.8 -.6 -.4 -.2 0 .2 .4 .6 .8
Availability	0.8292	
Timeliness	0.8544	
Pleasant	0.9486	

What I did

- Presented at faculty meeting
- Explained *would not* be used for compensation
- *Would* be discussed in annual reviews
- Up to faculty member to decide if actionable or not

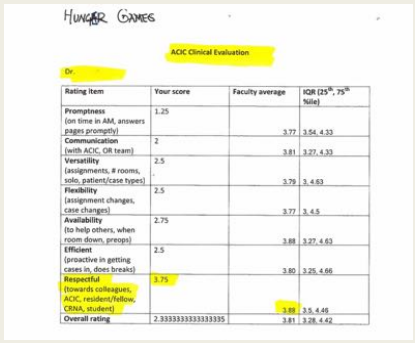
What happened



What happened

- Faculty with below average scores vigorously objected

"Illusory superiority" (Dunning–Kruger effect)



Hunger Games

ACIC Clinical Evaluation

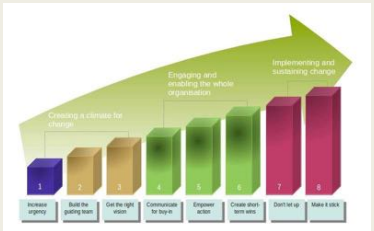
Dr.

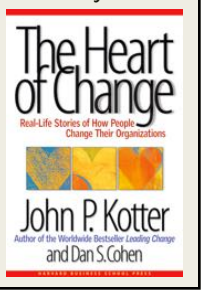
Rating item	Your score	Faculty average	IQR (25th, 75th %ile)
Promptness (on time in AM, answers pages promptly)	1.25	3.77	3.54, 4.33
Communication (with ACIC, OR team)	2	3.81	3.27, 4.33
Versatility (assignments, # rooms, solo, patient/case types)	2.5	3.79	3, 4.63
Flexibility (assignment changes, case changes)	2.5	3.77	3, 4.5
Availability (to help others, when room down, preops)	2.75	3.88	3.27, 4.63
Efficient (proactive in getting cases in, does breaks)	2.5	3.80	3.25, 4.66
Respectful (towards colleagues, ACIC, resident/fellow, CRNA, student)	3.75	3.88	3.5, 4.46
Overall rating	2.3333333333333335	3.81	3.28, 4.42

What happened

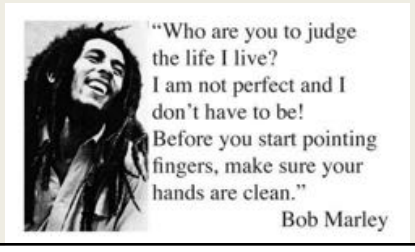
- Faculty with below average scores vigorously objected
- Rumors that pay cuts would come
- "Only the elite (favorites, etc.) will benefit"

Mistake #1: Failed to achieve true buy-in from faculty





Mistake #2: Clinical leaders were not trusted to be evaluators



Mistake #3: failed to appreciate fear of economic consequences

When somebody says it's not about the money, it's about the money.

H. L. Mencken

Lessons learned: subsequent attempts

- Evaluated clinical leadership (by faculty) *first*, before next round of faculty evaluations
- Formed faculty committee to construct next evaluation template
  - *Involved strongest detractors from first round*
  - *Gave up statistical rigor in exchange for faculty engagement*
  - *Broadened range of evals: included CRNAs, Peers*
- Explicitly abandoned faculty incentive program during deployment

HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

The Chair as Mentor and Departmental Mentoring Processes

George F. Rich, MD, PhD

11/03/2017
1:30pm – 1:50pm

The Chair as Mentor
and the
Departmental Mentoring Processes

George F. Rich, M.D., Ph.D.
Professor and Chair
University of Virginia

Disclosures

No disclosures that are relevant to this talk

Objectives

- Importance of knowing your faculty member, their goals, abilities and how it fits with departmental missions
- Identify that mentorship includes research, education, clinical and career paths
- Realize that mentoring includes professionalism and wellness
- Comprehend the importance of finding specific mentors

What is a Mentor?

Association of Professors of Medicine

"an active partner in an ongoing relationship who helps a mentee maximize potential and reach personal and professional goals."

State of Mentoring

- Poorly studied
- Poor rates of mentorship: typically 30-40%
- Inadequate mentoring for those who are mentored
- Poor training for mentors/ rewards for mentoring
- Less likely for clinician/ educators vs researchers
- Fall off with promotion
- Appointed rather than chosen

What the Best Mentors Do…

Harvard Business Review, 2017

- Put the relationship before the mentorship. A genuine, collegial relationship.
- Focus on character rather than competency. Shape character, values, self-awareness, empathy, respect.
- Shout loudly with your optimism, and keep quiet with your cynicism. Givers of energy, not takers of it.
- Be more loyal to your mentee than your organization. Best way to inspire is to be committed to the mentor.

Mentoring in Medicine:
Keys to Satisfaction

- Personal communication
- Not abusing power
- Counsel of professional decisions and providing help with professional networking
- Providing advice relative to career plans and research and providing opportunities to develop communication skills

Benefits of Mentoring

- Research, increased productivity
- Satisfaction, increased
- Promotion, more likely to be successful
- Mentor satisfaction

Mentors

- Chair or Primary, mentor responsible for providing career guidance, support and direction
- Secondary, scientific or scholarly expertise
- Co-mentor, guidance in a specific area
- Not all successful senior faculty are good mentors
- Mentors must be mentored i.e. classes, reading

Chair Mentorship

- Listen to mentees needs and desires
- Faculty will rarely do what doesn't interest them
- Guide mentees based on their abilities
- Is it in their best interest?
- Does it fit in with departmental missions?
- Is it realistic and practical?
- Is it financially possible?
- Is it focused?

Research Interests

- I want to do research, but I have no idea on what
- I know what research I am interested in, but don't know how to do it
- I know what research I want to do, and I have distant experience
- I just finished my fellowship and can do research
- I am an experience professor of research

Research

- Training
- Do you have specific mentor
  - Laboratory vs clinical
  - Internal vs external
- Financial support
- How many researchers can you afford

Clinical and Education

- Applies to most faculty
- Rare for faculty to ask how to be a better clinician or educator, but it is mission critical
- Departmental education fellowships, M.Ed.
  - Mentors: educational research, simulation
- Clinical fellowships
  - Mentors: division heads
- Regular feedback

Promotion

- Know the criteria
- Are they on the correct track?
- Clearly define expectations
- National reputation
- Encouragement
- Women and minorities

Mentoring: Evaluations

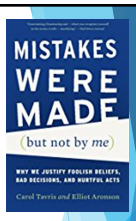
- Clinical
- Education
- Research
- Professionalism
- Promotion

Information-
Evaluations and Mentoring

- Resident evaluations
- CRNA/ staff evaluations
- Peer evaluations
- Surgical communication
- Chair evaluation and mentoring

Professionalism

- Act soon, poor behavior won't go away
- Most faculty appreciate feedback
- Advice for the denier vs the recognizer
- What about the unprofessional excellent teacher/clinician



Burnout

- Learn to recognize- professionalism
- Intervene before it is too late
- Health is most important
- Flexible schedules, reduced effort
- Wellness program

Rewards and Recognition

- Public praise
- Incentives
  - Direct towards missions
  - Transparency
- Medical School Awards
  - Teaching, clinical and research

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HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

How Chairs Can Recognize and Develop Leaders

W. Scott Jellish, MD, PhD

11/03/2017
1:50pm – 2:10pm

How Chairs can Recognize and Develop Leaders

W. Scott Jellish, MD, PhD

Top 3 Challenges Facing Academic Medicine in Searching for Leaders

1. Looking for diversity
2. Candidates with leadership and management skills in addition to clinical, research and educational excellence
3. Ensure a good fit between candidate and institutional culture

How Chairs Recognize and Develop Leaders

A. Challenges of building a pool of leading candidates. Transition from department centric to one that embraces strategic initiatives of the school and hospital
B. Competition for candidates locally or nationally can be difficult
C. Few organizations can passively place ads and wait for crush of candidates to develop
D. Personal contacts key to identifying candidates who would not respond to an ad

Developing Faculty as Leaders

A. First and foremost, remind the faculty that he/she is not yet doing what may be needed to be a leader.
B. This can be uncomfortable but is important to do.
C. Three outcomes from this:
    1. Faculty will finally take the message and comply
    2. May decide that leadership is an area that is not his/her goal and either he/she will step away from her role or leave
    3. Faculty decides they will tolerate the constant reminder and won't leave

Expectations are Set

A. Provide immediate and unambiguous feedback to translate into desire to change
B. Tactful encouragement is important, along with patience, during the initial stages of development

Characteristics of Traditional Versus Future-Oriented Leaders in Academic Medicine

Characteristic	Example
Traditional Institutional Leaders (Department Chair, Center Director, etc.)	
National stature and visibility	Prominence and distinction among peers nationally
Recruitment from a prestigious institution	Comes from an academic medical center that has a solid reputation
Track record in research	Externally funded; publications in prestigious journals
Clinical competency	Recognized as a legitimate practicing physician with expertise in a particular field
Appreciation for teaching students	Understands the educational and training needs of residents and medical
"Gets along well with others"	Reasonable social skills
Characteristic	**Example**
Future-Oriented Institutional Leader	
Business and administrative experience	Understands the economics and interdependence of patient care, research, and education; familiar with mission-based management
Institutional orientation	Able to balance departmental affairs with institutional priorities
Emotional competence	Self-aware and adaptive
Resilience	Does not panic after a poor financial quarter, but takes decisive action
Fit with the organization's values and guiding principles	Is a team player cognizant that her or his success is tied to the success of others
Strong communication skills	Is a good listener
Able to build and lead a team	Articulates a shared vision; removes obstacles to success, creates commitment, provides resources
Results orientation	Focuses on execution, sets clear expectations, and holds people accountable

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Should You Do a Search?

1. Succession planning is import for senior leadership position
2. If robust succession planning in place, why search?
3. If talent available, why go through process – promote from within

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The 10 C's of Searching

1. Continuity
2. Communication
3. The Charge
4. Culture
5. Candidates (and their competence)
6. The Chair
7. Composition
8. Conduct
9. Confidentiality
10. Closure

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Average search for a leader takes approximately a year

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Table 3 *Duration of search process for department chairs and center directors in U.S. medical schools*

	Clinical chair	Basic science chair	Center director
1 - 6 months	21%	21%	39%
7 - 12 months	48%	44%	21%
13 - 18 months	21%	18%	29%
19 - 24 months	3%	10%	7%
Over 24 months	7%	8%	4%
Mean	11.8	13.5	9.9
Range	2 - 45	1 - 47	2 - 27

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What to Consider for Outside Search

1. Affirmative action to ensure entire range of candidates explored
2. Search for the best and most qualified candidate
3. If solid internal candidate, may overlook more qualified candidates
4. Validate that the internal candidate is a viable option. Individual treated as heir apparent – gets job because known entity

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Casting the Net

1. Delusion – advertise and they will come
2. Ads in prominent journals or newsletters to peers around the country
3. Might work for high level position (directorship, division chiefs)
4. Many times word of mouth or individual known by another faculty member

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Interview Process

A. Don't be generic
B. Be specific about targeted behavior and attributes
C. Ask real questions concerning characteristics
    1. Any issues you have dealt with that require diplomacy
    2. Most important accomplishment
    3. How did you handle embarrassment or failure?
    4. What kind of hours do you work?
    5. Hobbies, non-work activities
    6. How would you describe yourself?

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Confidentiality

1. Is the person looking to move or just leveraging their position?
2. Does the individual's Chair know they are looking?
3. Determine where they are in the process and inform them if they are serious, their program should know about intention to move

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Get Insight from all Faculty who Interviewed

A. Don't just ask a few
B. Query all members who interviewed. Sometimes they pick up on red flags you missed. Candidate might state things to faculty they would never say to Chair.

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1. Always eventually ask about individual you intend to hire
2. No information can come back to bite you later on

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Other Ideas to Help Entice Leaders to a Program

A. Active engagement of others in the interview process that may be involved with the candidate (other department Chairs, University leadership, major benefactors with an interest in this area)
B. Recruit family: Arranging services for spouses or partners. Relocation services, school visitation or appointments with real estate agents
C. Sell the position. Ability to make a difference. Camaraderie and spirit of the institution

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Components of Onboarding at Medical Schools and Teaching Hospitals

A. Help in developing a peer network (often, the search committee chair can be effective in this role)
B. Mentoring, formally or informally
C. Assistance and resources to plan a department or unit retreat
D. Assistance (internal or external) in strategic planning
E. Leadership development, such as a national program like the AAMC's Executive Development Seminar for Associate Deans and Department Chairs
F. Executive coaching
G. An "operational orientation" to the few but critical systems, processes, and policies used in day-to-day work
H. Concierge program, such as assistance with childcare, pets, banking, personal services, schools, and faith communities; "concierge-level" service in completing benefits process
I. Services for spouse/partner/family
J. A series of scheduled short-term and informally structured "check-in" meetings or conversations to make the assurance of ongoing support explicit

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How to Find a Team Player

Humble
Hungry
Smart

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Develop Passion for the Mission and Team

1. Connect individual to the importance of work being done
2. Make them understand connection between what they do and how it impacts others
3. Job security is not a prime motivator
4. Set clear expectations

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"It's not a great mission statement, but we'll revise it if things get better."

Too Humble

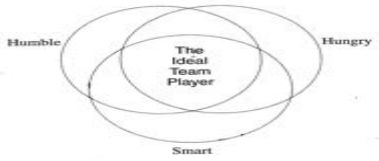
A. Pleasant, kind hearted, unassuming
B. No great need to get things done
C. Cannot build effective relationships with colleagues
D. Survives for long periods of time on groups that value harmony without performance

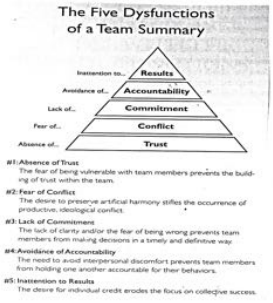
Hungry Only: The Bulldozer

A. Determined to get things done
B. No concern about how actions affect others
C. Standout and are quickly identified
D. Though gets things done, destroys teamwork and develops intense acrimony

Smart Only - Charmers

A. Smart without humility or hunger
B. Entertaining and likeable – little interest in long-term wellbeing
C. Contributions to the team are negligible





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- Coercive Leaders – Demand immediate compliance
- Authoritative Leaders – Mobilize people toward a vision
- Affiliative Leaders – Create emotional bonds and harmony
- Democratic Leaders – Build consensus through participation
- Pacesetting Leaders – Expect excellence and self-direction
- Coaching Leaders – Develop people for the future

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Domain	Competency
Strategic Skills	Business acumen
	Decision quality
	Intellectual horsepower
	Learning on the fly
	Problem solving
	Dealing with ambiguity
	Creativity
	Innovation management
	Perspective
	Strategic Agility
Operating Skills	Priority setting
	Organizing
	Developing direct reports and others
	Process Management
Courage	Command skills
	Sizing up People
Energy and Drive	Drive for Results
Organizational and positioning skills	Political savvy
	Presentation skills
	Comfort around higher management
Personal and interpersonal skills	Customer focus
	Managing diversity
	Motivating others
	Negotiating
	Managing vision and purpose
	Ethics and values
	Integrity and trust
	Composure
	Personal learning

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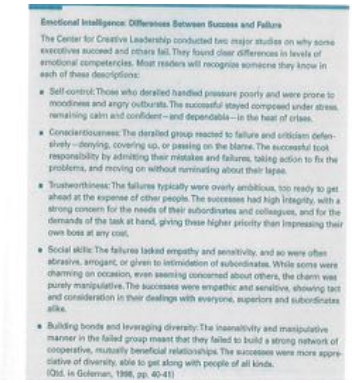

Emotional Intelligence: Differences Between Success and Failure

The Center for Creative Leadership conducted two major studies on why some executives succeed and others fail. They found clear differences in levels of emotional competencies. Most readers will recognize someone they know in each of these descriptions:

- Self-control: Those who derailed handled pressure poorly and were prone to moodiness and angry outbursts. The successful stayed composed under stress, remaining calm and confident—and dependable—in the heat of crises.
- Conscientiousness: The derailed group reacted to failure and criticism defensively—denying, covering up, or passing on the blame. The successful took responsibility by admitting their mistakes and failures, taking action to fix the problems, and moving on without ruminating about their lapse.
- Trustworthiness: The failures typically were overly ambitious, too ready to get ahead at the expense of other people. The successes had high integrity, with a strong concern for the needs of their subordinates and colleagues, and for the demands of the task at hand, giving these higher priority than impressing their own boss at any cost.
- Social skills: The failures lacked empathy and sensitivity, and so were often abrasive, arrogant, or given to intimidation of subordinates. While some were charming on occasion, even seeming concerned about others, the charm was purely manipulative. The successes were empathic and sensitive, showing tact and consideration in their dealings with everyone, superiors and subordinates alike.
- Building bonds and leveraging diversity: The insensitivity and manipulative manner in the failed group meant that they failed to build a strong network of cooperative, mutually beneficial relationships. The successes were more appreciative of diversity, able to get along with people of all kinds.

(Qtd. in Goleman, 1998, pp. 40-41)

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Mentor Faculty Selection

1. Provide a safe environment for the faculty to comfortably share information
2. Build a level of trust with the faculty
3. Actively listen to concerns
4. Guide faculty to determine correct course of action (mentor cannot make decisions for faculty)
5. Serve as a role model
6. Introduce faculty to others who can help her/him advance
7. Recommend a faculty for assignments
8. Provide faculty with honest feedback

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Five Ways to Fail as New Leader (What to Avoid)

1. Ignore the Culture
   A. Failure to understand or ignore existing culture
   B. Impulse to act may be off target – assess the climate
2. Focus too Much Attention on Quick Wins
   A. Too much focus on short-term victories overshadows long-term problems that become urgent
3. Stop Listening and Start Squawking
   A. Sometimes talks too much
   B. Seagull management – swoop in, squawk loudly and dump orders
   C. Too much talk may be function of anxiety
4. Will Ignore Conflict
   A. Enhances the chance of failure
   B. Cannot be avoided
   C. Ignoring conflict of ten signs of leadership immediately
5. Create a Strategic Plan that is Neither
   A. Invest weeks or months in the planning and process only to emerge with no plan that has any strategy

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Conclusion

1. Challenging to develop a pool of leaders – Competition for talent
2. Must be cognizant of what a leader should be
3. Traditional leaders different from future oriented
   A. Different skill sets, more emotional competence
4. Know the 10 C's of an outside search
5. Activitely engage others in the interview process
6. What leaders should develop – Strategy, operation, energy and drive
7. Mentor faculty
   A. Share information
   B. Build trust
   C. Listen
   D. Guide
   E. Serve as role model
   F. Provide feedback
8. Know what to avoid to fail as a leader
   A. Ignore existing culture
   B. Focus on quick wins
   C. Stop listening
   D. Ignore conflict

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HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

The Annual Faculty Review

Timothy E. Morey, MD

11/03/2017
2:10pm – 2:30pm

THE ANNUAL FACULTY REVIEW

Timothy E. Morey, MD
Professor and Chair
Department of Anesthesiology
University of Florida
Gainesville, FL

SAAA 2017
November 3, 2107
Chicago, IL

UF UNIVERSITY of FLORIDA

LEARNING OBJECTIVES

Learning Objectives

- Provide an effective faculty evaluation
- Do it on time
- De-conflict the evaluation process

COI

Conflicts of Interest

Company	IP	Equity	BOD
Xhale, Inc. (Gainesville, FL)	✓	✓	
NanoMedex Therapeutics (Madison, WI)	✓	✓	✓

"So, I'm the only one who sees a conflict of interest here?"

No conflicts related to writing faculty evaluations

Historical Perspective on Annual Performance Evaluations

- Some form has been used for centuries
- Merit Rating System for Federal Civil Service Commission in 1887
- Lord & Taylor in 1914: focus on personality/traits
- Drucker in 1950s: focus on objectives and performance

Purpose

- Provides opportunity for self-reflection for faculty member
- Gauges progress towards objectives for chair and faculty member
- Documents performance in writing for:
  - Promotion and tenure process
  - Legal reasons (non-renewal/termination)
- Allows opportunity to set new objectives
- Encourages one on one communication with chair

What it is not

"Dear Dr. XX,

You produced 8,984 RVU last year.
Your RVU target for next year is 9,882.
Thank you for your hard work.

Sincerely,

YY, MD, PhD
Professor and ZZ Chair of AA"

Not personal

One dimensional

Not(?) informative to faculty

No assessment

Little expectation setting

\+ Doesn't meet university needs

NOT EFFECTIVE

2017-2018 Faculty Evaluation Timeline

• November 15, 2017	Staff - Faculty Dashboard Update
• December 11, 2017	Faculty - Dashboard Overview, 5pm, 2147
• February 21, 2018	Faculty – Dashboard Overview: Everything you need to know about the dashboard and AAA Tool
• March 6, 2018	Staff – Faculty Dashboard Update
• April 29, 2018	Faculty Completed Evaluation Letter Due
• April 30, 2018	Service Chief's Edit Evaluation & Meet with their faculty
• May 29, 2018	Karen Pulls Letters from Dashboards
• June 11, 2018	Evaluation Meetings with Dr. Morey Start
• August 17, 2018	Completed Evaluations Due in Deans' Office

Anatomy of a Evaluation Letter

- Statement of letter
- Assessment of last year's goals
- Mission based review of activity
  - Education
  - Research
  - Clinical Care
  - Service
- Overall assessment of performance
- Assignment of time and new goals
- Boilerplate from COM and University
- Signatures

Anatomy of a Evaluation Letter

Use the University P/T guidelines to help construct the letter:

CLINICAL:

- Scope of the faculty member's clinical practice
- Interdisciplinary evaluations
- Patient satisfaction scores
- Commitment to ongoing growth in clinical performance
- Quality of care metrics
- Clinical leadership
- Professional contributions
- Clinical referrals
- Clinical publications
- Clinical presentations
- Awards and Honors
- Other pertinent information

Physiology of a Evaluation Letter

- Good news: 95% are no problem
  - Problematic faculty: Goal setting with strict timelines
  - Interim Evaluation in January
- FMLA / Military Leave = no evaluation
- 5 year tail on promotion/tenure applications
- Caution with negative statements
  - "You will again take a disruptive physician course and present to me a certificate of completion by April 30, 2018."
  - "You will not massage the residents' shoulders in the OR."
  - "You will not continue the practice of using the same methohexital syringe for multiple patients in the ECT suite."
- Adverse review, email faculty ahead of time
- For any review, email it to your assistant when written (date/time stamp)

Day of Annual Review

Time (min)	Subject
0-5	Warm-up the faculty Offer a refreshment
5-20	Faculty Agenda
20-40	Chair Communication Letter Review
40-50	Assessment and Conclusions
50-60	Break

Notes:
- No faculty draft = no appointment with chair
- Two copies of the letter printed
- Put a clock on wall behind faculty's head
- Include Chief / Associate Chair?
- Female faculty: Door ajar / chaperone in outer office
- Additional information or faculty disagrees with assessment
  - Faculty written addendum
- Limit of 4 evaluations / day

Items to Avoid:

- Compensation topics
- Issuance of non-renewal
- Terminations
- Gossip about other faculty / hospital / etc.
- Assessment of chair performance

Options for Dissatisfied Faculty

- Complain to other faculty
- Complain to division chief / senior professor / mentor
- Complain to you
- Write an addendum
- Engage institutional mechanisms
  - Ombuds
  - Faculty initiated grievance
- Law
- Resign

Faculty Grievance Process

- "…dispute or complaint alleging a violation of the regulations of the University or the Board of Governors concerning tenure, promotion, … annual evaluation, …"
- Discuss with chair within 30 days of evaluation
- Step I: Submit a written grievance to the Office of the President within 30 days
  - Reviewed by 3 faculty member committee appointed by the Dean within 15 days
  - Committee issues final report to the Dean within 30 days
  - Dean meets with faculty and chair within 15 days
  - Dean issues final decision and remedies within 30 days of meeting
- Step II: File an appeal of Dean's decision to Provost within 15 days
  - Provost meets with faculty and chair within 15 days
  - Provost issues final decision and remedies within 30 days of meeting

7.042 University Grievance Procedure for Faculty and Postdoctoral Associates: Definitions, General Information, and Procedures.

Faculty Grievance Process

- Step III: Appeal Provost's decision within 15 days
  - American Arbitration Association arbitrator appointed within 15 days
  - President presents final decision within 30 days
- "…shall not substitute his or her judgment for that of the administrator…:"
- Evaluating for violations of law and regulations:
  - Errors of fact
  - Violations of federally protected status
  - Violations of university policies and/or procedures

Future Perspective on Annual Performance Evaluations

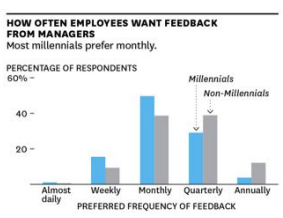
Millennials and Annual Performance Evaluation

- 62% of felt "blindsided" by a performance review
- 74% feel "in the dark" about how managers think they're performing
- 26% have called in sick on day of performance review
- 14% have cried during the performance review

Future Perspective on Annual Performance Evaluations

Millennials and Annual Performance Evaluation

- Annual to constant feedback
- Personalize the evaluation
- Map out career path
- Emphasize impact of their work
- Tie new objective to new training
- Validate their priorities



End / Questions?

HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

How Chairs Can Manage Culture Change: Perspective from a New and Experienced Chair

Douglas R. Bacon, MD, MA
John F. Butterworth, IV, MD

11/03/2017
2:30pm – 2:40pm

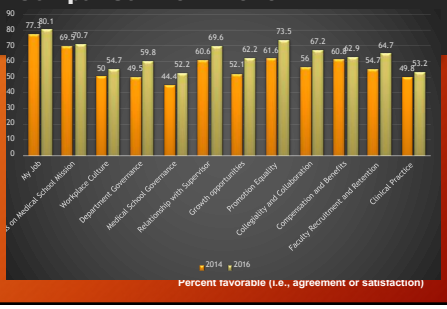
How Chairs Can Manage Culture Change: Perspectives from a New Chair

Douglas R. Bacon, M.D., M.A.
Professor and Chair
Department of Anesthesiology
University of Mississippi Medical Center
Jackson, Mississippi

Faculty Forward Data 2014 VS. 2016

- I assumed leadership of the department on August 4, 2014
- 2014 data was gathered around the time of my arrival
- 2016 data demonstrates the first 24 months or so of my tenure in the department
- There had been three interim chairs and one permeant chair in the five years before I arrived

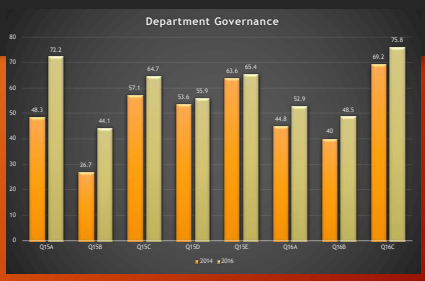
Department: Summary Scores Comparison 2014-2016



What Changed?

- The largest changes were over items which the chair has a great deal of control
  - Relationship with Supervisor (+9)
  - Workplace Culture (+4.7)
  - Departmental Governance (+10.3)
  - Growth Opportunities (+10.1)
  - Promotion Equality (+11.9)
  - Collegiality and Collaboration (+11.2)
  - Faculty Recruitment and Retention (+ 10.0)

Department Governance 2014 - 2016



What Changed?

- The deeper dive into departmental governance was equally as interesting:
  - Communication from the Chair (+23.9)
  - Explaining Departmental Finances (+ 20.4)
  - Decision Making (+ 8.1)
  - Faculty Participation (+8.5)

Making Change Occur?

- The Golden Rule
- An Open Door
- Transparency—Faculty Meeting Slides
- SAAA
- David Zvara (an others)
- Retreat
- Structure
- Operating Room Time

One Management Book

- Michael Abrashoff was a plenary session speaker at the ASA in San Diego
- Many lessons about listening
- Can reform the department from within
- Allows empowerment of the faculty

Questions????

Culture Change in a Department of Anesthesiology

John F. Butterworth, IV, MD
Professor & Chair
Department of Anesthesiology
VCU School of Medicine
Richmond, Virginia 23298-0695
john.butterworth@vcuhealth.org

17 Nov 2017

Culture eats strategy for breakfast.
-Peter F. Drucker, PhD
-1909-2005

Why is Organizational Culture Important?

- It affects the organization's productivity and performance
- It provides guidelines on customer care and service, product quality and safety, attendance and punctuality, and concern for the environment.

http://www.businessdictionary.com/definition/organizational-culture.html

Definition of Organizational Culture

- Values and behaviors that contribute to the unique social and psychological environment of an organization.
- Expectations, experiences, philosophy, and values … expressed in its self-image, inner workings, interactions …, and … expectations.
- Based on shared attitudes, beliefs, customs, and written and unwritten rules … developed over time and are considered valid

http://www.businessdictionary.com/definition/organizational-culture.html

Organizational Culture = Corporate Culture

It is shown in:
(1) the ways the organization conducts business, treats employees, customers, and community
(2) the extent to which freedom is allowed in decision making, developing new ideas, and personal expression
(3) how power and information flow through its hierarchy
(4) how committed the employees might be towards collective objectives

http://www.businessdictionary.com/definition/organizational-culture.html

Toxic Individuals Have Excessive Influence on Corporate Culture

- Bullies
- Antagonists
- Poor performers

Your Tolerance of Toxic Bullies, Antagonists, & Poor Performers Will Define Your Department's Culture

How to Identify the Bullies

- After encountering the person, do people feel oppressed, humiliated or otherwise worse about themselves?
- Does the person target people who are less powerful than him/her?

Robert I. Sutton. *The No Asshole Rule: Building a Civilized Workplace and Surviving One That Isn't* Random House, 2007

Sutton's "Dirty Dozen"

- Insults
- Violation of personal space
- Unsolicited touching
- Threats
- Sarcasm
- Flames
- Humiliation
- Shaming
- Interruption
- Backbiting
- Glaring
- Snubbing

Robert I. Sutton. *The No Asshole Rule: Building a Civilized Workplace and Surviving One That Isn't* Random House, 2007

How to Identify the Antagonists

- Does this person enjoy arguing for arguing's sake (opinions on every subject)?
- Does this person seek "evidence" for every decision or policy, however obvious (RCT for parachutes)?
- Does this person invoke safety when there is no safety issue?
- Does this person invoke professionalism when the issue is compensation?
- Is this person's motto "There's no team in I?"

How to Identify the Poor Performers

- You need to develop your own metrics based on the needs of your department and medical center
  - Clinical: on time starts
  - Educational: resident/student education encounters
  - Research: appropriate productivity from protected research time

Department Chair = Manager?

- A manager *sets objectives*
- A manager *organizes*
- A manager *motivates and communicates*
- A manager, by establishing yardsticks, *measures*
- A manager *develops people*.

Drucker PF. *The Practice of Management* New York,: Harper, 1954, p 344

How to Change Culture

- **Structure and Process**. Allow section and program directors to innovate and to be accountable for results.

See: https://executiveeducation.wharton.upenn.edu/thought-leadership
Larry Hrebiniak. *Making Strategy Work*

How to Change Culture

- **Structure and Process**. Allow section and program directors to innovate and to be accountable for results.
- **People**: Bring in fresh blood and thinking. Counsel/isolate/remove antagonists, bullies, poor performers.

See: https://executiveeducation.wharton.upenn.edu/thought-leadership
Larry Hrebiniak. *Making Strategy Work*

How to Change Culture

- **Incentives.** Change incentive structure to give authority/control/rewards to those who perform rather than to those who are older.

See: https://executiveeducation.wharton.upenn.edu/thought-leadership
Larry Hrebiniak. *Making Strategy Work*

How to Change Culture

- **Incentives.** Change incentive structure to give authority/control/rewards to those who perform rather than to those who are older.
- **Changing and Enforcing Controls.** Increase frequency/intensity of performance evaluations, feedback, and remedial actions. Emphasize activities central to implementing strategy. Hold directors and faculty accountable for results.

See: https://executiveeducation.wharton.upenn.edu/thought-leadership
Larry Hrebiniak. *Making Strategy Work*

So What Aside From Culture Leads to Failure of a Chair's Strategy?

- Failure to manage your bosses
- Failure to get advice from others
- Failure to understand that some of the "rules" advocated on LinkedIn or in the HBR must be adapted to the medical school environment
- Failure to obey the same rules as others
- Arrogance
- Rigidity

Did Drucker Really Invent the Quote?

- *More and more management consultants … are noting explicitly that, because **"culture constrains strategy,"** a company must analyze its culture and learn to manage within its boundaries or … change it.*[1,2]
- *As stated in the March 2000 Giga Information Group headline **"Culture Eats Strategy for Breakfast!"** Will the culture of the recovered paper transaction business stymie those using an e-strategy to improve the marketplace?*[2,3]

1. Schein Edgar H: "Organizational Culture and Leadership" 1985
2. https://quoteinvestigator.com/2017/05/23/culture-eats/ (accessed 9.2717)
3. Moore B, Rose J: North American Papermaker 82 (9):26-28, 2000

HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

Perfect Storm

Charles W. Whitten, MD

11/03/2017
3:15pm – 3:50pm

PERFECT STORM PART II: IS A TSUNAMI BREWING?

Charles W. Whitten, M.D.
Professor and Chairman

Margaret Milam McDermott Distinguished Chair
in Anesthesiology and Pain Management
Department of Anesthesiology and Pain Management

UT Southwestern Medical Center
5323 Harry Hines Boulevard
Dallas, Texas 75390-9068
Office phone: 214-648-5413
Fax: 214-648-5461
charles.whitten@utsouthwestern.edu

Conflict of Interest & Why am I qualified to do this?

- I have no conflicts except:

(1) I have a long standing interest in the economics of academic anesthesia practice dating back to collaborations which began with Amr Abouleish and others in the late 1990's.

(2) We continue to perform collaborative research utilizing national databases.

2

Perfect Storm Overview: Part I

This has been presented from 2000-2011 and leaves a wonderful legacy for us in Academic Anesthesiology.

- **No data was presented in 2012 at the SAAA Meeting. I have included this for completeness in some of the slides.**

3

The Etiology of Perfect Storm Part I

Match Day 1994

4

Wall Street Journal March 17, 1995 – *G. Anders* "Once a hot specialty, Anesthesiology cools as insurers scale back"

- 1994 Grads-1,863 Residents graduate from Anesthesia Residencies
- 1995 Start – 892 Residents, consisting of 348 IMG's and 544 AMG's
- "This was the start of the lost generation." The specialty is now feeling this loss at another level, as individuals from this "lost generation" should be morphing into significant leadership positions.

5

Size of Residency Training Programs

- In 2016- 1,631 Senior Residents graduated (**35% women enrolled in all training programs**). A total of 6, 051 Anesthesiology Residents are enrolled in 135 Core Residency Programs.

Residency Production: Confounding Factors

- In 2015, we know that the following pursued ACGME fellowships:

Number of Programs (N)	Positions Filled	% Women
Critical Care Medicine (N=54)	175	31%
Pain Medicine (N=100)	337	22%
Pediatrics (N=56)	205	55%
Adult Cardiothoracic (N=62)	183	28%
OB (N=28)	38	68%
Clinical Informatics (N=1)	0	N/A

6

Understanding Clinical Productivity for Anesthesiology Departments

Utilize the Following:

- Not Simple
- Key Point: Organizational factors that determine a facility type impact clinical productivity.
- To best understand, compare to similar types of facilities:
  - ASC to ASC
  - Community Hospital to Community Hospital
  - AMC / Trauma to AMC / Trauma

7

Understanding Anesthesia Clinical Productivity and Survey Results

Utilize the Following:

- Figure from 2003 Paper
- Median Data by Facility Type, 2013 Survey

8

Clinical Productivity by Facility Type

- 2003 Survey
  Anesth Analg 2003:96:802-12
- 2013 Survey


Organizational Factors Affect Comparisons of the Clinical Productivity of Academic Anesthesiology Departments


2013 Survey of Clinical Productivity of Academic Anesthesiology Departments

9

Benchmarks by Facility Type SAAA 2013

MEDIAN VALUES (50%)	All Groups (n=143)	All non ASC (n=111)	ASC (n=32)	AMC/ Indigent* (n=80)	Children (n=11)	Community (n=20)
Sites						
tASA/OR	tASA = Total ASA units billed, OR = Anesthetizing Site					
H/OR/d	H = 4 time units, d = 250 weekdays/year					
tASA/h	Hourly productivity					
Base/case						
H/case						
Staffing Ratio						

* Includes 1 Heart Hospital
2013 Survey of Clinical Productivity of Academic Anesthesiology Departments, ww2.SAAAhq.org

10

Benchmarks by Facility Type SAAA 2013

MEDIAN VALUES (50%)	All Groups (n=143)	All non ASC (n=111)	ASC (n=32)	AMC/ Indigent* (n=80)	Children (n=11)	Community (n=20)
Sites	21.0	26.0	4.0	31.4	18.0	14.5
tASA/OR	What is Overall Clinical Productivity?					
H/OR/d						
tASA/h						
Base/case						
H/case						
Staffing Ratio						

* Includes 1 Heart Hospital
2013 Survey of Clinical Productivity of Academic Anesthesiology Departments, www.SAAAhq.org

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Benchmarks by Facility Type- SAAA 2013

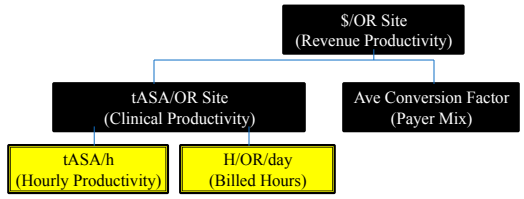
MEDIAN VALUES (50%)	All Groups (n=143)	All non ASC (n=111)	ASC (n=32)	AMC/ Indigent* (n=80)	Children (n=11)	Community (n=20)
Sites	21.0	26.0	4.0	31.4	18.0	14.5
tASA/OR	11,215	11,632	8,912	11,982	10,839	10,630
H/OR/d						
tASA/h						
Base/case						
H/case						
Staffing Ratio						

What determines tASA/OR?

* Includes 1 Heart Hospital
2013 Survey of Clinical Productivity of Academic Anesthesiology Departments, www.SAAAhq.org

12

Anesthesia Clinical Productivity



$$tASA/h = \frac{(base\ unit + time\ unit)}{(time\ unit/4)}$$

13

Benchmarks by Facility Type- SAAA 2013

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H/OR/d						
tASA/h	6.7	6.7	7.4	6.5	7.3	7.1
Base/case	5.8	6.0	4.5	6.2	5.8	5.4
H/case	2.2	2.3	1.2	2.5	1.7	1.6
Staffing Ratio						

* Includes 1 Heart Hospital
2013 Survey of Clinical Productivity of Academic Anesthesiology Departments, www.SAAAhq.org

14

Benchmarks by Facility Type- SAAA 2013

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H/case	2.2	2.3	1.2	2.5	1.7	1.6
Staffing Ratio						

* Includes 1 Heart Hospital
2013 Survey of Clinical Productivity of Academic Anesthesiology Departments, www.SAAAhq.org

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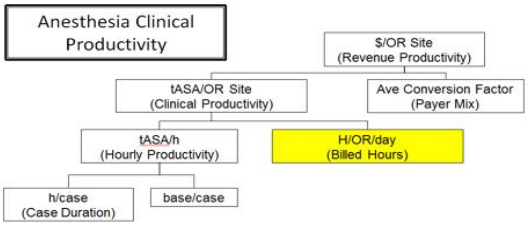
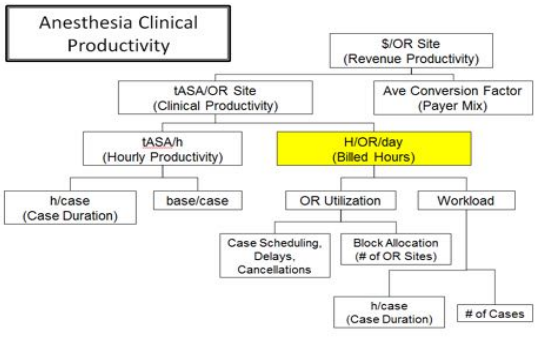
Anesthesia Clinical Productivity



Anesth Analg 2003:96:802-12

16

Anesthesia Clinical Productivity



Anesth Analg 2003:96:802-12

17

Benchmarks by Facility Type- SAAA 2013

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H/case	2.2	2.3	1.2	2.5	1.7	1.6
Staffing Ratio						

* Includes 1 Heart Hospital
2013 Survey of Clinical Productivity of Academic Anesthesiology Departments, www.SAAAhq.org

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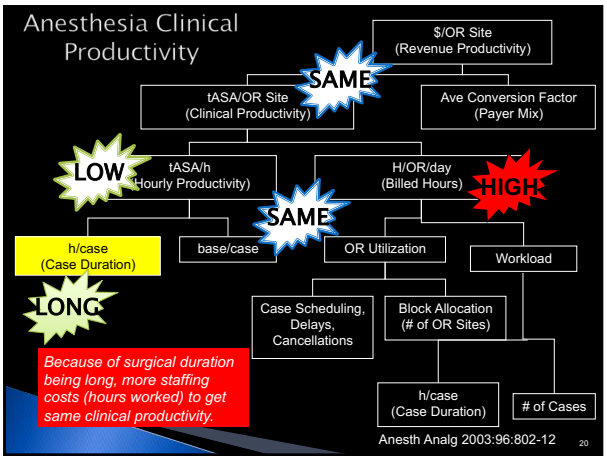
How to use the Benchmark Data?

- Compare similar facilities
- Use to identify where to investigate more
- Use to confirm your understanding
- Example: Similar overall productivity (tASA/OR), but long surgical cases (High H/case)
- Example: Low tASA/OR but similar tASA/h



Benchmarks by Facility Type, SAAA 2013

MEDIAN VALUES (50%)	All Groups (n=143)	All non ASC (n=111)	Facility Type ASC (n=32)	AMC/ Indigent* (n=80)	Children (n=11)	Community (n=20)
Sites	21.0	26.0	4.0	31.4	18.0	14.5
tASA/OR	11,215	11,632	8,912	11,982	10,839	10,630
H/OR/d	6.5	6.9	4.3	7.3	6.0	6.0
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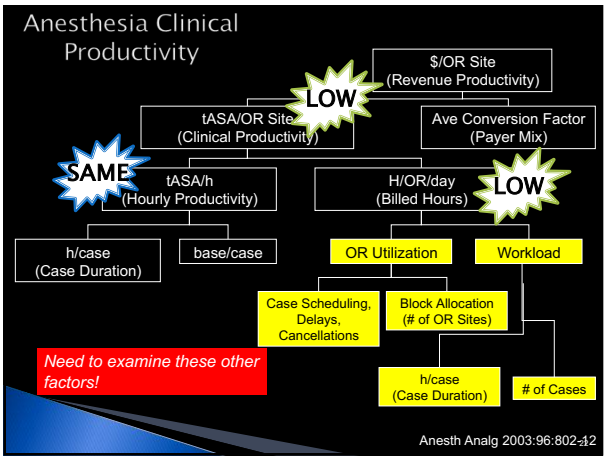
H/case	2.2	2.3	1.2	2.5	1.7	1.6
Staffing Ratio						

2013 Survey of Clinical Productivity of Academic Anesthesiology Departments, www.SAAAhq.org

*Includes 1 Heart Hospital

21



Other Findings

- Breakdown by number of sites, type of surgical staff (academic or mixed private/academic)
- Staffing ratio

Benchmarks by Facility Type, SAAA 2013

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tASA/h	6.7	6.7	7.4	6.5	7.3	7.1
Base/case	5.8	6.0	4.5	6.2	5.8	5.4
H/case	2.2	2.3	1.2	2.5	1.7	1.6
Staffing Ratio	1.8	1.7	2.8	1.8	1.7	1.8

*Includes 1 Heart Hospital

2013 Survey of Clinical Productivity of Academic Anesthesiology Departments, www.SAAAhq.org

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Benchmarks 2013

MEDIAN VALUES (50%)	All Groups (n=143)	All non ASC (n=111)	ASC (n=32)	AMC/ Indigent* (n=80)	Children (n=11)	Community (n=20)	Academic Only (n=57)	Mixed/ Private Practice ** (n=54)
Sites	21.0	26.0	4.0	31.4	18.0	14.5	29.0	25.0
FTE	12.0	15.0	2.0	17.0	13.0	6.0	16.0	13.0
Staffing Ratio	1.8	1.7	2.8	1.8	1.7	1.8	1.8	1.7
tASA/case	14.3	15.6	9.1	16.6	12.5	12.3	16.6	14.1
Base/case	5.8	6.0	4.5	6.2	5.8	5.4	6.2	5.8
H/case	2.2	2.3	1.2	2.5	1.7	1.6	2.5	2.1
tASA/h	6.7	6.7	7.4	6.5	7.3	7.1	6.5	6.8
Case/OR/d	3.1	3.0	3.6	3.0	3.5	3.2	2.9	3.3
tASA/OR/d	11,215	11,632	8,912	11,982	10,839	10.630	12,023	11,445
H/OR/d	6.5	6.9	4.3	7.3	6.0	6.0	7.2	6.8

*Includes 1 Heart Hospital, **Private practice only

25

2013 AAAC/SAAA Clinical Productivity Report

Key Findings:

1) Similar to previous reports, ambulatory surgical centers (ASC) have different clinical productivity measurements than full-service facilities. This finding is consistent with the fact that ASC are smaller, do less complex cases, do shorter procedures, and do not function 24/7.
2) Smaller facilities (1-9 sites, 10-19 sites) were associated with shorter cases that leads to higher tASA/h productivity. The number of billed hours worked per day (H/OR/d) was less that may be consistent with less after-hour cases and weekend cases.
3) Compared to AMC's, Children's Hospitals (not reported in 2003 report) showed lower case duration cases that leads to higher tASA/h numbers. But the overall tASA/OR was not much less despite lower H/OR/d due to this higher hour billing productivity.

26

My observation in running a large Department, AND SPEAKING TO OTHER CHAIRS, is that there is a shifting emphasis to concurrency rates, by hospital administration.

27

SAAA YEARLY SURVEY DATA 2016

28

2016 Average Department

	Mean	+/- SD	Median
Surgical Anesthesiologist FTE's	43	29.5	39.5
Acute Pain	1.9	1.77	1.2
Chronic Pain	3.0	2.09	2.2
ICU	3.0	3.45	2.0
Residents			
CA-1	14.7	6.8	11
CA-2	14.6	6.8	14
CA-3	14.6	6.8	14
CA-4	11	10.6 (Max 42)	14
Per ACGME Average sized Program – CAs 1,2 & 3 = 41.8			
Internship CA-0	10.3	7.3	10
Interns in home Dept.	11.8	6.6	11

29

National Clinical Coverage

	Mean	+/- SD	Median
How many OR's does your Department cover each day?			
Sunday	3.7	3.3	3
Monday	43.4	23.3	40
Tuesday	43.5	23.5	40
Wednesday	43.3	23.1	40
Thursday	43.4	23.1	40
Friday	42.8	22.5	40
Saturday	4.6	4	4

30

National Clinical Coverage, *con't.*

	Mean	+/- SD	Median
How many Non-OR/Off Site locations does your Department cover each day?			
Sunday	0.8	1.7	0
Monday	12.1	9.09	9
Tuesday	12.1	8.9	9
Wednesday	12.2	8.9	9
Thursday	12.1	8.8	9
Friday	12.1	8.7	9
Saturday	1.0	1.8	0
How many OB deliveries with anesthesia involvement does your Department have each year?	3,173	2,411 (maximum 11,500)	2,548

31

Total Work FTE

	Mean	+/- SD	Median
If your institution funds retirement/pension, what is the average percentage of total compensation provided?	9.1%	4.62%	8%
What is the total number of part-time clinical physicians faculty that your Department employs?	11.2	11.45	7
What is the average percentage of faculty fringe benefits, excluding malpractice premium and pension as compared with the base?	19.1%	10%	18%
What is the total number of clinical faculty members who have 40% or greater academic time for scholarly work ?	4.5	6.6 (Max 37)	2

32

Clinical Coverage

	Mean	+/- SD	Median
How many faculty do you have on each of these services per day on average, Monday thru Friday in the daytime.			
OB	1.5	1.03	1
ICU	2.1	1.9	2
Acute Pain	1.5	1.17	1
Pain Clinic	2.5	1.76	2
Pre-Op Clinic	1.0	0.59	1
Other	0.3	1.06	0
Total	8.9		

33

CRNAs/AAs

	Mean	+/- SD	Median
Paid for by Dept.	40.3%	42.7%	23%
Paid for by your Hospital	57.3%	43.2%	74%
By other sources	2.4%	12.7%	0%

*Previous years have reported these as total #'s. Total # of CRNAs, AAs employed is not available.

34

Average Department Clinical Coverage Monday-Friday

	Mean	+/- SD	Median
ORs	43.4	23	40
Off Site	12.1	8.9	9
OB	1.5	1.03	1
ICU	2.1	1.9	2
APS	1.5	1.17	1
Pain	2.5	1.76	2
Pre-Op	1.0	0.59	1
Other	0.3	1.06	0
Total	64.4		
Faculty/Sites	**50.9/64.4= 0.7953 (In 2015 0.9555)**		

35

Average National Department Clinical Revenue

	Mean	+/- SD
Average Department Clinical Revenue	$ 36,497,149	$ 29,947,595
Clinical Revenue per FTE	$ 545,357	$ 346,678
Research Revenue	$ 1,876.973	$ 3,467,917 (Max $22,670,991)
Research Revenue per FTE	$ 22,281	$ 35,072
Total Institutional Support	$ 11,223,736	$ 9,158,329
Total Institutional Support per FTE	$ 190,584	$ 117,589

36

Average National Department Clinical Revenue *Con't.*

	Mean	+/- SD
Support from the Hospital	$ 8,418,023	$ 6,869,062
Support from Medical School	$ 1,372,671	$ 3,806,483
Support from other sources	$ 1,433,042	$ 4,248,390
Other income	$ 392,801	$ 784,247
Total Department Revenue	$ 49,990,658	$ 33,413,649
Total Department Revenue per FTE	$ 763,516	$ 321,704

37

Comparison of Economic Status by Departmental Size

<40 (n=21) +88 (n=21)

38

<40 n= 21	Mean	+/- SD	Median
Total Support per FTE	$ 245,952	$ 117,203	$ 245,897
Total Revenue per FTE	$ 688,333	$ 182,788	$ 650,043
Support w/o CRNA support per FTE	$ 193,222	$ 120,714	$ 153,846
Expenses per FTE	$ 658,941	$ 184,528	$ 622,959
Margin per FTE those w/ Profit (n=11)	$ 80,899	$ 115,474	$ 39,949
+88 n= 21	**Mean**	**+/- SD**	**Median**
Total Support per FTE	$ 139,332	$ 92,719	$ 119,575
Total Revenue per FTE	$ 818,530	$ 146,040	$ 819,250
Support w/o CRNA support per FTE	$ 120,348	$ 80,494	$ 99,011
Expenses per FTE	$ 771,885	$ 121,526	$ 775,081
Margin per FTE those w/ Profit (n=20)	$ 49,801	$ 64,130	$ 32,496

39

Billing Production National

	Mean	+/- SD
Total Anesthesia Units Billed	722,172	359,585
Total Anesthesia Units Billed Per FTE	12,055	3,361
Time Units per Case	11.7	4.04
Cases Billed	46,451	23,501
Total Work RVUs for Intraoperative Procedures (Line Placement/TEE)	32,918	59,666
How many work RVUs did you bill for your ICU Service last year? (n=55)	14,476	16,189

40

Pain Billing Production National

	Mean	+/- SD
How many work RVUs did you bill for Pain Management last year?		
In-Patient-Acute Pain	4,882	8,784
Regional Blocks-Post-Op	4,423	7,919
In-Patient-Chronic Pain	1,344	3,395
Regional Blocks-Post-Op	4,418	10,912
Out-Patient-Chronic Pain	14,840	13,238

41

Billing Data

	Mean	+/- SD
What is your gross unit value?	$121.00	$ 37.60
What is your average $ amount collected per unit?	$ 37.60	$ 14.10
What unit value do you receive from Medicaid?	$ 16.40	$ 5.84

42

ICU Data

	Mean	+/- SD	Median
On average how many patients does each type of resident cover while on service?			
CBY-1	3.2	3.57	2
CA-1	4.7	4.04	4
CA-2	6.2	4.37	6
CA-3	4.8	4.58	4

43

ICU Data

	Mean	+/- SD	Median
On average how many patients does each fellow cover while on service?	8.3	8.03	9
How many ICU weeks are required for a faculty member to be considered as 100% clinical with no OR commitment?	23.1	9.2	25
How many ICU weeks are required for faculty member to fulfill their departmental on call requirement?	13.1	6.31	12
Following a seven day ICU assignment, how many post-call days off are provided to your intensivist?	2.3	2.14	1
How many distinct ICU does your department cover?	2.6	1.65	3

44

Billing – Median Data

	Median
Total Anesthesia Units	633,568
Total Anesthesia Units Billed per FTE	11,706
Total Anesthesia Time Units Billed Per Case	10.5
What is the Average Unit Dollar Amount Collected?	$35.00

45

Margin Analysis

	Mean	+/- SD
Margin (n=83)	$ 3,384,167	$13,620,323
Margin: Those with profit(n=56)	$5,843,203	$15,951,290
Margin: Those with loss (n=17)	-$2,725,503	$2,849,928

46

Compensation

How much additional compensation do you pay for the following subspecialty excluding 0?	Mean	+/- SD	Median
For Departments paying additional comp. (50%)			
Cardiac	$ 18,104	$ 13,943	$ 15,000
ICU	$ 17,699	$ 15,178	$ 11,728
Pediatrics	$ 19,075	$ 23,421	$ 10,000
Pain	$ 17,676	$ 26,174	$ 10,000
OB	$ 10,775	$ 5,859	$ 10,000
Neurology	$ 10,000	$ 2,887	$ 10,000
Call – How much do you pay per hour for late/weekend In-House Coverage	$163.00	$43.80	$ 150.00

47

SAAA 2016 Compensation Total Compensation Including Income Plus Pension Contributions

Compensation Includes Income Plus Pension Contribution	25%	Median	75%
Instructor	257,398	295,202	319,267
Assistant Professor	318,247	350,131	367,485
Associate Professor	340,200	377,715	406,157
Professor	366,072	401,282	442,446
Chair	528,042	577,751	652,705

48

Faculty Benefits

	Mean	+/- SD	Median
Number of vacation days	25.1	5.33	24
Number of meeting days	7.3	3.47	7

49

Total National Department Support 2016 (Without CRNA Support)

	Mean	+/- SD	Median
Support without CRNA Support	$ 8,754,049	$ 7,558,722	$ 781,910
Support without CRNA Support per FTE	$ 149,229	$ 106,373	$ 127,957

50

Mean Total National Department Support (Without CRNA Support)

	$ Support	$ Per FTE (Mean)
2009	$ 5,630,386	$ 133,196
2010	$ 6,579,848	$ 128,619
2011	$ 7,008,978	$ 140,435
2012	$ 6,920,575	$ 132,339
2013	$ 7,413,000	$ 144,000
2014	$ 7,851,927	$143,964
2015	$ 7,727,345	$150,182
2016	$ 8,754,049	$149,229

51

Mean National Institutional Support

Total Support/FTE	2016	$ 190,584
	2015	$ 191,912
	2014	$ 196,441
	2013	$ 181,000
(Total support – CRNA Support)/FTE	2016	$ 149,229
	2015	$ 150,182
	2014	$ 143,964
	2013	$ 144,000
	2012	$ 132,338
	2011	$ 140,435

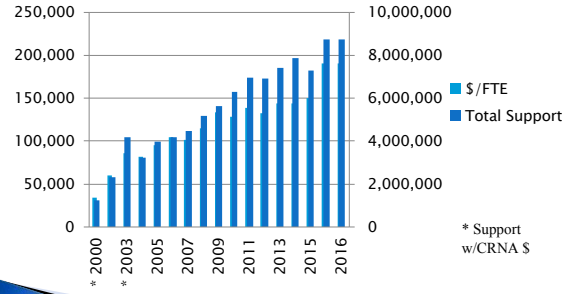
52

Mean National Institutional Support

(Support without CRNA support)/Site	2016	$ 8,754,049 ÷ 64.4= $ 135,932
	2015	$ 128,789
	2014	$ 131,744
	2013	$ 137,277
	2012	$ 128,831

53

Total National Department Support (Without CRNA Support)



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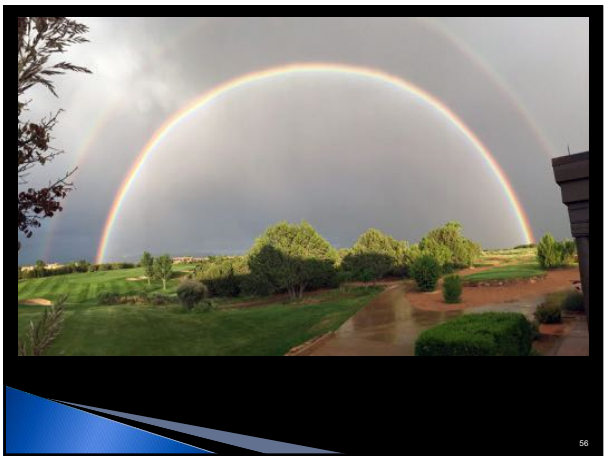
NEW SURVEY SIMPLICITY!!!

55



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HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

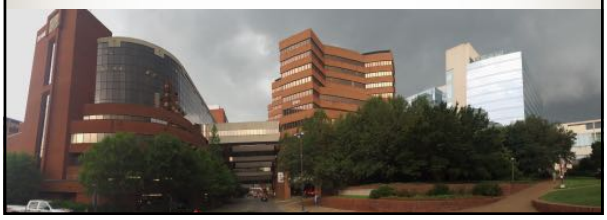
Defining the Roles and Expectations of Division Chiefs and Vice-Chairs

Warren S. Sandberg, MD, PhD

11/03/2017
3:50pm – 4:10pm

Defining the Roles and Expectations of Division Chiefs and Vice Chairs

Warren S. Sandberg, M.D., Ph.D.
Professor & Chair,
Department of Anesthesiology,
Vanderbilt University Medical Center



Disclosures

- None

"Nothing in the world can take the place of Persistence. Talent will not; nothing is more common than unsuccessful men with talent. Genius will not; unrewarded genius is almost a proverb. Education will not; the world is full of educated derelicts. Persistence and determination alone are omnipotent. The slogan 'Press On' has solved and always will solve the problems of the human race." *Calvin Coolidge*

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Objectives

- Justify investment in department leadership
- Distinguish between (i) Strong Vice Chair, (ii) Strong Division Chief and (iii) matrix models
- Describe one department's approach to leadership structure
  - Evaluate associated performance
- Appreciate the value and limitations of job descriptions
- Develop criteria for successful leader performance in their own departments

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Department Leaders

- Hard to find; tend to stick; carry your brand
- Seen as having outsize power, especially by the professionally aggrieved
- Effectively multiply the impact of the chair *iff* they are engaged, effectively delegated to
- Effective leaders make it possible
  - for the department to get things done
  - to do new things
  - to attract more leaders (positive feedback loop)

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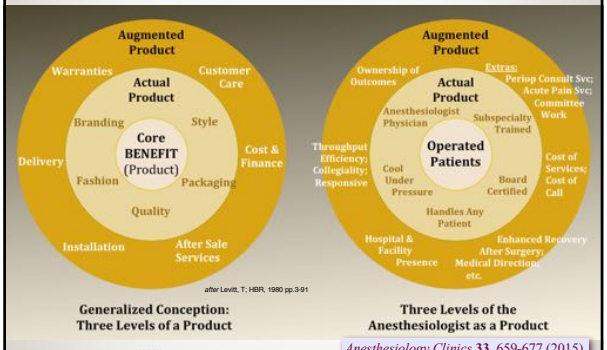
Anesthesiologist as 'Product'



Anesthesiology Clinics **33**, 659-677 (2015)

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For the New Chair Taking Over

- Diagnose your organization's current state
  - the obvious: unless there is an emergency, take time to learn the current team
  - Develop an understanding of the documented and actual structure
- Set a desired state goal
  - a well functioning current state team deserves a shot at incumbency
  - relationships are key - does your team have good ones?
- Move towards your goal state deliberately

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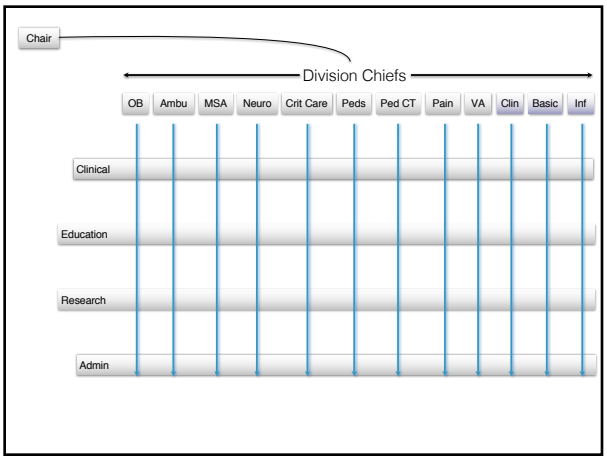

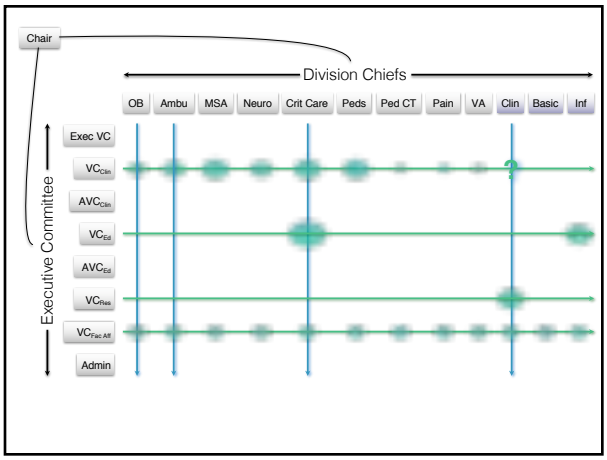

Vanderbilt Matrix

- In 2010, we were definitely a strong VC department
- Exec Committee of 5 Vice Chairs made all important decisions
  - time to work together
  - energetic & committed
  - but incomplete (open positions)
- By 2014: dynamic - moving resolutely towards a matrix model of active Division Chiefs and Vice Chairs

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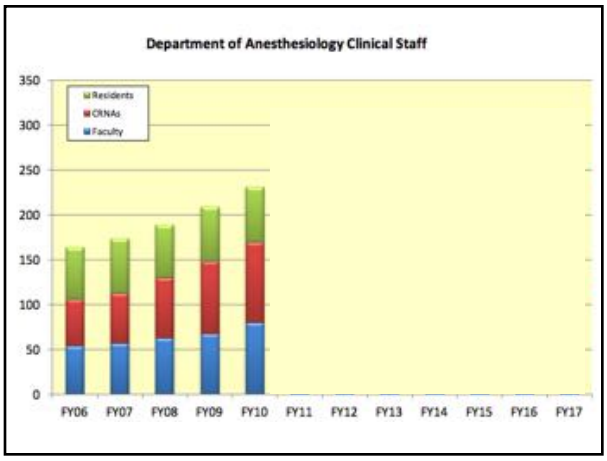
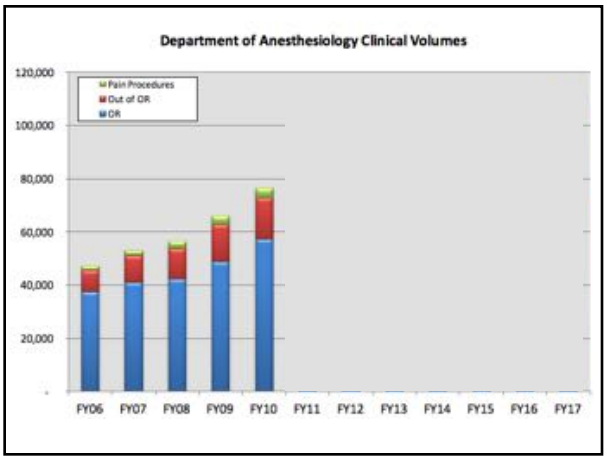
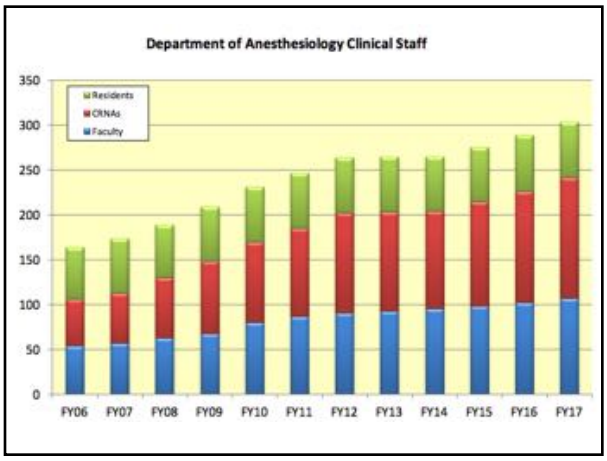
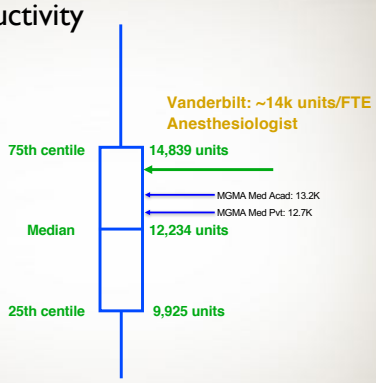






Clinical Productivity

- ASA units billed per FTE:



Data: SAAA 2015 Annual Survey (2014 Data)

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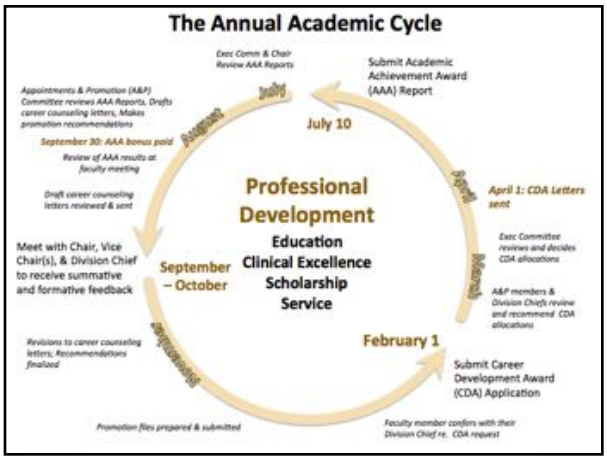

The AAA Program provides clinical faculty with a tangible annual reward for scholarship, education, and academic service that complements the financial rewards associated with clinical work

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AAA 16-17 Highlights

- 10% increase in AAA points for those faculty who received points last year
- 28% increase in total AAA points (202,800)
- 29% increase in AAA points per faculty (new mean of 1,733)
- 12 faculty increased their shares earned while 6 had a decrease

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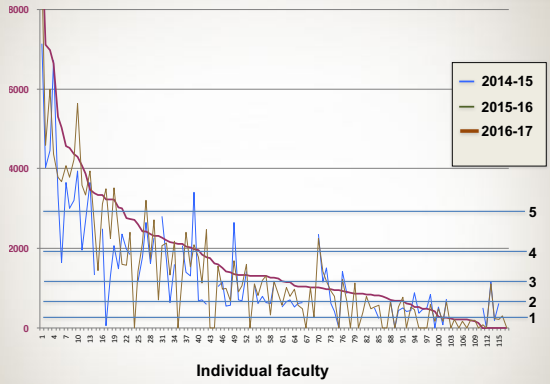

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AAA 16-17 by Division

	Crit Care	Cardiac	MSA	Ambu	Pain	OB	Peds Card	Peds	Neuro
Number	25	11	25	9	9	9	4	19	6
% w/Award	96%	100%	76%	78%	89%	78%	100%	68%	100%
Median	1618	1315	1960	808	955	693	1864	1017	1046
Mean	2182	1917	2210	1105	1201	1099	1993	956	2521
SD	1548	1670	1933	1293	945	1003	1272	728	3569

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AUA Members

Warren Sandberg
Edward Sherwood
*Pratik Pandharipande
*Kelly McQueen
*Brian Donahue
Andrew Shaw
*Susan Eagle
*Curtis Baysinger
*Heidi Smith
*Lisa Weavind
Matthew Weinger
Mark Rice
Matthew McEvoy
*Steve Bruehl
*Michael Higgins
*Chris Hughes
*Jesse Ehrenfeld
Yandong Jiang
*Paul St. Jacques
*Liza Weavind
*Josh Billings
*Avi Kumar
Matt Riess
*Arna Banerjee
*Brian Donahue
David Chestnut
*Jeff Balser
*Tracy Jackson

*Elected from Vanderbilt.
28 members; ~1/4 of Dept.

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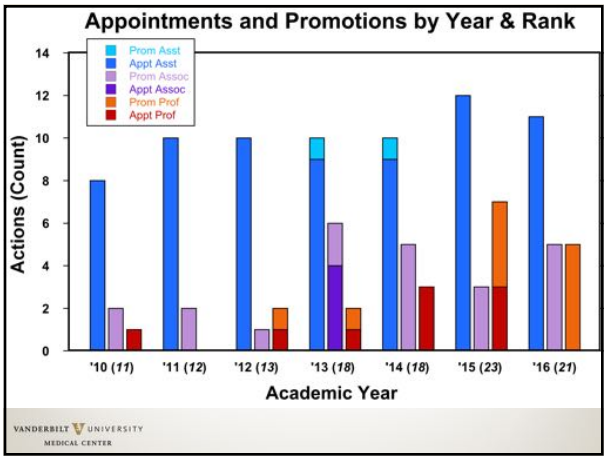

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Department's 10-yr Academic Trajectory

	2004	2009	2014
Number of faculty	67	99	130
Assistant Professors	64%	52%	61%
Average clinical salary (percentile AAMC)	~75th	~75th	~70th
Avg. non-clinical days per clinical faculty	66	53	57
Publications (all faculty)	~45	~95	149
NIH grant funding (Dept PI only)	$3.3M	$2.4M	$4.3M
Extramural funding to clinician-scientists	$0.4M	$0.6M	$2.7M
National Academic Leadership roles	A few	Some	Many
External Presentations	Some	~80	222
AAA points (all clinical faculty)	n/a	52,611	135,681

* Kevin Strange, PhD had ~$1.5M (2004) & ~$1M (2009) in NIH grants; He left in late 2009

Your Leadership Plan

- Depends on a few things:
  - Available talent
    - internal vs external
  - Resources
  - Your commitment level to the development work
  - Your appetite for conflict vs avoidance
  - The state of the department
    - destination? challenge? something between?
- Have a process to recruit; embrace turnover

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Leader Phenotypes

- Just passing through
- This is my dream job and I want to do it for a decade while grooming a successor
- The young gun
- Retired in place
- 'For love of the game' candidates
- Combinations

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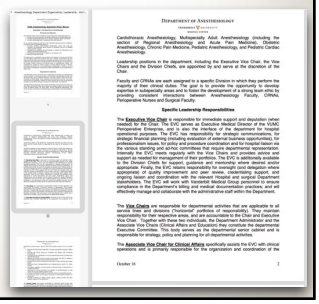
Leader Job Descriptions

- Important documents - the spirit is at least as important as the details
- Set out the basic scopes
- Define relationships, responsibility & authority
- Leave room for discretion!

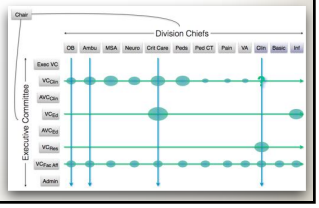


Commit to Delegation

- Quantity
- Time
- Resources

Leader Performance Assessment

- Division Chiefs: Are you making substantive advances on all the missions?
- Vice Chairs: Are all the Divisions advancing in your portfolio area?
- Mutually reinforcing collaboration at nodes?
- Are we working well together?
- Advancing into leadership?



Potential Granular Metrics

- O/E ASA units (& wRVU) per FTE per Day
  - [clinical days] vs [all days]
  - Expected = prior year

VS.

- O/E Academic Achievement Award points per FTE per year
  - Expected = prior year

Potential Granular Metrics

- Promotions per FTE per year

VS.

- RMS error on clinical days worked
  - RMS: square root of the mean of $[(\text{planned}) - (\text{actual})]^2$ clinical days; smaller is better

Potential Granular Metrics

- O/E % of academic time funded by (any) extramural source
  - Expected = prior year

VS.

- O/E potential grateful patient referrals per FTE per year
  - Expected = prior year

Potential Granular Metrics

- O/E FCOTS
  - Expected = prior year

VS.

- Quality metrics: e.g % observed hand hygiene opportunities taken

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Alternative:

- Continually assess the big picture:
  - is the team working well together?
  - are they moving toward the goals?
- Are the big goals being achieved?
  - takes constant coaching effort and attention
  - sometimes takes professional coaching
  - takes a long view (years)
- Requires independent leaders

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Summary

- Diagnose your model: (i) Strong Vice Chair, (ii) Strong Division Chief or (iii) matrix
- Plan to change?
- Leadership is important - curate your bus (Collins)
- Cultivate cult-like culture to help with bus curation (Collins)
- Are metrics right for your style?
- Always be re-evaluating whether your structure and team are right for the times

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Department of Anesthesiology

VANDERBILT UNIVERSITY
MEDICAL CENTER

Compassionate | Creative | Committed | Collaborative

VANDERBILT UNIVERSITY MEDICAL CENTER

Risk of Getting it Wrong:

- Leaders carry your brand
  - Can come to be seen as:
    - over-resourced 'Suits'
    - checked out
    - self serving
    - don't appreciate the faculty experience

VANDERBILT UNIVERSITY School of Medicine

HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

Lessons Learned from Mergers of Community Practices With an Academic Department

Andrew B. Leibowitz, MD

11/03/2017
4:10pm – 4:30pm

Lessons learned from mergers of community practices with an AMC

Andrew B. Leibowitz, MD
System Chair of Anesthesiology
Mount Sinai Health System
Professor of Anesthesiology, Perioperative and Pain Medicine, and Surgery
Icahn School of Medicine at Mount Sinai

SAAAPM Meeting November 2017

http://saaahq.org/meetings/faculty-portal

Mount Sinai

Lessons learned from acquisition of community practices by an AMC

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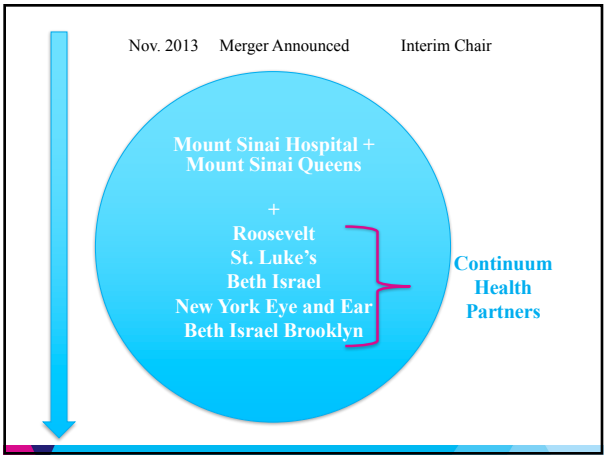
Mount Sinai

Mount Sinai Health System

1. 2nd or 3rd largest employer in NYS (> 38,000 employees)
2. Accounts for ≈ 30% of the hospital discharges in Manhattan
3. Controls 7 distinct hospitals, soon to add an 8th
4. One medical school
5. > 200 distinct GME programs (9 in Anesthesiology)
6. #2 in NIH $/PI and #3 $/ ft²
7. Compete with NYU, Columbia and Cornell on same island
8. Also compete with Einstein/Montefiore, SUNY-Downstate, Northwell-Hofstra (#1 employer in NYS), New York Med all in < 25 mile radius

Department of Anesthesiology, Perioperative and Pain Medicine

1. Highest departmental clinical revenue
2. Lowest departmental hospital/school support (<1% of total)
3. Cover 4 hospitals
4. Staff ≈ 85-95 sites at the beginning of everyday
5. 98,000 total / 2500 cardiac / 11000 L+D cases /year
6. Budget > $95M / year
7. 125 faculty, 170 housestaff (2 core residency programs, 7 ACGME approved fellowships), only 25 CRNAs (many paid directly from clinical revenue)



Mount Sinai Health System, Hospitals, School, Department Overview

Mount Sinai Health System

- **Mount Sinai Hospital**
  Main AMC
- **Mount Sinai West**
  formerly known as Roosevelt Hospital
  Secondary AMC
- **Mount Sinai St. Luke's**
  linked to Mount Sinai West
- **Mount Sinai Beth Israel**
- **New York Eye and Ear Infirmary at Mount Sinai**
- **Mount Sinai Brooklyn**
  non-academic community hospital
- **Mount Sinai Queens**
  non-academic community hospital

Icahn School of Medicine at Mount Sinai

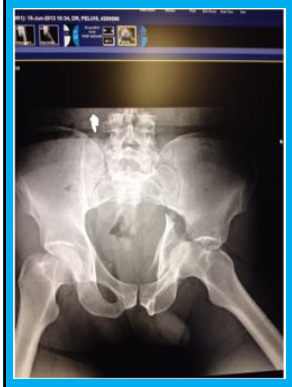
Department of Anesthesiology
Mount Sinai Health System

System Chair and Mount Sinai Chair
Andrew Leibowitz, MD

St. Luke's Roosevelt Chair
Meg Rosenblatt, MD

Mount Sinai Queens Chair
Yulia Shustorovich, MD

Affiliated Chairs of non-incorporated Departments



Nov. 2013	Merger Announced	Interim Chair
Feb. 2014	Chair	Begin merger process with MSW + MSSL
Nov. 2014	Merge with MSW + MSSL	
Feb. 2015	Begin merger process with MSBI	
Nov. 2015	Begin **de**-merger process with MSBI	**PAINFUL**
CY 2016	98,000 Anesthetics 170 housestaff	125 Faculty 4 hospitals
Nov. 2017	SAAA Presentation	

Why merge?

- **Bigger = Better**
- **Economy of scale**
- **Weaker + stronger = Strongest**
- **Better negotiating power with insurers and vendors (e.g., rates, billing services, IT)**
- **Standardization of services**
  - **People**
  - **Equipment**
  - **Pharmacy**
  - **Policy/procedure**
- **Population Health / VBP /Capitation**
- **Larger research and training platform**
- **Diversification smooths out the bumps**

Why not merge?

- **Bigger = more headaches – multiplier effect, e.g., unions**
- **Economy of scale at a certain size do not exist**
- **Weaker + stronger ≈ mean??**
- **Better negotiating power with insurers and vendors (e.g., billing), but could be anti-trust violation (DOH, FTC) and they need you → you need them**
- **Standardization of services**
  - **People…but they may not like this**
  - **Equipment… on different life cycles and local favorites**
  - **Pharmacy this may be the easiest win-win**
  - **Policy/procedure more difficult than appears**
- **Population Health / VBP /Capitation - with Trump??**
- **Larger research and training platform – can be unwieldy**
- **Diversification may require new skillsets**

Types of mergers

1. New signage - superficial
2. Central HR, credentialing, etc
3. Synch policy + procedure
4. True merger – everything
   a) centralized administrative effort without duplication
   b) hiring, recruitment and retention
   c) credentialing and privileging – hospital and insurers
   d) payroll
   e) compensation plan
   f) share "roaming" faculty – positives and negatives
   g) culture

When to merge a Department?

Read the contracts, don't trust lawyers

- When does it expire?
- What is the notification process?
- Is there a need for "cause" clause?
- Does a hospital subsidy exist? Will one?
- Is the Anesthesiologist's insurance occurrence based?

January 1 is business-wise easiest, no FICA, common medical benefits cycle and other issues

July 1 is best opportunity to recruit new faculty

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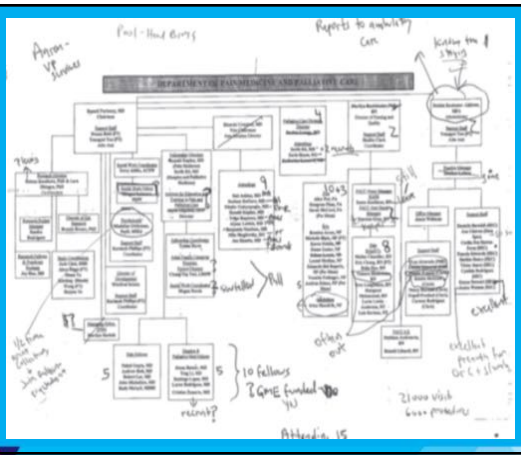
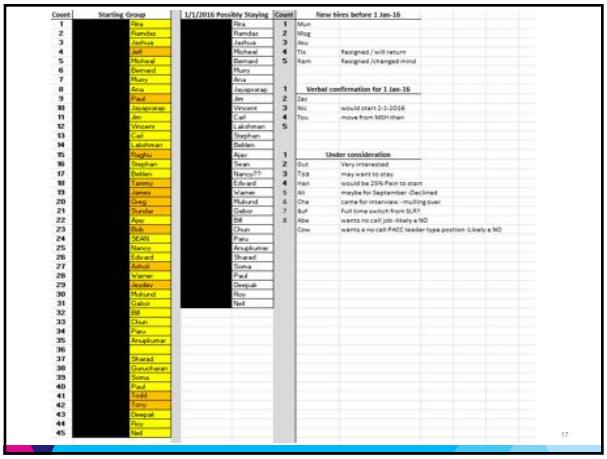
Approach – 1st things 1st

1. Go to ground – look, see, meet, greet, eat
2. Dissect the current table of organization
3. Interview nursing, housestaff, surgeons – find out the good, the bad and the ugly
4. Interview EVERY faculty member
   1. CV
   2. W-2
   3. malpractice hx
   4. opinion of co-faculty (e.g., who is a potential leader, who do they ask to care for their significant others, etc.)



Approach – nitty gritty details

1. Financial due diligence – main approaches:
   a) Review practice details with current practice and current biller – not so easy, you are unwelcome
   b) With W-2s in hand easy to determine faculty costs
   c) Do a mock 2 month simulation with your current biller using hospital OR data in real time
      a) Determine likely run rate
      b) A/R gap calculation is key
2. Have HR handout, call in #, face to face contact with new potential hires – <u>everyone</u> is most worried about a Δ in benefits



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Who should I hire from the existing practice?

- Everyone – being nice will pay off, fewer headaches-known quantity
- No one - I do not recommend this approach
- Cement key rain makers – almost no choice here
- Do you have a choice? - if too few persons stay what are my chances of recruiting up to practice's needs?

Inability to cover locations = most obvious of failures

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MSW/MSSL merger timeline

Feb. 2014	34 FTEs Begin merger process with MSW + MSSL
June 2014	5 resignations - ↓ to 29 FTEs, but OR volume ↓ too. Identified IT needs for $650K upgrade.
July 2014	Hired new PD + identified 4 Faculty I did not want. ↓'ed Faculty count to **26 (a problem in waiting)**
Aug. 2014	Identified a new Chair + 1 Faculty member from MSH + 3 graduates hired. Have 31 FTEs!
Nov. 2014	Go live with 29 FTEs with 2 last minute no shows.
CY 2015	~ 26,000 Anesthetics ACGME approval + margin
CY 2016	nearly 31,000 Anesthetics best match ever + margin

MSW/MSSL merger – 3 years later

- Success!!
- 1 of only 2 practices fully merged
- 1 of only 2 practices with a net + margin realized from merged sites
- Only practice without hospital support from merged sites
- New programs in Pain, Cardiac, Endoscopy
- Improved training program – all US grads
- Robust PI process

A tale of 2 sites

MSW/MSSL ≈ 34 faculty	MSBI ≈ 44 faculty
academic	private practice
private corporation – 1 owner	private corporation shares
individuals with W2s	individuals-their own corporations
trusting in nature	suspicious anti-AMC mentality
familiar EMR	paper records
losing huge $ - sense of turnaround	losing huge $ - bad physical plant

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BI Integration Meeting August 13, 2015

Problems with current group's coverage model:

- Mount Sinai Health System does not want to employ large private physician corporations to supply services within the system
- Group provides/provided no Pain coverage, no preoperative assessment, no postoperative assessment, no floor or ER emergency services (e.g., intubation, ACLS)
- Group had no Echo certified MDs – a standard for Cardiac Anesthesiology
- Group routinely has members working > 24 hours in a row

How many Anesthesiologists will be required at a minimum to start?

Daily:

Petrie locations	18
Radiology	1
OB (if have CRNAs)	1
Endo	4
ECT and /or EPS minimum	1
PACC	7
BI Cancer Center West	1 (if consolidate to 1 room)

Call / Not covering patients 1:1:

Off from prior nights work	2 (main OR and OB)
Off for following nights work	2 (main OR and OB)
Supervisor/coordinator	1
Float (sick, jury duty, maternity)	1
Subtotal	**39**
Vacation / CME (subtotal x 6/52)	4.5
Total:	**44**

How much will this cost (very gross estimates):

AAMC 75%'ile is $409K/year without NYC 20% "bump"	
44 x $409 =	$18 M
Fringe @ 30% (@ official base of ~ $125K)	$1.6 M
Malpractice @ $12,500 per	$.6 M
Dues, License, CME @ $2500 per	$.11M
Administration (lean model)	$.5M
Miscellaneous	$.2M
Total:	**$21 M**

Paper charting/billing

Predicted days in A/R >70

Maybe zero $ for 6-8 weeks

Needed 2-3 months $ support at beginning of fiscal year = $5M!

Summary

Don't believe anyone -
everyone thinks they have the best MDs, the best contracts, the most efficient organization

Luck favors the prepared mind – details matter

What you don't know will hurt you

It ain't over 'til it's over (Yogi Berra)

Good people may be replaceable, but you don't want to have to find out

Sometimes $ talk, and everything else walks

Mount Sinai

HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

Defining Anesthesia Services in a Value-Based Era

Laureen L. Hill, MD, MBA

11/03/2017
4:30pm – 4:50pm

Defining Anesthesia Services in a Value-based Era

Laureen L. Hill, MD, MBA
SVP-COO NYP-Columbia
November 3, 2017
SAAA

Disclosures

- I have no conflicts of interest related to this presentation

Objectives

- Review current factors driving need for anesthesiology support
- Discuss approaches for hospital-based support of anesthesiology departments
- Examine a proposed model for defining value of anesthesiology-based services

The problem…

- Anesthesiology departments increasingly dependent on hospital support
- Current manpower, economic and legislative realities will increase that need
- Hospitals less able/willing to financially support academic missions
- Inadequate resources impact clinical care and patient safety

Status of the Anesthesia Workforce in 2011: Evolution During the Last Decade and Future Outlook

Armin Schubert, MD, MBA,* Gifford V. Eckhout, MD, MBA,† Anh L. Ngo, MD, MBA,†
Kevin K. Tremper, PhD, MD,§ and Mary D. Peterson, MD, MHA‖

Anesthesia Analgesia 2012; 115: 407-27

Table 1. Data Relating to Demand for Anesthesia Services: 2000 to 2010

	2000–3[a]	2004–6[a]	2007–8[a]	2009–10[a]
Anesthesiologist salary (US $)	317,481	364,758	410,658	423,657[n]
% change (versus prior year)	3.9	3.0	3.3	—
CRNA salary[r] (US $)	145,000	164,000	189,000	—
% change (versus prior year)	NA	5.1	2.2	—
Hospital operating rooms	29,735	30,830	31,721	32,290
Medicare-certified surgery centers[d]	9620	12,220	13,452	NA
Surgery center operating rooms[d]	9620	12,220	13,452	NA
No. of active surgeons[e]	127,100	133,796	135,854	127,100
Estimated demand growth[f]	1.5%–2.0%	1.5%	0.5%–1.0%	0
Medicare case mix index[g]	1.0	1.17	1.19	—
Median ASA units/anesthesiologist/year[n]	—	11,394	11,202	12,575[o]
Median no. of cases/anesthesiologist/year[n]	1021	1007[r]	851	—

Number operating rooms, CMI, salaries and productivity increasing over time….

Status of the Anesthesia Workforce in 2011: Evolution During the Last Decade and Future Outlook

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Anesthesia Analgesia 2012; 115: 407-27

Table 2a. Growth of Median Anesthesiologist Income in the United States, 1999–2009

Year (data)[a]	Private sector median income (MGMA)[b]	%Δ[c]	Academic median income (MGMA)	%Δ[c]	Merritt Hawkins[d]	%Δ[c]	Academic institutional support[e]	%Δ[c]
1999	244,091	—	176,156	—	—	—	—	—
2000	279,977	14.7	194,375	10.3	—	—	34,300	—
2001	281,963	0.7	198,413	2.1	278,000	—	—	—
2002	305,676	8.4	—	—	290,000	4.3	60,000	75[f]
2003	317,481	3.9	220,144	11.0[f]	300,000	3.4	86,000	43
2004	321,686	1.3	240,489	9.2	303,000	1.0	98,000	14
2005	354,241	10.1	241,455	0.4	306,000	1.0	116,000	18
2006	364,758	3.0	267,881	10.9	300,000	−2.0	120,000	3
2007	398,925	9.4	285,618	6.6	336,000	12.0	126,000	5
2008	410,658	2.9	276,045	−3.3	344,000	3.6	136,000	8
2009	423,657	3.2	299,802	?	331,000	−2.0	159,000	17
2010	404,996	−4.4	?	?			166,000	4

Institutional support increasing over time……

Professional Staffing Practice of Academic Anesthesia Departments in the United States

Steven Ginsberg[1], Jonathan Kraidin[1], Christopher Gallagher[1], Don R. Hoover[2], Alann Solina[1]

Table 4. Staffing related problems.

Staffing Issues	N	%
The average % of clinical assignments that are performed by a faculty member alone	60	11.25
% of institutions indicating that inadequate clinical staffing affects their ability to provide adequate faculty non-clinical time	62	74.2
% of institutions indicating that inadequate clinical staffing affects their ability to provide maximal resident educational experience	62	48.39
% of institutions indicating that inadequate staffing creates situations where patient safety is compromised secondary to suboptimal supervisory ratios	62	32.26
% of institutions indicating that inadequate staffing creates obstacles to providing vacation time for faculty	62	38.71
% of institutions reporting that they occasionally supervise 3 simultaneous anesthesia sites	60	7
% of institutions reporting that they only supervise one clinical site at a time	60	1.7

Open Journal of Anesthesiology 2013

System in crisis…….

The Consequences: Hospital Relationship

- Dependence on hospital support erodes department autonomy
  - staffing patterns, resident workforce, service /site choices i.e. preop clinic
- Hospital focus on clinical service and costs
  - Lack of clarity around financial drivers (call, remotes, OR block policies)
  - Lack of aligned interest in academic missions
  - Poor understanding of opportunity in leveraging anesthesiologist expertise
- Negotiations may be difficult and strain relationship
  - Hospital emphasis on *support* rather than *contributions*
- Stigma of "charity"
- Competition from external groups offering economies of scale

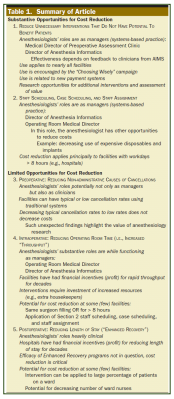


Table 1. Summary of Article

Substantive Opportunities for Cost Reduction

1. Reduce Unnecessary Interventions That Do Not Have Potential To Benefit Patients
   Anesthesiologists' roles are as managers (systems-based practice):
   Medical Director of Preoperative Assessment Clinic
   Director of Anesthesia Informatics
   Effectiveness depends on feedback to clinicians from AIMS
   Use applies to nearly all facilities
   Use is encouraged by the "Choosing Wisely" campaign
   Use is related to new payment systems
   Research opportunities for additional interventions and assessment of value
2. Staff Assignments, Case Scheduling, and Shift Assignment
   Anesthesiologists' roles are as managers (systems-based practice):
   Director of Anesthesia Information
   Operating Room Medical Director
   In this role, the anesthesiologist has other opportunities to reduce costs
   Example: decreasing use of expensive disposables and implants
   Cost reduction applies principally to facilities with workdays < 8 hours (e.g., hospitals)

Limited Opportunities for Cost Reduction

3. Preoperative: Reducing Nonadministrative Causes of Cancellations
   Anesthesiologists' roles potentially not only as managers but also as clinicians
   Facilities can have typical or low cancellation rates using traditional systems
   Decreasing typical cancellation rates to low rates does not decrease costs
   Such unexpected findings highlight the value of anesthesiology research
4. Intraoperative: Reducing Operating Room Time (i.e., Increased "Throughput")
   Anesthesiologists' substantive roles are while functioning as managers:
   Operating Room Medical Director
   Director of Anesthesia Informatics
   Facilities have had financial incentives (profit) for rapid throughput for decades
   Interventions require investment of increased resources (e.g., extra housekeepers)
   Potential for cost reduction at some (few) facilities:
   Same surgeon filling OR for > 8 hours
   Application of Section 2 staff scheduling, case scheduling, and staff assignment
5. Postoperative: Reducing Length of Stay ("Enhanced Recovery")
   Anesthesiologists' roles heavily clinical
   Hospitals have had financial incentives (profit) for reducing length of stay for decades
   Efficacy of Enhanced Recovery programs not in question, cost reduction is critical
   Potential for cost reduction at some (few) facilities:
   Intervention can be applied to large percentage of patients on a ward
   Potential for decreasing number of ward nurses

Strategies for Net Cost Reductions with the Expanded Role and Expertise of Anesthesiologist in the Perioperative Surgical Home

Dexter F et al Anesth Analg 2014; 118:1062-1071

Acad Med. 2012 Mar;87(3):348-55. doi: 10.1097/ACM.0b013e31824c36e.

Perspective: Hospital support for anesthesiology departments: aligning incentives and improving productivity.

Hill LL[1], Evers AS

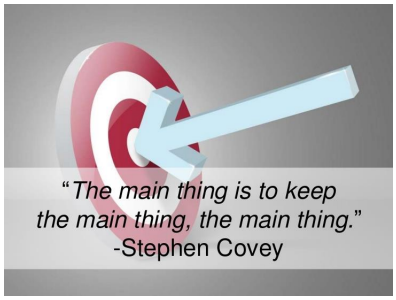
A. "Availability" services…….manpower intensive with inadequate revenue opportunities to cover costs
   (On-call teams, Pre-op / PACU, Directorships, OB…)

B. "Productivity" services…….can be managed for high efficiency
   (Elective OR locations, High case-density sites i.e. GI endoscopy)

C. "Remote" services…….anesthetizing locations that may have low case density and are inherently inefficient but may be necessary
   (Interventional radiology, cath lab, EP lab…)

SAAA Salary and Practice Survey…are these comparisons helpful?

- Compensation by rank
- Number of FTEs, part-time FTEs and academic FTEs
- Number of positions to be filled by subspecialty
- Number of residents in the program
- Amount of weekend call
- Number of CRNAs (does not specify CAAs)
- Pain RVUS generated and number of clinic sessions
- ICU covered by faculty and trainees
- Faculty and resident assignments by specialty each day
- Patients seen in preop clinic by provider type



C suite objectives….their “main thing”

Proposed survey measures

- What does your department produce?
  - Takes into account staffing ratios, scheduling density, OR utilization…
  - Recommend separate analysis each for OR, CCM and Pain services
- What does it cost your department to produce it?
  - Takes into account resident numbers, staffing ratios, compensation, NC time
  - Can include overhead, admin costs, preop, PACU, etc.
  - Helpful to split out call (availability) costs as “cost of doing business”
- Likely not useful to benchmark nationally due to unique local factors

OR Rack report template

Units
Base Units
Qualified Units
Time Units
Total Units
Expense
Cash Compensation
Physicians
Base
Variable
Anesthetists
Benefits
Malpractice
Assessment /Overhead
Other Operating
Total Operating Expenses
Total Operating Expenses less Call
Total FTEs
Total FTEs w/o Call, PACU, & Pre-Op
Call FTEs
PACU/Pre-Op FTEs
Anesthetist FTEs
Total Units/Physician FTE
~Units/MD FTE w/o PACU/Pre-op/Call
Physician Comp/FTE
Base/FTE
Variable/FTE
Anesthetist Comp/FTE
Physician Comp/Total Unit
Base Comp/Total Unit
Var Comp/Total Unit
Call Expense
Practice Expense/Total Unit

- Used to track year over year operating expenses
- Productivity data used to support comp and hiring
- Base/variable itemization used to target 80/20% ratio
- Administrative costs itemized separately for practice
- Call expenses include pre and post-call time
- Preop and PACU FTEs may be listed separately
- Useful to compare academic and private groups

Discussion

- Is this approach generalizable?
- Is this approach helpful for hospital negotiation?
- Could/should this be used for benchmarking externally?
- What details are missing?

HANDOUT

AACPD
ASSOCIATION OF ANESTHESIOLOGY CORE PROGRAM DIRECTORS

Physician Wellness, Moving Beyond the Burnout Conversation

Greg Ozark, MD, FAAP, FACP

11/03/2017
8:00am – 8:25am

LOYOLA UNIVERSITY HEALTH SYSTEM

Physician Wellness

Moving Beyond the Burnout Conversation

SAAAPM November 3, 2017

A MEMBER OF TRINITY HEALTH

Disclosures

- None

A MEMBER OF TRINITY HEALTH

Introduction

- NOT an Anesthesiologist
  - Internal Medicine-Pediatrics
- Recovering Program Director (1999-2014)
- VP & Assistant Dean Graduate Medical Education (*est*. 2014)
- Burnout/ Resiliency interest

A MEMBER OF TRINITY HEALTH

Objectives

- To review the new 2017 ACGME Common Program Requirements as they pertain to Well-Being
- To define and relate the concepts of “burnout”, “stress” and “resiliency”
- To understand the scope of burnout amongst physicians and know who is at risk
- To offer some considerations to implementing well-being into your department and training programs
- To encourage dialogue about well-being with your colleagues and trainees

A MEMBER OF TRINITY HEALTH

Section VI. C Well-Being

THE 2017 ACGME COMMON PROGRAM REQUIREMENTS (CPR)

A MEMBER OF TRINITY HEALTH

VI. The Learning and Working Environment

- *Residency education must occur in the context of a learning and working environment that emphasizes the following principles:*
  - …., and
  - ***Commitment to the well-being of the students, residents, faculty members, and all members of the health care team***

A MEMBER OF TRINITY HEALTH

ACGME CPR:
VI.C. Well-Being

- *In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Programs, in partnership with their Sponsoring Institutions, have the* ***same responsibility to address well-being as they do to evaluate other aspects of resident competence.***

ACGME CPR:
VI.C. Well-Being

- VI.C.1. *This responsibility must include:*
  - *efforts to enhance the* ***meaning*** *that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)*
  - *attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)*

ACGME CPR:
VI.C. Well-Being

- *policies and programs that encourage* ***optimal resident and faculty member well-being****; and, (Core)*
  - *Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)*
- *attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care*

ACGME CPR:
VI.C. Well-Being

- *…The program, in partnership with its Sponsoring Institution, must: (Core)*
  - *encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core)*
  - *provide access to appropriate tools for self-screening; and, (Core)*
  - *provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)*

Common Program Requirements

Accreditation Council for Graduate Medical Education

SAAAPM November 3, 2017

THE BURNOUT OF TALKING ABOUT BURNOUT

LOYOLA UNIVERSITY HEALTH SYSTEM

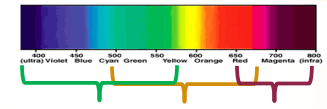
Stress is good…

to a point

Stress ≠ Burnout

- Stress
  - Over-engaged
  - Over-reactive emotions
  - Produces urgency and hyperactivity
  - Loss of energy
  - Leads to anxiety
  - Primary damage is physical
  - May kill you prematurely
- Burnout
  - Disengagement
  - Emotions are blunted
  - Produces helplessness and hopelessness
  - Loss of motivation, ideals, hope
  - Leads to detachment/ depression
  - Primary damage is emotional
  - May make life seem not worth living

Spectrum of Physician Resiliency



Engaged, Satisfied

Stress

Overwhelmed

Dissatisfied

Unengaged

Burnout

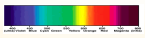
Burnout is…

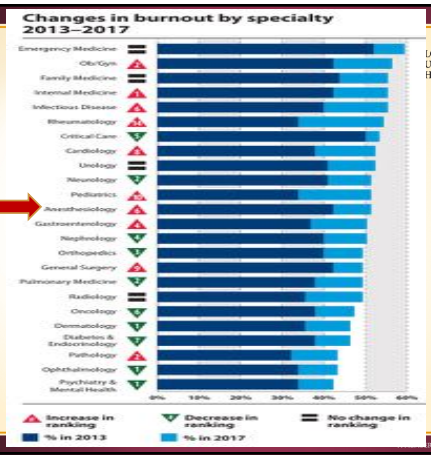
- **Emotional exhaustion**
  - feelings of being emotionally overextended and exhausted by one's work
- **Depersonalization**
  - unfeeling and impersonal response toward recipients of one's service, care treatment, or instruction
- **Decreased feelings of personal accomplishment**
  - lack of feelings of competence and successful achievement in one's work

Maslach, 1997

Burnout…

- is the index of the dissociation between what people *are* and what they *have to do*
- represents an erosion in values, dignity, spirit and will
- can lead to a spiral of chronic exhaustion, cynicism, and feelings of ineffectiveness
- True "burnout" can be an medical emergency.





Parks, AMA Wire, January 31, 2017

LOYOLA UNIVERSITY HEALTH SYSTEM

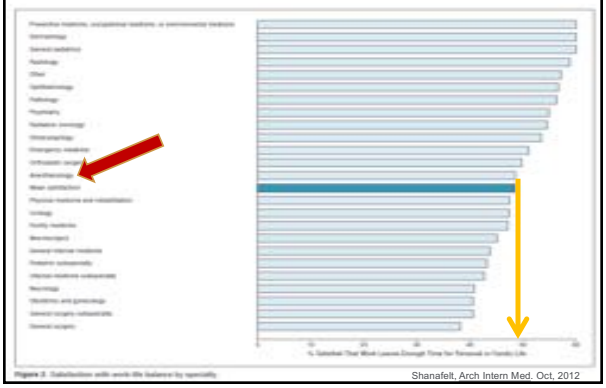
Comparison of Medical Student, Resident/Fellow, and Early Career Physician (≤ 5 Years in Practice) Respondents to a Survey About Burnout and Distress With Probability-Based, Age-Matched Samples of U.S. College Graduates, 2011-2012

Characteristic	Medical students, ages 22-32 (n = 4,333)	Population, college graduates, ages 22-32 (n = 739)	P value	Residents/ fellows, ages 27-40 (n = 1,489)	Population, college graduates, ages 27-40 (n = 992)	P value	Early career physicians, ages 27-47 (n = 908)	Population, employed, ages 27-47 (n = 1,832)	P value
Burnout index, no. (%)[a]									
Emotional exhaustion high score	1,647 (41.1)	511 (31.8)	<.0001	557 (37.6)	260 (26.4)	<.0001	243 (30.5)	462 (25.3)	.03
Depersonalization high score	1,084 (27.2)	297 (18.5)	<.0001	528 (35.7)	164 (16.6)	<.0001	181 (22.6)	302 (16.6)	<.001
Burned out	1,976 (49.6)	573 (35.7)	<.0001	739 (50.0)	310 (31.4)	<.0001	297 (37.3)	545 (29.9)	<.001
Screened positive for depression, no. (%)	2,337 (58.0)	761 (47.5)	<.0001	753 (50.7)	406 (41.1)	<.0001	319 (39.9)	801 (43.9)	.06
Suicidal ideation in the last 12 months, no. (%)	375 (9.3)	171 (10.6)	.25	120 (8.1)	86 (8.7)	.58	53 (6.6)	132 (7.2)	.55

Dyrbye, Acad Medicine, Jan 2014

A MEMBER OF TRINITY HEALTH

Satisfaction with Work/ Life Balance



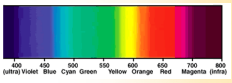
Shanafelt, Arch Intern Med. Oct, 2012

Why are physicians at such risk or burnout?

- The Environment
  - Productivity driven
  - Cog in a wheel
  - 24/7 access and demands
  - High stakes
  - Competitive
- The Person
  - Driven
  - Goal directed
  - Not self-forgiving
  - Trained to be independent and not ask for help
  - "M.D." is *what we are*, not what we do.

Burnout Realities

- 50% of your peers are NOT "burned out"
  - There is burnout about talking about burnout
  - This is a spectrum
- It is a complicated discussion
  - But, it is a worthwhile one



Physician Well-being Program

STARTING THE PROCESS

Principles of Wellness and Burnout Prevention

- Reflection
  - Maintaining alignment consistent with your values and ideals
  - Taking time to assess where you are/ where you are going
- Humanism
  - Taking time to connect with each person
  - Self- reflection and evaluation
  - Maintaining balance/ establishing boundaries
- Mindfulness
  - slowing down, being in the moment
  - understanding importance of each interaction

Creating a Resiliency Program

- Leadership Engagement (!)
- Open discussions on defining the issues (specific)
  - Venting (some)
  - Problem solving
  - Communication and Engagement
- Create a "Physician Resiliency Group"
  - Choose members carefully
    - Time capacity
    - Emotional Intelligence
  - Direct Resiliency group focus
  - Give them the tools they need

Establish Safety Nets

- Employee Assistance Program
- Psychiatry/ Psychology resources
- Offering Coaches
- Know your Policies
  - HR policies
    - absences
    - medical leaves
  - Understand your Hospital and GME policies
    - Fit for Duty
    - Probation
      - milestones
    - Progressive Disciplinary Action

Prepare for Difficult Conversations

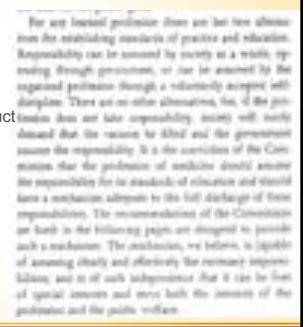
- Fit for Duty
- Medical Leaves
- Interventions for Professionalism Lapses
  - Conversations
  - Discipline
  - Remediation
  - Termination
- Confidentiality
- Future work application disclosures
  - State variance
  - Legal input

Offering Options and Enforcing the Effort

- Education on Stress, Burnout, and Resiliency
- Resiliency related options
  - Pragmatic vs "fluffy"
    - Benefits of both
  - Educational material covering the "Mindfulness Spectrum"
    - Books
      - *Attending*, Ronald Epstein, M.D.
      - *Peak Performance*, Brad Stulberg and Steve Magness
    - Lectures/ small group discussions
- ACGME CLER visit emphasis can focus leadership

The Medical Community: Doomed to not learn from history?

- 1966 Millis report of the AMA
- 1965 Coggeshal report of AAMC
  - urged universities to assume control of the content and conduct of **all** of medical education.
- Lessons (not) learned
  - Supervision
  - Duty Hours
  - Burnout and self-care



Can we save ourselves from ourselves?

- The Individual
  - Can we see ourselves at risk?
  - Do we recognize our pathology?
    - Motivated
    - Driven
    - Over achieving
    - Competitive
    - Goal Oriented
  - Can we recognize the symptoms?
  - Can we practice self-care?
  - Can we set and maintain boundaries?
- The Profession
  - Can we recognize and support those struggling?
  - Can we lead by example?
  - Can we encourage/ develop resiliency behavior?
  - Can we listen to and understand our teams?
  - Can we make some real changes?

HANDOUT

AACPD
ASSOCIATION OF ANESTHESIOLOGY CORE PROGRAM DIRECTORS

Quality and Safety

Daniel Rubin, MD

11/03/2017
8:25am – 8:50am

Quality/Safety and the new ACGME Common Program Requirements

(There are a lot of them)

Daniel Rubin M.D.
Assistant Professor
Associate Quality Chief
Department of Anesthesia and Critical Care
University of Chicago

I HAVE financial disclosures

- I am the president of DRDR Mobile Health
  - Create/license mobile healthcare applications at the University of Chicago
- Incident:
  - Mobile Adverse Event Reporting Application
  - I WILL discuss the use of Incident at the U of C
- UCAIR
  - University of Chicago BSD adverse event reporting application for Lab/General Safety incidents and near-miss
  - I will NOT discuss the use of UCAIR
- Step Test
  - Mobile application that reports activity recorded by an iOS device to evaluate perioperative functional status
  - I will NOT discuss the use of Step Test

Objectives

- 1. Analyze the new ACGME core program requirements for patient safety and quality improvement.
- 2. Identify methods to increase resident engagement in patient safety reporting and safety culture.
- 3. Develop strategies for collecting representative quality metrics and benchmarks to provide feedback for residents and faculty.

Outline

- Two very helpful online resources
- The two old requirements
- Ten new requirements were added
  - You have till 2019 to implement most of them
- Discuss strategies for implementing these requirements
  - Patient Safety
    - "Structure" of a culture of safety
    - Adverse Event Reporting/Safety reports
    - Root cause analysis
    - Disclosure of adverse events
  - Quality Improvement
    - QI metrics
    - Report cards
    - Resident driven QI projects
    - Health care disparities
- Questions

These two organizations have a number of helpful resources for patients safety and quality improvement

- Institute for Healthcare Improvement (IHI)
  - ihi.org
  - Online courses/curriculum for both patients safety and QI
    - Offers both free classes and a subscription service
    - Classes involve an online module/content with video case reports
    - Subscription service for residents costs ($500), I believe
  - Provide post-tests and a certificate after completion
- Agency for Healthcare Research and Quality (AHRQ)
  - Ahrq.gov
  - Online material provided, but not online courses
    - Provide the content in PDF/Power point slides, but not a formal "course"
  - Safety culture survey
- Many of the requirements can likely be satisfied with online resources from these websites

Previously there were two limited and non-specific requirements for patient safety and quality improvement

- The program must be committed to and responsible for promoting patient safety and resident well being in a supportive educational environment
- The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

Ten new requirements were added to common program requirements Section VI

(virtually all aren't citable until **2019**)

1. Structure that promotes safe care/culture of safety
   Participating in patient safety programs: holdover from previous requirements*
2. Reporting [know reporting responsibilities/how to report]*
3. Provide summary information of institutions patient safety reports
4. Formal educational activities that promote safety related goals, tools and techniques
5. Resident Participation in real/simulated root cause analysis
6. Education on disclosure of adverse events and participation
7. Data on quality metrics in resident patient population
8. Training/experience in QI processes, including health care disparities
9. Participate in interprofessional QI
10. Activities aimed at reducing health care disparities

*=Subject to citation in July 2017

https://www.acgmecommon.org/2017_requirements

1. Programs must establish a culture of safety

- The program, its faculty, residents, and fellows **must** actively participate in patient safety systems and contribute to a culture of safety
- The program **must** have a *structure* that promotes safe, interprofessional, team-based care.
- Taken together they want programs to develop a culture of safety
- But how does one build a *structure* that promotes a culture of safety?

A minimum of five aspects are involved in creating a "structure" that promotes patient safety

- Five* key aspects to developing a safety culture
- Measurement of departmental/institutional safety culture
  - Identify strengths/weaknesses and changes over time
- Leadership engagement
  - Departmental/hospital leadership need to take ownership
- Reporting adverse/patient safety events
  - Helps to identify gaps in safety
- Feedback/Education: Learn lessons from mistakes
  - Feedback lessons learned
- "Blame free" culture
  - Everyone needs to be able to admit mistakes/errors

* Thanks to Thomas R. Chidester

Measuring safety culture identifies the current state of a department

- Safety attitudes and safety climate questionnaire (SAQ)
  - www.med.uth.edu/chqs
  - No guidance for scoring OB or OR versions of the SAQ
- AHRQ
  - Two different survey types available
    - Hospital Survey on Patient Safety Culture
    - Ambulatory Surgery Center Survey on Patient Safety Culture
  - Neither are a perfect fit for anesthesia departments
  - Easily converted to survey monkey
- Identifies specific areas of strengths deficiencies of the institution/department
- Identifies baseline levels to track any changes over time

AHRQ Hospital survey measures 6 domains

- Likert Scale 1-5 [Strongly Disagree – Strongly Agree]
- Unit level variables
  - We have enough staff to handle to workload?
- Supervisor/Attending variables
  - My supervisor/manager seriously considers staff suggestions for improving patient safety?
- Communication
  - We are informed about errors that happen on this unit?
- Event reporting
  - When a mistake is made, but has *no potential to harm the patient*, how often is it reported?
- Hospital level variables
  - Important patient care information is often lost during shift changes?

Safety Culture in the Operating Room: Variability Among Perioperative Healthcare Workers

Marc Philip T. Pimentel, MD, MPH,†‡ Stephanie Choi, BA,† Karen Fiumara, PharmD, BCPS,‡ Allen Kachalia, MD, JD,†‡§ and Richard D. Urman, MD, MBA*†*

- AHRQ Hospital Survey on Patient Safety Culture
- Percent positive response:
  - Percentage of responses with a Likert score of 4 or 5
- Dimensions with the highest percent of positive scores
  - Teamwork within hospital units (69%)
  - Organizational learning and continuous improvement (57%)
- Lowest performance:
  - Feedback and communication about error (34%)
  - Hospital handoffs and transitions. (30%)
- Attending surgeons perceived the highest safety climate overall
  - Surgeon: 64%
  - Anesthesiologist: 47%
  - Nurses: 37%
  - Technologists: 37%

J Patient Saf 2017

Leadership must promote and engage its staff in patient safety

- Leadership sets the tone for safety in a department or unit
  - Determines the priorities of the departmental mission
- Allows for open discussion/collaboration
  - Encourage feedback, open discussion and value team members feedback
- Engage/encourage event reporting
  - Engage staff in identifying potential patient safety issues/concerns
  - Should actively encourage submitting reports

2. Residents **must** know their responsibilities in reporting patient safety events at the clinical site, **must** know how to report patient safety events, including near misses, at the clinical site

- Need a reporting infrastructure/how to report events
  - Hospital based vs. Departmental based
    - Departmental reporting may provide you with more relevant events
    - Residents may be reluctant to report system wide
    - Lack of coordinated response unless events are shared with hospital quality infrastructure
- Different methods of reporting
    - Paper list/E-mail/Web based site/Mobile Application
    - All work and have their own limitations
    - We deployed Incident mobile application in 2015
    - Increased resident participation in adverse event reporting
      - Resident monthly reporting rates went from 4.0±1.7 to 7.3±3.3 reports/months
      - It can be hard to type a lengthy report using a mobile device.
- Residents need to know what to report
  - To specific and reports may reflect what you tell residents to report
  - To vague and you may not get any reports
  - We don't explicitly specify what to report but we do give guidelines

Elucidating Reasons for Resident Underutilization of Electronic Adverse Event Reporting

Jonathan Hatoun, MD, MPH[1], Winnie Suen, MD, MSc[2,3], Constance Liu, MD[4], Sandy Shea, BA[5], Gregory Patts, MPH[6], Janice Weinberg, ScD[6], and Jessica Eng, MD, MS[7,8]

- Survey of residents at tertiary medical center (66% survey completion)
  - Surgery, Medicine, Hospital Based (Anesthesia, EM, Pathology, Radiology)
- Overall top barriers of reporting:
  - Not knowing what to report (50%)
  - Not knowing how to report (43%)
- Of residents involved in an adverse event only 43% actually reported an event
- Primary barriers to reporting for Medicine/Hospital Based Residents:
  - Not knowing what to report
  - Not knowing how to report
- Primary barriers to surgery residents reporting:
  - "I don't think the system will change as a result of my reporting"
  - The majority of surgery residents reported an event (61%)

Am J Med Qual 2016

An Assessment of an Educational Intervention on Resident Physician Attitudes, Knowledge, and Skills Related to Adverse Event Reporting

Barbara G. Jericho, MD
Rosalie F. Tassone, MD, MPH
Nikki M. Centomani, RN, BSN
Jennifer Clary, BA
Crescent Turner, RN, MS
Michael Sikora, MD
David Mayer, MD
Timothy McDonald, MD, JD

- Resident physicians don't report adverse events
  - <1% of adverse event reports came from residents at UIC
- Educational training and expectation of reporting
  - Educational intervention
    - Survey to identify baseline attitudes toward reporting
    - Understanding of errors and relation to ACGME core competencies
    - Methods of reporting and institutional response to a report
    - Expectation of event reporting
    - Case based lecture format
- Increase in adverse event reporting by residents
  - From 0 per quarter in prior years to 28 in last quarter of study
    - Average of 18 reports/quarter over the study period
  - Improved resident attitudes toward error disclosure

JGME, June. 2010

Need to provide individual and departmental feedback on reported events

- Individual feedback with members involved in the event
  - Insufficient feedback is a barrier to reporting
  - Associated with a static system: Why report if the system won't change!
  - We follow up individually after a report is submitted
- Departmental feedback
  - Our departmental M and M has two methods:
    - Quick Hits: quick mention of a number of safety issues reported through our adverse event reporting system
    - In depth: more extensive presentation for events exposing systems issues
  - Limitations
    - Attendance
    - Time constraints: Its only an hour long monthly conference
- Departmental Safety e-mail (I've always wanted to do this)
  - Send out an e-mail with safety events and analysis
  - Limitation would be the high time commitment

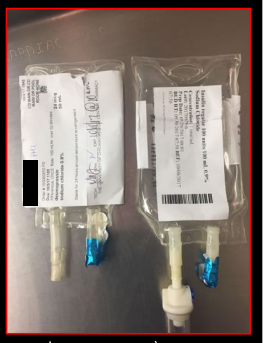
Medication Error: Medication Swap

- Patient Name: ####
- MRN: ####
- Date of event: 10/3/17, 1:39 PM

Description: Insulin infused instead of desmopressin. Bags look similar. 50 units infused mistakingly before noticing. No harm to patient. Blood glucose 250 after infusion.

Reported by: Resident

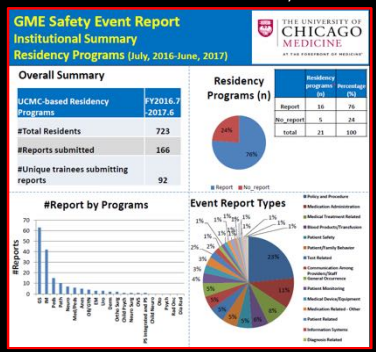
Submitted by Incident version 1.0 (14)



(This would be a quick hit in our department)

3. …**must** Be provided with summary information of their institution's patient safety reports. (This is a report from U of C GME Office)

This report contains:
1. Total number of reports
2. Reports by specialty
3. Total of individual residents submitting a report*
4. Types of events reported

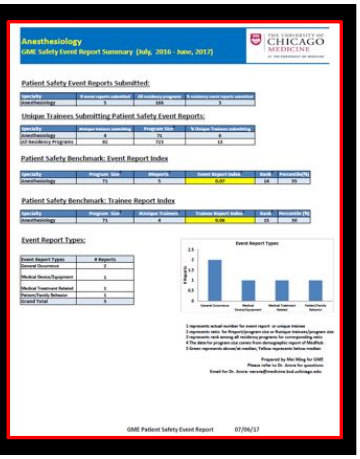


* If a resident submits a report it is not anonymous

They also provide departmental specific data on reporting.

Compares our residents against other residencies with:

Event Report Index
(# reports/program size)
Trainee Report Index
(# reporters/program size)



"Blame free" or "just culture"

- Blame free environment encourages reporting and discussion of safety concerns
  - If individuals will be reprimanded for reporting events, who will report?
  - Emphasizes a deficiency in the system and not the individual practitioner
  - However, some events are worthy of disciplinary action
    - Gross negligence or reckless behavior
- "Just culture" is now widely used to add some accountability
  - Focuses on identifying systems issues that lead to unsafe behavior
  - Holds individuals accountable for gross negligence or recklessness
- Reports submitted to an adverse event reporting system should not impact Clinical Competency
  - Exception: Gross negligence or Reckless behavior
  - Very important to maintain resident engagement in reporting

4. **Must** participate as team members in real/simulated interprofessional clinical patient safety activities, such as RCA or other activities that include analysis, as well as formulation and implementation of actions

- ACGME gives root causes analysis as an example
  - RCA's are the easiest activity to attend/simulate
  - IHI has an online course: PS 201
- Getting every resident to an RCA would be challenging
  - How educational is it if they were not a member of the care team?
  - RCA's are frequently held at the worse possible time for anesthesiologists: 9:00AM
- Simulated RCA's can be challenging to deploy for residents
  - Residents are not familiar with the process
  - Identifying causal factors can be difficult
  - Engaging residents in this process can/was difficult…

Simulated root cause analyses are difficult to engage the residents, we tried!

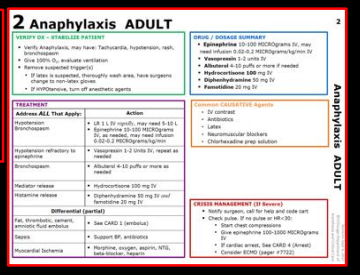
- We did a two stage RCA last year
  - 1st day was didactics on the RCA process
  - 2nd day was a "simulated RCA"
  - Resident engagement was challenging
- Covered the different components of an RCA
  - Identify the intended flow process
  - Identify relevant factors that contributed to the event
    - (e.g: Human, equipment, environmental, etc)
  - Assessment of organizations culture/risk assessment
  - Action Plan: What can we fix and how can we fix it?
- We are going to try again!
  - Rather than have everyone participate, we are going to have "actors" to facilitate the process and discussion
  - Script the discussion and talking points

5. Programs **must** provide formal educational activities that promote patient safety related goals, tools, and techniques.

- The most relevant anesthesia tools are handoffs and checklists
- Handoffs/Transitions of care tools
  - SBAR technique: Situation-Background-Assessment-Recommendation
  - Develop in-house handoff technique/checklist
  - We developed an in house transition of care checklist
- Checklists/Cognitive Aids
  - Critical events series: Dr. Anna Clebone
  - Educational process on checklist/cognitive aid use
  - Review of events/low fidelity simulation
- Institute of healthcare improvement based
  - PS 203: Teaming up against healthcare associated infections
  - PS 204: Preventing pressure ulcers

Example of the Cognitive Aid developed at U of C

11 different diagnoses
- Verify the diagnosis
- Treatment
- Medications
- Causative factors
- Crisis Management



Anesth Analg, July. 2017

6. **Must** receive training in how to disclose adverse events to patients and families. **Should** have the opportunity to participate in the disclosure of patient safety events, real or simulated..

- This one is tricky due to significant institutional variability
  - Some institutions tend toward full disclosure, some less
  - State laws vary regarding an apology as an admission of guilt. ("I'm sorry law")
    - Illinois does NOT have an I'm sorry law*
  - Our institution requires *attendings* to lead the conversation in disclosure
- Coordinate with in-house risk management!
  - I talked to them and they approach this on a case by case basis
  - We do not have an official policy but we do have a tip sheet
    - Its okay to say "I'm Sorry."
  - They may want you to take a specific approach
    - Call them after an event, but prior to disclosure
    - U of C has a preference towards disclosure, but your institution might not!
- U of C risk management had no idea this is an ACGME requirement

http://www.ncsl.org/

There are online curricula for adverse event disclosure

- IHI does have an online course addressing this
  - PS 105: Responding to an Adverse Event
  - Structured curriculum
  - Patient story: Cardiac arrest secondary to Local Anesthetic Systemic Toxicity
- AHRQ also has a course material (CANDOR)
  - Online content with sample disclosure videos
    - How to disclose and how not to disclose an event (insulin overdose)
- Make sure your local risk management approves of the on-line curriculum

7. Residents and faculty **must** receive data on quality metrics and benchmarks related to their patient population

- It does NOT need to be patients that they directly care for
- The ACGME FAQ* allows for
  - Providing individual, specialty-specific data is desirable, but not required. The requirement seeks to ensure that quality metrics used by the *institution* are shared with residents/fellows and faculty members.
- Examples of metrics include, but are not limited to, those provided by the following:
  - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
  - Centers for Medicaid and Medicare Services (CMS)
  - Press Gainey
  - National Surgical Quality Improvement Program (NSQIP)

* https://www.acgme.org/Portals/0/PDFs/FAQ/CommonProgramRequirementsFAQs.pdf

We provide an attending level report card for 7 different patient outcomes

- Report card outcomes:
  - Post-op pain score >7 in PACU
  - Post-op reintubation <7 days
  - Patient Safety Indicator #11
    - (Diagnosis of respiratory failure)
  - Post-op MI <7 days
  - Post-op Stroke <7 days
  - Mortality <7 days after anesthetic
  - Perioperative hyperglycemia (>250mg/dl)
- For each metric we provide:
  - Departmental range
  - Individual practitioners incidence
  - Case list of affected patients

Our data comes from the EMR (EPIC) and other novel databases

- EPIC provides data for 4 of our metrics:
  - Mortality/Post-op pain/Hyperglycemia/AKI
- We have relationships with other departments for their data:
  - Cardiology has a record of all left heart catheterizations
  - Neurology has a record of all stroke code activations
  - Billing data for a floor intubation
  - Hospital Quality Center provides PSI-11 data
- We then reference out these databases against our billing data
  - To compare the date of surgery to the date of outcome/complication
- It is extremely labor intensive!
  - Each report takes roughly 1-2 hours to complete
  - Setting up the report took a tremendous amount of time
    - (Credit to Dr. Avery Tung)
  - We have a quality nurse who compiles the reports.
  - These resources may be useful for QI projects though…

8/9. **Must** receive training and experience in quality improvement processes, including an understanding of health care disparities. **Must** have the opportunity to participate in interprofessional QI activities.

- I combined these two as they are focused on the same thing: QI processes and experience
- We developed an in-house curriculum utilizing faculty didactics
  - Morning lectures throughout the year
  - Focus is on quality theory:
    - Systems based improvement
    - PDSA system of QI
    - QI theory (Taylorism, Demming, Donabedian)
    - National QI initiatives and Large Databases
  - We do Not have a a dedicated QI rotation
- IHI does have online quality improvement courses
  - 8 different QI courses

We are creating longitudinal QI groups to focus on a care area for QI experience

- Groups of 6 residents [2 CA1, 2 CA2, 2 CA3]
  - CA-3's are the group leaders and divides up the workload
  - Allows for leadership opportunities for the senior residents
  - 9 groups total [54 residents]
  - Allows for continuity for each project
- Focus on a specific product line within a departmental area of care or complication
  - Anesthesia perioperative medicine clinic
    - Compliance with anti-HTN medication instructions for RALP patients.
  - Out of OR airway management:
    - Crowd control during airway management/code activation
- Each group has a faculty leader
  - Faculty working in that care area
  - Each group will require a faculty adviser to keep the group on track
  - However, it is a resident driven project

Each project will focus on a specific high volume procedure in the department

- The P in PDSA requires identifying current practice
  - We target case procedures at U of C >100/yr to identify a baseline practice pattern
  - Try to find relatively homogenous anesthetic cases
    - Robotic Prostates: 350 cases/yr
    - Knee arthroplasty: 261 cases/yr
  - Chart review is performed to identify possible systems issues
- Discuss ways to improve care
  - Identify why it happens
  - Deploy improvement and study
- Minimal objective is to learn the QI process
  - Even if we don't implement the project we have satisfied ACGME requirements
  - Hopefully would present at Hospital Quality fair
  - Ideally publish the results in a quality improvement journal

10. QI activities **should** include activities aimed at reducing health care disparities

- Health care disparities are very real but solutions to reduce those disparities are as yet unknown
  - African American women had highest adjusted odds ratio (1.7, 1.5-1.8) for general anesthesia for c-section (Anesth Analg 2016;122:472-9)
  - The etiology and solutions in the anesthetic world are unclear
- Language/cultural barriers may be an area to focus on
  - Decreased adjusted relative risk of neuraxial anesthetic in Hispanic speaking women (aRR 0.70, 0.53-0.92) (Anesth Analg 2016,122:204-9)
  - Coordinated initiative to overcome Spanish speaking language barrier resulted in a higher rates of adherence with appointments (OR: 1.32, 1.06-1.64) (Pain Medicine 2017;18:265-274)

Enhanced Recovery After Surgery (ERAS) Eliminates Racial Disparities in Postoperative Length of Stay After Colorectal Surgery

Tyler S. Wahl, MD, MSPH, Lauren E. Goss, MSPH,* Melanie S. Morris, MD,* Allison A. Gullick, MSPH,* Joshua S. Richman, MD, PhD,* Gregory D. Kennedy, MD, PhD,* Jamie A. Cannon, MD,* Selwyn M. Vickers, MD,* Sara J. Knight, PhD,* Jeffrey W. Simmons, MD,† and Daniel I. Chu, MD**

- Impact of enhanced recovery after surgery on racial disparities on post-operative length of stay
- Pre-ERAS black patients stayed a mean 2.7 days longer than white ($p < 0.05$)
- Post-ERAS no differences were noted in mortality or length of stay between black and white patients.

(This would be an ambitious but laudable QI initiative)

Ann Surg, June 2017.

I hope all of these new requirements improve patient care and physician engagement in PS/QI

- Patient safety and quality improvement are critical aspects of being a physician
  - …but so is everything else we already have included in a residency curriculum
- Quality Interventions to improve care may not always be effective at accomplishing there goal
  - Surgical Care Improvement Project
- The tension between needing to improve care and knowing how to do it:
  - "Just as in the rest of medicine, we must pursue the solutions to quality and safety problems in a way that does not blind us to harms, squander scarce resources, or delude us about the effectiveness of our efforts."

NEJM, Aug 2007

Thank you!

Questions?

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- www.ahrq.gov
- www.ihi.org

HANDOUT

AACPD
ASSOCIATION OF ANESTHESIOLOGY CORE PROGRAM DIRECTORS

Point of Care Ultrasound

Robina Matyal, MD

11/03/2017
8:50am – 9:15am

POINT OF CARE ULTRASOUND

Robina Matyal , MD.
Associate Professor
Harvard Medical School
Beth Israel Deaconess Medical Center
Boston, MA.
(617) 754-2670

How is point of care ultrasound defined?

Ultrasound is used widely in the perioperative arena by the anesthesiologists, for echocardiography, vascular access, regional anesthesia; Point of care ultrasonography refers to the use of ultrasound for management of surgical patients during the perioperative period. Current applications of perioperative ultrasound which are specific to anesthesiologists include, transthoracic and transesophageal echo (TTE and TEE), ultrasound for procedural guidance, and emergency point-of-care abdominal, chest wall and airway US.

What is the model for ultrasound education during anesthesia training?

Currently there is no structured training program available for introduction to the broad applications of perioperative ultrasound during anesthesia residency training. Proficiency in the use of ultrasound is implied with clinical exposure, which is neither graduated from simple to complex nor appropriate to trainee skill level. Clinical exposure and training varies with setting (university vs. community hospital, faculty comfort and patient load). Whereas some ultrasound training is conferred during regional and critical care fellowship training, only accredited cardiac anesthesia fellowship has a pathway for achieving advanced TEE certification through the National Board of Echocardiography (NBE). The NBE also offers a basic level TEE certification for anesthesiologists not formally trained in cardiac anesthesia.

Why it is important to develop a point of care ultrasound program?

Multiple other specialties have initiated the process of defining the scope of ultrasound training and practice within their domains. In the perioperative arena, specific to anesthesiologists ultrasound is practiced as individual techniques and not as a broad skill set essential for a modern day anesthesiologist. There is no procedure non-specific ultrasound education curriculum to prepare trainees for these specialized applications of ultrasound. We need to introduce a curriculum based on “Fundamentals of Ultrasound” to encompass the basic principles and workflow of a perioperative ultrasound examination could address this requirement.

Are there similar programs for other specialties?

We are currently faced with the challenge of clinical adoption of a technology i.e. ultrasound, prior to development of guidelines of its use. Other specialties have faced similar challenges and have introduced broad-based educational programs for fully trained and physicians in training. Fundamentals of laparoscopic and endoscopic surgery (FLS and FES) are such multi-modality educational programs to teach and test cognitive knowledge and objectively test basic manual dexterity skills of trainees prior to actual clinical exposure. These are mandatory for all surgical trainees in accredited surgical residency programs and trained surgeons as part of their continuing education for recertification. However, these are specialty non-specific and open to other surgical disciplines as well.

What is the role of a web-based multi-modality training program?

Restraints on trainee duty hours necessitate innovations for qualitative and quantitative enhancements in clinical educational. The advantages of a web-based didactics over conventional methods are that they can be interactive, offered remotely, and can be flexibly integrated with focused hands-on sessions. This concept of a flipped classroom can be utilized to offer better training without impacting resident duty hours. A web-based model also offers the opportunity to have a uniform content across multiple locations and standardized testing.

Why it is important to describe a learning curve for point of care ultrasound?

Ultrasound training requires repetitive performance for mastery and may benefit from objective performance assessment tools to individualize this process. Latest generation ‘mixed’ ultrasound simulators with haptic components have shown value as task trainers and performance evaluation tools. Hence, all components of the ‘orientation phase’ of ultrasound training (cognitive knowledge, instrument operation and psychomotor skills) can be acquired and objectively tested. Clinical performance is evaluated with detailed performance evaluation by faculty during specialty rotations. This makes every clinical encounter maximally educational. Establishing training requirements to achieve proficiency can develop into a standardized national curriculum with performance evaluation tools similar to FLS and FES programs.

Using simulation technology for ultrasound training

Simulation technology has been employed to reduce the initial learning curve in procedures requiring fine motor skills and eye-hand coordination. Even a brief warm-up time with a simulator prior to an actual surgery has been shown to reduce errors during actual laparoscopic procedures. Due to similarities in the requirement of manual dexterity and fine motor skills, it is possible that a degree of training facilitation could possibly be achieved for ultrasound training utilizing a simulator. An understanding of normal views, anatomy, and acquaintance with the technical and manual skills of the examination can improve the comfort level and quality of image acquisition during an actual ultrasound guided examination. The inclusion of this method of training in the anesthesia residency curriculum has the potential to improve resident education and training and eventually, patient safety.

Currently, expertise in ultrasound is defined principally by the amount of time spent performing this technique, denoted by the number of studies

performed. The trainee can objectively explore both the development of manual dexterity and the acquisition of knowledge critical to successful implementation of this clinical skill set. Standard tests exist for dexterity, but the interaction between manual and cognitive skills for complex procedures is less understood.

Curriculum based approach:

The point of care ultrasound should be incorporated as a specific curriculum. We have successfully incorporated it as a part of the curriculum for the last four years. There is a comprehensive course in the beginning of the training period. During the first three months as a categorical resident in anesthesia the residents learn the basics of perioperative ultrasound and complete the orientation phase. It is a multimodal curriculum utilizing various steps and resources. At the end of the training, readiness for performance of clinical ultrasound examination will be established with demonstration of successfully completing the orientation phase of the training that consists of:

1. Cognitive knowledge of ultrasound
2. Understanding of the workflow of an ultrasound examination
3. Possession the necessary psychomotor skills

Cognitive Knowledge

Cognitive knowledge is imparted through a web-based education model. The website has faculty narrated presentations on point of care ultrasound modalities (basic to advanced), with pre and post-review questions to assess the knowledge gain.

Testing of cognitive knowledge is performed with serial multiple choice question examinations.

Workflow of an Ultrasound Examination

It is defined as a trainee's ability to integrate their cognitive knowledge with the available information to select, prepare and operate the ultrasound

equipment most appropriate for the indicated examination. This is taught through faculty moderated hands-on sessions that will have a detailed description of available equipment, operation, image acquisition, storage and retrieval. There is a detailed description of various ultrasound machine functions e.g. Doppler, linear measures and image optimization and troubleshooting (Table).

Resident's understanding of workflow is assessed with hands-on sessions of standardized tasks relating to various aspects of basic perioperative ultrasound.

What is being performed? TEE Examination/TTE/Abdominal & Chest/Vascular Access

Why it is being performed? Indications (Emergency/Elective)/Contraindications

Which equipment to use? Ultrasound system capable of desired examination

How to operate the equipment: Power on/appropriate probe selection/probe calibration/patient information.

Procedure Non-Specific Workflow

1. Appropriate ultrasound machine selection
2. Equipment operation
3. Ultrasound examination preparation (Appropriate patient information)
4. Procedure specific ultrasound probe selection
5. Probe insertion and calibration
6. Final equipment check and readiness

Psychomotor Skills for an Ultrasound Examination

Possession of psychomotor skills is establishment by the resident's ability to satisfactorily complete pre-defined tasks for each application of ultrasound. Visual metrics Assessment of manual dexterity skills is assessed with completion of pre-defined tasks with various applications of basic ultrasound skills.

How to perform the indicated examination? TEE probe insertion/patient positioning for TTE and surface ultrasound examination

What information to acquire? Indication specific views for TTE and TEE/Identification of neurovascular bundle for regional anesthesia and vascular access

What to do with the information? Clinical decision-making

Point of care training for Anesthesia Faculty:

Proficiency in US is currently considered a desirable skill; it should be an expectation for all anesthesiologists. Universal adoption and recognition of US as a necessary skill set requires concerted efforts at multiple levels. Individual practitioners have to recognize this training gap and be motivated to enhance their technical skills. Anesthesia departments should facilitate provision of meaningful training opportunities and create mechanisms to ensure continued clinical use of US technology by faculty. Such efforts may include but not limited to credentialing and quality assurance and improvement initiatives for professional development and patient safety. Finally, professional societies should strive to get proficiency in US recognized as a core competency for anesthesiologist with simultaneous provision of opportunities for innovative educational research. Establishing a broad proficiency in perioperative US will possibly obviate the need for establishing a specific certification for proficiency in clinical use of US. The use of US has contributed to improvement in quality and value, specifically in regards to procedural safety, timeliness of care, diagnostic accuracy, and cost reduction.

Summary:

Other than for transesophageal echo (TEE) and ultrasound for vascular access there are no guidelines to define the scope, training and clinical applications of perioperative ultrasound in general. Despite having the same basic physical principles and workflow as a task, perioperative ultrasound is practiced as isolated individual techniques. Ideally there should be a unified basic curriculum encompassing physics of ultrasound, equipment operation and workflow of image acquisition and optimization. Trainees should be oriented to the fundamentals of ultrasound that are common to all the perioperative applications prior to its use. In the current era of technological advancements US fulfills the concept of “staged

imaging" where the use of US first can answer important clinical questions accurately without the expense, time or side effects of advanced imaging or invasive procedures. Whereas an advanced clinical use of US will require specialized training, a basic level understanding can and should be imparted to all the anesthesiologist. An analogy can be made to the expectation of basic level understanding of EKG strips and chest radiographs by all clinicians and advanced level interpretations requiring expert input and advice. In fact, handheld US systems are being introduced in medical school curricula as the modern stethoscopes. The design of our program can be criticized for not including improvement in patient outcome as a metric. Anesthesiologists have been at the forefront of innovations in patient safety. The 10-fold reduction in anesthesia related mortality over the decades could be attributed to adoption of clinical practices and technologies over time that incrementally enhanced patient safety. This was also based on inferential implied logic and common sense rather than rigid controlled trials of outcome benefit. We believe incorporation of US in our daily practice qualifies as a similar patient safety initiative. It would be unjust to subject this obvious safety practice to this litmus test. This recognition will most likely improve outcome and prevent a large number of anesthesiologists from being disenfranchised.

HANDOUT

AACPD
ASSOCIATION OF ANESTHESIOLOGY CORE PROGRAM DIRECTORS

Associate Program Director Panel

Jack C. Buckley, MD
Kristina Sullivan, MD

11/03/2017
9:30am – 10:00am

Associate Program Directors in Anesthesia Residency Programs

Jack Buckley M.D.
UCLA Medical Center
Assoc. Residency Program Director

Kristina Sullivan M.D.
UCSF Medical Center
Assoc. Residency Program Director

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Outline

- Review of ACGME requirements for Program Directors (PDs) and Associate Program Directors (APDs) in various specialties of medicine
- Brief overview of our individual roles as Associate Program Director
  - Current responsibilities
  - Things we have learned
- Survey results of anesthesia programs directors regarding APDs, other directors, and administrative assistants

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Disclosure

- Dr. Buckley does not have any financial relationships or disclosures for this talk
- Dr. Sullivan does not have any financial relationships or disclosures for this talk

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Developing an Effective Leadership Team

Goals of a residency program

- Education
- Clinical Competence
- Scheduling
- Scholarship
- Wellness
- Innovation
- Adherence to ACGME requirements
- Other

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ACGME Program Requirements

- Program Director and Associate Program Director Requirements
  - Internal Medicine
  - Pediatrics
  - Surgery
  - Anesthesia

ACGME Accreditation Council for Graduate Medical Education

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ACGME Program Requirements for Graduate Medical Education in Internal Medicine

- > 50% salary (20 hours per week) support for PD
- 20 hours per week salary support for each APD
  - 24-40 residents = 1 APD
  - 41-79 residents = 2 APDs
  - 80-119 residents = 3 APDs
  - 120-159 residents = 4 APDs
  - > 159 residents = 5 APDs

ACGME Accreditation Council for Graduate Medical Education

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Example of Leadership Structure in IM

- UCSF Department of Medicine
- 1 PD
- 2 Directors
  - Track director for primary care
  - Track director for General Internal Medicine
- Associate Program Directors
  - APD for curriculum and special projects
  - APD for ambulatory affairs
  - APD for resident scholarly activity
  - APD for subspecialty education

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ACGME Program Requirements for Graduate Medical Education in Pediatrics

- PD must have 50% salary support (0.5 FTE)
- Combined PD + APD requirement depending on number of residents
  - 12-30 residents = 0.75 FTE
  - 31-60 residents = 1.0 FTE
  - 61-90 residents = 1.25 FTE
  - 91-100 residents = 1.5 FTE
  - >120 residents = 1.75 FTE

ACGME Accreditation Council for Graduate Medical Education

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ACGME Program Requirements for Graduate Medical Education in General Surgery

- PD must have 30% salary support
- Must appoint 1 APD for a program > 20 residents

ACGME Accreditation Council for Graduate Medical Education

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ACGME Program Requirements for Graduate Medical Education in Anesthesiology

- ≥ 20% salary support for PD if ≤ 20 residents
- ≥ 40% salary support for PD if > 20 residents

NO APD REQUIREMENT FOR ANESTHESIA

ACGME Accreditation Council for Graduate Medical Education

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Why is there not an ACGME Anesthesia APD requirement?

Barriers:

- No time?
- No financial incentive (or financial disincentive)?
- Peer perception?
- No compelling need?
- Others?

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Our Experience as Associate Program Director

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Jack Buckley – UCLA Medical Center

- Assistant Program Director (2013 – 2014)
- Associate Program Director (2014 – Current)
- Categorical Program – Since 2007
- 25 residents per class
- 20 fellows (ACGME 14)
- Program Director (since 2011)
- 1 Assistant Program Director
- 1 Associate Program Director
- 4 Education Coordinators

Jack Buckley - Responsibilities

- Resident Didactic Curriculum
- Clinical Scheduling
- Residency Recruitment Chair
- Rotation Evaluations
- Member of all residency committees (Clinical Competence, Education, and Recruitment)

Kristina Sullivan – UCSF Medical Center

- Director of Clinical Base Year (2008 – Current)
- Associate Program Director (2009 – Current)
- Categorical Program – Since 2008
- 10 interns; 22-25 residents per class
- 23 fellows (ACGME 18)
- Program Director (since 2009)
- 1 Associate Program Director
- Well-Being Director, Clinical Competence Director, Curriculum Director, Scholarship Director
- 5 Education Coordinators

Kristina Sullivan - Responsibilities

- Director of the clinical base year (anesthesia internship)
  - Clinical scheduling
  - Didactic component (6 hours per month plus 4 weeks in June)
  - Intern Feedback and Mentoring
- Co-chair of residency recruitment
  - Review applications
  - Interview team captain
- Oversee special pathways
- Member of all residency committees (Well-being, Clinical Competence, Education, Scholarship, and Recruitment)
- Resident feedback/

What We Have Learned As the Associate PD

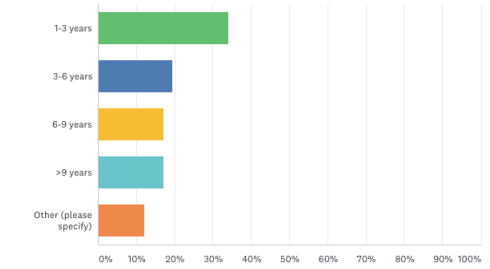
- Useful to be involved in the major responsibilities of the Program Director
  - Graduate Medical Education Committee
  - SAAAPM
  - Professionalism Issues with Residents
  - Substance Abuse
  - Resident Wellness
  - Anesthesia Faculty
  - After Residents Graduate

Survey of Anesthesiology Program Directors

- 41 program directors responded
- Goal of survey
  - Level of support from Associate and Assistant Program Directors (APD)
  - Responsibilities of the APD
  - Financial and non-financial support for the APD

How long have you been the Program Director?

Answered: 41 Skipped: 0



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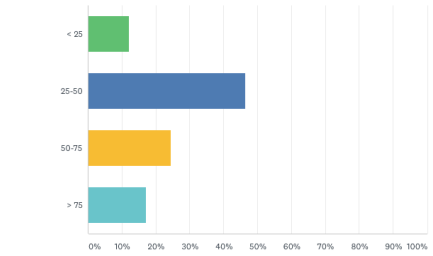
How many residents are in your program (Intern through CA-3)?

Answered: 41 Skipped: 0



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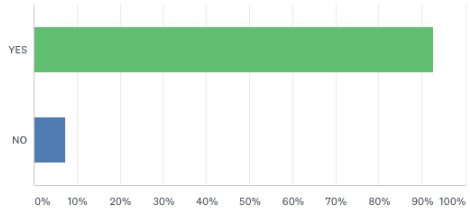
Do you have one or more Associate Program Directors (APDs)?

Answered: 41 Skipped: 0



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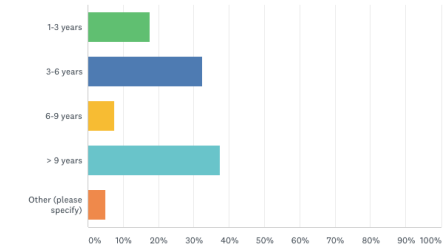
How long has your program had an APD?

Answered: 40 Skipped: 1



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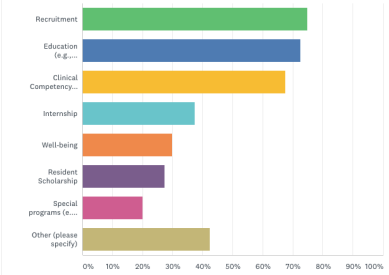
Which of the following domains does your APD help to manage?

Answered: 40 Skipped: 1



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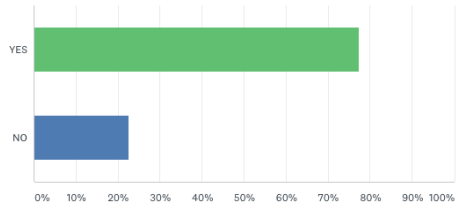
Does your APD receive additional non-clinical time for their role?

Answered: 40 Skipped: 1



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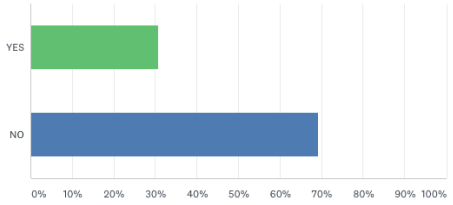
Does your APD receive additional compensation for their role?

Answered: 39 Skipped: 2



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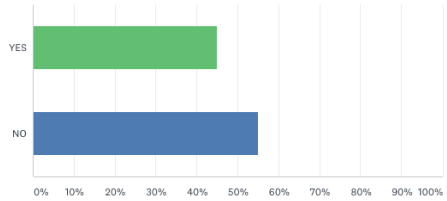
Do you have an Assistant Program Director or Directors for other aspects of your residency (e.g., education, well-being, scholarship, etc.)?

Answered: 40 Skipped: 1



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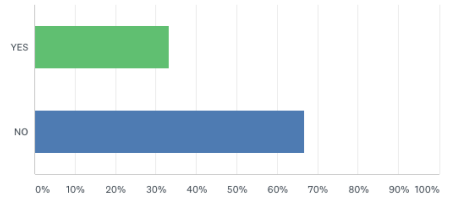
Does the Assistant Program Director or other Director receive additional non-clinical time or financial compensation?

Answered: 36 Skipped: 5



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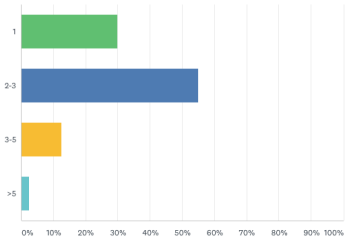
How many non-physician staff (e.g., program administrators or educators) are employed to help manage your residency?

Answered: 40 Skipped: 1



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HANDOUT

AACPD
ASSOCIATION OF ANESTHESIOLOGY CORE PROGRAM DIRECTORS

Preparing Residents for the OSCE Exams

Robert S. Isaak, DO

11/03/2017
10:30am – 11:00am

Preparing Residents for OSCEs

Rob Isaak, DO
Associate Professor
Department of Anesthesiology, Liver Transplant Division
The University of North Carolina at Chapel Hill
Assistant Residency Program Director
Director, Consortium of Anesthesiology Patient Safety and Experiential Learning (Simulation)

UNC SCHOOL OF MEDICINE

CAPSEL

Objectives

1. **Recognize key elements** necessary to prepare residents for the OSCE exam.
2. **Formulate plan to assess** ACGME sub-competency milestones *and* skills from the ABA Applied Exam Content Outline.
3. **Develop a plan** for constructing an OSCE at your residency program

Disclosure

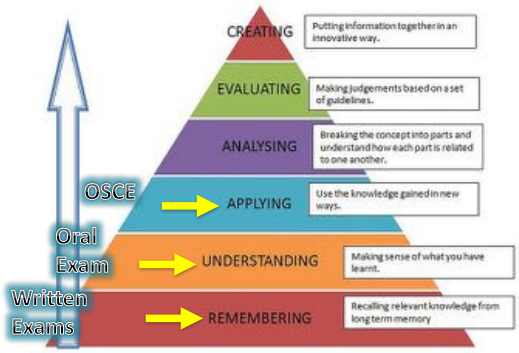
- Member of the ABA OSCE Committee
- No financial conflicts

What is an OSCE?

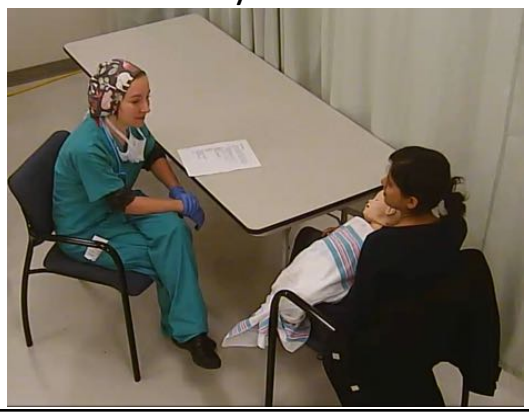
Objective.....**S**tructured.....**C**linical.....**E**xamination

- Standardized evaluation (e.g. checklist) → **O**bjectivity
- Clinical scenarios are **S**tructured (*scripted/standardized*)
- Variety of **C**linical Skills **E**xamined
  - Procedural skills (e.g. ultrasound guidance)
  - Data interpretation (e.g. monitors, TEE)
  - Interpersonal interactions (e.g. informed consent)

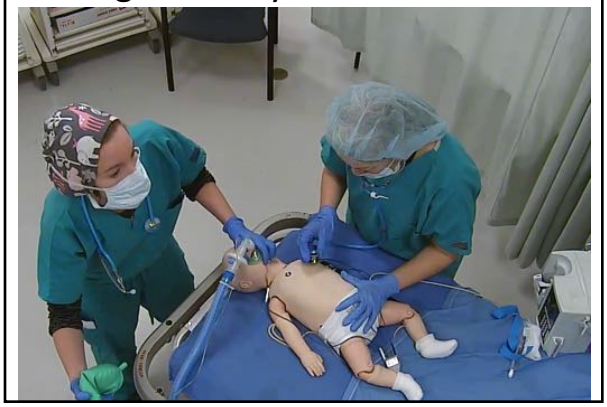
Bloom's Taxonomy



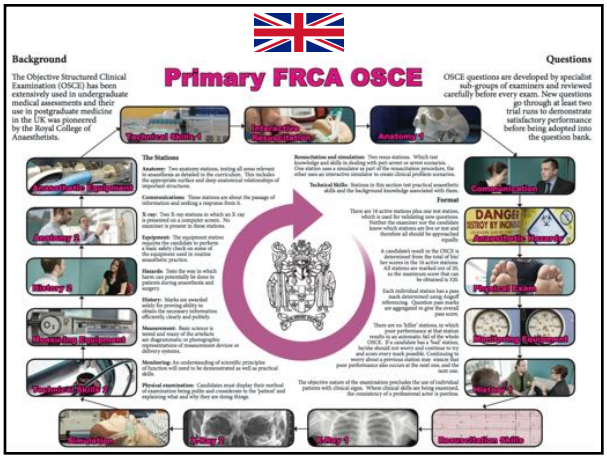
Low-Fidelity OSCE Scenario



High-Fidelity OSCE Scenario



Mixed-Fidelity OSCE Scenario



Israeli National Board of Anesthesiology OSCE

Five - 15 minutes scenarios:

1. **Trauma Management in ER**: Mannequin based; ATLS skills
2. **Resuscitation**: Mannequin based; ACLS Skills
3. **OR Crisis Management**: Mannequin based; "help" junior resident
4. **Mechanical Ventilation**: Artificial lung based; ABG based adjustments
5. **Regional Anesthesia**: Actor based; U/S guidance, LA, complications

- All scenarios will be low-fidelity
  - No items like mannequins or tasks trainers
  - Will have computer stations, ultrasounds, standardized patients

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Advancing the Highest Standards of the Practice of Anesthesiology

ABA APPLIED EXAMINATION
OBJECTIVE STRUCTURED CLINICAL EXAMINATION (OSCE)
CONTENT OUTLINE

A. Communications & Professionalism

1. Informed consent *(Obtain informed consent from a patient)*
2. Treatment options *(Analyze a clinical scenario, formulate appropriate treatment options, and discuss these options with a patient)*
3. Peri-procedural complications *(Conduct a focused evaluation of a peri-procedural complication, formulate an action plan, and discuss this plan with the patient)*
4. Ethical issues *(Frame and discuss appropriate plans to address common ethical dilemmas in clinical care settings)*
5. Communication with other professionals *(Effectively communicate with other healthcare team members in a professional manner)*
6. Practice-based Learning and Improvement *(Articulate and apply principles of patient safety and quality improvement to a clinical scenario)*

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ABA APPLIED EXAMINATION
OBJECTIVE STRUCTURED CLINICAL EXAMINATION (OSCE)
CONTENT OUTLINE

B. Technical Skills

1. Interpretation of monitors *(Identify clinical conditions associated with patterns of data presented on monitors)*
2. Interpretation of echocardiograms *(Interpret basic echocardiograms relevant to anesthesia practice)*
3. Application of ultrasonography *(Identify relevant normal anatomy using ultrasonography)*

ABA OSCE Physical Layout

OSCE Hallway

Creating OSCE Prep Scenarios

- Decide if OSCE for **board prep** +/- **ACGME milestones**
- Know your environment/setting for the OSCE
  - Sim center, faculty offices, OR, PACU
- Prepare scenario documents for OSCE
  - use templates

Documents for an OSCE Scenario

1. Learner Prompt
- Used by learners to orient to setting and task
- Used by assessors to understand resident's orientation

2. Script
- Used by SP's to know role, environment & contingencies
- Used by assessors to understand scenario context

3. Grading Sheet
- Objective grading criteria used by assessors
  - based upon milestones rubrics or other standards

Sample Scenario

- ACGME Milestone: *Interpersonal &Communication Skills 1*
- ABA Skill Area: *Periprocedural complications*

Learner Prompt

- **5 Elements**:
  1. Describe **role of the examinee** – *Who* are they
  2. Describe **context/timeframe** – *When & where* are they located
  3. Describe **patient**– *What* is the history and status
  4. Additional **background information** – PE, vitals, labs
  5. **Scenario Objective** – *Why* is there an interaction and *how* is it happening.

Learner Prompt Template

Background/Setting: (e.g. PACU, Preop Clinic, Conference Room)

OSCE Scenario Objective: Your task is to….

HPI:

PMHx:
PSHx:
Allergies:
Meds:
Social: () smoker, () drinker, () other drugs.
NPO:

Vitals:
BP:
HR:
SPO2: %
ETCO2:

PE:
General:
Airway:
Lungs:
Heart:
Neuro:
Vascular:

Labs:

Scenario Title: "Medical Error Disclosure"

Milestone: Interpersonal and Communication Skills 1

ABA Skill Area: Periprocedural complications

Background/Setting: Conference room/waiting room 1

HPI: You have just completed a laparoscopic appendectomy taking for an otherwise healthy 9yo male (Michael Williams) with acute appendicitis. You took over the case just prior to the beginning of surgical closing. The procedure lasted 45min, but the patient was not initiating any breaths at the end of the surgery. A twitch monitor was placed and 0/4 twitches were observed. 2 3 4

After going back over the EPIC documentation and syringes in your work area, you realized the previous anesthesia provider administered 2mg/kg of cisatracurium instead of 0.2mg/kg for induction. You made the decision to take the patient to the PICU intubated. The attending surgeon has already discussed the outcome of the surgery with the mother but left the OR prior to making the decision to go to the PICU, so he did not inform the mother. The previous anesthesia provider has already left the hospital and is unavailable. The preop from the operating is shown below for your reference. 4 5

OSCE Scenario Objective: Your objective is to meet with the mother, who is waiting for you in the family conference room, and explain the current situation and answer her questions.

Scripts

- 5 Elements:
  1. **States** – i.e. initial state, transitions, resolution
  2. **SP/Actor lines**
  3. **Learner's "Lines"** (most likely to be stated)
  4. **Contingency SP/Actor lines**
  5. **Staging/moulage**

Script Template

Response 4	Should explain that the patient will need to stay in PICU for a few hours, and that the PICU physicians will decide when it is safe to take the breathing tube out.	The mother should then ask, "Will this cause any long-term problems for my son?"	
Response 5	Should reassure the mother that there is a very low chance of having any long-term problems for the child due to remaining intubated until the medication wears off.	The mother should ask "How are you going to keep this from happening to other kids in the future?"	
Response 6	May offer many different answers to this question (ie. Drug doses and volumes should be verbally double-checked between care team members)	Parent should ask "What about the person who made the mistake?"	
Response 7	May briefly explain the role of the anesthesia care team. Should inform the mother that the initial team members will be notified of the error for feedback and may follow up with mother at a later time.	GO BACK TO RESPONSE 4 IF NOT ALREADY COMPLETED	
Resolution	May apologize that this error happened to their child. Should ask the mother if she has any further questions.	The mother should state, "No, thank you. I appreciate you your honesty in admitting the mistake and coming to talk to me about it."	

Grading Sheets

- Behaviorally anchored, objective actions
  - "Yes"/"No" observable actions (i.e. disclosed error)
  - Translation of milestones to scenario context
- Global rating score for overall performance
  - Fluency
  - Style/Approach
  - Order of actions

Grading Sheet Template

		Senior	Communicates challenging information and addresses complex circumstances with conditional independence	1. Avoids blaming other team members. 2. Asks the mother if she has any further questions/concerns	1. 2.
		Adv.	Independently discloses medical errors or medical complications Consistently ensures effective communication and resolution of concerns occurs with patients and/or families	1. Explains a plan to avoid similar errors in future (some examples include a discussion with previous team members, AQI/PSQI committee reporting, presenting at M&M) – need at least 2 steps to the action plan. 2. Accepts responsibility for the error on behalf of the anesthesia team	1. 2.
				Global Rating Score	_out of 5

Global Rating Scores

5 = Excellent:
- Excellent performance of all skills during the scenario.
- Outstanding demonstration of the technical and non-technical aspects of the scenario.
- Confident and clear in the performance of the scenario.

4 = Very Good Pass:
- Very good performance of the skills of the scenario.
- A majority of the technical aspects of the skill were demonstrated.
- A few minor and non-essential omissions or errors.

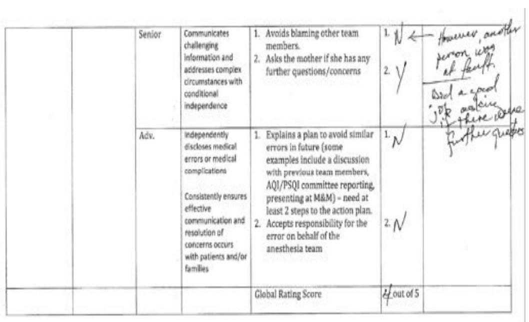
Global Rating Scores

3= Pass:
- Acceptable performance of the skills of the scenario.
- Despite some omissions and errors demonstrated adequate patient care.
- At times may be formulaic in approach to the scenario.

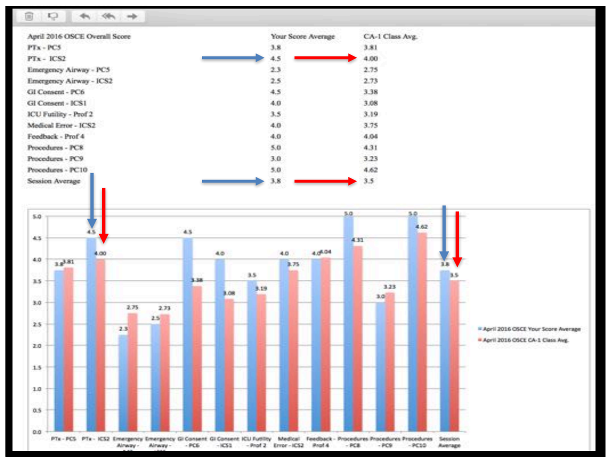
2= Borderline Pass:
- Patchy performance of the skills of the scenario.
- Demonstrated some aspects of the skill, however, omissions and inaccuracies occurred during the performance of the scenario.
- Often formulaic in approach and struggled with the scenario.

1=Fail:
- Performance of the skills did not meet a passing standard.
- Was disorganized or unsafe in patient care.

Grading Sheet Sample



		Senior	Communicates challenging information and addresses complex circumstances with conditional independence	1. Avoids blaming other team members. 2. Asks the mother if she has any further questions/concerns	1. N 2. Y	However, another person was at fault. Did a good job asking if there were further questions
		Adv.	Independently discloses medical errors or medical complications. Consistently ensures effective communication and resolution of concerns occurs with patients and/or families	1. Explains a plan to avoid similar errors in future (some examples include a discussion with previous team members, AQI/PSQI committee reporting, presenting at M&M) – need at least 2 steps to the action plan. 2. Accepts responsibility for the error on behalf of the anesthesia team	1. N 2. N	
				Global Rating Score	4 out of 5	



April 2016 OSCE Overall Score	Your Score Average	CA-1 Class Avg.
PTx - PC5	3.8	3.81
PTx - ICS2	4.5	4.00
Emergency Airway - PC5	2.3	2.75
Emergency Airway - ICS2	2.5	2.73
GI Consent - PC6	4.5	3.38
GI Consent - ICS1	4.0	3.08
ICU Futility - Prof 2	3.5	3.19
Medical Error - ICS2	4.0	3.75
Feedback - Prof 4	4.0	4.04
Procedures - PC8	5.0	4.31
Procedures - PC9	3.0	3.23
Procedures - PC10	5.0	4.62
Session Average	3.8	3.5

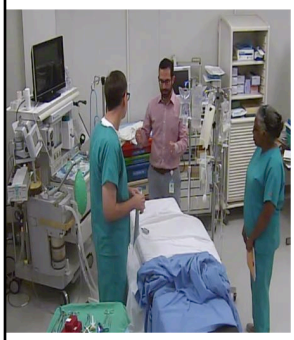
SP Training Process

3 Stages:
1. Orientation
2. "Simulate the Simulation"
3. Dress Rehearsal

Benefits to Process:
- Ensures consistency of training from session to session
- Gives SPs adequate time to learn scripts
- Allows for time to adjust scenarios if needed
- ~2 weeks pre-OSCE

Stage 1: Orientation

Stage 2: "Simulate the Simulation"



Stage 3: Dress Rehearsal

Tips for Training SPs

- Show your appreciation x 10 to the SPs!
- Learn their names
- Know their backgrounds
  - i.e. occupation, education, family
- Bagels and Coffee in break-room
- Say "Thank You" face-to-face

Limitations of SP's

- Cost: $15-$20 per hour per SP
- Background knowledge may be limited
- Scheduling/availability can vary
- Acting skill sets (ability to improvise)
- High-Stakes (no "second takes")

Advice for using SP's in OSCE's

- Build a Core Team of SP's
- Start Training Early – at least 2-4 weeks early
- Know your SP's limitations
- Make time for rehearsal
- Make time for constructive feedback
- Record the training session for the SP to review.

Timeline for creating an OSCE

1. **Start to Write Scenarios** – 2-3 months in advance
2. **Train Actors** – 2 weeks in advance
3. **Rehearsal** – Day of session (prior to 1st resident)
4. **OSCE Session** – 1-2 full days
5. **Faculty Assessments**– 3 weeks deadline
6. **Send Reports to Residents** – 4 weeks after OSCE
7. **Clinical Competency Committee** (CCC) –June/Dec
8. **Portfolio** – Provided upon graduation

Summary

- Decide if are incorporating milestones into OSCEs.
- Build a core set of templates:
  - Learner prompt
  - Script
  - Grading sheet
- Make deliberate efforts to train SP's properly.
- Provide some form of feedback to residents

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UNC SCHOOL OF MEDICINE

CAPSEL

HANDOUT

AACPD
ASSOCIATION OF ANESTHESIOLOGY CORE PROGRAM DIRECTORS

An Academic Medicine Rotation

Harendra Arora, MD

11/03/2017
11:00am – 11:30am

An Academic Medicine Rotation
&
Transition from Residency to Practice

Harendra Arora, MD
Professor and Vice Chair of Education
Residency Program Director,
Department of Anesthesiology,
University of North Carolina School of Medicine

Disclosures

No conflicts of interest or financial disclosures

Objectives

- Identify gaps and focus areas in medical education that need emphasis during residency training.
- Designing a novel curriculum to train residents on leadership, quality improvement, teaching skills and critical appraisal of the literature.
- Prepare residents in practice management issues pertaining to operating room management, practice evaluation, contract negotiations, billing arrangements, professional liability, as well as legislative issues and regulatory issues.

ACGME Program Requirements for Graduate Medical Education in Anesthesiology

ACGME

Int.B. Definition and Scope of the Specialty

The Review Committee representing the medical specialty of anesthesiology exists in order to foster and maintain the highest standards of education and educational facilities in anesthesiology, which the Review Committee defines as the practice of medicine dealing with the peri-operative management of patients. This includes the peri-operative/peri-procedural management of patients during surgical and other therapeutic and diagnostic procedures. This management encompasses the pre-operative preparation of the patient and their peri-operative maintenance of normal physiology, as well as the post-operative relief and prevention of pain. An anesthesiologist is skilled in the management and diagnosis of critically-ill patients, including those experiencing cardiac arrest, and in the diagnosis and management of acute, chronic, and cancer-related pain. These goals are achieved through a thorough understanding of physiology and pharmacology, and the ability to conduct, interpret, and apply the results of medical research. Finally, the anesthesiologist is skilled in the leadership of health services delivery, prudent fiscal resource stewardship, and quality improvement, as well as the supervision, education, and evaluation of the performance of personnel, both medical and paramedical, involved in peri-operative and peri-procedural care.

Anesthesiolog.

Clinical skills
Technical skills
Medical knowledge

Leadership
Communication
Analytical thinking
Willingness to learn
Ability to judge
Hard worker
Adaptability
Accountability
Teamwork
Cooperation

Why focus on the softer skills?

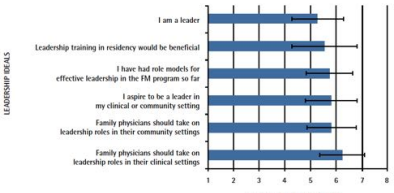
Leadership, the seventh competency

Leadership training in a family medicine residency program

Cross-sectional quantitative survey to inform curriculum development

Erin Gallagher MD CCFP Ainsley Moore MD MSc CCFP Inge Schabort MD MB ChB CCFP FCFP

- Survey of 152 PGY1 and PGY2 family medicine residents @ McMaster University
- 50% desired more training:
  - Personal mastery
  - Mentorship and coaching
  - Conflict resolution
  - Teaching
  - Effective teamwork
  - Administration



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Moving Beyond Accidental Leadership: A Graduate Medical Education Leadership Curriculum Needs Assessment

LTC Joshua D. Hartzell, MC USA; COL Clifton E. Yu, MC USA†; MAJ Brian M. Cohee, MC USA‡; COL Michael R. Nelson, MC USA§; LTC Ramey L. Wilson, MC USA ‖ ¶*

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Hard evidence on soft skills☆

James J. Heckman[a,b,c,*] and **Tim Kautz**[a]

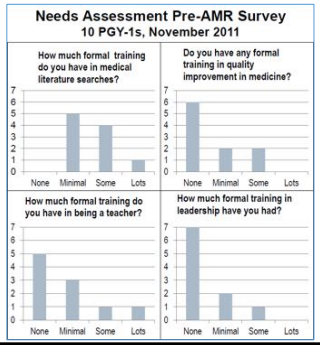
[a]Department of Economics, University of Chicago, 1126 E. 59th Street, Chicago, IL 60637, USA [b]American Bar Foundation, 750 North Lake Shore Drive, Chicago, IL 60611, USA [c]University College Dublin, Ireland

Abstract

This paper summarizes recent evidence on what achievement tests measure; how achievement tests relate to other measures of "cognitive ability" like IQ and grades; the important skills that achievement tests miss or mismeasure, and how much these skills matter in life.

Achievement tests miss, or perhaps more accurately, do not adequately capture, *soft skills*—personality traits, goals, motivations, and preferences that are valued in the labor market, in school, and in many other domains. The larger message of this paper is that soft skills predict success in life, that they causally produce that success, and that programs that enhance soft skills have an important place in an effective portfolio of public policies.

Needs Assessment Pre-AMR Survey
10 PGY-1s, November 2011



Academic Medicine Rotation: Structure

- 5 week rotation: 4 key tenets
  - Critical appraisal of the literature
  - Teaching
  - Quality Improvement
  - Leadership
- No clinical commitment
- > 60 hours instructor led sessions
- Daily self-directed learning
  - Complete several online Institute for Health Care Improvement Open School courses
- Involved all core competencies except direct patient care
- Fits within the ACGME, ABA requirements

Academic Medicine Rotation: Timing

	Block 1	Block 2	Block 3	Block 4	Block 5	Block 6	Block 7	Block 8	Block 9	Block 10	Block 11	Block 12
	6/24	7/18	8/15	9/19	10/17	11/15 – 12/20	1/2	1/30	2/27	3/27	4/24	5/22
A	SRT	SICU	PAC	NEPH	PED	AMR	OB/GYN	REDPED	MICU	MED	CARD	ANES
B	MICU	SRT	REDPED	PAC	NEPH	AMR	SICU	PAIN	MED	CARD	PED	ANES
C	CARD	MICU	PED	SRT	PAC	AMR	REDPED	MED	SICU	PAIN	NEPH	ANES
D	MED	CARD	MICU	PED	SRT	AMR	PAC	NEPH	PAIN	SICU	REDPED	ANES
E	REDPED	MED	SRT	MICU	SICU	AMR	PED	PAC	CARD	NEPH	PAIN	ANES
F	PAIN	NEPH	CARD	MED	MICU	AMR	SRT	SICU	PED	REDPED	PAC	ANES
G	PAC	PAIN	MED	CARD	REDPED	AMR	MICU	SRT	NEPH	PED	SICU	ANES
H	SICU	PED	PAIN	REDPED	CARD	AMR	NEPH	MICU	SRT	PAC	MED	ANES
I	NEPH	PAC	SICU	PAIN	MED	AMR	CARD	PED	REDPED	MICU	SRT	ANES
J	PED	REDPED	NEPH	SICU	PAIN	AMR	MED	CARD	PAC	SRT	MICU	ANES

Course Faculty

- Experts within and outside of our department and institution:
  - Anesthesiologists
  - Health science librarians
  - IRB members
  - Researchers
  - Grant experts
  - Legal staff
  - Clinical faculty
    - Pediatricians
    - Obstetricians
    - Surgeons
  - Non-clinical faculty
    - School of Public Health
    - Business School
  - Risk-managers
  - Members of the NC medical board

Academic Medicine Rotation			
Critical Appraisal	**Leadership / Professional Development**	**Teaching**	**Quality Improvement**
An overview of the HSL-Anesthesiology Library Resource Guide	Coping Strategies	Simulation in Medical Education	Bringing ERAS to UNC using Lean Six Sigma
Understanding and Working with the IRB	Personality Inventory Sessions	Anesthesia Olympics	QI Statistics
EBM and Outcomes Research	Healthcare Policy	Optimizing Problem-based Learning	Making a Charter and A3
Asking a Question and Searching for Answers: An Overview	Leadership Series: Planning your Future in an Anesthesiology in a Knowledge-based Environment	Clinical teaching while you work and getting started in educational scholarship	Yellow Belt Training
Introduction to Anesthesiology Resident Research	Leadership Series: Skills Workshop	An Academic Medicine Career	Creating Surveys
Review of Study Designs and Smart Searching	Financial and Benefits Planning Workshop	Generations Workshop	M&M Talk
Journal Club-Sellick Maneuver	Leadership Series: Conflict Resolution	Feedback in Learning and teaching	Quality Improvement Exercises
Journal Club Lunch	TeamSTEPPS	Social Media Workshop	A3 Workshop
Abstract writing workshop and brainstorm	Advancement		Overview of Risk Management at UNCH
EBM: Clinical Application	Wellness		National Surgical Quality Databases
Designing and Making a Poster	Benefits of Advanced degrees		AQI, AIRS and NACOR: Specialty quality tools
Writing an Abstract	Leadership Series: Persuasion and Negotiation		An Overview of Health Care System Based Quality Reporting
Research Workshop	Health Care Policy Advocacy and UNC		
Excel Workshop	Understanding MOCA and Lifelong Learning		
PowerPoint Presentations Fine Tuning	Leadership Series: Public Speaking-Getting your point across		
Public Speaking Lecture	NC Tort Reform and Malpractice Case Walkthrough		
How to give an Entertaining Scientific Presentation	How to get involved in Regional and National Meetings/QI Emphasis		
	Role of the NCSA and Specialty Advocacy		
	Demonstrating value outside of clinical care		
	Understanding Anesthesia Billing		
	CRNA/AA Issues		

Critical Appraisal
An overview of the HSL-Anesthesiology Library Resource Guide
Understanding and Working with the IRB
EBM and Outcomes Research
Asking a Question and Searching for Answers: An Overview
Introduction to Anesthesiology Resident Research
Review of Study Designs and Smart Searching
Journal Club
Abstract writing workshop and brainstorm
EBM: Clinical Application
Designing and Making a Poster
Writing an Abstract
Research Workshop
Excel Workshop
PowerPoint Presentations Fine Tuning
Public Speaking Lecture
How to give an Entertaining Scientific Presentation

Leadership / Professional Development
Coping Strategies
Personality Inventory Sessions
Healthcare Policy
Leadership Series: Planning your Future in an Anesthesiology in a Knowledge-based Environment
Leadership Series: Skills Workshop
Financial and Benefits Planning Workshop
Leadership Series: Conflict Resolution
TeamSTEPPS
Advancement
Wellness
Benefits of Advanced degrees
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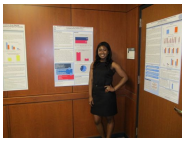
Role of the NCSA and Specialty Advocacy
Demonstrating value outside of clinical care
Understanding Anesthesia Billing
CRNA/AA Issues

Teaching
Simulation in Medical Education
Anesthesia Olympics
Optimizing Problem-based Learning
Clinical teaching while you work and getting started in educational scholarship
An Academic Medicine Career
Generations Workshop
Feedback in Learning and teaching
Social Media Workshop

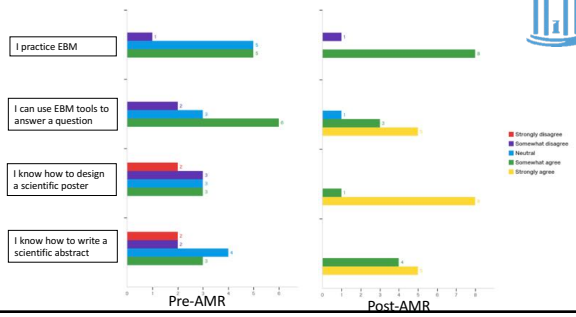
Quality Improvement
Bringing ERAS to UNC using Lean Six Sigma
QI Statistics
Making a Charter and A3
Yellow Belt Training
Creating Surveys
M&M Talk
Quality Improvement Exercises
A3 Workshop
Overview of Risk Management at UNCH
National Surgical Quality Databases
AQI, AIRS and NACOR: Specialty quality tools
An Overview of Health Care System Based Quality Reporting

Individual Project

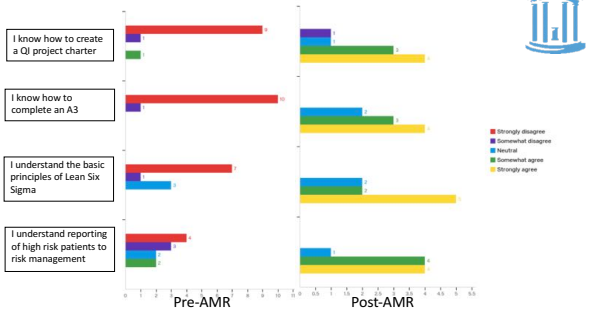
- Evidence based review vs. QI project
- Apply principles of Lean Six Sigma
- Faculty mentor
- Graduation symposium
  - oral presentation



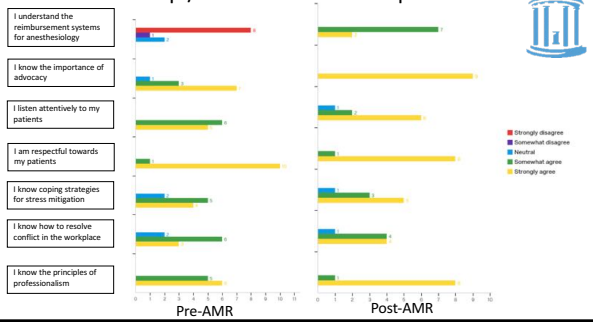
Critical Appraisal / Presentation Skills



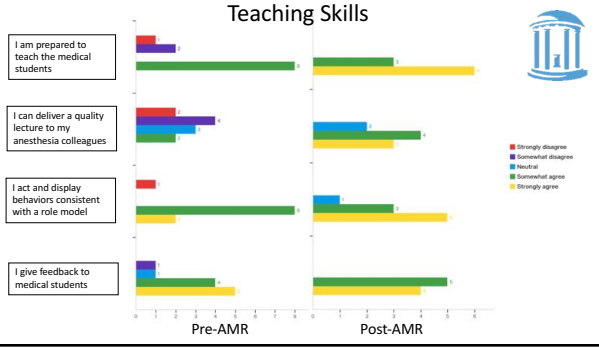
Quality Improvement



Leadership / Professional Development Skills



Teaching Skills



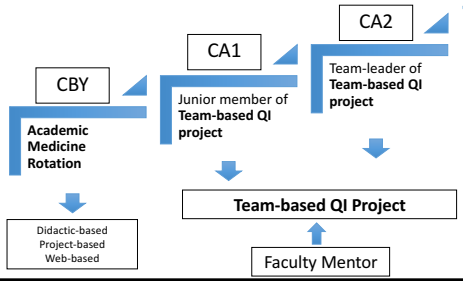
Is this a Worthwhile Investment?

- Several AMR projects presented at regional / national conferences
  - 19/41
- Provides foundation / motivation for future scholarly work
- Development of interpersonal and communication skills
- Leadership skills
- Better teachers
- Positive feedback
- Camaraderie and team-building

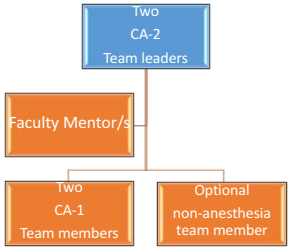
How can other programs do it?

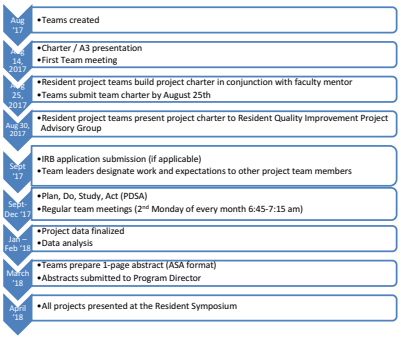
- Connections with other departments
  - School of Public Health
  - Health Sciences Library
  - Business School
- Intern time off rotations
- Need approval from DIO

Quality Improvement Training



Team-based QI Projects





Practice Management: ACGME Requirements

IV.A.5.b).(1).(a)	practice management to address issues such as: (Outcome)
IV.A.5.b).(1).(a).(i)	operating room management; (Outcome)
IV.A.5.b).(1).(a).(ii)	evaluation of types of practice; (Outcome)
IV.A.5.b).(1).(a).(iii)	contract negotiations; (Outcome)
IV.A.5.b).(1).(a).(iv)	billing arrangements; (Outcome)
IV.A.5.b).(1).(a).(v)	professional liability; (Outcome)
IV.A.5.b).(1).(a).(vi)	legislative and regulatory issues; and, (Outcome)
IV.A.5.b).(1).(a).(vii)	fiscal stewardship of health services delivery. (Outcome)

Program directors in surgery agree that residents should be formally trained in business and practice management

Vincent C. Lusco, M.D., Serge A. Martinez, M.D., J.D., Hiram C. Polk, Jr., M.D.*

- 189/242 General Surgery PDs responded
  - 70% believed their current residents received inadequate TTP training

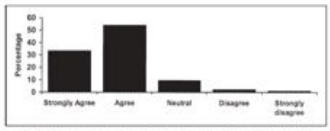


Fig. 1. Results of survey question that asked whether residents should receive instruction in business and practice management.

The American Journal of Surgery 189 (2005) 11–13

Facilitating the transition to practice: a weekend retreat curriculum for business-of-medicine education of United States anesthesiology residents

Elena J. Holak · Olga Kaslow · Paul S. Pagel

How do I find a job?
Academic anesthesia—a career for me?
Construction of an effective curriculum vitae
Successful interviewing strategies
Fundamentals of coding and billing
Medicare and Medicaid guidelines
Regulatory compliance
Medical malpractice insurance
The Wisconsin Patients and Families Compensation Fund
Life, disability, and long-term care insurance
Fundamentals of contracts
Negotiating an effective employment agreement
Managing your money
Retirement planning

J Anesth (2010) 24:807–810

Transition from Residency to Practice

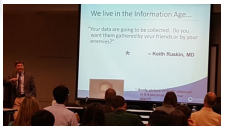
- Mentorship
- Networking
- Seminars / workshops / didactics
- Professional society resources
- Experiences designed towards transition to practice
- Other unique experiences

Academice Medicine Rotation

Critical Appraisal	Professional Development	Quality Improvement	Teaching
An overview of the HSL-Anesthesiology Library Resource Guide	Coping Strategies	Bringing ERAS to UNC using Lean Six Sigma	Simulation in Medical Education
Understanding and Working with the IRB	Personality Inventory Sessions	QI Statistics	Anesthesia Olympics
EBM and Outcomes Research	Healthcare Policy	Making a Charter and A3	Optimizing Problem-based Learning
Asking a Question and Searching for Answers: An Overview	Leadership Series: Planning your Future in an Anesthesiology in a Knowledge-based Environment	Yellow Belt Training	Clinical teaching while you work and getting started in educational scholarship
Introduction to Anesthesiology Resident Research	Leadership Series: Skills Workshop	Creating Surveys	An Academic Medicine Career
Review of Study Designs and Smart Searching	Financial and Benefits Planning Workshop	M&M Talk	Generations Workshop
Journal Club-Sellick Maneuver	Leadership Series: Conflict Resolution	Quality Improvement Exercises	Feedback in Learning and teaching
Journal Club Lunch	TeamSTEPPS	A3 Workshop	Social Media Workshop
Abstract writing workshop and brainstorm	Advancement	Overview of Risk Management at UNCH	
EBM: Clinical Application	Wellness	National Surgical Quality Databases	
Designing and Making a Poster	Benefits of Advanced degrees	KQI, AIRS and NACOR: Specialty quality tools	
Writing an Abstract	Leadership Series: Persuasion and Negotiation	An Overview of Health Care System Based Quality Reporting	
Research Workshop	Health Care Policy Advocacy and UNC		
Excel Workshop	Understanding MOCA and Lifelong Learning		
PowerPoint Presentations Find Tuning	Leadership Series: Public Speaking-Getting your point across		
Public Speaking Lecture	NC Tort Reform and Malpractice Case Walkthrough		
How to give an Entertaining Scientific Presentation	How to get involved in Regional and National Meetings/QI Emphasis		
	Role of the NCSA and Specialty Advocacy		
	Demonstrating value outside of clinical care		
	Understanding Anesthesia Billing		
	CRNA/AA Issues		

Resident Day: Transition to Practice Seminar

8:00—8:05	**Welcome** *Kim Nichols, MD and Fran D'Ercole, MD*
8:05—8:35	**Medical Regulation: The Importance of Following the Rules** *Bryant Murphy, MD, MBA*
8:35—9:05	**Life as a Private Practice Anesthesiologist** *Marc Abrams, MD*
9:05—9:20	**Break**
9:20—10:05	**Legal Perspectives from a Defense Attorney** *Kelly Street Brown, JD*
10:05—10:50	**Legal Perspectives from a Defending Anesthesiologist** *Fran D'Ercole, MD*
10:50—11:45	**Questions/Open Discussion**
12:00—1:00	**Lunch Session:** **Policy and Regulatory Law—Judith Semo, MD**
1:05—1:35	**The Culture of Anesthesia: Working with CRNAs** *Marc Levi, MD*
1:35—2:05	**Wealth Building: Focus for the Young Physician** *Kevin Swan, ChFC, FSCP, CASL, LUTCF*
2:05—2:35	**Dissecting Physician Contracts** *Kim Korando, JD*
2:35—3:15	**Alumni Panel: Life AFTER Training** *Kim Nichols, MD—Moderator* **Panelist: Sean Claar, MD; Mary Jennette Judd, MD; Drew Karenz, MD**
3:15—3:30	**Questions/Open Discussion**



Professional Society Resources

- American Society of Anesthesiologists (ASA)
  - ASA Annual Conference
  - ASA Practice Management Conference
  - ASA Legislative Conference
- State Societies
  - Resident track @ North Carolina State Society
- Subspecialty Societies

Experiences geared towards TTP

- Senior call responsibilities
- Electives
  - Admin-E
- Transition to Practice rotation

Unique Experiences

- Health Policy Elective at George Washington University
- ASA's Policy Research Rotation in Political Affairs

Dual MHA / MPH Track

- Dual tracks
  - Masters in Health Administration
  - Masters in Public Health
- Executive MHA / MPH Track
  - Gillings School of Public Health (Ranked no. 2)
  - 2-year program – online with 14 days onsite sessions
  - CA-3 year: 1 day non-clinical time / week
  - CA-4 year: Instructor/Fellow position with 2 days of non-clinical time / week

Summary

- Residency training has to be all encompassing
- Softer skills (leadership, quality improvement, communication, teaching, interpersonal skills, professionalism) are teachable
- Programs should create curricula targeted towards SMOOTH transition from residency to practice

HANDOUT

AACPD
ASSOCIATION OF ANESTHESIOLOGY CORE PROGRAM DIRECTORS

The RRC: From Idea to Program Requirement

Robert R. Gaiser, MD, MSEd

11/03/2017
11:30am - 11:40am

Idea to Program Requirement

Robert Gaiser, M.D., M.S.Ed.
Professor and Chair

A revision to the program requirements includes an addition, deletion, or a change. Only changes to the specialty and subspecialty requirements may be done by the Anesthesiology RC. Every ten years, the ACGME requires the RC to review the specialty requirements and consider a revision. Changes to the Common Program Requirements are initiated by the ACGME and involve a multispecialty committee with representation from the Board of the ACGME and the chairs of the various RCs.

There are two types of revisions: major revisions, which reflect significant changes in specialty policy or practice, and minor revisions, which tend to focus on word choice or organizational restructuring. A minor revision does not involve additional resources to the program and does not have an impact to the other residencies. A major revision often involves the need for a program to obtain additional resources to implement the change and/or has an impact on other residencies.

If a specialty group or individual would like the RC to consider a change to the specialty program requirements, the first step in the process is to contact the Executive Director or the Chair of the RC with the idea, outlining the proposed change. The ED and Chair discuss and bring the specific proposal to an RC meeting for discussion and a vote. If the RC is in support of the change, the impact of the change is gauged and the procedure moves forward either as a major or minor revision.

For minor changes, the change and its specific location within the program requirements is submitted to the Department of Accreditation and Standards. If this group also feels that the change is indeed minor, it is submitted to the Committee of Requirements, which will either approve or deny the change at one of its meetings. This committee meets at the same time of the Board of Directors for the ACGME and will submit the recommendation for the change to the consent agenda for the board meeting.

For major changes, a subcommittee is formed by the ACGME and RC to investigate the impact of the change. This subcommittee will generate recommendations for the RC to consider. The RC will vote on the change and that change, the subcommittee recommendations, and the RC vote will be submitted to the Department of Accreditation and Standards. This group will generate questions regarding the clarity and intent of the proposed changes that must be addressed by the ED and Chair of the RC. This process is iterative and may involve several rounds. Once the concerns have been addressed, the proposed major revisions will be released to the community for public comment. The community receives 45 days to comment. Once the comments have been received and organized, the ED and Chair of the RC must develop responses to the concerns raised by the community. This too is an iterative process. After responding to the concerns, the final program revisions are sent to the Committee of Requirements, which will vote upon the proposed revisions. If the committee accepts, the proposed change is sent to the ACGME Board for final approval.

HANDOUT

AACPD
ASSOCIATION OF ANESTHESIOLOGY CORE PROGRAM DIRECTORS

Survey Results: Teaching Practice Management

Joy L. Hawkins, MD

11/03/2017
11:40am - 11:45am

Survey Results: Teaching Practice Management

Joy L. Hawkins, MD

University of Colorado School of Medicine

I have no conflicts to disclose.

ASA Ad Hoc Committee on Practice Management Issues in Anesthesia Training Programs

- Background: Feedback from several ASA committees including Practice Management, Large Group Practice, Economics and Future Models of Anesthesia Practice indicated concern that that residency programs lack training, didactics, and rotations in practice management topics.
- The Committee was asked to define what types of educational programs have been implemented and to identify opportunities to improve the training.
- Survey: 10 questions, 56 responses from AACPD.

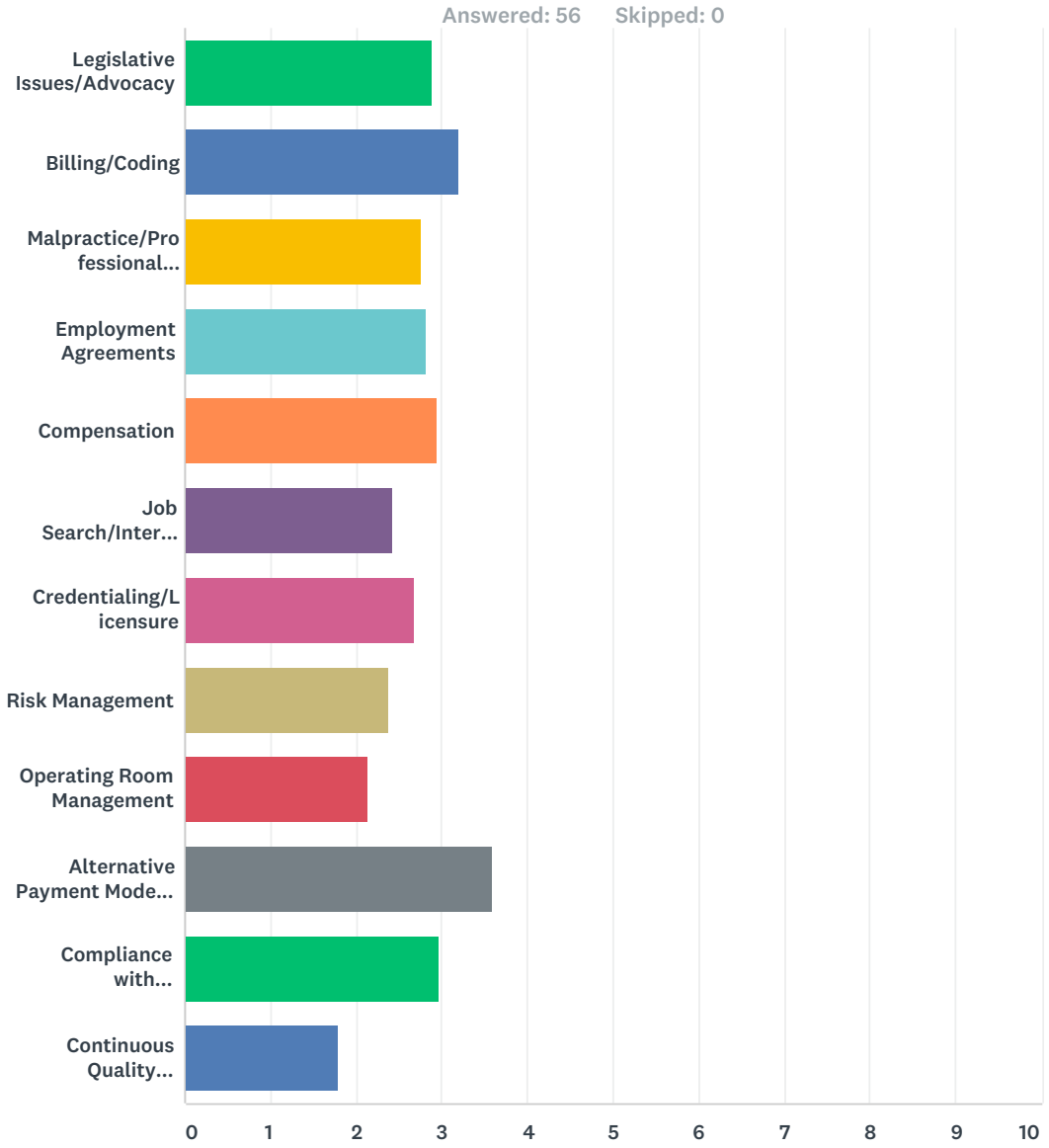
Findings from the Survey

- A significant proportion of programs do not teach major aspects of practice management, e.g. 27% do not teach Billing/Coding, 38% do not cover Compensation, 21% Employment Agreements, 25% Compliance with Medicaid and Medicare, and 57% do not teach Alternative Payment Methods.
- Didactics are still the major format for covering most topics, although OR Management (whatever that might include) is often taught as a rotation or by shadowing.
- The time devoted to didactics is small – an average of 6.8 hours. For those programs who *have* created a rotation, about half devote at least 40 hours to the topic.

Conclusions and Future Directions

- Residency programs would benefit from and would appreciate more specific and structured guidance from the RRC.
- Residencies need concrete examples of comprehensive curricula that individual programs could then adopt or adapt.
- Program Directors would appreciate resources such as webinars, updates to the COPM syllabus, and other on-line tools they could incorporate.

Q1 Please rank how adequately your program exposes residents to the following topics:

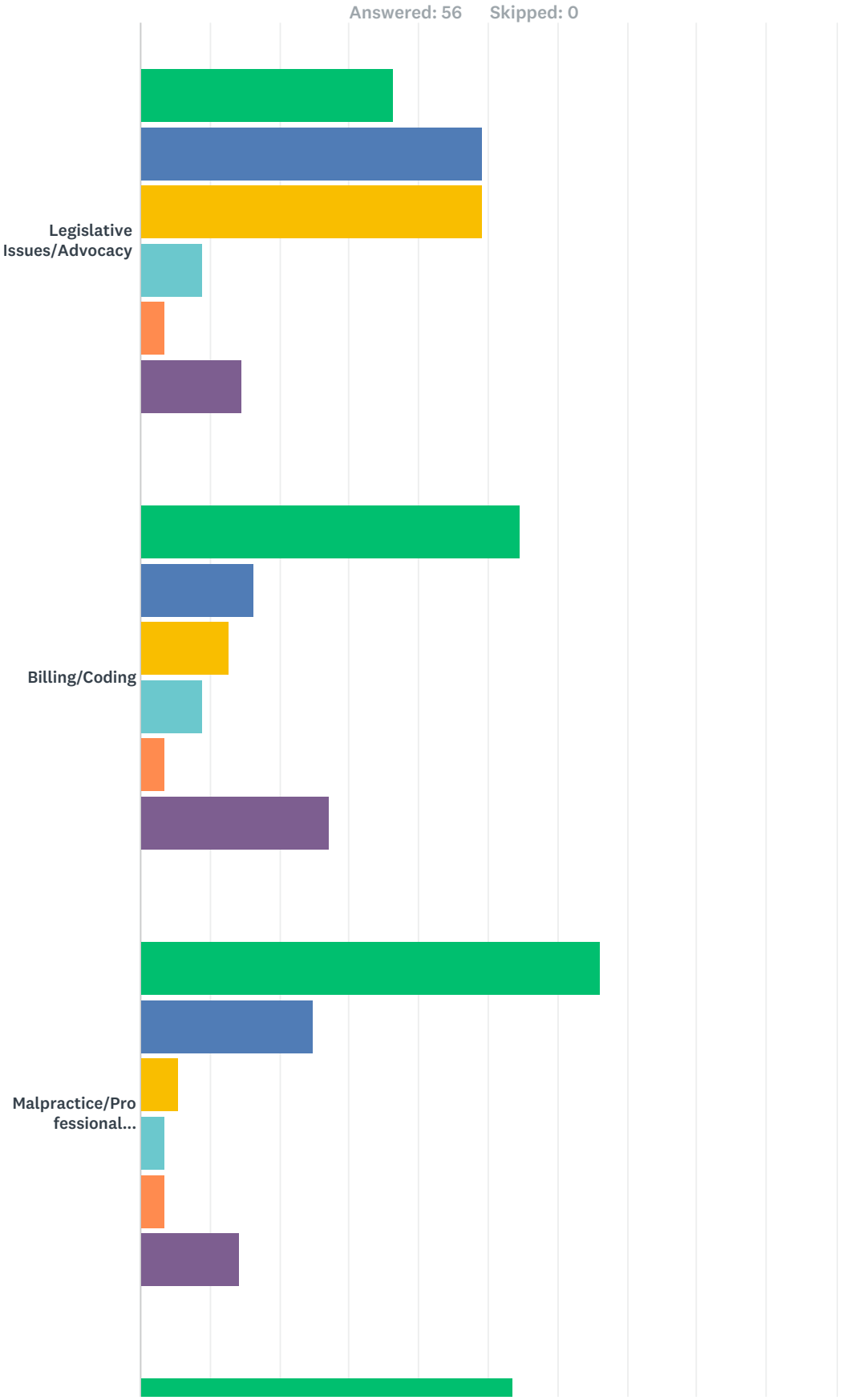


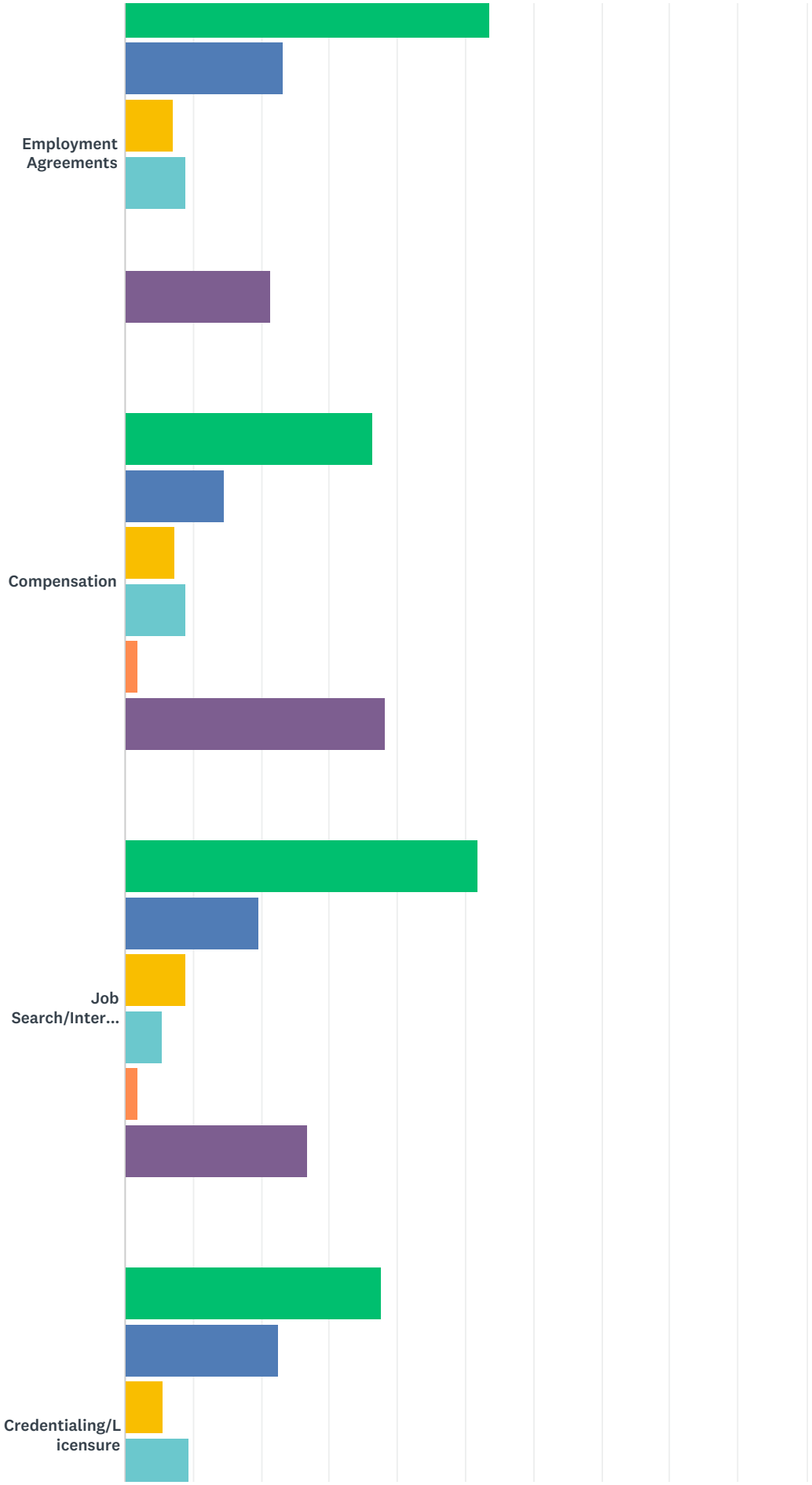
	Thoroughly	Adequately	Inadequately	Minimally/Not at All	Don't Know	Total	Weighted Average
Legislative Issues/Advocacy	12.50% 7	42.86% 24	33.93% 19	10.71% 6	0.00% 0	56	2.88
Billing/Coding	7.14% 4	37.50% 21	37.50% 21	17.86% 10	0.00% 0	56	3.21
Malpractice/Professional Liability	7.14% 4	55.36% 31	28.57% 16	8.93% 5	0.00% 0	56	2.77
Employment Agreements	8.93% 5	48.21% 27	37.50% 21	5.36% 3	0.00% 0	56	2.82
Compensation	5.36% 3	46.43% 26	44.64% 25	3.57% 2	0.00% 0	56	2.95

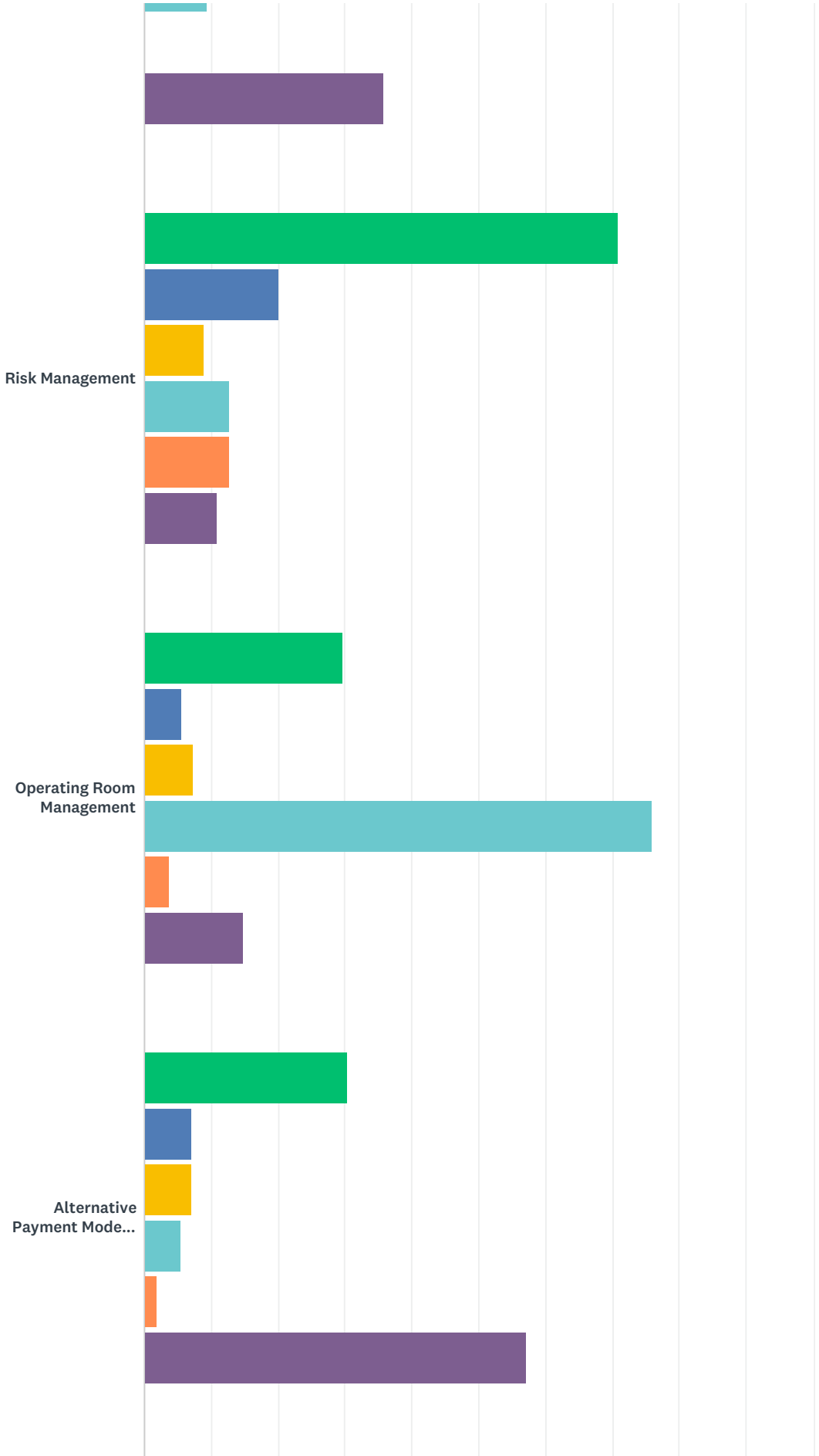
Job Search/Interviewing	**14.29% 8**	**60.71% 34**	**17.86% 10**	**7.14% 4**	**0.00% 0**	**56**	**2.43**
Credentialing/Licensure	**7.27% 4**	**58.18% 32**	**29.09% 16**	**5.45% 3**	**0.00% 0**	**55**	**2.67**
Risk Management	**23.21% 13**	**48.21% 27**	**25.00% 14**	**3.57% 2**	**0.00% 0**	**56**	**2.38**
Operating Room Management	**33.93% 19**	**44.64% 25**	**17.86% 10**	**3.57% 2**	**0.00% 0**	**56**	**2.13**
Alternative Payment Models (Accountable Care Organizations, Health Maintenance Organizations, etc.)	**3.57% 2**	**23.21% 13**	**57.14% 32**	**16.07% 9**	**0.00% 0**	**56**	**3.59**
Compliance with Medicare/Medicaid	**8.93% 5**	**42.86% 24**	**37.50% 21**	**10.71% 6**	**0.00% 0**	**56**	**2.98**
Continuous Quality Improvement Process	**35.71% 20**	**57.14% 32**	**5.36% 3**	**1.79% 1**	**0.00% 0**	**56**	**1.80**

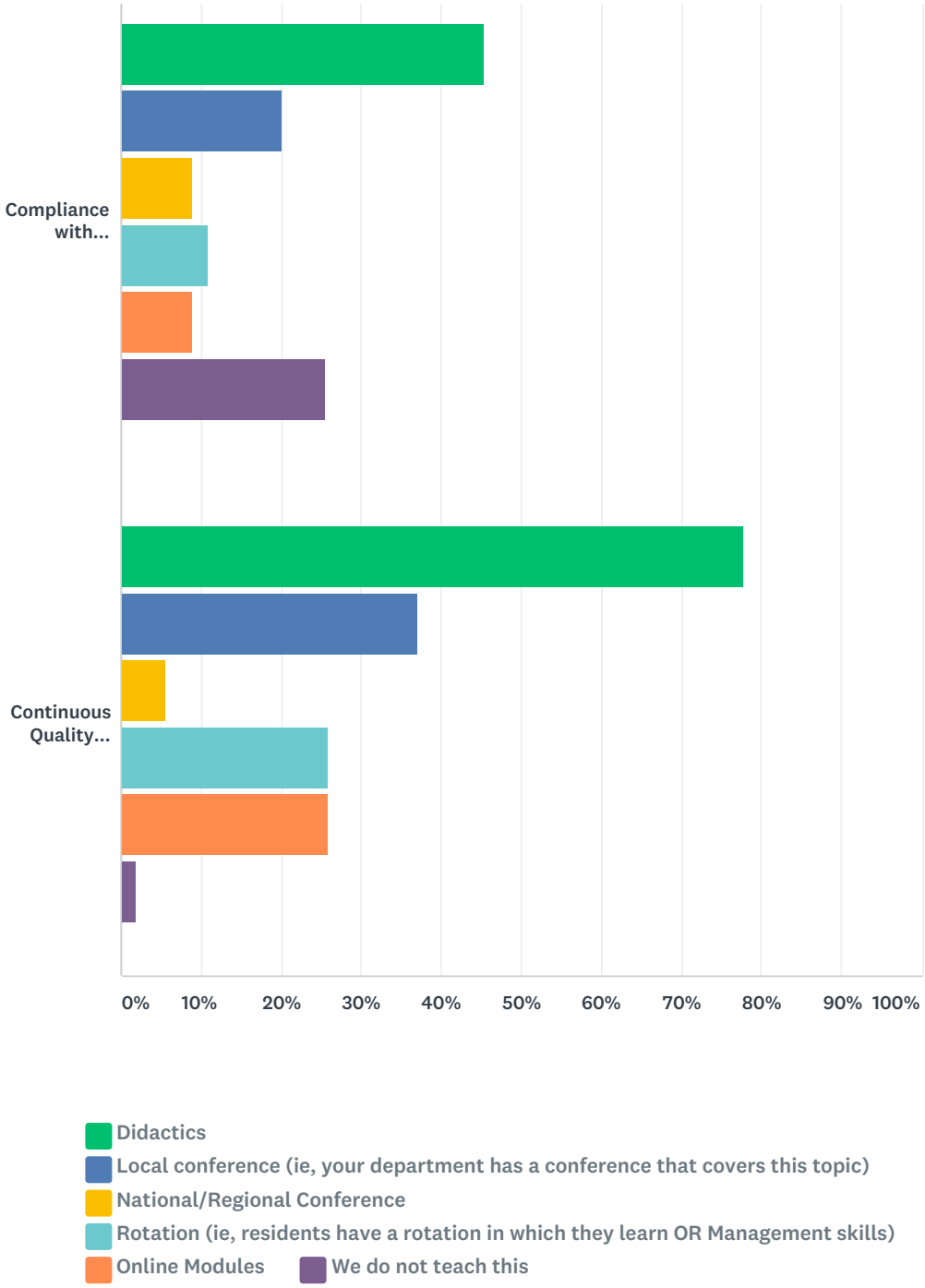
Q2 How does your program teach the following to residents? (Mark all that apply.)

Answered: 56 Skipped: 0




Employment Agreements
Compensation
Job Search/Inter...
Credentialing/Licensure


Risk Management
Operating Room Management
Alternative Payment Mode...

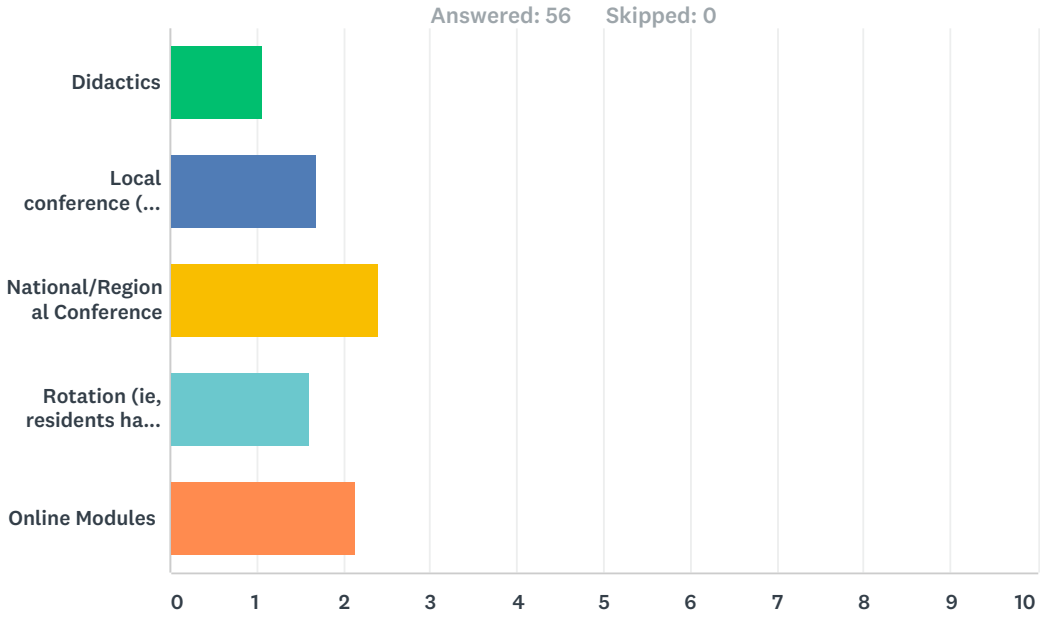


	Didactics	Local conference (ie, your department has a conference that covers this topic)	National/Regional Conference	Rotation (ie, residents have a rotation in which they learn OR Management skills)	Online Modules	We do not teach this	Total Respondents
Legislative Issues/Advocacy	36.36% 20	49.09% 27	49.09% 27	9.09% 5	3.64% 2	14.55% 8	55
Billing/Coding	54.55% 30	16.36% 9	12.73% 7	9.09% 5	3.64% 2	27.27% 15	55
Malpractice/Professional Liability	66.07% 37	25.00% 14	5.36% 3	3.57% 2	3.57% 2	14.29% 8	56

Employment Agreements	53.57% 30	23.21% 13	7.14% 4	8.93% 5	0.00% 0	21.43% 12	56
Compensation	36.36% 20	14.55% 8	7.27% 4	9.09% 5	1.82% 1	38.18% 21	55
Job Search/Interviewing	51.79% 29	19.64% 11	8.93% 5	5.36% 3	1.79% 1	26.79% 15	56
Credentialing/Licensure	37.74% 20	22.64% 12	5.66% 3	9.43% 5	0.00% 0	35.85% 19	53
Risk Management	70.91% 39	20.00% 11	9.09% 5	12.73% 7	12.73% 7	10.91% 6	55
Operating Room Management	29.63% 16	5.56% 3	7.41% 4	75.93% 41	3.70% 2	14.81% 8	54
Alternative Payment Models (ex, Accountable Care Organizations, Health Maintenance Organizations)	30.36% 17	7.14% 4	7.14% 4	5.36% 3	1.79% 1	57.14% 32	56
Compliance with Medicare/Medicaid	45.45% 25	20.00% 11	9.09% 5	10.91% 6	9.09% 5	25.45% 14	55
Continuous Quality Improvement Process	77.78% 42	37.04% 20	5.56% 3	25.93% 14	25.93% 14	1.85% 1	54

#	Comment (optional)	Date
1	CA-3 residents have a dedicated rotation at business headquarters that covers these topics and more.	5/23/2017 2:19 PM
2	All of our residents during various rotations must participate and complete PI/QI projects.	5/2/2017 10:21 AM
3	We have a yearly 4-hour practice management seminar for all residents that covers many of these topics.	2/6/2017 10:03 AM
4	1-2 week business rotation outside the hospital at our business headquarters.	1/31/2017 1:28 PM

Q3 If your program uses any of the following to teach these topics to residents, is attendance mandatory for all residents?

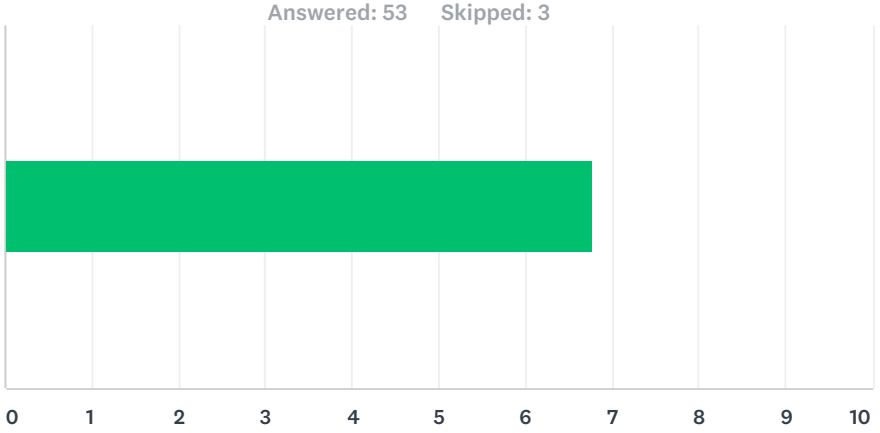


	Yes, most or all of the time.	No, never or rarely.	Don't Know.	We do not use this method.	Total	Weighted Average
Didactics	94.44% 51	5.56% 3	0.00% 0	0.00% 0	54	1.06
Local conference (ie, your department has a Conference that covers this topic)	56.25% 27	31.25% 15	0.00% 0	12.50% 6	48	1.69
National/Regional Conference	20.41% 10	46.94% 23	4.08% 2	28.57% 14	49	2.41
Rotation (ie, residents have a rotation in which they learn OR Management skills)	71.70% 38	11.32% 6	0.00% 0	16.98% 9	53	1.62
Online Modules	53.06% 26	12.24% 6	2.04% 1	32.65% 16	49	2.14

#	Other (please specify)	Date
	There are no responses.	

Q4 About how many hours is a resident required to invest in didactics for Practice Management education?

Answered: 53 Skipped: 3

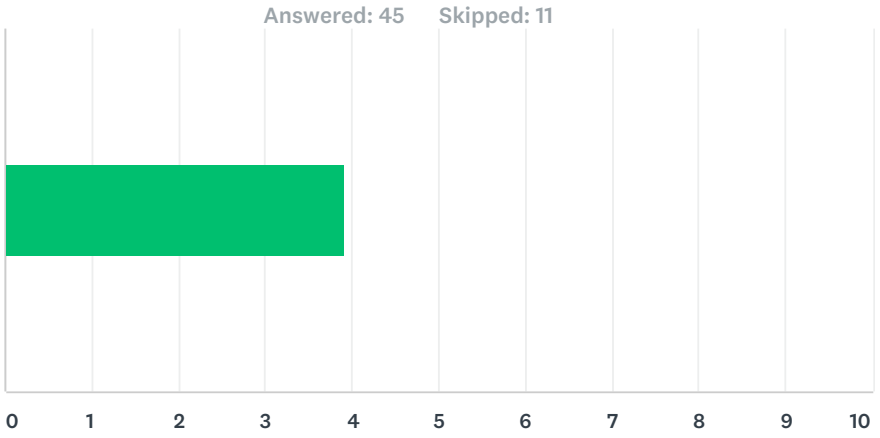


Answer Choices	Average Number	Total Number	Responses
	7	359	53
Total Respondents: 53			

#		Date
1	8	7/1/2017 2:15 PM
2	10	7/1/2017 11:14 AM
3	0	6/14/2017 8:44 AM
4	4	5/25/2017 8:18 AM
5	1	5/24/2017 1:15 PM
6	4	5/23/2017 2:19 PM
7	2	5/17/2017 9:17 AM
8	16	5/9/2017 10:49 AM
9	10	5/9/2017 8:52 AM
10	2	5/8/2017 6:42 PM
11	5	5/8/2017 2:18 PM
12	0	5/8/2017 2:16 PM
13	15	5/8/2017 1:51 PM
14	21	5/4/2017 8:26 PM
15	12	5/4/2017 11:28 AM
16	4	5/2/2017 10:21 AM
17	10	5/1/2017 2:57 PM
18	4	5/1/2017 1:50 PM
19	3	5/1/2017 1:14 PM
20	4	3/23/2017 7:58 AM
21	13	3/22/2017 6:54 AM
22	7	3/21/2017 1:45 PM

23	3	3/21/2017 12:39 PM
24	8	2/17/2017 2:47 PM
25	9	2/10/2017 9:33 PM
26	5	2/10/2017 5:25 PM
27	5	2/10/2017 11:54 AM
28	5	2/10/2017 11:50 AM
29	2	2/10/2017 11:43 AM
30	10	2/10/2017 10:06 AM
31	10	2/6/2017 10:03 AM
32	5	2/3/2017 10:41 AM
33	3	2/2/2017 9:09 PM
34	2	2/2/2017 11:40 AM
35	10	2/2/2017 10:41 AM
36	3	2/1/2017 2:07 PM
37	1	2/1/2017 10:45 AM
38	5	2/1/2017 9:55 AM
39	15	2/1/2017 9:18 AM
40	12	1/31/2017 5:12 PM
41	5	1/31/2017 2:29 PM
42	10	1/31/2017 1:31 PM
43	0	1/31/2017 1:28 PM
44	3	1/31/2017 1:26 PM
45	0	1/31/2017 12:58 PM
46	5	1/31/2017 12:53 PM
47	11	1/31/2017 12:36 PM
48	10	1/31/2017 12:31 PM
49	0	1/31/2017 12:20 PM
50	21	1/31/2017 12:07 PM
51	6	1/31/2017 12:06 PM
52	10	1/31/2017 11:58 AM
53	10	1/31/2017 11:57 AM

Q5 About how many hours is a resident required to invest in local conference (i.e., your department has a conference that covers this topic) for Practice Management education?

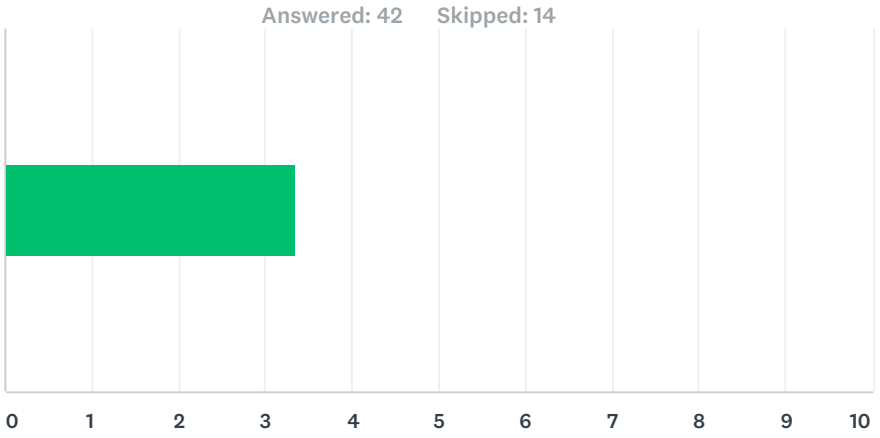


Answer Choices	Average Number	Total Number	Responses
	4	176	45
Total Respondents: 45			

#		Date
1	6	7/1/2017 11:14 AM
2	0	6/14/2017 8:44 AM
3	3	5/25/2017 8:18 AM
4	1	5/24/2017 1:15 PM
5	2	5/17/2017 9:17 AM
6	0	5/9/2017 10:49 AM
7	10	5/9/2017 8:52 AM
8	1	5/8/2017 6:42 PM
9	0	5/8/2017 2:18 PM
10	2	5/8/2017 1:51 PM
11	12	5/4/2017 8:26 PM
12	2	5/4/2017 11:28 AM
13	4	5/2/2017 10:21 AM
14	6	5/1/2017 2:57 PM
15	1	5/1/2017 1:50 PM
16	0	5/1/2017 1:14 PM
17	1	3/23/2017 7:58 AM
18	0	3/21/2017 1:45 PM
19	0	3/21/2017 12:39 PM
20	3	2/17/2017 2:47 PM
21	5	2/10/2017 9:33 PM

22	5	2/10/2017 5:25 PM
23	4	2/10/2017 11:54 AM
24	0	2/10/2017 11:50 AM
25	1	2/10/2017 11:43 AM
26	2	2/10/2017 10:06 AM
27	13	2/6/2017 10:03 AM
28	0	2/3/2017 10:41 AM
29	6	2/2/2017 9:09 PM
30	2	2/2/2017 11:40 AM
31	8	2/2/2017 10:41 AM
32	2	2/1/2017 2:07 PM
33	1	2/1/2017 10:45 AM
34	5	2/1/2017 9:55 AM
35	24	2/1/2017 9:18 AM
36	5	1/31/2017 2:29 PM
37	10	1/31/2017 1:31 PM
38	0	1/31/2017 1:26 PM
39	0	1/31/2017 12:58 PM
40	5	1/31/2017 12:53 PM
41	10	1/31/2017 12:31 PM
42	1	1/31/2017 12:20 PM
43	3	1/31/2017 12:07 PM
44	6	1/31/2017 12:06 PM
45	4	1/31/2017 11:58 AM

Q6 About how many hours is a resident required to invest in national/regional conference for Practice Management education?



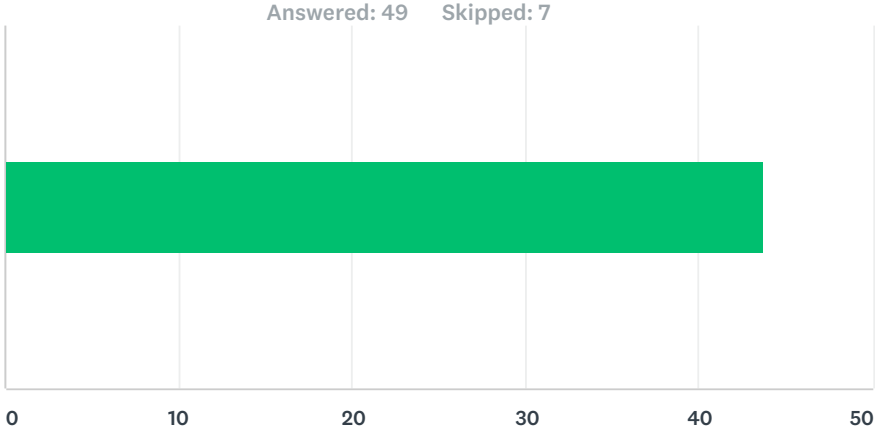
Answer Choices	Average Number	Total Number	Responses
	3	141	42
Total Respondents: 42			

#		Date
1	15	7/1/2017 2:15 PM
2	6	7/1/2017 11:14 AM
3	0	6/14/2017 8:44 AM
4	19	5/25/2017 8:18 AM
5	2	5/17/2017 9:17 AM
6	0	5/9/2017 10:49 AM
7	0	5/9/2017 8:52 AM
8	4	5/8/2017 6:42 PM
9	0	5/8/2017 2:18 PM
10	0	5/8/2017 1:51 PM
11	20	5/4/2017 8:26 PM
12	0	5/4/2017 11:28 AM
13	2	5/2/2017 10:21 AM
14	0	5/1/2017 1:14 PM
15	3	3/23/2017 7:58 AM
16	0	3/21/2017 1:45 PM
17	0	3/21/2017 12:39 PM
18	4	2/10/2017 9:33 PM
19	4	2/10/2017 11:54 AM
20	0	2/10/2017 11:50 AM
21	11	2/10/2017 11:43 AM

22	1	2/10/2017 10:06 AM
23	0	2/6/2017 10:03 AM
24	0	2/3/2017 10:41 AM
25	0	2/2/2017 9:09 PM
26	0	2/2/2017 11:40 AM
27	0	2/2/2017 10:41 AM
28	0	2/1/2017 2:07 PM
29	0	2/1/2017 10:45 AM
30	5	2/1/2017 9:55 AM
31	18	1/31/2017 5:12 PM
32	0	1/31/2017 2:29 PM
33	0	1/31/2017 1:31 PM
34	0	1/31/2017 1:28 PM
35	0	1/31/2017 1:26 PM
36	0	1/31/2017 12:58 PM
37	5	1/31/2017 12:53 PM
38	0	1/31/2017 12:31 PM
39	0	1/31/2017 12:20 PM
40	7	1/31/2017 12:07 PM
41	0	1/31/2017 11:58 AM
42	15	1/31/2017 11:57 AM

Q7 About how many hours is a resident required to invest in rotation (ie, residents have a rotation in which they learn OR Management skills) for Practice Management education?

Answered: 49 Skipped: 7



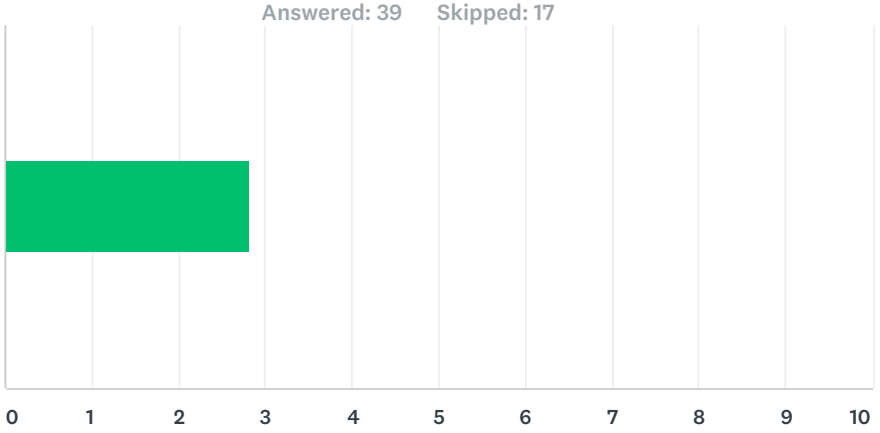
Answer Choices	Average Number	Total Number	Responses
	44	2,143	49
Total Respondents: 49			

#		Date
1	5	7/1/2017 2:15 PM
2	80	7/1/2017 11:14 AM
3	41	5/25/2017 8:18 AM
4	3	5/24/2017 1:15 PM
5	40	5/23/2017 2:19 PM
6	10	5/17/2017 9:17 AM
7	0	5/9/2017 10:49 AM
8	40	5/9/2017 8:52 AM
9	4	5/8/2017 6:42 PM
10	0	5/8/2017 2:18 PM
11	100	5/8/2017 2:16 PM
12	25	5/8/2017 1:51 PM
13	70	5/4/2017 8:26 PM
14	100	5/4/2017 11:28 AM
15	2	5/2/2017 10:21 AM
16	50	5/1/2017 2:57 PM
17	100	5/1/2017 1:14 PM
18	100	3/23/2017 7:58 AM
19	100	3/22/2017 6:54 AM
20	0	3/21/2017 1:45 PM
21	5	3/21/2017 12:39 PM

22	50	2/17/2017 2:47 PM
23	30	2/10/2017 9:33 PM
24	41	2/10/2017 5:25 PM
25	0	2/10/2017 11:50 AM
26	10	2/10/2017 11:43 AM
27	40	2/10/2017 10:06 AM
28	0	2/6/2017 10:03 AM
29	100	2/3/2017 10:41 AM
30	0	2/2/2017 9:09 PM
31	40	2/2/2017 11:40 AM
32	0	2/2/2017 10:41 AM
33	100	2/1/2017 2:07 PM
34	63	2/1/2017 10:45 AM
35	60	2/1/2017 9:55 AM
36	100	2/1/2017 9:18 AM
37	24	1/31/2017 5:12 PM
38	100	1/31/2017 2:29 PM
39	0	1/31/2017 1:31 PM
40	60	1/31/2017 1:28 PM
41	17	1/31/2017 1:26 PM
42	100	1/31/2017 12:58 PM
43	0	1/31/2017 12:53 PM
44	38	1/31/2017 12:36 PM
45	100	1/31/2017 12:31 PM
46	6	1/31/2017 12:20 PM
47	9	1/31/2017 12:07 PM
48	80	1/31/2017 11:58 AM
49	100	1/31/2017 11:57 AM

Q8 About how many hours is a resident required to invest in online modules for Practice Management education?

Answered: 39 Skipped: 17

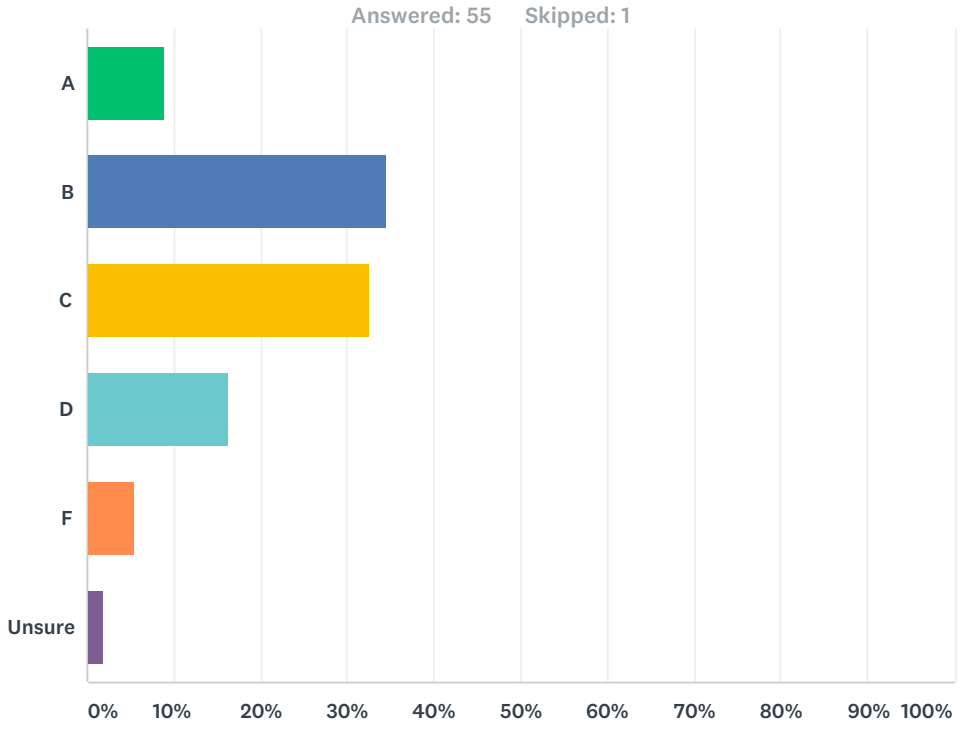


Answer Choices	Average Number	Total Number	Responses
	3	110	39
Total Respondents: 39			

#		Date
1	0	6/14/2017 8:44 AM
2	2	5/17/2017 9:17 AM
3	1	5/9/2017 10:49 AM
4	0	5/9/2017 8:52 AM
5	2	5/8/2017 6:42 PM
6	1	5/8/2017 2:18 PM
7	1	5/8/2017 1:51 PM
8	5	5/4/2017 8:26 PM
9	2	5/4/2017 11:28 AM
10	0	5/2/2017 10:21 AM
11	0	5/1/2017 1:50 PM
12	0	5/1/2017 1:14 PM
13	2	3/23/2017 7:58 AM
14	0	3/21/2017 1:45 PM
15	0	3/21/2017 12:39 PM
16	2	2/17/2017 2:47 PM
17	6	2/10/2017 9:33 PM
18	1	2/10/2017 11:54 AM
19	3	2/10/2017 11:50 AM
20	0	2/10/2017 11:43 AM
21	0	2/6/2017 10:03 AM
22	10	2/3/2017 10:41 AM

23	0	2/2/2017 9:09 PM
24	10	2/2/2017 10:41 AM
25	0	2/1/2017 2:07 PM
26	0	2/1/2017 10:45 AM
27	10	2/1/2017 9:55 AM
28	0	2/1/2017 9:18 AM
29	6	1/31/2017 5:12 PM
30	0	1/31/2017 2:29 PM
31	0	1/31/2017 1:31 PM
32	0	1/31/2017 1:28 PM
33	0	1/31/2017 1:26 PM
34	1	1/31/2017 12:58 PM
35	10	1/31/2017 12:53 PM
36	10	1/31/2017 12:31 PM
37	0	1/31/2017 12:20 PM
38	0	1/31/2017 11:58 AM
39	25	1/31/2017 11:57 AM

Q9 Overall, what grade would you give your residency in providing Practice Management education that prepares your graduates for his/her first job?



Answer Choices	Responses	
A	9.09%	5
B	34.55%	19
C	32.73%	18
D	16.36%	9
F	5.45%	3
Unsure	1.82%	1
Total		55

Q10 Please specifically document any innovative ways you teach this material.

Answered: 20 Skipped: 36

#	Responses	Date
1	Each resident attends one ASA Pract Manag Conf before graduation	7/1/2017 2:15 PM
2	Special CA-3 seminars with invited speakers from private practice who now work in our group	5/17/2017 9:17 AM
3	Conferences with the billing company, credentialing office, quality office	5/9/2017 8:52 AM
4	Rotation in OR management is supplemented with conferences regarding compliance, quality improvement.	5/8/2017 2:16 PM
5	Required one month rotation in OR management as CA-3 Residents perform a variety of tasks from supervision of ORs, participation in Managing GI endoscopy, managing L&D, and also serving as the Anesthesiologist in charge. There is a curriculum that they are required to cover during the month, articles regarding OR management issues, concepts on PSH, among others	3/22/2017 6:54 AM
6	N/A	3/21/2017 1:45 PM
7	rotation, hands on conference	2/17/2017 2:47 PM
8	Several of us have advanced degrees and or experience in practice management at large institution levels.	2/10/2017 9:33 PM
9	We provide lectures that are given by the President of the Academic Health Center, Commissioner of the State Board of Health, Presidents of the State Society and faculty that have an interest in the area of practice management.	2/10/2017 11:50 AM
10	Formal education is difficult Each dept runs differently based upon system based practices. We have them follow coordinator and involve residents on hospital committees	2/10/2017 11:43 AM
11	We use our faculty who have been in private practice and former graduates who have been in private practice to speak at a yearly practice management seminar and to participate in panels where residents can ask questions.	2/6/2017 10:03 AM
12	n/a	2/3/2017 10:41 AM
13	We organize a "Transition to Practice" - full day event on a weekend in spring for our residents. In addition to our own faculty, we bring in speakers from outside to cover a number of topics related to practice management. We also bring in some of our recent graduates and they serve on a panel to discuss do's and dont's of job search as well as what to focus on during their training.	2/2/2017 10:41 AM
14	High degree of state society level education and meeting attendance. Those in attendance share info with others. Monthly quality meetings in the department with multiple projects.	2/1/2017 9:55 AM
15	we have a rotation in which residents manage the OR's, PACU, and relief	1/31/2017 2:29 PM
16	Practice Management block of lectures; the block is given each year during their CA-2 & CA-3 years	1/31/2017 1:31 PM
17	Shadowing best method for us	1/31/2017 1:26 PM
18	Senior faculty members with experience in private practice hold seminars for the third years. We also have some billing/management items during the first month.	1/31/2017 12:53 PM
19	One month mandatory "Transition to Practice" rotation for CA-3s in which they have concentrated didactics and small group discussions with TTP faculty on most or all of these topics. They spend time running the OR schedule with loose attending oversight, as well as supervising AAs and CRNAs.	1/31/2017 12:31 PM
20	Required attendance at ASA practice management and legislative meetings	1/31/2017 11:57 AM

Q11 Additional comments:

Answered: 9 Skipped: 47

#	Responses	Date
1	On the issues of credentialing and licensure, job search/interviewing and compensation, I am of the opinion that you surely can sit down and teach these, but often times this knowledge is gained by just going through the process. We have all done it. It is not fun, but it is a necessary element in gaining employment. For that reason, there is substantial motivation for the individual to get these items covered. Should we really have to teach this?	5/17/2017 9:17 AM
2	Very important initiative.	5/9/2017 8:52 AM
3	We need to add more of these modules to our program teaching	5/2/2017 10:21 AM
4	The concepts can be integrated into daily OR teaching as well as have a rotation, special lectures with meetings, etc.	2/10/2017 9:33 PM
5	We send a number of residents each year to practice management seminars and governmental affairs meetings. The above answers in many cases were represented as zero hours since not all residents participate in these activities.	2/10/2017 11:50 AM
6	The syllabus on practice management that the ASA Committee produces is excellent, but we haven't figured out how to incorporate it effectively into our didactic program or into a rotation.	2/6/2017 10:03 AM
7	n/a	2/3/2017 10:41 AM
8	This year, we (UNC anesthesiology program) are collaborating with Duke's anesthesiology program on a "Transition to Practice" seminar for this spring for residents from both programs. We'll be happy to report on this after the event.	2/2/2017 10:41 AM
9	We have frequent discussions with the residents on the topic of practice management	1/31/2017 1:31 PM

HANDOUT

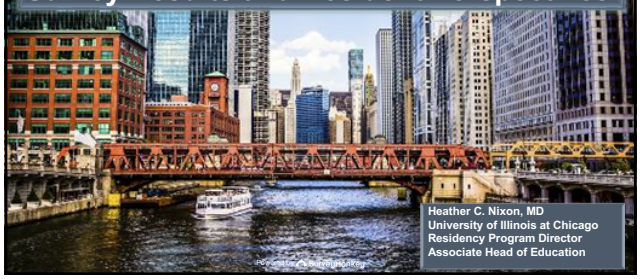
AACPD
ASSOCIATION OF ANESTHESIOLOGY CORE PROGRAM DIRECTORS

Technology in Anesthesia Education Panel: Survey Results and Resident Perspectives

Heather C. Nixon, MD

11/03/2017
1:35pm – 2:15pm

Technology in Anesthesia Education: Survey Results and Resident Perspectives



Heather C. Nixon, MD
University of Illinois at Chicago
Residency Program Director
Associate Head of Education

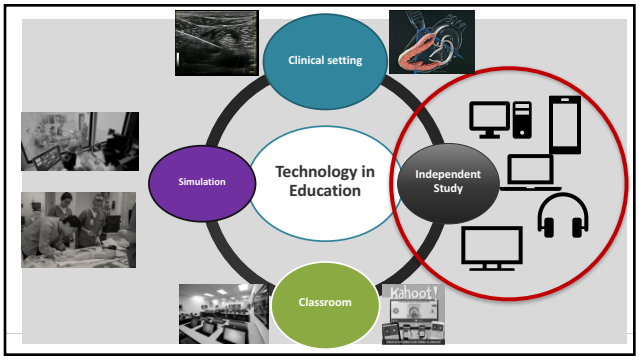
Today's Resident Panelists:

Dr. Omar Al-Qudsi – Loyola University

Dr. Erin Haggerty - University of Illinois at Chicago

Dr. Matthew Hire - Northwestern University

Dr. Logan Kinch - University of Chicago



Program Directors vs Residents

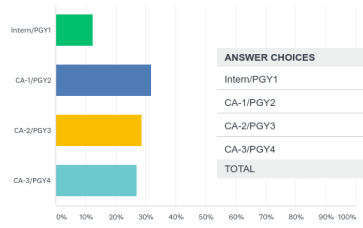
Generational Differences:

Use	Baby Boomers	Gen-X	Millennials
Technology	Digital expat	Digital immigrant	Digital native
Writing device	Typewriter	Desktop | tablet	Laptop | tablet
Writing implement	Pen | pencil	Stylus	Finger-tips
Writing surface	Paper	Touchscreen	Touchscreen
Phone call	Rotary phones	Flip-phone	Smartphone
Receive & display numeric | voice messages	Morse Code	Pager	Text | FaceTime
Personal digital assistant	Walkie-talkie	Palm Pilot	iPhone
Listen to music	Radio	MP3	iPod
Films	VHS	DVD	Blu-ray
Data storage	File cabinet	Hard drive	USB Flash
Presentation	Paper	PowerPoint	Pod-cast
Collection of sources of information	Encyclopedia	Library	MOOC
Photographs	Photo album	Digital picture frame	Instagram
Family Communication	Written letter	Phone call	Facebook | Twitter

http://www.clomedia.com/2016/10/17/beyond-hype-technologys-true-place-learning/ - Sydney Savion, 2016

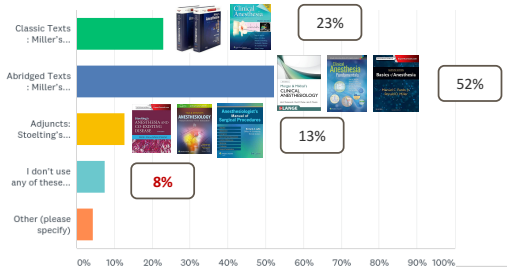
Q1: At what level of training are you?

Answered: 416

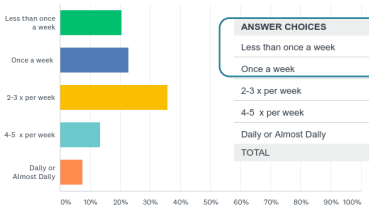


ANSWER CHOICES	RESPONSES
Intern/PGY1	12.41%
CA-1/PGY2	31.87%
CA-2/PGY3	28.71%
CA-3/PGY4	27.01%
TOTAL	

Q2: Of the following textbooks, which are you most likely to use?

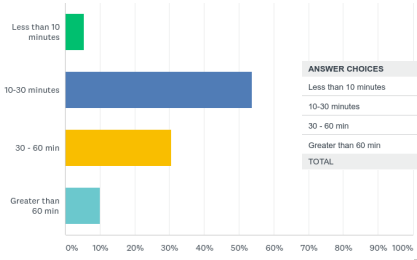


Q3: How frequently do you use this resource?



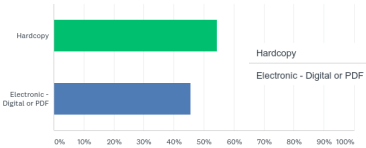
ANSWER CHOICES	RESPONSES
Less than once a week	20.44%
Once a week	22.89%
2-3 x per week	35.69%
4-5 x per week	13.35%
Daily or Almost Daily	7.63%
TOTAL	

Q4: How long do you use this resource at a given time?



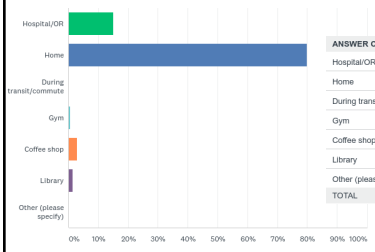
ANSWER CHOICES	RESPONSES
Less than 10 minutes	5.46%
10-30 minutes	53.83%
30 - 60 min	30.60%
Greater than 60 min	10.11%
TOTAL	

Q5: What format do you use?



Hardcopy	54.37%
Electronic - Digital or PDF	45.63%

Q6: Where are you most likely to use this resource?



ANSWER CHOICES	RESPONSES
Hospital/OR	14.99%
Home	79.84%
During transit/commute	0.27%
Gym	0.54%
Coffee shop	3.00%
Library	1.36%
Other (please specify)	0.00%
TOTAL	

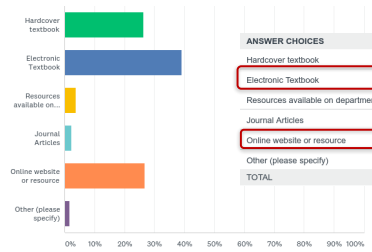
To the Residents……

Why are you choosing the abridged versions most commonly?

If you are only reading 10-30 min at a time less than 3 times a week, what parts are you reading?

If you grew up in a digital world, why is there still a preference for hardcopies?

Q7: What is the main resource you use to prepare /read up for cases



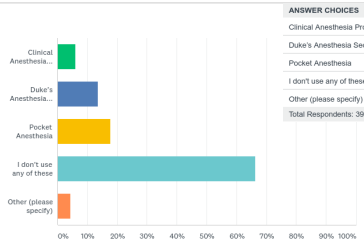
ANSWER CHOICES	RESPONSES
Hardcover textbook	26.26%
Electronic Textbook	39.14%
Resources available on department website	3.79%
Journal Articles	2.27%
Online website or resource	26.77%
Other (please specify)	1.77%
TOTAL	

To The Residents……

What websites are you using to prepare for cases?

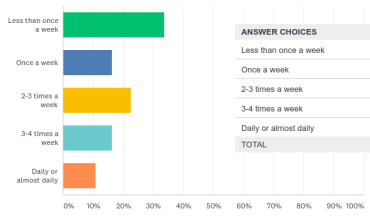
Why do you think most people are not using resources on departmental websites?

Q8: Do you use quick reference guides? Check all that apply



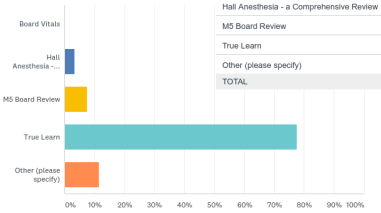
ANSWER CHOICES	RESPONSES
Clinical Anesthesia Procedures of Mass General	6.08%
Duke's Anesthesia Secrets	13.67%
Pocket Anesthesia	17.72%
I don't use any of these	66.33%
Other (please specify)	4.30%
Total Respondents: 395	

Q9: How frequently do you use this resource?



ANSWER CHOICES	RESPONSES	
Less than once a week	33.59%	43
Once a week	16.41%	21
2-3 times a week	22.66%	29
3-4 times a week	16.41%	21
Daily or almost daily	10.94%	14
TOTAL		128

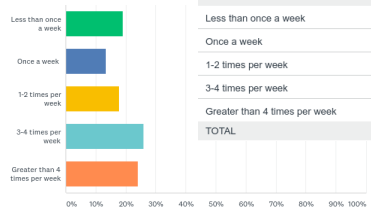
Q11: Of the following, which Q-Bank do you find most valuable?



ANSWER CHOICES	RESPONSES	
Board Vitals	0.00%	0
Hall Anesthesia - a Comprehensive Review	3.26%	12
M5 Board Review	7.61%	28
True Learn	77.72%	286
Other (please specify)	11.41%	42
TOTAL		368

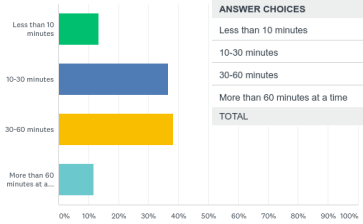
Q12: How frequently did you use this resource?

Answered: 367 Skipped: 49



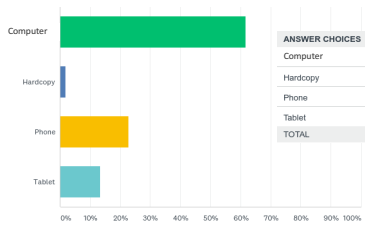
ANSWER CHOICES	RESPONSES
Less than once a week	19.07%
Once a week	13.35%
1-2 times per week	17.71%
3-4 times per week	25.89%
Greater than 4 times per week	23.98%
TOTAL	

Q13: How long do you use Qbanks at a given time?



ANSWER CHOICES	RESPONSES
Less than 10 minutes	13.39%
10-30 minutes	36.61%
30-60 minutes	38.25%
More than 60 minutes at a time	11.75%
TOTAL	

Q14: How do you generally access this resource?



ANSWER CHOICES	RESPONSES
Computer	61.81%
Hardcopy	1.92%
Phone	22.80%
Tablet	13.46%
TOTAL	

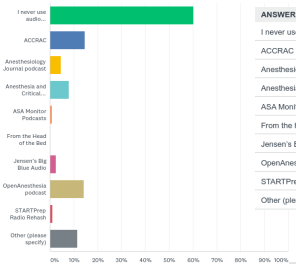
To the Residents….

Does this surprise you?

Why is this Qbank the best or most used?

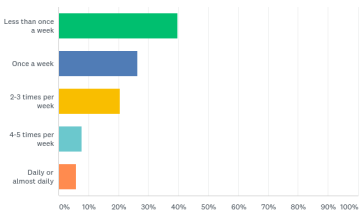
Which are best for what test?

Q15: Do you use podcasts or audio study guides? If yes, check all that apply.



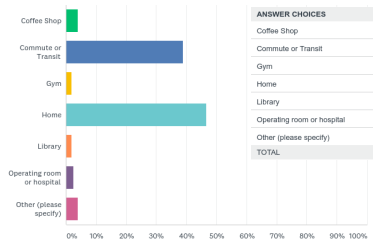
ANSWER CHOICES	RESPONSES
I never use audio anesthesia educational material	60.17%
ACCRAC	14.61%
Anesthesiology Journal podcast	4.58%
Anesthesia and Critical Lectures	8.02%
ASA Monitor Podcasts	0.86%
From the Head of the Bed	0.00%
Jensen's Big Blue Audio	2.58%
OpenAnesthesia podcast	14.33%
STARTPrep Radio Rehash	1.15%
Other (please specify)	11.46%

Q16: How frequently do you use this resource?



Q17: Where are you most likely to use podcast or audio education?

Answered: 154 Skipped: 262



ANSWER CHOICES	RESPONSES	
Coffee Shop	3.90%	6
Commute or Transit	38.96%	60
Gym	1.95%	3
Home	46.75%	72
Library	1.95%	3
Operating room or hospital	2.60%	4
Other (please specify)	3.90%	6
TOTAL		154

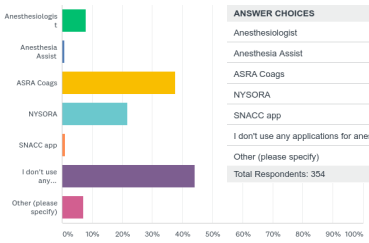
To the Residents…..

Are residents listening to other types of podcasts?

Why do you think 40% of residents are spending time listening to podcasts versus reading books?

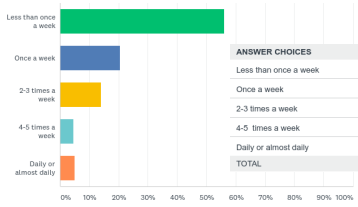
Q18: Do you use phone applications for your anesthesiology education? If yes, check all that apply.

Answered: 354 Skipped: 62



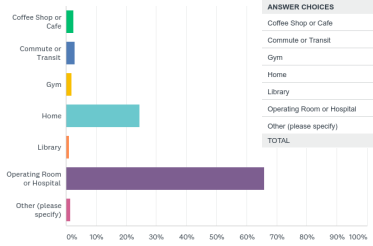
ANSWER CHOICES	RESPONSES
Anesthesiologist	7.91%
Anesthesia Assist	0.85%
ASRA Coags	37.57%
NYSORA	21.75%
SNACC app	1.13%
I don't use any applications for anesthesiology education	44.07%
Other (please specify)	7.06%
Total Respondents: 354	

Q19: How frequently do you use this resource?



ANSWER CHOICES	RESPONSES	
Less than once a week	56.00%	112
Once a week	20.50%	41
2-3 times a week	14.00%	28
4-5 times a week	4.50%	9
Daily or almost daily	5.00%	10
TOTAL		200

Q20: Where do you most often use applications for anesthesiology education?



ANSWER CHOICES	RESPONSES	
Coffee Shop or Cafe	2.44%	5
Commute or Transit	2.93%	6
Gym	1.95%	4
Home	24.39%	50
Library	0.98%	2
Operating Room or Hospital	65.85%	135
Other (please specify)	1.46%	3
TOTAL		205

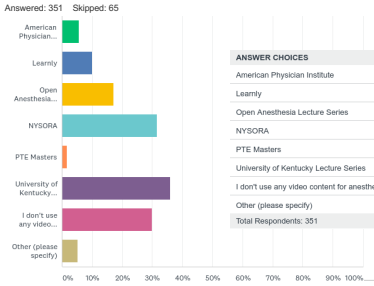
To the Residents…..

Do these results surprise you?

What are the best apps to use and how do you use them?

Q21: Do you use online video content for your anesthesiology education? If yes, check all that apply.

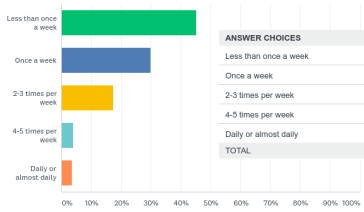
Answered: 351 Skipped: 65



ANSWER CHOICES	RESPONSES	
American Physician Institute	5.70%	20
Learnly	9.97%	35
Open Anesthesia Lecture Series	17.09%	60
NYSORA	31.62%	111
PTE Masters	1.71%	6
University of Kentucky Lecture Series	35.90%	126
I don't use any video content for anesthesiology education	29.91%	105
Other (please specify)	5.13%	18
Total Respondents: 351		

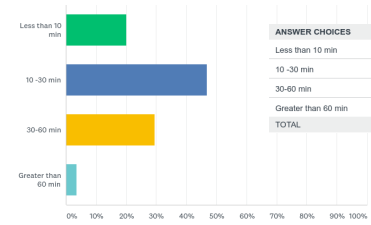
Q22: How frequently do you use these resources?

Answered: 248 Skipped: 168



ANSWER CHOICES	RESPONSES	
Less than once a week	45.16%	112
Once a week	29.84%	74
2-3 times per week	17.34%	43
4-5 times per week	4.03%	10
Daily or almost daily	3.63%	9
TOTAL		248

Q23: How long do you use videos at a given time?



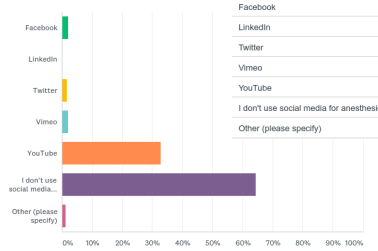
ANSWER CHOICES	RESPONSES
Less than 10 min	20.16%
10 -30 min	46.77%
30-60 min	29.44%
Greater than 60 min	3.63%
TOTAL	

To the Residents……

What about a video makes it useful to you as learners?

Q24: Do you use social media for additional anesthesia education? If yes, check all that apply.

Answered: 346 Skipped: 70



ANSWER CHOICES	RESPONSES
Facebook	2.02%
LinkedIn	0.29%
Twitter	1.73%
Vimeo	2.02%
YouTube	32.95%
I don't use social media for anesthesiology education	64.45%
Other (please specify)	1.16%

To the Residents….

What are you watching on YouTube for Education?

Why not Social Media for Education?


THANK YOU!
CHICAGO

HANDOUT

AACPD
ASSOCIATION OF ANESTHESIOLOGY CORE PROGRAM DIRECTORS

Program Director Perspective on Integrating Multiple Tech Tools

Catherine Barden, MD

11/03/2017
2:15pm – 2:45pm

UT Southwestern Medical Center

Program Director Perspective on Integrating Multiple Tech Tools

Catherine Barden, MD

1

Disclosure

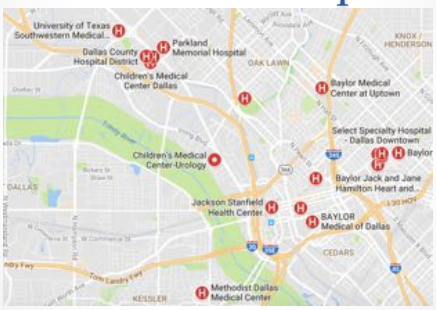
Where we started

10 years ago

- Resistance to 0530 resident lectures

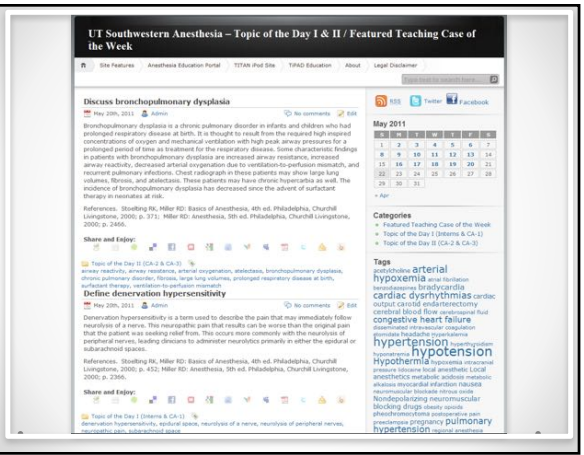
- Nine clinical sites
- Variable baseline knowledge base

Educational footprint



E-learning initiative

- "Topic of the Day"
- "Featured case of the week"
- Quiz banks
- Intern "directed reading plan"



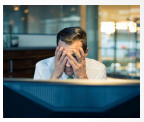
The BASIC exam

- Push to solidify/assess knowledge earlier
  - Challenging for our program
- How to deliver information evenly/consistently?
- How to track engagement?
- What information is high-yield?

Starting homegrown

- Moodle: open format learning platform
- Free through institution
- Direct access to content

Challenges



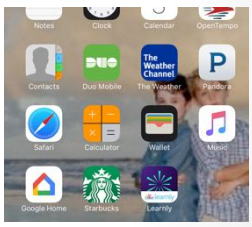
- Substantial faculty time
- Generational differences
  - Faculty: Boomers, Gen-X: limited tech savvy
  - Users: Millenials: difficult to capture sustained attention
- Need for IT support
- Full-time administrative support/oversight
- No significant changes in ITE performance

Resource transition

- **2015**
  - Open Anesthesia
- **2016**
  - Start program for Interns
    - Advanced residents
  - Learnly- CA1 didactics
  - Anesthesia Toolbox

Learnly

- Trackable
- Dynamic
- Overall cost savings
- Tailored lectures across clinical sites



Subspecialty didactics

MATERIAL TYPE	Pre - Rotation	Week 1	Week 2	Week 3	Week 4
Faculty Guided Content					
Faculty Guided Learning		Lect 3 - Basic Upper Ext +/- Lect 23 Advanced UE	Lect 4 - Lower Ext + PBLD 04 LE	Lect 12 Anticoagulation and RA + PBLD 12	Lect 6 & 7 - Neuraxial and PNB Complications +/-
		Lect 2 Periop Epidural Analg I and II	Lect 8 Local Anesthetic Pharmacology and LAST PBLD 18	CPNB PBLD 30	Lect 5 Truncal Blocks
Self-Study Content					
CA-2					
Online Modules	OM 1 - US Physics	OM 8 - Brach Plex Above Clav	OM 6 - Femoral		
	OM 2 - US Machine Controls	OM 15 - Practical Interscalene	OM 12 - Adductor Canal		
	OM 3 - Procedure Setup/Probe Handling	OM 25 - Practical Guide for Thoracic Epidural	OM 7 - Sciatic		
	OM 4 - Needle guidance	OM 9 - TAP			
Images/Videos		UE Videos - Interscalene Block & the Stoplight	LE Videos - Nmi Femoral Nerve US		
		UE Images - Interscalene	LE Images - Femoral Nerve		
			LE Videos - Nmi Sciatic Nerve US		
			LE Images - Sciatic Popliteal		
CA-3 (if haven't already done CA-2 material)					
		OM 5 - Sonographic Landmarks	LE Videos - Anterior Thigh Simulation	Lect 17 - Periph Nerve ID Methods	
		Lect 1 - Periph Nerv Anat	LE Videos - Posterior Thigh Simulation	OM 13 - US for Neuraxial	
		OM 10 - Advanced Sonoanatomy above Clavicle	OM 11 - Infraclavicular		

HANDOUT

AACPD
ASSOCIATION OF ANESTHESIOLOGY CORE PROGRAM DIRECTORS

Everything You Always Wanted to Know About Other Programs

Timothy R. Long, MD
Michael Wiisanen, MD

11/03/2017
3:30pm – 5:00pm

Session Name: Current Session

Date Created:	11/3/2017 2:18:27 PM	**Active Participants:**	111 of 111
Average Score:	0.00%	**Questions:**	52

Results by Question

1. My favorite Chicago delicacy is: (Multiple Choice)

	Responses	
	Percent	**Count**
The Chicago-style hot dog	11.24%	10
The deep dish pizza	50.56%	45
Garrett’s popcorn	17.98%	16
Italian beef sandwiches	4.49%	4
I haven’t tried any of these!	15.73%	14
Totals	**100%**	**89**

2. Do you pay the ABA Basic Exam Fee for your residents? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	39.33%	35
Yes, if they exceed a specific expectation on the ITE	26.97%	24
No	33.71%	30
Totals	**100%**	**89**

3. Do you pay for any of these for Basic Exam prep? (Multiple Choice)

	Responses	
	Percent	**Count**
Subscription to a Qbank (e.g. TrueLearn, etc.)	51.11%	46
Subscription to an online study guide (e.g. Pass Machine)	7.78%	7
Send to external board prep course	3.33%	3
More than one	18.89%	17
No	18.89%	17
Totals	**100%**	**90**

4. Do you have Grand Rounds, lectures, or other activities solely dedicated to Basic Exam prep? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, a combination of the above	51.06%	48
Yes, one of the above	32.98%	31
No	15.96%	15
Totals	**100%**	**94**

5. Would you consider terminating a resident who fails the Basic Exam? (Multiple Choice)

	Responses	
	Percent	**Count**
No	2.11%	2
Yes, after 1 failure	1.05%	1
Yes, after 2 failures	76.84%	73
Yes, after 3 failures	20%	19
Totals	**100%**	**95**

6. Should the ABA provide individualized list of key words from the Basic Exam? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	87.91%	80
No	12.09%	11
Totals	**100%**	**91**

7. Do you offer incentives for good ITE performance? (Multiple Choice)

	Responses	
	Percent	**Count**
No	46.59%	41
Yes, we pay for ABA basic exam	5.68%	5
Yes, we pay for ABA advanced exam	11.36%	10
Yes, we pay for basic and advanced exam	17.05%	15
Yes, we give out an award	15.91%	14
Yes, we use non-monetary incentives (e.g. easier call schedule, etc.)	3.41%	3
Totals	**100%**	**88**

8. What are consequences of poor performance on the ITE? (Multiple Choice)

	Responses	
	Percent	**Count**
Formal warning with remediation plan	45.56%	41
ABA unsatisfactory for knowledge	4.44%	4
Overall ABA unsatisfactory	3.33%	3
A & B	25.56%	23
A, B, & C	5.56%	5
None	11.11%	10
Other – please share	4.44%	4
Totals	**100%**	**90**

9. What is threshold for remediation from low ITE? (Multiple Choice)

	Responses	
	Percent	**Count**
<50th %ile	6.45%	6
<33rd %ile	19.35%	18
< 25th %ile	52.69%	49
<10th %ile	12.9%	12
No penalty for poor performance	8.6%	8
Totals	**100%**	**93**

10. How are you preparing your residents for the OSCE? (Multiple Choice)

	Responses	
	Percent	**Count**
A formal mock OSCE program is in place	51.81%	43
We plan to do mock OSCEs in the future	37.35%	31
I'm not sure	10.84%	9
Totals	**100%**	**83**

11. How many days are allowed for fellowship/job interviews? (Multiple Choice)

	Responses	
	Percent	**Count**
None	3.37%	3
Unlimited as long as the ABA 60 day policy is maintained	39.33%	35
1-3, staying with ABA policy	3.37%	3
3-5, staying within ABA policy	21.35%	19
1-5, in addition to the 60 ABA days	23.6%	21
Other	8.99%	8
Totals	**100%**	**89**

12. How do you manage increased requests for interview days and maintain compliance with the ABA 60 day rule? (Multiple Choice)

	Responses	
	Percent	**Count**
Use vacation days	39.77%	35
Use sick days	4.55%	4
Work the weekend to make up the time	11.36%	10
Make up the time another way	15.91%	14
We don't limit these days – what ABA rule?	14.77%	13
Other	13.64%	12
Totals	**100%**	**88**

13. The ABA should change its absence policy to allow for trainees who take 6 weeks FMLA (i.e. maternity leave) to finish their program on time (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	16.84%	16
Maybe	14.74%	14
No	68.42%	65
Totals	**100%**	**95**

14. How much elective time do your residents get? (Multiple Choice)

	Responses	
	Percent	**Count**
None	7.78%	7
< 1 month	7.78%	7
1 month	6.67%	6
1-2 months	18.89%	17
> 2 months	58.89%	53
Totals	**100%**	**90**

15. How soon do residents enter subspecialty rotations (CV, thoracic, peds, neuro, OB) in your program? (Multiple Choice)

	Responses	
	Percent	**Count**
As early as July of CA1 year for some	13.19%	12
Mid CA1 year	67.03%	61
End of CA1 year	8.79%	8
CA2 year	9.89%	9
CA3 year	1.1%	1
Totals	**100%**	**91**

16. Do your residents spend time in the endoscopy suite? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, as part of a formal rotation	30.85%	29
Yes, randomly	36.17%	34
Both A & B	28.72%	27
No	4.26%	4
Totals	**100%**	**94**

17. Do you send residents outside your institution for required rotations? (Multiple Choice)

	Responses	
	Percent	**Count**
No	51.58%	49
Yes, for one rotation	23.16%	22
Yes, for multiple rotations	25.26%	24
Totals	**100%**	**95**

18. What is the timing for your core didactics? (Multiple Choice)

	Responses	
	Percent	**Count**
Mornings before clinical duty	35.16%	32
Mid-day, requiring relief from clinical duty	10.99%	10
Afternoon with relief from clinical duty by 3pm	31.87%	29
Afternoons with relief from clinical duty by 5pm	6.59%	6
Dedicated education day with no clinical duty	15.38%	14
Weekends	0%	0
We have no dedicated time for didactics	0%	0
Totals	**100%**	**91**

19. For categorical programs, do you provide interns with anesthesia based didactics (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, administered weekly	15%	12
Yes, administered monthly	15%	12
Yes, administered quarterly	0%	0
Yes, administered with other frequency	31.25%	25
No, but we would like to and we face obstacles	15%	12
No and we have no interest in doing so (we want them to focus on learning “medicine”)	23.75%	19
Totals	**100%**	**80**

20. Do you purchase textbooks for residents? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, the department provides certain books	64.77%	57
Yes, the residents purchase through department provided book funds	30.68%	27
No but I wish we did	1.14%	1
No and I don't think it's necessary	3.41%	3
Totals	**100%**	**88**

21. How much discretionary $$ do you provide residents? (Multiple Choice)

	Responses	
	Percent	**Count**
Zero	6.9%	6
< $250	5.75%	5
$250-$499	9.2%	8
$500-$749	18.39%	16
$750-$999	17.24%	15
≥$1000	42.53%	37
Totals	**100%**	**87**

22. How much $ do you provide for trip/presentation? (Multiple Choice)

	Responses	
	Percent	**Count**
<500	2.41%	2
$500-$999	8.43%	7
≥$1000	26.51%	22
Each trip has $ limit and there is no total cap per year	24.1%	20
Each trip has $ limit and there is total cap per year	19.28%	16
Other	19.28%	16
Totals	**100%**	**83**

23. Is research a required rotation for residents? (Multiple Choice)

	Responses	
	Percent	**Count**
No	83.53%	71
Yes, 1-2 months	16.47%	14
Yes, 3-4 months	0%	0
Yes, 5-6 months	0%	0
Yes, >6 months	0%	0
Totals	**100%**	**85**

24. Do you have dedicated quality and safety project time? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, we have a dedicated month away from clinical duty	14.29%	12
Yes, we schedule time within the week as needed	20.24%	17
No but I wish we did	44.05%	37
No, that's a waste of time	21.43%	18
Totals	**100%**	**84**

25. How are your residents completing quality projects? (Multiple Choice)

	Responses	
	Percent	**Count**
They're not	13.95%	12
Individual projects	18.6%	16
Team projects with other residents	30.23%	26
Team projects with other residents and/or other providers	37.21%	32
Totals	**100%**	**86**

26. Completion of quality projects is worthwhile during residency: (Multiple Choice)

	Responses	
	Percent	**Count**
Strongly agree	29.89%	26
Agree	37.93%	33
Neutral	20.69%	18
Disagree	5.75%	5
Strongly disagree	5.75%	5
Totals	**100%**	**87**

27. Do you offer a rotation in the Perioperative Surgical Home? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	22.73%	20
No	63.64%	56
What are you talking about?	13.64%	12
Totals	**100%**	**88**

28. Do you receive the minimum required administrative time as PD? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	71.43%	65
No	27.47%	25
I didn't know there was a minimum	1.1%	1
Totals	**100%**	**91**

29. How would you best describe your administrative time? (Multiple Choice)

	Responses	
	Percent	**Count**
I get plenty of it	15.48%	13
I don't have enough but APDs pick up the slack	21.43%	18
I don't have enough but I'm compensated well	13.1%	11
Not enough time, assistance or compensation	10.71%	9
Not enough time, assistance, compensation and continually worry if I'm doing my job well	39.29%	33
Totals	**100%**	**84**

30. Service over education (as defined by ACGME) is an issue within our department: (Multiple Choice)

	Responses	
	Percent	**Count**
Always	19.54%	17
Frequently	27.59%	24
Sometimes	24.14%	21
Rarely	20.69%	18
Never	8.05%	7
Totals	**100%**	**87**

31. How many calls do your residents take monthly (averaged among CA1-3 classes)? (Multiple Choice)

	Responses	
	Percent	**Count**
2-3	19.51%	16
4-5	60.98%	50
6-7	19.51%	16
8-9	0%	0
>9	0%	0
Totals	**100%**	**82**

32. How do you fill call when a resident is ill at the last minute? (Multiple Choice)

	Responses	
	Percent	**Count**
Chiefs ask residents	59.55%	53
Coordinator asks residents	2.25%	2
Program director asks residents	2.25%	2
We have a back-up call system in place	29.21%	26
We leave it un-covered	2.25%	2
Other	4.49%	4
Totals	**100%**	**89**

33. Do your resident log time in the EMR to pre-op patients for the next day as duty hours? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	36.47%	31
No, but I think they're supposed to	18.82%	16
No and I don't think it's required	44.71%	38
Totals	**100%**	**85**

34. How are you implementing the new program requirements in well-being? (Multiple Choice)

	Responses	
	Percent	**Count**
Institution-driven wellness curricula	16.85%	15
Department-driven wellness curricula	19.1%	17
A & B	48.31%	43
No plans yet	13.48%	12
Other	2.25%	2
Totals	**100%**	**89**

35. How would you best describe faculty supervision on call (Multiple Choice)

	Responses	
	Percent	**Count**
In house for OR and OB	97.73%	86
In house for OR but home for OB	1.14%	1
In house for OB, home for OR	0%	0
Home call for both	1.14%	1
Totals	**100%**	**88**

36. Do you allow anesthesia resident moonlighting within the department? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	70.11%	61
No	29.89%	26
Totals	**100%**	**87**

37. Do you allow external moonlighting? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	38.37%	33
No	61.63%	53
Totals	**100%**	**86**

38. What is your policy on USMLE/COMLEX scores? (Multiple Choice)

	Responses	
	Percent	**Count**
We have lower limit and don't make exceptions	6.98%	6
We have lower limit but occasionally make exceptions	84.88%	73
We don't have a lower limit	8.14%	7
Totals	**100%**	**86**

39. If you had to pick one, which characteristic is most important in successful recruitment? (Multiple Choice)

	Responses	
	Percent	**Count**
USMLE scores	13.64%	12
Transcript/grades	18.18%	16
Scholarly accomplishments	1.14%	1
Letters	3.41%	3
Personality	63.64%	56
Totals	**100%**	**88**

40. If you had to pick one, which characteristic is Least important in successful recruitment? (Multiple Choice)

	Responses	
	Percent	**Count**
USMLE scores	3.61%	3
Transcript/grades	7.23%	6
Scholarly accomplishments	45.78%	38
Letters	43.37%	36
Personality	0%	0
Totals	**100%**	**83**

41. Do you provide alcohol at recruitment events? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes and we learn a lot about our applicants by giving them alcohol	31.33%	26
Yes, but we don't pay much attention to it	40.96%	34
No	27.71%	23
Totals	**100%**	**83**

42. Do you pay for recruits' airfare? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, of course	1.16%	1
No, are you kidding me?!	98.84%	85
Totals	**100%**	**86**

43. Do you pay for recruits' hotel? (Multiple Choice)

	Responses	
	Percent	**Count**
No	29.55%	26
No, but they get a discounted rate	34.09%	30
Yes, 1 night	32.95%	29
Yes, 2 or more nights	3.41%	3
Totals	**100%**	**88**

44. Do you interview rotating medical students? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, always	55.68%	49
Yes, only if qualified for our program	35.23%	31
No, but they go through a less formal interview process while on rotation	6.82%	6
No, we are able to rank them simply on rotation performance (i.e. no interview at all)	2.27%	2
Totals	**100%**	**88**

45. Does your program reimburse residents for attending the ASA annual meeting? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	12.36%	11
No	1.12%	1
Only if they are presenting or it is an approved attendance trip	83.15%	74
Other	3.37%	3
Totals	**100%**	**89**

46. Does you institution allow for random drug testing of residents? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	14.77%	13
No, we only test for cause	85.23%	75
Totals	**100%**	**88**

47. Following a drug discrepancy, does your department remove a trainee from the OR until it is resolved? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	21.11%	19
No	78.89%	71
Totals	**100%**	**90**

48. How does your department manage a drug discrepancy? (Multiple Choice)

	Responses	
	Percent	**Count**
Drug testing after first episode	2.2%	2
Drug testing after more than 1 episode	0%	0
Collect more information and proceed based on situation	96.7%	88
Other (please explain)	1.1%	1
Totals	**100%**	**91**

49. At your institution are residents permitted to sign out patients from the PACU? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, independently	59.76%	49
Yes, as long as a supervising physician attests to the evaluation	26.83%	22
No, only attendings or CRNAs can do this	2.44%	2
No, only attendings can do this	10.98%	9
Totals	**100%**	**82**

50. How do you handle “practice habits” that are queried on the ACGME survey. (Multiple Choice)

	Responses	
	Percent	**Count**
Automated data collection fed back to trainee	22.89%	19
Information provided at semiannual review	14.46%	12
We sort of do this but not the way I would like (general performance metrics)	21.69%	18
We cross our fingers every year with this question	40.96%	34
Other	0%	0
Totals	**100%**	**83**

51. When it comes to lower scores on the FACULTY ACGME survey, our chairman: (Multiple Choice)

	Responses	
	Percent	**Count**
Is very concerned and tries to correct any issues	9.3%	8
Is concerned, but relies on the PD to correct any issues	63.95%	55
Is not concerned	11.63%	10
I am not sure that the chairman reads the results of the ACGME survey	15.12%	13
Totals	**100%**	**86**

52. Do you have a dedicated "CLER Officer" at your institution (separate from the Chief Quality Officer and DIO)? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, and the position is supported by the hospital	3.7%	3
Yes, and the position is supported by GME	8.64%	7
Yes, but it is largely unsupported and voluntary	1.23%	1
Yes, but I don't know how or if it is supported	7.41%	6
No	35.8%	29
I am not sure	43.21%	35
Totals	**100%**	**81**

HANDOUT

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Defining How Faculty Are Qualified to Teach Point of Care Ultra Sound? Should We and Methods.

Santhanam Suresh, MD

11/03/2017
8:15am – 8:35am

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

Defining How Faculty are Qualified to Teach Point of Care Ultrasound? Should we and methods?

Regional Anesthesia

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

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

Disclosures

- Director, American Board of Anesthesiology
- Board of Trustees, IARS
- Member, Review Committee (RRC) in Anesthesiology, ACGME

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Outline

- Brief history
- What are the relevant questions in USGRA training?
- What are the current guidelines for
  - Elements to teach?
  - Teaching pathways?
  - Who is qualified to teach?

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Earliest Reports of USGRA

Br. J. Anaesth. (1978), **50**, 965 1978

APPLICATION OF THE DOPPLER ULTRASOUND BLOODFLOW DETECTOR IN SUPRACLAVICULAR BRACHIAL PLEXUS BLOCK
P. DU P. LA GRANGE, P. A. FOSTER AND L. K. PRETORIUS

La Grange – 1978
- First case-series of US in peripheral block in 61 patients

Br. J. Anaesth. (1989), **63**, 326–329

ULTRASONOGRAPHIC STUDY OF THE SPREAD OF LOCAL ANAESTHETIC DURING AXILLARY BRACHIAL PLEXUS BLOCK
P. L. TING AND V. SIVAGNANARATNAM

Ting and Sivagnanaratnam -1989
- Describe spread of LA during axillary brachial plexus

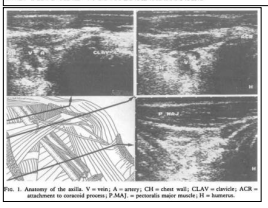

Fig. 1. Anatomy of the axilla. V = vein; A = artery; CH = chest wall; CLAV = clavicle; ACR = attachment to coracoid process; P.MAJ. = pectoralis major muscle; H = humerus.

Ultrasound-Guided Supraclavicular Approach for Regional Anesthesia of the Brachial Plexus
Stephan Kapral, MD*, Peter Krafft, MD*, Klemens Eibenberger, MD*, Robert Fitzgerald, MD*, Max Gosch, MD*, and Christian Weinstabl, MD*
(Anesth Analg 1994;78:507–13)

Kapral – 1994; Systematic exploration of brachial plexus

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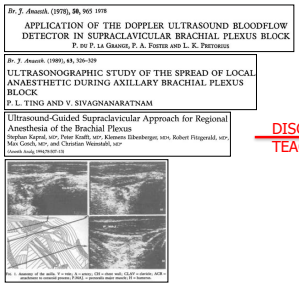
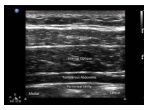
From then to today…



DISCOVERY → TEACHING

Deep Blocks Possible:
TAP, Quadratus Lumborum

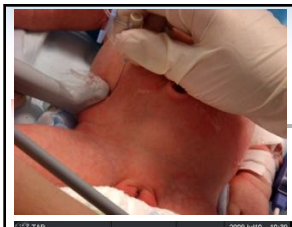


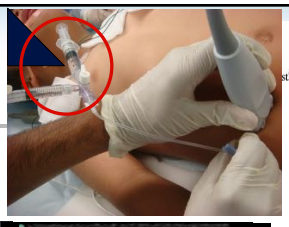
In Anesthetized Children

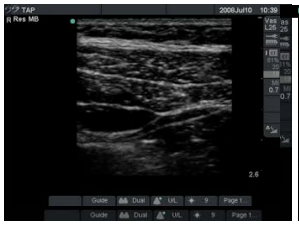
Asleep Versus Awake: Does It Matter?
Pediatric Regional Block Complications by Patient State: A Report From the Pediatric Regional Anesthesia Network
Andreas H. Taenzer, MD, MS,* Benjamin J. Walker, MD,† Adrian T. Bosenberg, MBChB, FFA(SA),‡ Lynn Martin, MD,§ Santhanam Suresh, MD,§ David M. Polaner, MD, FAAP,‖ Christie Wolf, MBLS,# and Elliot J. Krane, MD**

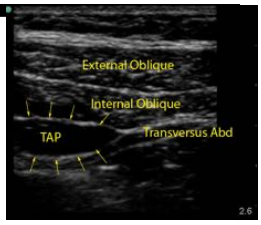
Interventional Acute/Chronic Pain Procedures

- USG has facilitated rapid expansion of regional anesthesia possibilities; subsequently all techniques need to be TAUGHT









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A New Question for USGRA

Old Question:
"Can ultrasound INCREASE the SAFETY of RA procedures?" → **YES**

Lumbar Neuraxial Ultrasound for Spinal and Epidural Anesthesia
A Systematic Review and Meta-Analysis
Anahi Perlas, MD, FRCPC,† Luis E. Chaparro, MD,‡ and Ki Jinn Chin, MD, FRCPC*†*

Ultrasound compared with nerve stimulation guidance for peripheral nerve catheter placement: a meta-analysis of randomized controlled trials
BJA
A. Schnabel[1*], C. H. Meyer-Frießem[1], P. K. Zahn[1] and E. M. Pogatzki-Zahn[1]

Cochrane Library
Cochrane Database of Systematic Reviews
The use of ultrasound guidance for perioperative neuraxial and peripheral nerve blocks in children (Review)
Guay J, Suresh S, Kopp S

TEACHING →

NEW Question:
"How can we safely teach USGRA??"

- The evidence is clear for USGRA
- What has been the primary method for teaching USGRA?

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Teaching USGRA

- **"See one, do one, teach one"**
- Shortcomings:
  - Decreases quality of care
    - Unsuccessful blocks
    - Procedure-related pain
  - Impairs patient safety
  - Risks of complications and injury
- Dependent on:
  - Case mix, center volume
  - Teacher capacity
- Need for new ways of training colleagues

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Elements to be taught…

A Scoping Review of the Evidence for Teaching Ultrasound-Guided Regional Anesthesia

Catherine M. Nix, MBChB, FCARCSI, Clarita B. Margarido, MD, PhD,† Imad T. Awad, MBChB, FCARCSI,* Arsenio Avila, MD,* Jeffrey J.H. Cheung, MSc,‡ Adam Dubrowski, PhD,‡ and Colin J.L. McCartney, MBChB, FCARCSI, FRCA, FRCPC**

- Three main themes:
  - Development of **motor skills**
  - Learning and teaching **sonoanatomy**
  - Understanding the requirements for establish USGRA **education program** and **evaluation**

9

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USG RA Learning Curve

Characterizing Novice Behavior Associated With Learning Ultrasound-Guided Peripheral Regional Anesthesia

Brian D. Sites, M.D., Brian C. Spence, M.D., John D. Gallagher, M.D., Christopher W. Wiley, M.D., Marc L. Bertrand, M.D., and George T. Blike, M.D.
Reg Anesth Pain Med 2007;32:107-115.

- 6 Residents, No prior USG experience, performing 520 USG blocks, videotaped and reviewed
- Received: Introductory didactic, ultrasound imaging, simulated block training
- 93% success rate, 398 errors, 4 complications
- Common Errors: Failure to 1) visualize needle before advancing and 2) unintentional probe movement

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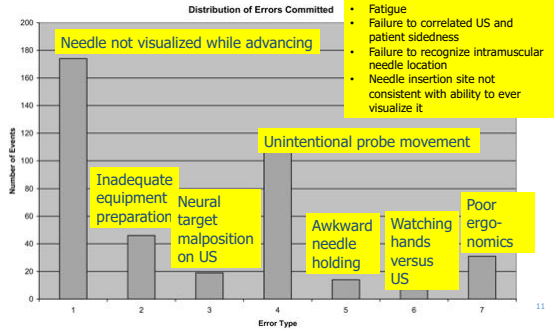
Errors Committed

5 New Behaviors Identified:
- Failure to recognize maldistribution of LA
- Fatigue
- Failure to correlated US and patient sidedness
- Failure to recognize intramuscular needle location
- Needle insertion site not consistent with ability to ever visualize it



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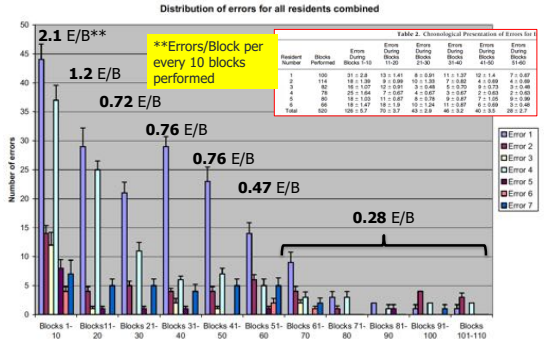
Errors Committed

*Each performed at least 66 blocks



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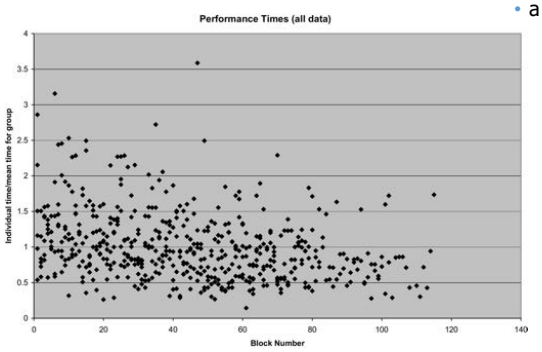
Performance Times

- a



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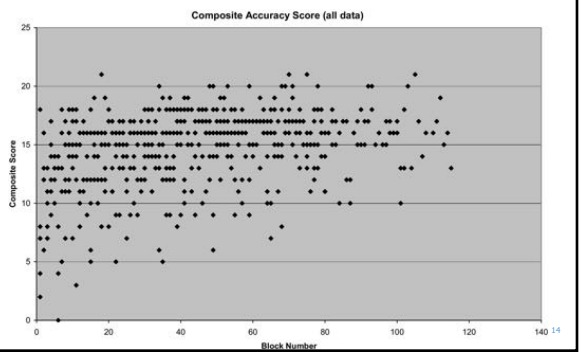
Accuracy Score



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Elements to be taught…

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Catherine M. Nix, MBChB, FCARCSI, Clarita B. Margarido, MD, PhD,† Imad T. Awad, MBChB, FCARCSI,* Arsenio Avila, MD,* Jeffrey J.H. Cheung, MSc.,‡ Adam Dubrowski, PhD,‡ and Colin J.L. McCartney, MBChB, FCARCSI, FRCA, FRCPC**

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Training Guidance

The American Society of Regional Anesthesia and Pain Medicine and the European Society of Regional Anaesthesia and Pain Therapy Joint Committee Recommendations for Education and Training in Ultrasound-Guided Regional Anesthesia

Brian D. Sites, MD, Vincent W. Chan, MD,† Joseph M. Neal, MD,‡ Robert Weller, MD,§ Thomas Grau, MD, PhD,|| Zbigniew J. Koscielniak-Nielsen, MD, PhD,¶ and Giorgio Ivani, MD#*

- 2010 ASRA Guidelines
  - TWO training pathways (practice pathway & residency-based pathway) to minimize COMMON mistakes
    - Needle advancement without visualization
    - Unintentional transducer movements
- Practice pathway includes:
  - CME accredited 8 hour didactic and hands-on event, imaging oneself/others, simulators/phantoms, spending time with *experienced* individuals, incorporating into practice
- Residency pathway:
  - Covers 6 core ACGME competencies, structure determined by residency directors

However no definition of "experienced individual" or who is qualified to teach USGRA

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Training Guidance

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However no definition of "experienced individual" or who is qualified to teach USGRA

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One step further…

- 2012 ASRA Guidelines for USG Interventional Pain Procedures

The American Society of Regional Anesthesia and Pain Medicine, the European Society of Regional Anaesthesia and Pain Therapy, and the Asian Australasian Federation of Pain Societies Joint Committee Recommendations for Education and Training in Ultrasound-Guided Interventional Pain Procedures

Samer N. Narouze, MD, PhD, David Provenzano, MD,† Philip Peng, MBBS, FRCPC,‡ Urs Eichenberger, MD,§ Sang Chul Lee, MD, PhD,¶ Barry Nicholls, MD,|| and Bernhard Moriggl, MD, FIACA***

- Has recommendation of "USG Pain Medicine Coordinator"
  - Identified by departmental leadership to assist in the safe and skilled implementation of USPM, overseeing education and supervision

Ultrasound-Guided Pain Medicine Coordinator

A staff physician in each Department of Pain Medicine may be identified by the departmental leadership to assist in the safe and skilled implementation of USPM. The USPM coordinator will support the education and supervision of pain physicians performing USPM. In a training institution, the coordinator, if available, will also be responsible for developing and coordinating the fellow educational instruction needed to achieve the core competencies required for USPM.

Recommendations for qualification (below):

The Joint Committee recommends that physician candidates for the position of USPM coordinator obtain the following:

1. a letter of recommendation from department leadership;
2. a written description of clinical experience, including case volume, length of experience, and safety; and
3. participation in at least 1 accredited ultrasound workshop (as described in the training section).

Answering the question

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- Defining How **Faculty** are **Qualified** to Teach Point of Care Ultrasound?
- Defining the proficient practitioner→
  - Understands ultrasound image **generation**, **optimization, interpretation**
  - Good **ergonomics, economy of motion**
  - Direct or indirect **needle tip** identification
  - **Beyond "pattern recognition",** ie. "advanced" using USG as a **tool**
- Should we? → **YES**
- And methods? →
  - **A yearly Competency testing for staff teaching regional anesthesia**
  - **Mandatory training for common blocks for all staff**
  - Adjuncts to teaching/learning USGRA
    - **Faculty** to lead training programs
    - **Faculty** to teach simulation and phantom training

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Lurie Children's Anesthesia Faculty Training

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- Hands-on workshop every Monday from 630 am to 7 am
- Teach the teachers workshop on Wednesdays for teaching nuances in regional anesthesia to faculty.
- Mandatory training and Competencies in
  - Caudal blocks
  - Supraclavicular brachial plexus blocks
  - Femoral nerve blocks
  - TAP blocks
  - Sciatic Nerve blocks
  - Tied to Yearly Incentives and performance reviews

20

Advantages in Faculty Training

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

- No need for separate regional anesthesia team especially on weekends and nights.
- Uniform care for all children 24/7
- Clear commitment to surgeons regarding care provided.
- ERAS protocol followed 24/7

21

Summary

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

- ~~"Can ultrasound INCREASE the SAFETY of RA procedures?"~~
- **"How can we safely teach USGRA??"**
- ASRA Guidelines detail elements to teach safely

Future Directions:

- Continued Growth
- Competition and Prospects
- Incentivizing Regional Anesthesia

Thank you!

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

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HANDOUT

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Defining How Faculty Are Qualified to Teach Point of Care Ultra Sound? Should We and Methods.

James P. Rathmell, MD

11/03/2017
8:35am – 8:55am

Defining How Faculty are Qualified to Teach Point of Care Ultrasound

James P. Rathmell, M.D.
Chair, Department of Anesthesiology,
Perioperative and Pain Medicine
Brigham and Women's Health Care
Leroy A. Vandam Professor of Anaesthesia
Harvard Medical School
Boston, Massachusetts USA

Conflict of Interest

Director, American Board of Anesthesiology

The ABA oversees preparation and administration of Primary and subspecialty physician board certification examinations in Anesthesiology

Objectives

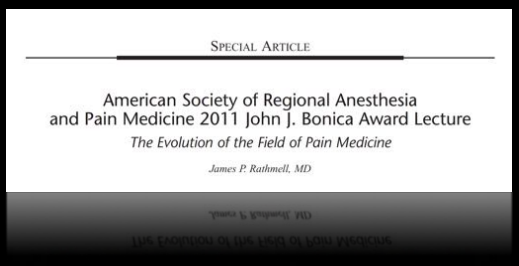
- Discuss the advantages, disadvantages, and difficulties in establishing rigid assessment criteria for defining competence in point of care ultrasound
- Describe approaches for defining qualification for those instructing in point of care ultrasound

POINT-OF-CARE ULTRASOUND

NEW KNOWLEDGE & SKILLS

Learning and Teaching

New Knowledge and Skills: Learning and Learning to Teach



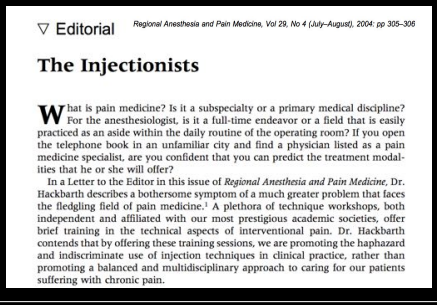
SPECIAL ARTICLE

American Society of Regional Anesthesia and Pain Medicine 2011 John J. Bonica Award Lecture

The Evolution of the Field of Pain Medicine

James P. Rathmell, MD

New Knowledge and Skills: Learning and Learning to Teach



▽ Editorial *Regional Anesthesia and Pain Medicine, Vol 29, No 4 (July–August), 2004: pp 305–306*

The Injectionists

What is pain medicine? Is it a subspecialty or a primary medical discipline? For the anesthesiologist, is it a full-time endeavor or a field that is easily practiced as an aside within the daily routine of the operating room? If you open the telephone book in an unfamiliar city and find a physician listed as a pain medicine specialist, are you confident that you can predict the treatment modalities that he or she will offer?

In a Letter to the Editor in this issue of *Regional Anesthesia and Pain Medicine*, Dr. Hackbarth describes a bothersome symptom of a much greater problem that faces the fledgling field of pain medicine.[1] A plethora of technique workshops, both independent and affiliated with our most prestigious academic societies, offer brief training in the technical aspects of interventional pain. Dr. Hackbarth contends that by offering these training sessions, we are promoting the haphazard and indiscriminate use of injection techniques in clinical practice, rather than promoting a balanced and multidisciplinary approach to caring for our patients suffering with chronic pain.

POINT-OF-CARE ULTRASOUND

INTEGRATING TRAINING

Knowledge and skills for all anesthesiologists

Point-of-care Ultrasound: Training for Anesthesiologists

Accreditation Council for Graduate Medical Education

ACGME

ACGME Program Requirements for Graduate Medical Education in Anesthesiology

Point-of-care Ultrasound: Training for Anesthesiologists

Journal of Cardiothoracic and Vascular Anesthesia, Vol 22, No 4 (August), 2008: pp 490–494

ORIGINAL ARTICLES

Focused Cardiovascular Ultrasound Performed by Anesthesiologists in the Perioperative Period: Feasible and Alters Patient Management

Brian Cowie, MBBS, FANZCA

Objectives: The aim of this study was to assess the feasibility and effects on perioperative management of a focused transthoracic echocardiogram performed by anesthesiologists.

Design: A prospective observational study of all patients having a focused cardiovascular ultrasound (FoCUS).

Setting: A single tertiary referral university teaching hospital.

Participants: Fifty consecutive perioperative patients who had a clinical indication for a FoCUS.

Interventions: After performing a FoCUS, relevant clinical information was communicated to the anesthesiologist in charge of the case, who then decided on the appropriate management of the patient including the choice of anesthesia, invasive monitoring, fluids, vasoactive drugs, and postoperative care. If indicated, patients were referred for a formal cardiology-based transthoracic echocardiogram.

Measurements and Main Results: Anesthesiologists were able to obtain diagnostic-quality images during a FoCUS in 98% of patients. The most common indication for a FoCUS was an undifferentiated ejection systolic murmur in 50% of cases, with 38% of all patients having aortic stenosis. In 94% of patients, some change in their perioperative care occurred as a result of the FoCUS study. Major findings correlated with a formal cardiology-based transthoracic echocardiogram in 87% of cases.

Conclusion: Anesthesiologists with a cardiac and echocardiography background can successfully perform a FoCUS in almost all patients when indicated, which provides valuable new diagnostic information guiding changes in perioperative management in the majority of patients.

KEY WORDS: focused transthoracic echocardiography, anesthesiologist, perioperative

Point-of-care Ultrasound: Training for Anesthesiologists

Journal of Cardiothoracic and Vascular Anesthesia, Vol 29, No 1 (February), 2015: pp 82–88

A Review of 364 Perioperative Rescue Echocardiograms: Findings of an Anesthesiologist-Staffed Perioperative Echocardiography Service

Nicholas W. Markin, MD, Benjamin S. Gmelch, MD, Matthew J. Griffee, MD, Timothy J. Holmberg, MD, David E. Morgan, MD, and Joshua M. Zimmerman, MD, FASE

Objective: Review the findings and use of rescue echocardiography performed by the Division of Perioperative Echocardiography and its impact on patient management.

Design: Retrospective observational study.

Setting: Single institution, tertiary care hospital.

Participants: Three hundred sixty-four consecutive rescue echocardiograms in the perioperative setting.

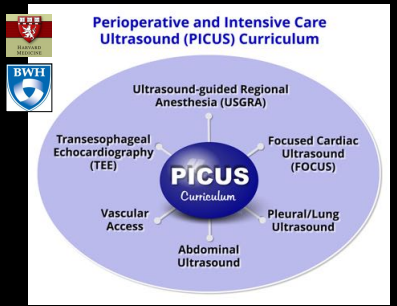
Interventions: Rescue transesophageal or rescue transthoracic echocardiography.

Measurements and Main Results: Of a total of 1,675 perioperative echocardiograms performed in a 28-month period, 364 (21.8%) were rescue studies. Of these, 95.9% were transesophageal and 4.1% were transthoracic. Location at time of rescue echocardiography was intraoperative (55.5%), postoperative (44.2%), and preoperative (0.3%). No single diagnosis predominated the intraoperative or postoperative environment, and the frequency of common etiologies did not allow for assumption. There was a change in management for 214 patients (59%) as the result of findings. The methods used in performing rescue echocardiography at the authors' institution are reported.

Conclusions: The heterogeneity of diagnoses and the frequency with which rescue echocardiography changed management further supports the growing body of evidence that the hemodynamically unstable perioperative patient benefits from its use.

KEY WORDS: rescue echocardiography, hemodynamic instability, transesophageal echocardiography, transthoracic echocardiography, intraoperative hypotension

Point-of-care Ultrasound: Training for Anesthesiologists



Point-of-care Ultrasound: Training for Anesthesiologists

PICUS Curriculum in the PACU

Week 1

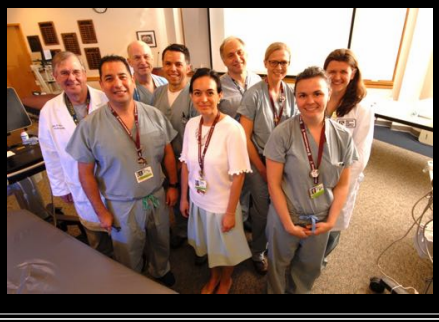
Monday

- 8-8:30am
  - Complete questionnaire
  - Complete pretest exam
- 8:30-9:00am
  - Meet Lindsey at STRATUS to complete simulator exam

Tuesday

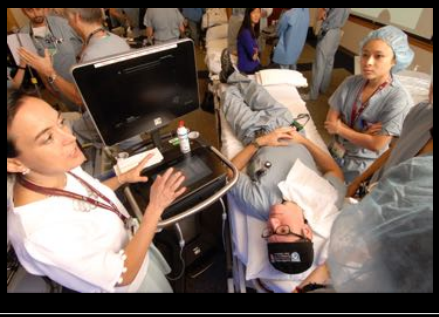
- 8-9am
  - Watch online lectures on "Parasternal Long Axis", "Parasternal Short Axis", "Apical 4-chamber", 'Subcostal 4 chamber and IVC'.
  - Watch "Introduction to QPath"

Point-of-care Ultrasound: Training for Anesthesiologists



Point-of-care Ultrasound: Training for Anesthesiologists

Point-of-care Ultrasound: Training for Anesthesiologists



Point-of-care Ultrasound: Training for Anesthesiologists

- Teachers in our program are all motivated and interested in point of care ultrasound
- They have acquired skills/knowledge via fellowship training and/or went to outside perioperative ultrasound conferences with hands on training

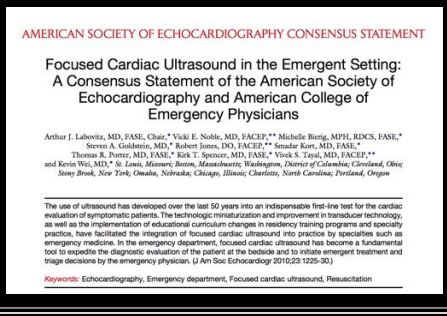
Point-of-care Ultrasound: Training for Anesthesiologists

- When getting a "critical mass" of teachers it depends on what area of point of care (perioperative) ultrasound you aim to teach: regional, TEE, FoCUS (Focused cardiac ultrasound)/TTE, lung, abdominal, vascular
- Regional and TEE are areas with knowledge and existing educational infrastructure

Point-of-care Ultrasound: Training for Anesthesiologists

- Assure that the three essential components of an US training program are in place:
  - Didactics
  - Hands-on sessions
  - QA

Point-of-care Ultrasound: Training for Anesthesiologists



AMERICAN SOCIETY OF ECHOCARDIOGRAPHY CONSENSUS STATEMENT

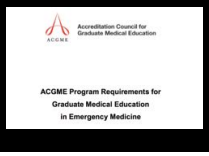
Focused Cardiac Ultrasound in the Emergent Setting: A Consensus Statement of the American Society of Echocardiography and American College of Emergency Physicians

Arthur J. Labovitz, MD, FASE, Chair,* Vicki E. Noble, MD, FACEP,** Michelle Bierig, MPH, RDCS, FASE,* Steven A. Goldstein, MD,* Robert Jones, DO, FACEP,** Smadar Kort, MD, FASE,* Thomas R. Porter, MD, FASE,* Kirk T. Spencer, MD, FASE,* Vivek S. Tayal, MD, FACEP,** and Kevin Wei, MD,* *St. Louis, Missouri; Boston, Massachusetts; Washington, District of Columbia; Cleveland, Ohio; Stony Brook, New York; Omaha, Nebraska; Chicago, Illinois; Charlotte, North Carolina; Portland, Oregon*

The use of ultrasound has developed over the last 50 years into an indispensable first-line test for the cardiac evaluation of symptomatic patients. The technologic miniaturization and improvement in transducer technology, as well as the implementation of educational curriculum changes in residency training programs and specialty practice, have facilitated the integration of focused cardiac ultrasound into practice by specialties such as emergency medicine. In the emergency department, focused cardiac ultrasound has become a fundamental tool to expedite the diagnostic evaluation of the patient at the bedside and to initiate emergent treatment and triage decisions by the emergency physician. (J Am Soc Echocardiogr 2010;23:1225-30.)

Keywords: Echocardiography, Emergency department, Focused cardiac ultrasound, Resuscitation

Point-of-care Ultrasound: Training for Anesthesiologists



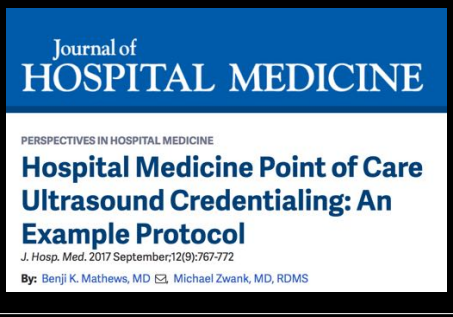
Accreditation Council for Graduate Medical Education

ACGME Program Requirements for Graduate Medical Education in Emergency Medicine

IV.A.5.a).(2).(c).(viii)	emergency department bedside ultrasound; (Outcome)
IV.A.5.a).(2).(c).(viii).(a)	Residents must use ultrasound for the bedside diagnostic evaluation of emergency medical conditions and diagnoses, resuscitation of the acutely ill or injured patient, and procedural guidance. (Outcome)

POINT-OF-CARE ULTRASOUND
ASSESSING COMPETENCY
Core competencies for all anesthesiologists

Assessing Competency



Journal of HOSPITAL MEDICINE

PERSPECTIVES IN HOSPITAL MEDICINE

Hospital Medicine Point of Care Ultrasound Credentialing: An Example Protocol

J. Hosp. Med. 2017 September;12(9):767-772

By: Benji K. Mathews, MD ✉, Michael Zwank, MD, RDMS

ABA The American Board of Anesthesiology

ABA Technical Skill OSCE:
Application of Ultrasonography

Application of Ultrasonography

For this OSCE station candidates will be assessed on their ability to use a common ultrasound machine to identify the normal anatomy relevant to placing a nerve block or an intravascular catheter

During the exam candidates will be required to:

- interact with an examiner and a standardized patient
- position the patient appropriately for the procedure
- instruct the examiner on how to adjust the depth and gain in order to obtain the best image
- demonstrate simulated needle placement technique

Application of Ultrasonography

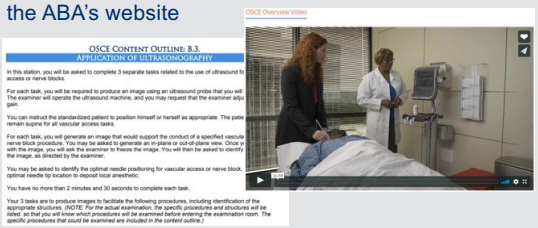
The images to be obtained will be chosen from among the following procedures:

Vascular cannulation
- Internal jugular vein
- Cubital fossa vessels
- Radial artery
- Femoral vessels

Nerve blocks
- Interscalene
- Supraclavicular
- Transversus abdominis plane (TAP)
- Femoral
- Adductor canal (saphenous)
- Popliteal

Resources

Exemplar scenarios and a video preview of the Application of Ultrasonography station can be found on the ABA's website



Go To:
www.theaba.org/PDFs/APPLIED-Exam/OSCE-Exemplar-Scenarios

Summary

- The best way to assure competence in this technical skill is to make training in ultrasonography a part of the core training for all anesthesiologists
- Individual programs will have to assess their own resources and build upon their existing strengths with guidance from those who have assembled successful programs

Summary

- Those who have already developed interest and expertise should assemble and disseminate guidelines that suggest how faculty can best assure that faculty are highly qualified to teach point-of-care ultrasound

HANDOUT

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Developing Ultrasound Curriculum Across and Specific to the Subspecialties

Kevin C. Thornton, MD

11/03/2017
9:00am – 9:25am

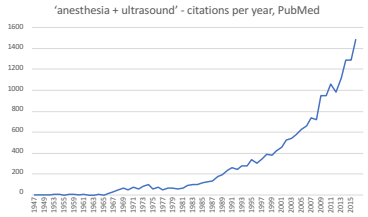
Establishing Ultrasound Curricula – Challenges and Practical Considerations

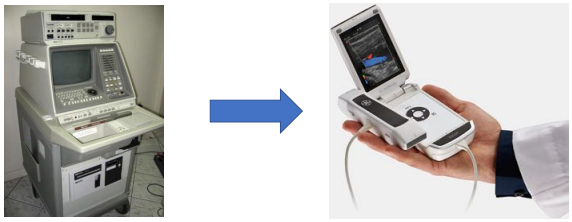
Kevin Thornton, MD
Associate Clinical Professor
Department of Anesthesia and Perioperative Care
Division of Critical Care Medicine
University of California San Francisco

Objectives

- Review the evolution of ultrasound in clinical practice
- Discuss expert consensus surrounding ultrasound education
- Explore challenges and barriers to establishing educational programs
- Propose pragmatic strategies for success across anesthesia subspecialties

Ultrasound really is exploding





Coming *now* to a med school near you…

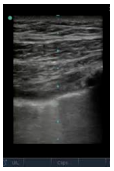
TOPICS IN ULTRASOUND EDUCATION

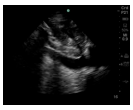
National Ultrasound Curriculum for Medical Students

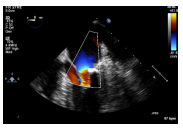
Oksana H. Baltarowich, MD, Donald N. Di Salvo, MD,† Leslie M. Scoutt, MD,‡ Douglas L. Brown, MD,§ Christian W. Cox, MD,|| Michael A. DiPietro, MD,¶# Daniel I. Glazer, MD,# Ulrike M. Hamper, MD, MBA,** Maria A. Manning, MD,†† Levon N. Nazarian, MD,*‡‡ Janet A. Neutze, MD,§§ Miriam Romero, MD,||| Jason W. Stephenson, MD,¶¶ and Theodore J. Dubinsky, MD##*

US Applications in Anesthesia

- Vascular access
- Procedural guidance
- Cardiac diagnostic applications – TEE and TTE/ACCE/FoCUS
- Hemodynamic evaluation
  - Cardiac
  - Abdominal
  - Lung
- Airway assessment/management
- Neuraxial and regional anesthesia
- Neurologic/ICP assessment
- Gastric volume assessment

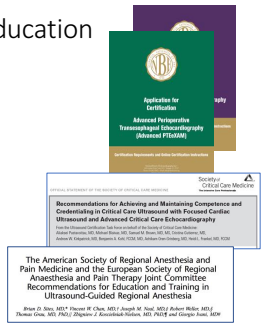






Defining Outcomes of US Education

- Defining proficiency
  - Technical/acquisition skills and interpretive ability that allows for integration into clinical practice
- Certification: NBE – Periop TEE
  - Exam
  - Case logs/supervised interpretation
  - MOC
- Specialty-specific consensus statements: CCUS, Regional
  - Recommended case numbers with supervised interpretation
  - Recommended curriculum/didactic topics
  - Local credentialing
- What about trainees who come with advanced experience?
  - How do we help them grow?

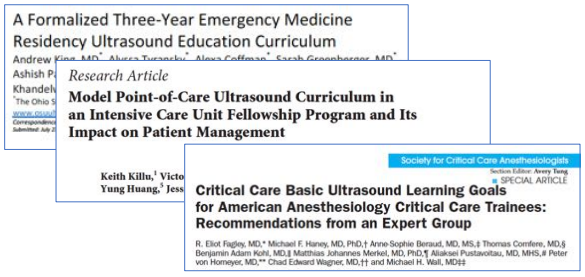


Challenges of Teaching Ultrasound

- Dependent on $ equipment and IT/biomed support
- Wide spectrum of faculty knowledge/skill
- Rapidly evolving field
- Requires new workflows, burdens for QA, credentialing
- Scope of practice, local 'traditions' that dictate/complicate professional boundaries

**Need to teach advanced skills to a small group of learners over a short period of time

Curriculum Recommendations



The task can be daunting…

Table 8. Sample Curriculum for Critical Care Ultrasound

Title	Type	Time or no.
Equipment and artifacts	Didactic	30 min
Equipment and artifacts practical*	Wet lab	15 min
Vascular ultrasound	Didactic	45 min
Vascular ultrasound practical*	Wet lab	30 min
Vascular ultrasound study review	Exam	10
Vascular ultrasound study performance	Exam	10
Abdominal ultrasound	Didactic	90 min
Abdominal ultrasound practical*	Wet lab	60 min
Abdominal ultrasound study review	Exam	30
Abdominal ultrasound study performance	Exam	30
Lung and pleural ultrasound	Didactic	45 min
Lung and pleural ultrasound practical*	Wet lab	30 min
Lung and pleural ultrasound study review	Exam	10
Lung and pleural ultrasound study performance	Exam	10
Transthoracic echocardiographic views and anatomy	Didactic	90 min
Transthoracic echocardiographic views and anatomy*	Wet lab	90 min
Transesophageal echocardiographic views and anatomy*	Didactic	60 min
Transesophageal echocardiographic views and anatomy**	Wet lab	60 min
Transthoracic and transesophageal echocardiographic pathology	Didactic	120 min
Transthoracic echocardiographic study review	Exam	50
Transthoracic echocardiographic study performance	Exam	50
Transesophageal echocardiographic study review*	Exam	50
Transesophageal echocardiographic study performance*	Exam	50
Critical care ultrasound quality assurance and quality improvement	Meeting	At least quarterly

*May include simulation sessions.
†Strongly suggested, but not required.

What are some solutions?

What works? A lot…

Curriculum Development and Evaluation of a Hemodynamic Critical Care Ultrasound: A Systematic Review of the Literature

Hussein D. Kanji, MD, MSc, MPH[a,b]; Jessica L. McCallum, BSc[b]; Kapil M. Bhagirath, MD, FASE[b]; Andrew S. Neitzel, MD, MSc[a,b]

- Review of 15 studies
- High variability among programs
  - Some combination of theory and hands-on instruction in almost all
  - Short/intense workshops vs. longitudinal instruction
  - Techniques: Formal didactics, web-based instruction, bedside scanning, live models/simulation
- Consensus that learners gain skill ~30-50 scans
- 'Hands-on' time ranged from 3-15 hours (more seems better)
  - This is a crucial element

Hands-On Learning is Essential

- Image acquisition is a critical skill (and can be challenging)
  - Probe/patient manipulation
  - Image optimization
  - Facility with equipment
- Numerous opportunities
  - Live scanning on patients
  - Scanning on live models
  - Simulation

Simulation is Effective

The Use of Computerised Simulators for Training of Transthoracic and Transoesophageal Echocardiography. The Future of Echocardiographic Training?

David Gerard Platts, FRACP[a,b,*], Julie Humphries, FRACP[a], Darryl John Burstow, FRACP[a,b], Benita Anderson, M Anest Sc[a,c], Tom Forshaw, M Cardiac Ultrasound[d]

Comparison of the didactic lecture with the simulation/model approach for the teaching of a novel perioperative ultrasound curriculum to anesthesiology residents☆

Davinder Ramsingh MD (Assistant Professor)[a,*], Brenton Alexander BS (Medical Student II)[a], Khanhvan Le BA (Research Assistant)[a], Wendell Williams MD (PGY-4 Resident)[a], Cecilia Canales MPH (Director of Operations, Simulation Center)[a], Maxime Cannesson MD, PhD (Professor of Anesthesiology)[a]

[a]Department of Anesthesiology, University of California at Irvine Medical Center, Orange, CA 92868, USA
[b]University of California at Irvine School of Medicine, Orange, CA 92868, USA

Utility of a Transesophageal Echocardiographic Simulator as a Teaching Tool

Ruma R. Bose, MD,*† Robina Matyal, MD,*† Haider J. Warraich, MD,*† John Summers, MD,† Balachundher Subramaniam, MD,*† John Mitchell, MD,*† Peter J. Panzica, MD,*† Sajid Shahul, MD,*† and Feroze Mahmood, MD*†

Web-Based Instruction

A Comparison of Web-Based with Traditional Classroom-Based Training of Lung Ultrasound for the Exclusion of Pneumothorax

Thomas Edrich, MD,* Matthias Stopfkuchen-Evans, MD,* Patrick Scheiermann, MD, PhD,† Markus Heim, MD,‡ Wilma Chan, MD,§ Michael B. Stone, MD,‖ Daniel Dankl, MD,‖ Jonathan Aichner,¶ Dominik Hinzmann, MD,‡ Pingping Song, MD,* Ashley L. Szabo, MD,* Gyorgy Frendl, MD, PhD,* Kamen Vlassakov, MD,* and Dirk Varelmann, MD*

Comparison of Web-Versus Classroom-Based Basic Ultrasonographic and EFAST Training in 2 European Hospitals

Elke Platz, MD, RDMS, Katja Goldflam, MD, Maria Mennicke, MD, Emilio Parisini, PhD, Michael Christ, MD, PhD, Christian Hohenstein, MD

From the Department of Emergency Medicine, Brigham and Women's Hospital, Boston, MA (Platz, Goldflam, Mennicke); the Harvard School of Public Health, Boston, MA (Platz, Parisini); the Department of Emergency Medicine, Klinikum Nürnberg, Nürnberg, Germany (Christ); and the Department of Anesthesiology, Klinikum Kempten Oberallgäu, Kempten, Germany (Hohenstein).

Web-Based Instruction – Practical Considerations

- What do you need to make a video?
  - Some software (<$100)
  - A decent microphone ($100-200)
  - A good talk (the hardest part)
  - Some time to learn the software, edit and optimize the video
- Good resources are already available online
- Curriculum development is a great project for fellows/junior faculty
- Once developed, can be deployed in numerous ways
  - Use from year-to-year
  - Inclusion in resident/student educational materials
  - Can aid with faculty development

Use It or Lose It

Internal Medicine Residents' Retention of Knowledge and Skills in Bedside Ultrasound

James A. Town, MD
Paul A. Bergl, MD
Akhil Narang, MD
John F. McConville, MD

SPECIAL ARTICLES

Retention of Ultrasound Skills and Training in "Point-of-Care" Cardiac Ultrasound

Bruce J. Kimura, MD, Sean M. Sliman, DO, MPH, Jill Waalen, MD, MPH, Stan A. Amundson, MD, and David J. Shaw, MD, *San Diego, California*

Evolution of a Program

Education

- Limited, basic lectures
- Occasional scanning sessions
- Limited expectations and assessment targeting basic proficiency

→

- Formalized curriculum
- Routine scanning, image review, reporting
- Case logs and assessment for proficiency
- Ability to help learners achieve advanced proficiency
- Prepares fellows for credentialing requirements

Clinical Program

- A few faculty champions/early adopters
- Intermittent, inconsistent use
- Minimal QA, IT integration

Faculty development

Outreach to administrative leadership

Establish US leadership and infrastructure

→

- Deep integration into routine clinical practice for majority of faculty
- Faculty credentialing
- QA/QI processes, standardized practice
- Robust IT integration with image archival, reporting
- Research/academic output

Bridging the Divide

- Cultivate the US champions
  - Advocate for faculty development!
- Intensive courses can be really effective
- Establish regular US teaching sessions
  - Journal club, didactics, fellow-led case conference, bedside scanning, image review
- Collaborate locally (leverage other educators)
  - Core residency program
  - Other anesthesia fellowships
  - Non-anesthesia fellowship programs
  - Regional peers
- Don't reinvent the wheel
  - Excellent web-based resources, hands-on workshops
- Establish clear expectations for proficiency
  - Case logs
  - Integration into clinical practice

Proficiency vs. Growth – The Advanced Learner

Help them help you:

- QI/QA process development
- Individual QI projects
- Educational program development
  - For co-fellows
  - For residents
  - For students
- Mentored research project

Our CCUS Program at UCSF

<u>Established Components:</u>

- 2-day intensive workshop with live models twice yearly
  - 50:50 mix of didactics and hands-on scanning
  - Focus on US basics, cardiac, vascular, lung, abdomen, ICP
  - **Advanced topics: RV and valvular assessment
- Inclusion of US into weekly fellow-led case conferences
- Quarterly US journal club/conferences
- Ultrasound 'attending of the week'
- Optional CCUS elective
  - ED scanning time, formal TTE experience with cardiology…

Our CCUS Program at UCSF

<u>Evolution:</u>

- Expectation of 'shock' exam for all new patients admitted with hypotension within 6 hours of admission by fellow
- Established formal ordering and digital archival capabilities
- Formal QA process with image review by US Director/Faculty

<u>Ongoing work:</u>

- Credentialing
- Billing
- Research projects

Vertical Expansion into the Residency

- 2-hour CCUS workshop for all residents on ICU rotations
  - Focused on the basics of cardiac ultrasound, lung ultrasound, and volume assessment
  - Includes scanning on patients with ICU fellows
- Longitudinal curriculum for CA1/2/3
  - During monthly education days (and embedded within rotations)
  - Includes didactics and hands-on scanning
  - Goal: establish proficiency in periop PoCUS for all residents

Acknowledgments

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HANDOUT

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Developing Ultrasound Curriculum Across and Specific to the Subspecialties

Aranya Bagchi, MBBS

11/03/2017
9:25am – 9:50am

Developing an ultrasound Curriculum for Anesthesia-Critical Care Trainees

Aranya Bagchi, MBBS
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Massachusetts General Hospital

Disclosures

Consultant for Lungpacer Medical, Inc.

Research funded by the US Department of Defense

My experience with ultrasound

- Using point-of-care ultrasound in critically ill patients for more than 5 years
- Completed the 'certificate of completion' course in critical care ultrasound developed by the American College of Chest Physicians
- A testamur of the NBE's Examination of special competence in adult echocardiography (the cardiology echo boards)
- Started an ultrasound curriculum for ICU fellows at MGH
- Teach ultrasonography at local, regional and national levels

Outline

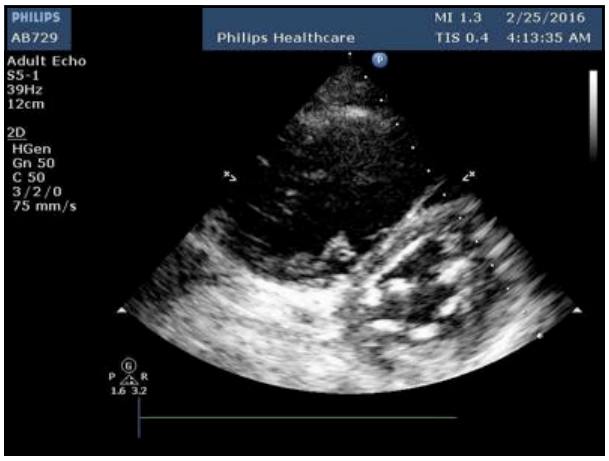
- What do we mean by 'focused' or 'point-of-care' ultrasound (FoCUS)?
- What questions can we ask with FoCUS?
- What guidelines exist to assist the development of curricula?
- Basic vs. advanced training
- Creating an ultrasound course at your department – what do you need in terms of:
  - Expertise
  - Infrastructure
- Should basic critical care ultrasound become a mandatory part of Anesthesia-ICU fellowship training?

BLUF (Bottom line up front)

- Focused ultrasound adds a useful and versatile tool to the arsenal of anesthesia and ICU clinicians
- I believe that FoCUS should be part of the required curriculum in Anesthesia-CCM programs
- The single most important requirement for setting up a FoCUS program is having intensivists who use FoCUS routinely in clinical practice

Why use ultrasound in the ICU?

- FoCUS has become increasingly popular in intensive care settings, but many clinicians remain underwhelmed
- Ultrasound is not an ideal monitor (there is no single, ideal monitor)
- It is a great adjunct to tools we routinely use in the ICU/OR, and adds another dimension to our ability to assess our patients' physiology
- It is non-invasive, can be performed immediately, and can be repeated as needed



What is the scope of FoCUS?

FoCUS is a **focused** examination of the **cardiovascular system** performed by a physician using ultrasound as an **adjunct to the physical examination** to recognize specific ultrasonic signs that represent a **narrow list of potential diagnoses in specific clinical settings**. (ASE Consensus statement 2010)

I am not a huge fan of this narrow definition

FoCUS/PoCUS/FCS/CCUS

FoCUS involves multiple organ systems:
- Heart
- Lung
- Vascular
- Abdominal

FoCUS tries to answer specific questions:
- Why is my patient hypotensive?
- What is the volume status of my patient?
- Why is my patient hypoxemic?

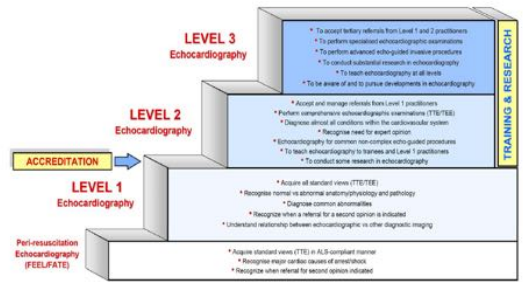
FoCUS is adaptable to the expertise and resources available:
- Basic vs. advanced
- Resource rich (ICU in a teaching hospital) vs. austere (disaster medicine) settings

Current status of FoCUS training

- Many societies have published recommendations for training in focus – among them ACCP/SCCM/ESCIM/WINFOCUS/SOCCA
- There is general agreement that a formal certification process is NOT necessary for BASIC FoCUS (although some certification processes exist, such as the CoC by the ACCP in the US).
- Basic FoCUS training and credentialing can be handled at the level of the individual hospital/department
- Basic FoCUS training has now been incorporated in Pulmonary Critical Care medicine fellowships
- However, standards of training across hospitals vary widely
- Anesthesiology programs have years of experience with training in TEE/perioperative echo and the use of ultrasound for regional anesthesia and vascular access, but training standards for FoCUS vary quite dramatically

Basic and Advanced FoCUS

- Basic FoCUS
  - Heart/Lung/Vascular/Abdominal ultrasound
  - Cardiac exam limited to:
    - 5 standard views
    - No use of doppler
    - Limited measurements (IVC diameter, etc)
  - Local certification/credentialing
- Advanced FoCUS
  - High level of facility with basic exam
  - The ability to do a comprehensive echo exam with all views
  - Familiarity with various doppler modes/M mode
  - Facility with quantification as needed (SV, RVSP, TAPSE)
  - Experience with TEE
  - National Certification system (NBE)



Proposed Levels of competence for echocardiography in ICU. Emergency echocardiography represents the entry level, whilst Level 1 echocardiography is achieved through a modular training programme, based on blended-learning, proctored practiced, and link to existing national/international echocardiography courses. Completion of this level would allow to undertake accreditation via a recognized examination, then giving access to Level 2 competence training and further accreditation. Cutting edge expertise is represented by Level 3 competence.

Elements of a Basic FoCUS Curriculum

FoCUS Curriculum

Training

Cognitive elements:
- Lectures
- Flipped Classroom
- Online material
- Echo rounds

Technical elements:
- Simulation
- Scanning normal volunteers
- Supervised scanning of patients

Credentialing
- Define scope of basic/advanced practice
- Determine minimum number of supervised scans required for competence
- Examination?

Quality assurance
- Image archival system
- Logbook maintenance
- Regular image review and feedback to trainees

Training – what does a program need?

- Only about 36% of Anesthesiology programs had some elements of FoCUS training, according to a recent survey (Conlin F, et al. *J Cardiothorac and Vasc Anesth* 2016)
- In our experience, the following factors are helpful in beginning a FoCUS program:
- **Essential:** Anesthesiologists who use FoCUS at the bedside, and 24/7 availability of a FoCUS capable machine in the ICU
- **Helpful:** Image archival systems, simulators, a good relationship with the cardiology division

My own biases

- What kind of machine?
  - Should ideally be capable of M mode, color and spectral doppler, tissue doppler and image transmission/storage
  - Handheld machines are great for codes across the hospital, but too limited for routine use
- Image archival is critical
- Teach concepts rather than algorithms
- Get buy-in from department/division leadership
- Invest in developing a nucleus of ultrasound experts

Leverage locally available expertise

- Cardiac anesthesiologists
- Emergency medicine ultrasound experts
- Pulmonary Critical Care Specialists who have integrated ultrasound into their ICUs
- Pool expertise in neighboring institutions for joint ultrasound rounds/teaching sessions
- Send one or two 'ultrasound leaders' to a high quality national or regional ultrasound course to create the nucleus of an ultrasound group in your hospital

Pitfalls and challenges

- Lack of utilization – if residents and fellows do not see FoCUS utilized in real patients, they will not have an incentive to learn
- Lack of appropriate equipment – a hand-held scanner is NOT ideal, although it has some utility (in code teams, for example). The better the machine, the more versatile it's utility
- Lack of archival systems
- Lack of institutional support or resistance from other specialties (cardiology)
- An unrealistic standard for evidence to support 'improved outcomes' with FoCUS before adopting it
- Lack of a national certification system at the advanced level: The NBE is expected to introduce certification in advanced critical care echocardiography within the next year

Should FoCUS be a mandatory part of anesthesia/ICU training?

- YES!!!
- Medical schools are exploring ultrasound use in clinical practice
- Residents are increasingly interested in ultrasound
- Fellowships that do not teach ultrasound will be at a competitive disadvantage
- FoCUS skills may start to become more sought after in the job market
- Ultrasound is a great tool to improve understanding of deranged physiology in ICU patients!

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Department of Emergency Medicine, MGH
Vicki Noble, MD

Thank you!

HANDOUT

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Teaching Business of Medicine and Leadership Development: Teaching Practice Management in Fellowship

Jennifer E. Hofer, MD

11/03/2017
10:30am – 10:55am

TEACHING PRACTICE MANAGEMENT IN FELLOWSHIP

Jennifer Hofer, MD

The University of Chicago MEDICINE

Disclosures: None

Literature is limited for teaching practice management (PM) specifically in fellowship. The American Society of Anesthesiologists has practice guidelines focused on practice management information for residents moving on to private practice and academic careers. Personal PM advice received on the last day of critical care fellowship included:

1. Buy the least expensive house in the best neighborhood
2. Say yes to everything
3. Be punctual
4. Leave tracks
5. Do what you ask someone else to do.

This seemingly limited advice translated into a much larger spectrum covering much of what is professionalism in PM. 1. Save money, invest, contribute to a 401k; 2. Say yes meaning to academic projects for promotion, trades with colleagues, cover calls, be a good Departmental citizen; 3. Be punctual as it is a marker of dependability, turn work in on time, be early for work shifts already dressed in scrubs ready for signout by the time you are to assume care of the patient, be timely with compliance, billing, continuing medical education requirements; 5. Leave tracks means to document honestly and thoroughly, 5. Do what you ask of others- learn how to do what you are requesting from colleagues, nurses, other services and be a team player.

The outline for this talk includes:

1. Review basic tenets of PM published by the ASA
2. Discuss the role of the hidden curriculum
3. Explore how to teach leadership in fellowship
4. Know limitations to effectively teach PM
5. Assess where we are- how are we doing teaching PM?

The ASA PM guidelines offer practical advice on professionalism in addition to legal and regulatory information for anesthesiologists.[1] The guidelines address the strain put on physicians needing to be educated in negotiating contracts, running a business, and understanding legal implications to practice, while delivering patient care. Certain outcomes are expected, others we strive for. Legally clinicians need

to meet the minimum standard of care, medical care for a patient could be pass/fail (pass they live, fail is death), and for business, the goal is saving money. This might meet minimum standards, but does not address our moral and ethical obligation to do what is right, to have the best outcome for the patient with minimal morbidity, to exceed the standard of care legally, and to save money but not at the risk of patient safety.

Physicians face tremendous pressure including, as outlined in the ASA PM guidelines, managed care and regulations, shrinking resources, increased clinical volume, sicker patient population, lower compensation, often resulting in physician cynicism and burnout. This can affect professionalism that is defined as "a set of values, attitudes, and behaviors that focus on commitment to service". Attitudes and behaviors include integrity, availability, accountability, and altruism; honesty is a key value that is critical to an ethical and moral practice; respect and compassion need to be shown to patients, families, colleagues and coworkers; and effective communication requires active listening, closed loop communication, and confidentiality.

Physicians need to accept responsibility. This includes maintaining records that are accurate, legible, and temporally related to the timing of seeing the patient; embracing rules and regulations such as maintaining licensure, being compliant with a medical staff office, and completing continuing medical education; being a teacher instructing coworkers and patients; and being a role model to coworkers, students, and residents. Conduct is a component of responsibility that is evident in 1. appearance- you should dress for the job you want; 2. Clinical setting- being patient focused and present rather than distracted; 3. Being a good citizen by participating in hospital committees and medical societies; 4. And having a good attitude that is positive, "can do, will do" rather than obstructionist.

Components of medical education include the *formal curriculum*, which is stated, intended, required, the *informal curriculum* that is unscripted and interpersonal, and the *hidden curriculum* that is composed of values and influences reflecting the culture of the organization.[2] A formal curriculum may include set didactics on septic shock and acute lung injury, the informal curriculum can be the bedside teaching between faculty and resident discussing experiences managing septic shock, or more informal the discussion over dinner among the call team about the day's cases and co-worker interactions. The hidden curriculum however is the culture that is perceived and perpetuated among workers in an organization, whether positive or negative. For example, the cited article mentions an incident of a Chief resident saying to a medical student "why are you wasting my time? Just get to the important stuff". If this approach is tolerated, it suggests in a hierarchy it is acceptable to be rude if you are doing something important, it ignores the learning curve that the student would do better if the student knew better, and it negates that social aspects of medicine are important.

What is taught and what is learned may be very separate. Limitations to the informal and hidden curriculum include who the receiver is, their understanding, experience, and perceptions. For example, you can have emails sent and announcements at meetings stating the scrubs must be worn under a white coat, or you will risk suspension. Then you see a fellow in the garage in scrubs without a white coat. Did the fellow not read the email or attend the meetings (poor professionalism), did the fellow receive the information but not understand what was being said? Was the fellow's past experience that policies are not enforced so this won't affect him/her? Or is the fellow not agreeing with the policy and thinks he/she is above needing to follow the rules- the rules are for someone else. In this situation, a hidden curriculum

of demonstrating correct behavior by example (faculty wearing white coat with 3 buttons over scrubs) will not be sufficient to change the fellow's behavior. This "receiver" may need direct verbal correction of behavior since the subleties of the hidden curriculum may be ignored or not recognized as a teaching point by this fellow.

Leadership lessons from the military have been applied to postgraduate medical education for curricular development. Similarities between the military and medicine include fast decision-making, often in critical situations, advanced equipment, and changing team leadership/membership roles depending on dynamic situations. In both medicine and the military there is decision making that is proactive and collaborative.

Self-awareness has also been found to be critical in effective feedback during graduate medical education.[6] The Johari window separates feedback into 4 categories: 1. Behaviors known to self and others, 2. Behaviors unknown to self but known to others, 3. Behaviors known to self and unknown to others, 4. Behaviors unknown to self and others. Common to each window is how the self-awareness affects how the feedback is given and how it is received. A barrier in graduate medical education feedback is often the interpersonal relationships that develop on small teams, making it easy to provide compliments, but difficult to provide blinded or constructive criticism due to the close working environment. The learning environment becomes one that the faculty/fellow relationship can be friendly, but not friends.

Outside of financial and legal components to practice management, here is a top 10 list for graduates embarking on clinical practice:

1. Audition for your job everyday
2. Be a good citizen
3. If you don't know, say I don't know and figure it out
4. Talk when you have something to say
5. Learn names
6. Be willing
7. Say thank you
8. Be a patient teacher, and continue to learn yourself
9. Give your best
10. Have gratitude.

Character is "doing the right thing when nobody's looking". J.C. Watts.

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Teaching Business of Medicine and Leadership Development: Preparing a Fellow for Academic Practice

Gary J. Brenner, MD, PhD

11/03/2017
10:55am – 11:20am

Advising Fellows who are interested in Academic Medicine

Gary J Brenner, MD, PhD

Director, MGH Pain Medicine Fellowship
Dept. of Anesthesia, Critical Care, & Pain Medicine
Massachusetts General Hospital – Harvard Medical School

Conflicts of Interest/Disclosures:

None

Is Academic Anesthesia Healthy?

SPECIAL ARTICLES

Anesthesiology Physician Scientists in Academic Medicine

A Wake-up Call

EDITORIAL VIEWS

Can We Get There if We Don't Know Where We're Going?

Evers & Miller

Temple of Apollo at Delphi

The Oracle of Delphi

If you do not find within yourself that which you seek, neither will you find it outside.

Know thyself and you will know the universe

Fellows Must First Define Their Primary Area of Interest

What do you want your contribution to the institution's academic mission to be?

- Research
  - Basic science
  - Clinical science
  - Outcomes
- Education
- Clinical Care
- Leadership?

You must give talks and publish to succeed!

Some of the Requirements for Success (not rank ordered)

- Further education/experience
- Mentorship
- Departmental support
  - Non-clinical time (post-call only probably not adequate)
  - Adequate base salary (to avoid excessive moonlighting)
  - Administrative support (decrease administrative burden)
  - Research support (staff)
- Non-departmental support
  - Home institution
  - Gov't, foundation, etc.
- Time frame of departmental commitment?
- Expectations for new faculty?

Responsibilities of New Faculty

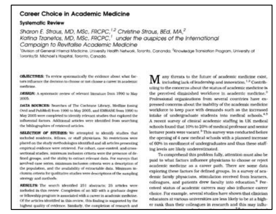
- Define professional goals and career path
  Clinician researcher
  Clinician education expert
  Clinician teacher
- Develop a written plan to meet career goals
  (ideally occurs with a mentor and department chair/their delegate)
- Be accountable for resources provided (non-clinical time, etc)
- Meet career goals within pre-defined time frame
- Meet general expectations of the department, hospital & institution
- Communicate developing resource and support gaps.

Data on Mentoring?


REVIEW

Mentoring in Academic Medicine
A Systematic Review

JAMA 2006


Career Choice in Academic Medicine
Systematic Review
Sharon E. Straus, MD, MSc, FRCPC, Christine Straus, BEd, MA, Kalina Tzanetos, MD, MSc, FRCPC, under the auspices of the International Campaign to Revitalise Academic Medicine

J Gen Int Med 2006

Some Traits of a Good Mentor

- Accessibility: an open door and an approachable attitude
- Empathy: personal insight into what the trainee is experiencing
- Open-mindedness: respect for each trainee's individuality and for working styles and career goals different from that of the mentor
- Patience: awareness that people make mistakes and that individuals progress at different rates
- Honesty: ability to communicate the hard truths about a trainee's chosen career path, work, progress
- Savvy: attention to the pragmatic, programmatic, and political aspects of career development

Advise fellows to be wary of mentors who exhibit the following characteristics:

- The avoider or the overcommitted: someone who is not available/accessible
- The criticizer: someone who criticizes freely but rarely makes positive comments
- The pushover: someone who compliments freely but rarely provides constructive criticism

When Looking for a Position

Advise trainees to:

First, articulate what they will contribute to the department then, secondly, discuss their needs for success.

Speak with current and past faculty prior to taking a position.

Don't be afraid to negotiate.

Careful attention to contracts is important; after-the-fact 'clarifying' emails can be very valuable.

Beware of "Privademic Practice."

Thank you

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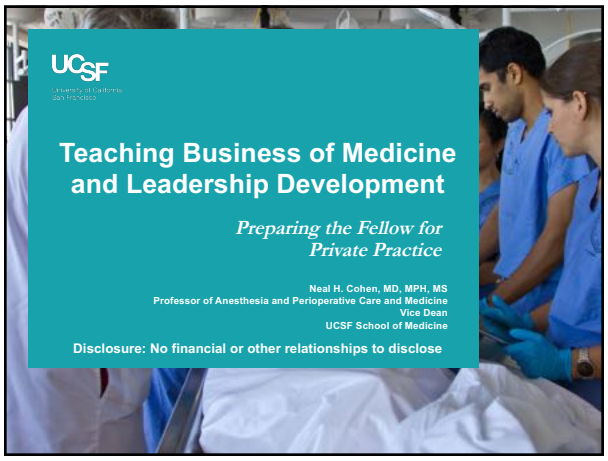
Teaching Business of Medicine and Leadership Development: Preparing a Fellow for Private Practice

Neal H. Cohen, MD, MPH, MS

11/03/2017
11:20am – 11:45am



Objectives

- Review the changes taking place in health care and anesthesia practices and the implications for private practice career opportunities for anesthesia fellows
- Describe educational opportunities to assist fellows in successfully transitioning to community practice and facilitate long-term career planning
- Identify leadership opportunities in the evolving health care system and how the training program can help prepare anesthesia fellows to assume leadership roles
- Identify ways to assist fellows in assessing job opportunities

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Health Care, 2017

- Health care is undergoing major transformation
  - **Hospitals transforming to health systems**
  - **Increasing emphasis on quality, safety and *patient experience***
  - **Payment reform**
  - **New care delivery models**
- Increasing pressure on providers/anesthesia practices to assume responsibility for **controlling costs and improving quality** through financial **incentives and penalties** for performance
- In spite of current uncertainty about the ACA and other reforms, shift to **value-based care and payment methods** will continue for both government (MACRA) and private payors
- To respond to these changes, every specialty is trying to redefine itself to maximize opportunities
- For anesthesia these changes provide the opportunity to expand scope of practice and coordinate care across all subspecialties

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Anesthesia Practice Environment

- Anesthesia practices are able to recruit outstanding clinicians, but workforce and job expectations are changing
  - Many new opportunities/needs outside of the operating room
  - Competition with other providers for some subspecialties (Pain, CCM)
  - Regional shortages of physician anesthesiologists
  - Expansion in practice opportunities for CRNAs and AAs; changes in scope of practice
- Many practices "requiring" fellowships; not always taking advantage of the additional areas of expertise
- Consolidation of Practices Accelerating
  - Majority of physicians are now in *employed* models
  - Transition from anesthesia practices to multispecialty groups
  - Acquisition of practices by hospitals and health systems
  - Some smaller or single facility practices struggling to compete

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What Do Community Practices Want?

- Highly skilled work force
- ***Needs vary by practice structure and location***
- In select practices, multidisciplinary, coordinated care
- Knowledge and skills to help the practice implement *care transformation*
  - *"Manage" the **continuum of (perioperative) care***, overcome "siloed" care
  - Participate in ***quality improvement*** programs
- Provide and document ***"Value"***
  - To patients
  - To hospital, health system
  - To the practice or "company"
- Control costs of care (resource use, reduce LOS/readmissions)
- Commitment to proprietary business and practice models

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What Do Health Systems Want?

*Hospitals and health systems recognize the need to **"partner" with physicians***

- ***Integrated delivery*** system, including coordinated inpatient and outpatient care
- ***Control*** through dedicated partnerships or "ownership" of practices that have aligned goals
- Providers who support the ***organizational culture***
- **Value**, efficiency, and outcome measures to support strategic vision – and external reporting requirements
  - Quality and safety
  - Optimizing patient experience
  - Financial strength

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What do Fellows Want (and Need)?

- Fellowship represents an opportunity to
  - Refine clinical skills
  - Expand scope of practice
  - Improve likelihood of employment
- Goals
  - Practice in which they can provide **high quality patient care (preferably within their subspecialty)**
  - For most, an **employed model** is not only acceptable, but preferred
  - Other "needs"
    - **Work-life balance**
    - **Income, benefits**
    - **Career growth opportunities**
    - **Non-clinical (leadership) roles**

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How Do We Prepare Fellows for Practice?

✓ **Diverse clinical experiences, opportunities to expand knowledge, skills and expertise *in subspecialty*** – and *differentiate* the fellow

What else can we do to prepare fellows?

- ❑ Provide overview of the **"business" of anesthesia practice** and its implications
- ❑ Identify potential practice opportunities created by **new models of care** that take advantage of subspecialty training
- ❑ Explain the **"new language" of health care**
- ❑ Provide **leadership training opportunities**
- ❑ Help the fellows **assess practice opportunities**

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The "Business" of Health Care and Anesthesia

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"Health Care is Complicated" *and BIG* Business

- **National healthcare expenditures continue to grow**
  - $3.2 trillion in 2015
  - Physician expenditures grew 6.3% to $645 billion
  - **Anesthesia allowed charges (2017) ~ $3B (does not include Pain Medicine)**
    - Anesthesiology $1.982B
    - CRNA $1.212B
- **Metrics of *"financial success"* for health system and practice differ, creating challenges in fulfilling diverse goals**
  - Critical factors include payor mix, payor contracts, staffing models, cost structure, clinical services, patient acuity, **"negotiating" skills, strategic support**
- **Difficult to reengineer care because of the differentiation of payment to hospitals and providers (Medicare Part A vs Part B)**

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Business of Anesthesia Practice

Fellows need to understand the unique features of an anesthesia practice

- Clinical and administrative roles, responsibilities, and opportunities
- Unique billing methodologies for anesthesia services versus other clinical services (RVG vs RBRVS)
- Compliance and Regulatory requirements
  - Medical direction, medical supervision
  - "Immediate availability"
- Professional Liability (Risk Management)
  - Definition of Standard of Practice

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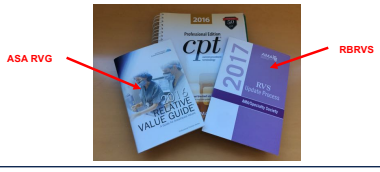
Payment For "Anesthesia" Services

ASA Relative Value Guide

- **Base Units plus Time**
- "Relative valuation" of anesthesia services based on conversion factor
- Anesthesia-Specific Conversion Factor

Resource-Based Relative Value System (RBRVS)

- Values all other professional services by comparing them to each other
- Applies to Evaluation and Management Codes (CCM, Pain)



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Different Physician Payment Methodologies Impact Relationships and Collaboration

- Different methodologies create ***perceived inconsistencies*** in payment for similar services across specialties
- Different metrics
  - Anesthesia base units and time
  - Separate Relative Value Guide
  - Different conversion factor
- *Ignorance about anesthesia RVG engenders distrust*
- Undermines efforts for collaboration, ability to develop bundled based payments, quantify "value" for alternative payment models

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Basis for Payment is Changing Transition to "Pay for Performance"

- Traditional FFS models not sufficient to support practice
  - Need for subsidies, strategic support
- Quality Performance Program (QPP) will significantly change how care is delivered by transitioning to value based payment methodologies
- 2 Alternatives
  - **MIPS**
  - Advanced alternative payment models (**APMs**)
- Critically important to understand the programs, their goals, and how they impact clinical care, payment, ***provider relationships*** and practice opportunities
  - Are there reasonable opportunities for anesthesiologists, intensivists, and/or pain medicine physician to report quality measures?
  - Do the metrics included in the model adequately measure outcomes attributable to anesthesiologists?

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New Models of Care

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Alternative Models of Care

- Fellows need to understand and participate in new models of care and understand their implications for practice
- All models rely on interdisciplinary, coordinated care
  - "Service Lines" (Transplant, Heart and Vascular, Spine, Neuro Sciences)
  - Enhanced Recovery after Surgery (ERAS) Programs
  - Perioperative Surgical Home (PSH)
  - Population Health
- Significant opportunities to improve collaboration across all anesthesia subspecialities

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The "New" Language of Health Care

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"New" Language of Health Care

- "True North"
  - Mission, Vision, Values
  - "Pillars" and Strategic Priorities
  - Lean and Six Sigma
  - A3 Continuous Improvement Programs
  - Internal Storyboards
- Transparency
  - Publicly reported metrics; outcomes
  - Patient satisfaction scores

TOYOTA

LEAPFROG

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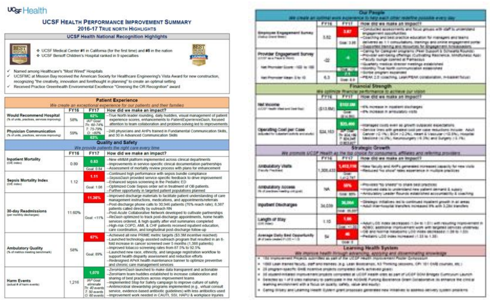
Health System "True North Board"



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New Language of Health Care *Creates Opportunities*

- To fulfill the requirements to succeed in this environment will require **breaking down silos**, reengineering of care through **interdisciplinary coordination**
- **Fellow Opportunities**
  - Lean Training
  - A3 Continuous Improvement Projects
  - Administrative Huddles, Interdisciplinary Team Discussions
  - Root Cause Analyses (RCAs)
  - Training in use of clinical data repositories

ACGME – "Pursuing Excellence"

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Leadership Development

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Leadership Development

- Fellowship programs should provide the opportunity to *educate and role model* regarding **leadership roles** within their practices
- Leadership skills

Communication	Care Transformation
Negotiation	IT/Decision Support
Organizational Behavior	Marketing
Team Building, Team Dynamics	Professionalism
Strategic Planning Process	Advocacy

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Leadership Training

At the same time,

- Leadership is not about "being in charge"
- "Leadership" roles must be earned based on knowledge, skills, and *integrity*
- *Some fellows want to be "leaders" rather than "doers"*
- Without making a political statement, ***bullies generally do not become leaders***

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Selecting the "Right" Practice

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Selecting the "Right" Practice

To paraphrase Yogi Berra…

"If you don't know what kind of practice you want, you'll end up making the wrong choice."

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Selecting the "Right" Practice

Key Issues to Consider

- Culture
- Structure of Practice
- Relationship to Hospital, Health System, Other Providers
- Local Health Care Environment
  - Implications for Future of Hospital, Practice
- Business Practices (Moral Compass)

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Assessing the *Culture* of a Practice

- What are the core values of the practice?
- How "secure" is the current model?
- What motivates colleagues, the anesthesia practice, health system?
- How is care delivered?
- Are there career development opportunities?

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Selecting the "Right" Practice *Getting to "Yes"*

- Contract Review and *"Negotiation"*
- Practice Opportunities
  - Opportunity to practice subspecialty
- Flexibility of Work Hours, Scheduling
- Compensation and Benefits
- Non-Compete Provisions

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In summary, Preparing the Fellow for Private Practice

- Facilitate the transition to practice by not only providing outstanding clinical training, but also by providing a broad perspective and skills
  - Understanding the **current health care environment**
  - Identification of **new models of care**, role of the anesthesiologist in the continuum of care
  - Knowledge of **finances of health care** and implications, including alternative payment models, bundled care
  - Training in **Lean methodology, A3 thinking**
  - **Performance improvement** experiences
- Help each fellow clarify personal and professional goals and identify the "right" practice

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Questions?

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UCSF
University of California
San Francisco

HANDOUT

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Updates from the Subspecialties: Regional Anesthesiology and Acute Pain Medicine

Edward R. Mariano, MD, MAS

11/03/2017
1:30pm – 1:40pm

Updates from Regional Anesthesiology and Acute Pain Medicine

Edward R. Mariano, M.D., M.A.S.
Professor of Anesthesiology, Perioperative & Pain Medicine
Stanford University School of Medicine
Chief, Anesthesiology and Perioperative Care
Veterans Affairs Palo Alto Health Care System

Stanford Children's Health | Lucile Packard Children's Hospital Stanford

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Brief History

- Regional Anesthesia Fellowships in the U.S.
  - Early 1980's
    - Virginia Mason, Brigham and Women's Hospital, Duke, Hospital for Special Surgery, Mayo Clinic, McGill, St. Luke's-Roosevelt/Columbia, U of Alberta, U of Florida, U of Manitoba, U of Texas/Houston, U of Toronto

Guidelines for Regional Anesthesia Fellowship Training

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

RAPM 2005;30:218-225

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Fellowship Directors Group

- Formed organically ~2002
- Twice-yearly meetings (ASA and ASRA Spring) organized and hosted by HSS Department of Anesthesiology
- Initiatives:
  - Development of Fellowship Training Guidelines
  - Information Repository
  - Knowledge/Practice Sharing
  - ACGME Accreditation

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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

- HSS maintains an email list of all graduates of regional anesthesia fellowship programs
  - Approximately 825 fellowship graduates

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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.

- 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

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2002

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2012

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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

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

  *371 Surveys Sent
  - 28 Bounced Back
  - 2 Opted Out of Survey

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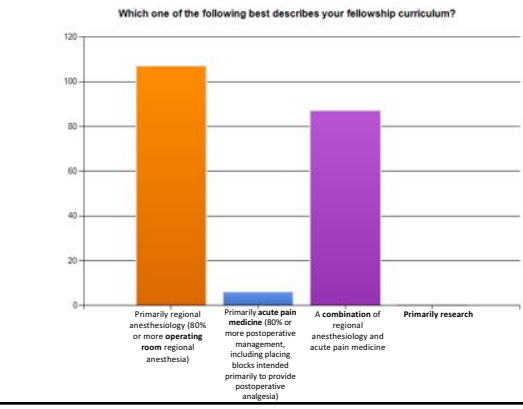

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Post-Fellowship Careers

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

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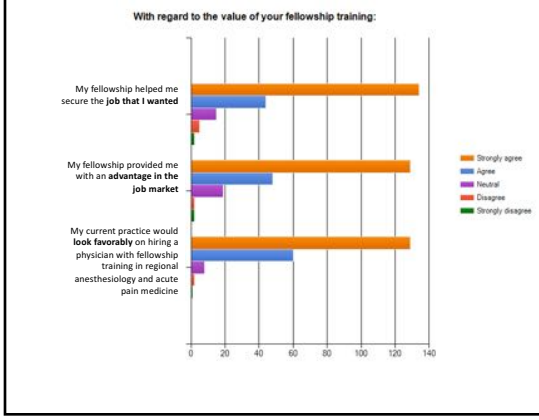

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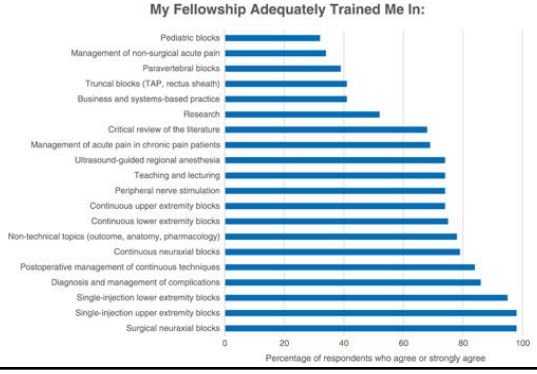
Adequacy of Skills



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Areas for Growth

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Road to Accreditation

- 2013 (May): Fellowship Directors agreed to pursue ACGME accreditation
- 2013 (Dec): Letter submitted to Dr. Nasca
- 2014 (Sept): ACGME approval to develop subspecialty program in RAAPM
- 2015-16: Development and revision of program requirements
- 2016: ACGME opened applications for RAAPM
- 2017-present: Milestones development

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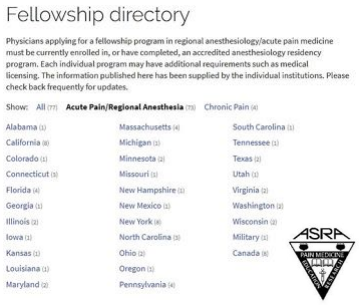
Today (2017)

- 73 RAAPM fellowships in US and Canada (+3 from 2016)
- 133 positions available in the US and Canada (+32 from 2016)



https://www.asra.com/fellowship-directory?showType=1

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Why RAAPM?

VALUE = Quality / Cost

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- "Unlike current questions, which ask about the efficacy of pain treatment, the new set will focus on the communication between doctor and patient about pain."

http://www.nytimes.com/2016/08/05/health/pain-treatment-hospitals-emergency-rooms-surveys.html?_r=0

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Develop Patient Care Pathways

A Comprehensive Anesthesia Protocol That Emphasizes Peripheral Nerve Blockade for Total Knee and Total Hip Arthroplasty

Hebl JR, et al. JBJS 2005;87 Suppl 2:63

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Decrease Inpatient Costs

A Self-Paired Comparison of Perioperative Outcomes Before and After Implementation of a Clinical Pathway in Patients Undergoing Total Knee Arthroplasty

Christopher M. Duncan, MD, Susan M. Moeschler, MD,* Terese T. Horlocker, MD,* Arlen D. Hanssen, MD,† and James R. Hebl, MD**

RESULTS: Fifty-four patients were identified for study inclusion. Patients undergoing their TKA after implementation of the clinical pathway had a significantly shorter hospital LOS (3.4 vs 4.4 days; $P < 0.001$). Patients reported significantly less postoperative pain, less postoperative confusion, and an easier time participating in physical therapy sessions after their second (after the clinical pathway implementation) TKA. Patients undergoing their TKA after the clinical pathway implementation had reduced total direct hospital costs ($956; 95% confidence interval, $233-$1785; $P = 0.02$).

CONCLUSIONS: Our findings demonstrated that the use of a standardized clinical pathway reduced hospital LOS, improved clinical outcomes and patient satisfaction while reducing costs for identical surgical procedures.

RAPM 2013;38:533

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Decrease Readmissions

The Fifth Vital Sign

Postoperative Pain Predicts 30-day Readmissions and Subsequent Emergency Department Visits

Tina Hernandez-Boussard, PhD, Laura A. Graham, MPH,† Karishma Desai, PhD,* Tyler S. Wahl, MD,† Elise Aucoin, PharmD,† Joshua S. Richman, MD, PhD,† Melanie S. Morris, MD,† Kamal M. Itani, MD,‡ Gordon L. Telford, MD,§ and Mary T. Hawn, MD, MPH*¶*

Results: Our sample included 211,231 surgeries—45.4% orthopedics, 37.0% general, and 17.6% vascular. Overall, the 30-day unplanned readmission rate was 10.8%, and 30-day ED utilization rate was 14.2%. Patients in the high pain trajectories had the highest rates of postdischarge readmissions and ED visits (14.4% and 16.3%, respectively, $P < 0.001$). In multivariable models, compared with the persistently low pain trajectory, there was a dose-dependent increase in postdischarge ED visits and readmission for pain-related diagnoses, but not postdischarge complications (χ^2 trend $P < 0.001$).

Conclusions: Postoperative pain trajectories identify populations at risk for 30-day readmissions and ED visits, and do not seem to be mediated by postdischarge complications. Addressing pain control expectations before discharge may help reduce surgical readmissions in high pain categories.

Ann Surg 2017;266:516

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ACGME-Approved RAAPM Programs

- Stanford Health Care-Sponsored Stanford University Program
- Cedars-Sinai Medical Center Program
- University of California (San Francisco) Program
- Massachusetts General Hospital Program
- Brigham and Women's Hospital Program
- Mayo Clinic College of Medicine and Science (Rochester) Program
- Montefiore Medical Center/Albert Einstein College of Medicine Program
- Icahn School of Medicine at Mount Sinai/St Luke's-Roosevelt Hospital Center Program
- New York Presbyterian Hospital (Columbia Campus) Program
- Duke University Hospital Program
- UPMC Medical Education Program
- Vanderbilt University Medical Center Program

http://www.edmariano.com/archives/1252

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ACGME Application Process

- Application in Accreditation Data System (ADS)
- 14-step process is outlined in ADS: participating sites, program details and personnel, requested number of fellows, evaluation methods and clinical experience, informational questions
- Application deadlines:
  - January 29-30th meeting is November 3, 2017
  - April 17-18th meeting is January 12, 2018

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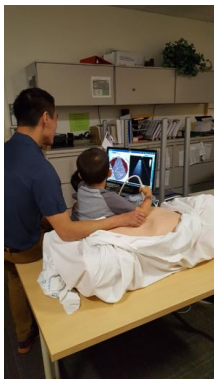

HANDOUT

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Updates from the Subspecialties: Critical Care Medicine

Nicholas Sadovnikoff, M.D.

11/03/2017
1:40pm – 1:50pm

AASPD SUBSPECIALTY UPDATE: CRITICAL CARE

Nicholas Sadovnikoff, MD, FCCM
Brigham and Women's Hospital
Boston, MA

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 (19 programs)

Numbers

	2014	2015	2016	2017
APPLICANT DATA				
Applicant registrations	196	189	194	203
# Applicant Rank Lists Submitted	147	148	153	157
Matched Total	127	137	149	150
Unmatched Total	20	11	4	7
Applicant Matching % (Overall)	86%	93%	97%	96%
Total # of Withdrawals	20	19	16	11
PROGRAM DATA				
# Of Participating Programs	47	49	52	53
Positions Offered	150	167	186	202
Positions Filled	127	137	149	150
Unfilled Positions	23	30	37	52

Match Timeline

	Date
Applicant Registration Begins	November 1, 2017
Rank List Submission Deadline	May 24, 2018
Results Released to Programs	May 31, 2018
Results Released to Applicants	May 31, 2018
Post-match vacancies posted	June 1, 2018
Fellowship Training Begins	July/August 2018

Match Process

- SF Match
- Common Application Service: new 2017 cycle
- Standardized LOR: not using
- Exceptions to the Match: unchanged

Match Timeline

	Date
Applicant Registration Begins	November 1, 2017
Rank List Submission Deadline	May 24, 2018
Results Released to Programs	May 31, 2018
Results Released to Applicants	May 31, 2018
Post-match vacancies posted	June 1, 2018
Fellowship Training Begins	July/August 2018

Exceptions to the Match

- Requires agreement from applicant and program
- Exceptions 2017 (42)
  - Active military service (0)
  - Commitment > 1 yr (24)
  - Outside US at time of application (0)
  - Not eligible for ABA certification (0)
  - 'Couples match' (1)
  - Internal candidates (19)

Issues with the ACCM Match

- Exception Process

	2014	2015	2016	2017
Positions Offered	150	167	187	202
Positions matched	127	137	149	150
Exceptions (%)	31(24)	36(26)	56(38)	42(28)

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

Subspecialty Organization

- SOCCA
  - Formally sponsored 2013
- PDs meet 3 times a year
  - now
  - SCCM: San Antonio, February 24, 2018
  - SOCCA/IARS: Chicago, April 27, 2018
  - SAAAPM/AASPD: Chicago November 2/3, 2018

Other Interests (?In Common)

- Discussion Board
- Common Competencies/ Collaboration
- Jobs in the Community & Academics
- Professional Development Opportunities for our PDs
- Critical Care Ultrasound
- ? Move towards common August starting dates

HANDOUT

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ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Updates from the Subspecialties: Pain Medicine

Magdalena Anitescu, MD, PhD

11/03/2017
1:50pm – 2:00pm

THE UNIVERSITY OF CHICAGO MEDICINE

Updates on Pain Medicine

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

Pain Medicine Programs

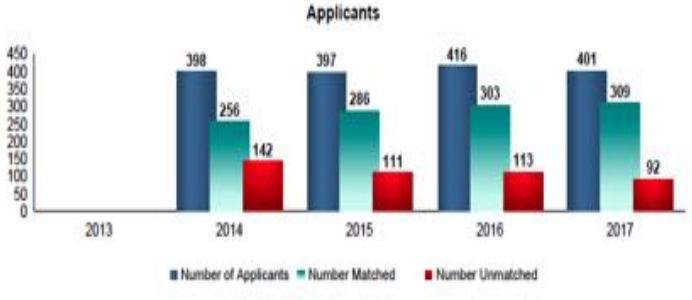
- Total for 2017: 102 programs
- Participating in match: 98
- % participation: 96%

Pain Medicine Positions

- Total for 2018: 367 positions
- Participating in match: 335
- % participation: 91%

Applicants

- Applicants for 2018: 437
- Matched: 331
- Not matched: 105



Positions and applicants

- In 2018:
  - 1.3 applicants per position
  - 76% matched

The applicants

Year	Program	Positions	Filled	% not matched	%US Grad	% US FMG	Osteo-paths	Interna tional
2014	82	261	256	36	73	8	9	10
2015	84	286	286	27	69	9	14	7
2016	90	305	303	37	71	10	14	5
2017	93	316	309	23	70	9	15	6
2018	98	335	331	24	61	8	14	7

Program Director Survey data

- Results lag 1 year.
- Survey on 2016.
- 90 programs in the match
- Limited responses, max 25

General information

2016 Survey

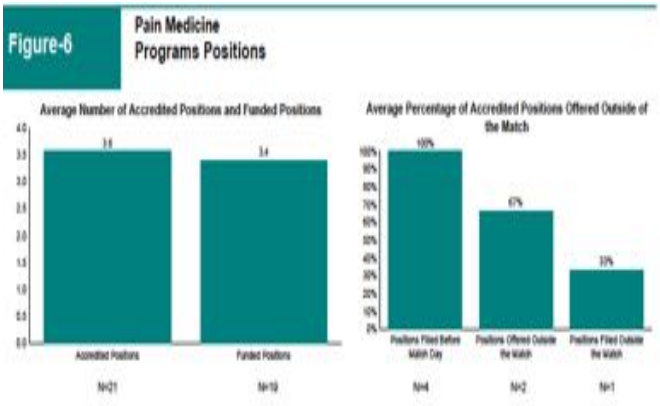
Number of responses	21
Response rate	25.0%

Match Information*

	Appointment Years		
	2016	2015	2014
Number of programs in the Match	90	84	82
Number of positions in the Match	305	286	261
Number of applicants ranking specialty	416	397	398

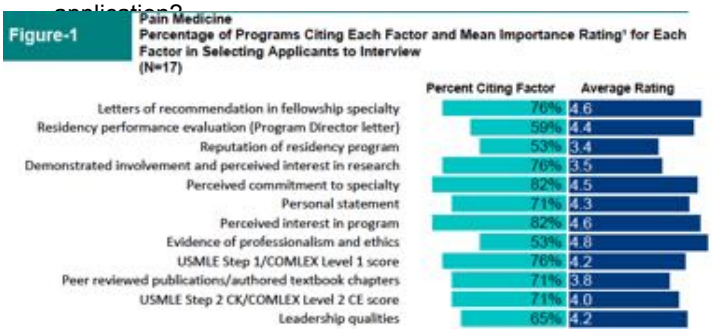
* Source: NRMP Data Warehouse

Who responded?



How do we select the applications

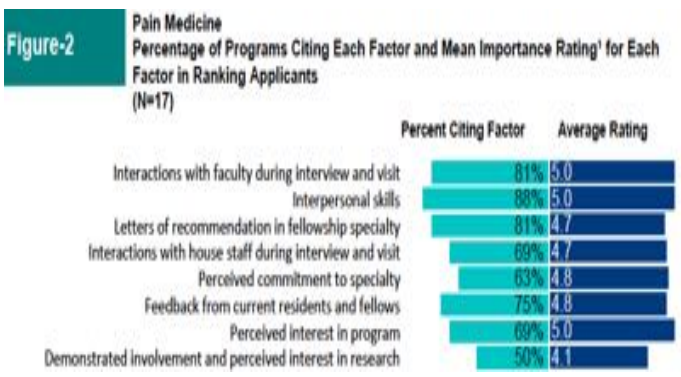
- Approximately 150 applications per program
- What becomes important for PD in looking at an application?



What do we think is of less importance?

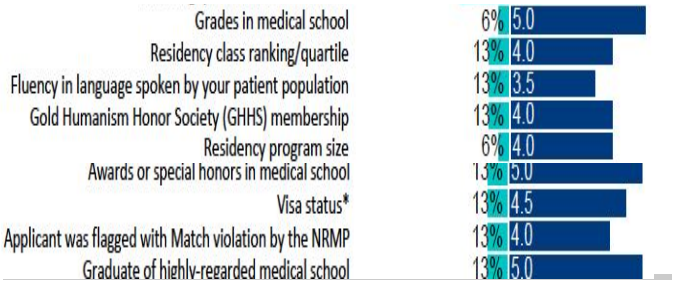
- What factors have less importance and how do we rank this factor?

What is important during an interview

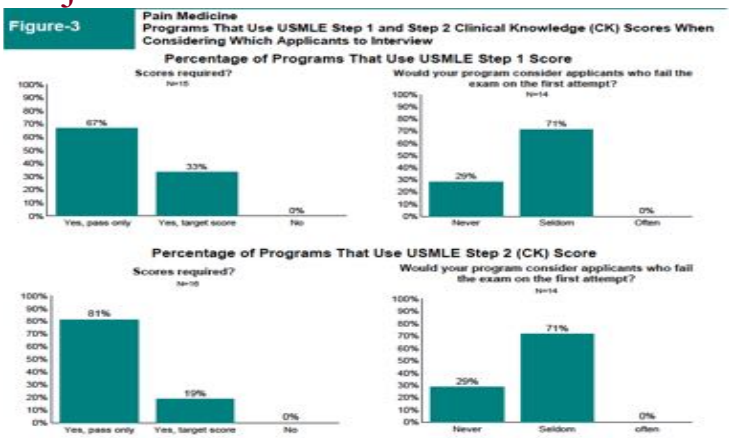


What is less important during an interview?

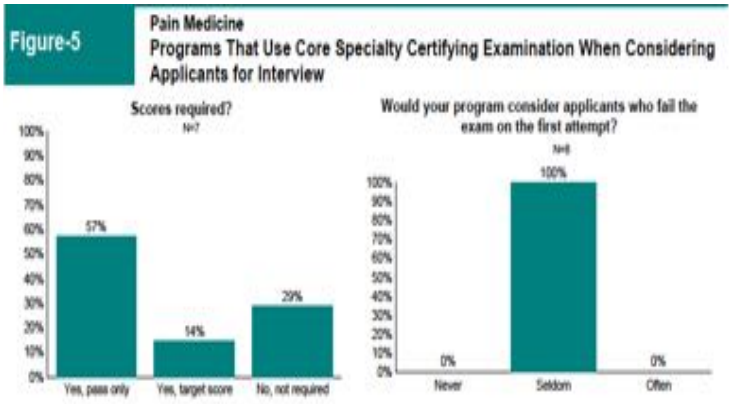
- AOA only 19%



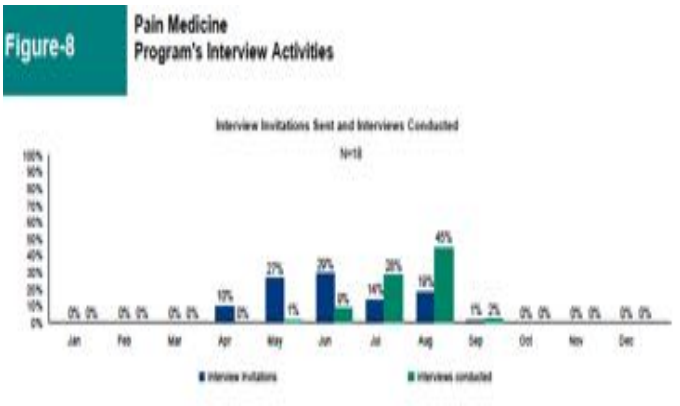
Objective measures: do scores count?



Core Specialty Exam Value



When do interviews happen?



Conclusions

- Consistent high competitive fellowship with 25% applicants not matching despite slight increase in number of positions every year
- High percentage of positions and programs in the match
- High volume of applicants per program
  - Choosing the good applicant from the application stack
  - Common criteria of quality of an applicant
  - Choosing an applicant to fit a program
  - Do we spent enough time during interview?
  - When shall we interview?
- Many benefits of the match, some disadvantage.
- Building a community of pain PD with similar aspirations for their incoming trainees.

HANDOUT

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Updates from the Subspecialties: Pediatric Anesthesiology

Susan R. Staudt, MD, MSEd

11/03/2017
2:00pm – 2:10pm

Pediatric Anesthesiology Fellowship Match Review and Updates SAAAPM 2017

Susan Staudt, MD, MSEd

PAPDA President

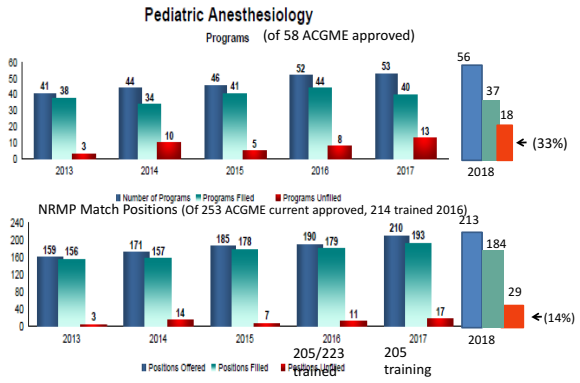
(No conflicts of interest)

Pediatric Anesthesiology Fellowships Metrics and Demographics ACGME Data

- 58 accredited acgme fellowships; 56 participated in the match
- 253 ACGME approved positions actual 235- positions *(with 3 +years site unfilled spot = est 15)* 213 certified match positions and 184 matched (84% in match is likely actually 90-92%)

- Per ACGME Data book, the 5 year increase in n of programs is 26%
- The 5 year increase in number of ACGME APPROVED positions is about 10-12% *(best estimate) (228 in 2014)*
- *The n of applicants fell -vs 5 yrs ago is up net 2.5%*

Trends in Programs & Match Positions Filling, NRMP data

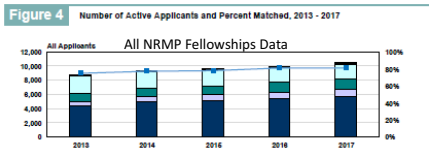


Match Applicant Pool from NRMP and SF match***

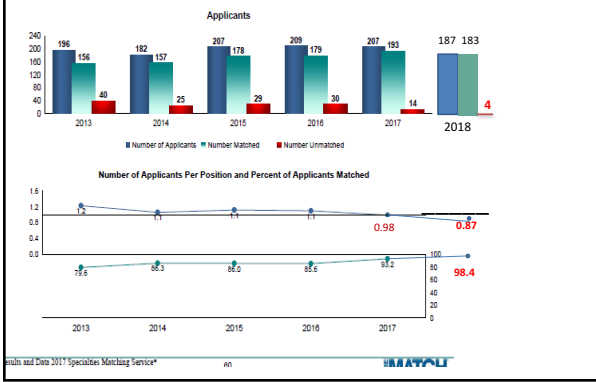
N of positions/n of applicants applying in match

	Crit care	Adult CT	Pain ***	pediatrics	OB	total
2014	-	168/230	261/398	171/182	-	600/810
2015	150/147	174/213	286/397	185/207	-	795/964
2016	167/148	183/211	305/416	190/209	48/25	893/1009
2017	186/153	199/258	316/401	210/207	43/29	954/1051
2018	202/157	207/258	335/437	213/187	38/26	995/1065

***Does not consider regional (45/42+) , palliative?, informatics (1/1)fellowships



Trends Peds Anes Match Applicant Pool in Relation to Positions



Concerns/Challenges

- Too many new and unfilled positions with a position to applicant ratio below 1 x 2 years: we have too many positions!
- 98% of applicants found a position --are they really all good training candidates?

Other PAPDA Changes

- Migration from a common application to ERAS worked well
- Sole ERAS negative is calendar -long cycle-opens in December but match closes late September
- Endorsement of an August 1 Official Fellowship Start Date (optional for programs)
- By laws were revised

PAPDA agenda Items

- Mandatory all positions in via ERAS vs Match is fine?
- Continued push to force ABA to move exam certification date back from mid August
- Ongoing need to revise case log system-trying to work via RRC
- ? Endorsement of a standard program director LOR
- (with PALC) Consideration of a 2 Year Fellowship

Possible Joint Fellowship Items

- Common format program director LOR?
- Consideration of a single subspecialties match?
- Regional Anesthesia entry into SAAPM?
- Is any other specialty looking at a 2 year fellowship training?

References

- ACGME DATA RESOURCE BOOK
  - Table D6 AY graduates
  - Table C6 n of Active residents
- NRMP ANNUAL MATCH REPORTS
- NRMP 5 YEAR SMS REPORTS
- SF MATCH REPORT STATISTICS
- ACGME REGISTRY OF PROGRAMS AND NUMBER OF FILLED POSITIONS (manually tallied)

HANDOUT

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Updates from the Subspecialties: ACTA

Mark Stafford-Smith, MD, CM, FRCPC, FASE

11/03/2017
2:10pm – 2:20pm

AASPD Panel: Update from the Subs: Where are we headed and what have we have learned: Adult Cardiothoracic Anesthesia (ACTA) Update

SAAA 2017 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:

Five successful matches using SF Match have now occurred since 2013 (see below). In the 2017 match the increased number of ACTA applicants continued from 2016, relative to the previous 3 years. Sixty-four ACGME-approved ACTA programs participated (up from 60), representing 210 total positions (up from 199). Most of the withdrawals each year are presumed to be individuals matching to a 2-year CT/SICU fellowship that choose to start with their ICU fellowship first, followed by an ACTA fellowship. 13 applicants made a 2yr agreement, many of these would be ICU fellows who chose to do their CT fellowship first. There were 43 pre-match "agreements" (recorded independently from SF match, through the SCA website tool) – this was up from last year (32), but fewer than the high of 56 (2014). The content of the electronic application for the 2018 match has been updated to include fellow interest in a combined adult cardiothoracic anesthesiology and critical care medicine fellowship.

Adult Cardiothoracic Anesthesiology Fellowship	June 2013	June 2014	June 2015	June 2016	June 2017
APPLICANT DATA					
Applicant registrations	267	**268**	**268**	**331**	**316**
# Applicant Rank Lists Submitted	230	**213**	**211**	**258**	**258**
Matched Total	166	**172**	**182**	**199**	**202**
Unmatched Total	64	**41**	**29**	**59**	**56**
Applicant Matching % (Overall)	72%	**81%**	**86%**	**77%**	**78%**
Total # of Withdrawals	9	**21**	**14**	**25**	**22**
PROGRAM DATA					
# of Participating Programs	54	**55**	**57**	**60**	**64**
Positions Offered	168	**174**	**183**	**199**	**207**
Positions Filled	166	**172**	**182**	**199**	**202**
Unfilled Positions	2	**2**	**1**	**0**	**5**
MATCH EXCEPTIONS					
Internal candidate	31	**46**	**21**	**21**	**27**
Commitment to come to institution for more than 1 year	7	**8**	**9**	**10**	**13**
Active military	3	**1**			**1**
Spouse/partner	1		**1**		
Residency outside US		**1**		**1**	**2**
Residency outside US not eligible for ABA certification due to non-US training					

Timelines for the upcoming June 2018 Match are as follows.

- Friday, November 10, 2017 — Applicant registration begins
- Monday, April 30, 2018 — CAS deadline date (suggested)
- Monday, June 4, 2018 — Rank lists must be submitted by 12:00 PM PST.
- Monday, June 18, 2018 — Match results available to programs/applicants
- Wednesday, June 20, 2018 — Vacancies listed on SF Match

Fellow/Program Director Questionnaire:

Using the pediatric anesthesia fellowship questionnaire as a template, a task force (Shook/Ural/Augoustides) edited and modified with input from PDs to be pertinent to the ACTA fellowship. Data processing still occurring.

ACGME Case Log:

After a failed first attempt (July 2016), roll out of the required ACGME case log for fellows occurred in time for the July 2017 year. In collaboration with the NBE, a printout format was created that summarizes TEE cases (performed and interpreted, and interpreted only) in a format suitable for submission for TEE certification. The tool should provide a useful way for Fellows to record their cases, but also provide data for ongoing monitoring of trends in ACTA fellow activities in future years.

Fellow Web Seminars:

The ACTA fellow web seminar task force (Weitzel, Bottiger, Ahlgren, Stafford Smith) have developed several online media to complement the existing 15 presentations constituting the SCA fellowship lecture series, for use by ACTA fellowships through the SCA website. Since proof of concept occurred through two well received prototypes, several more brief (15 min) videos have been created – these involved an interviewer (Bottger, Ahlgren) and two guests - all involved topics presented in a PBLD format at the SCA annual meeting and were filmed onsite soon after the PBLD. The SCA Board is in support, and a proposal is being considered to transition this successful idea into a more formal video pipeline through scheduling selected PBLDs each year for subsequent filming at future annual meetings.

ACTA Fellowship Certification:

The ACTA PD continue to voice concerns 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 all continue to be explored as viable SCA-sponsored pathways towards such a certification exam.

HANDOUT

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Updates from the Subspecialties: OB Anesthesia

Rebecca D. Minehart, MD, MSHPEd

11/03/2017
2:20pm – 2:30pm

AASPD 2017: OB Anesthesia Fellowship Update Session

Rebecca D. Minehart, MD, MSHPEd
Program Director, Massachusetts General Hospital Obstetric Anesthesia Fellowship
Chair, SOAP OB Fellowship Committee
Chair, SOAP Strategic Task Force Initiative for OB Anesthesia Fellowships

I have no relevant financial disclosures.

NRMP MATCH RESULTS FOR OB ANESTHESIA
OB anesthesia participated in its third NRMP Match this year.

MATCH RESULTS FOR 2017:
October 4, 2017, for fellows entering July 2018:

PROGRAMS: No non-accredited OB anesthesia fellowship programs participated in the Match this year. There are currently 33 ACGME-accredited programs in OB anesthesia, and 18 non-accredited programs in North America (14 in the US, 4 in Canada), for 51 total programs in North America and one in Israel (not involved in the Match).

27 programs participated in this year's Match with *at least one* of their positions, for a participation rate of 81.2%, above the 75% NRMP suggested threshold for success.

14 programs filled with all of their spots (51.9% of programs), 6 partially filled (all had 1 spot unfilled), and 7 went unfilled (2 did not submit rank lists, so 5 put a single spot in the Match and did not fill through the Match).

POSITIONS: There are 56 accredited positions in OB Anesthesia, 38 of which were placed in the Match. There are 20 non-accredited positions in OB Anesthesia, if all SOAP-reported fellowship information is correct, for a potential 76 fellowship spots per year available.

Only 38 of the positions were available in the Match (67.9% of 56), BELOW the NRMP suggested threshold for success.

25 applicants matched to our specialty. 1 did not receive a match to any program.

27 programs either withheld some spots from the Match (7, all ACGME-accredited) or did not put any spots in the Match (20 total, 6 ACGME- and 14 non-ACGME-accredited). Two programs withdrew from the Match, and two did not submit rank lists. This leaves a knowledge gap with how many of these programs are filling outside the Match. I have reached out to the PDs/PCs of these programs to get a better sense of their successes outside the Match, and am still awaiting some responses.

The 2016 Match was more successful in programs complying with Match positions, but similar in number of applicants. The 2017 Match was slightly more successful with programs filling spots.

Thoughts regarding the Match and our Fellowship:

1) Continued low numbers of applicants may lead to withdrawal from the NRMP Match related to different (more flexible) fellowship recruitment strategies; these are currently being discussed within the SOAP Fellowship Committee and the SOAP Strategic Task Force on Obstetric Fellowship Interest.
2) Program noncompliance with suggested NRMP success rates is multifactorial and is continuing to be explored if the SOAP Fellowship Committee votes to maintain our involvement with NRMP Match.
3) There is great interest in evaluating the ACGME program requirements for the OB Anesthesia Fellowship itself, as the "product" of our fellowship may not be as marketable to candidates looking for a definable skill set (e.g., TTE, QI Leadership, leadership in massive hemorrhage treatment). Modification of the ACGME program requirements will be a point of discussion among SOAP Board Members, the SOAP Fellowship Committee, and the SOAP Strategic Task Force members.

HANDOUT

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Subspecialty Breakout – Adult Cardiothoracic

Mark Stafford-Smith, MD, CM, FRCPC, FASE

11/03/2017
3:45pm – 5:30pm

AASPD Annual Meeting, Chicago, IL

ACTA Breakout Session
Friday, November 3, 3:45 5:30pm

Agenda

1. Fellow/PD Questionnaire (Shook/ Ural / Augoustides)
2. ACGME case log update (Stafford Smith)
3. SF Match Update (Stafford Smith)

   Time lines
   - Friday, November 10, 2017 Applicant registration begins
   - Monday, April 30, 2018 CAS deadline date (suggested)
   - Monday, June 4, 2018 Rank lists must be submitted by 12:00 PM PST.
   - Monday, June 18, 2018 Match results available to programs/applicants
   - Wednesday, June 20, 2018 Vacancies listed on SF Match

   Application Changes

   Addition of "I am interested in a combined adult cardiothoracic anesthesiology and critical care medicine fellowship: Yes NO

   SCA Exceptions

   Available on website November 13

4. August Start Date for ACTA Fellowships
5. Certification Update (Stafford Smith)
6. Fellow Web Seminars (Weitzel / Ahlgren / Bottiger / Stafford Smith)

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Commitment to come to institution for more than 1 year	7	**8**	**9**	**10**	**13**
Active military	3	**1**			**1**
Spouse/partner	1		**1**		
Residency outside US		**1**		**1**	**2**
Residency outside US not eligible for ABA certification due to non-US training					

HANDOUT

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Subspecialty Breakout – Critical Care

Nicholas Sadovnikoff, M.D.

11/03/2017
3:45pm – 5:30pm

ACCM Breakout Session

AASPD/ SAAAPM

November 3, 2017

Nick Sadovnikoff

Agenda

- Welcome
- ACCM Match
  - Results of 2017 Match
  - Common Application Service
  - Timeline for 2018 Match
  - Exception Process Updates
- Group Governance
- Task Force Updates
  - Out Reach
  - CAS/ Standardized Letter
  - Critical Care Ultrasound
  - Critical Care Anesthesiology Jobs
  - SOCCA Interchange
- Upcoming meetings
- ACGME/ABA updates
- Common August start
- Change of name of fellowship to **Adult** Critical Care Anesthesiology

Match Statistics

	2014	2015	2016	2017
APPLICANT DATA				
Applicant registrations	196	189	194	203
# Applicant Rank Lists Submitted	147	148	153	157
Matched Total	127	137	149	150
Unmatched Total	20	11	4	7
Applicant Matching % (Overall)	86%	93%	97%	96%
Total # of Withdrawals	20	19	16	11
PROGRAM DATA				
# Of Participating Programs	47	49	52	53
Positions Offered	150	167	186	202
Positions Filled	127	137	149	150
Unfilled Positions	23	30	37	52

Common Application Service

- SF Match
- Common Application
- 3 LORs
- Program Distribution List
- Applicant Pays Fee
- ***Programs responsible for this fee***
  - if a program pulls their only spot out of the match, they will be responsible for refund
  - $35 for each applicant
  - Affects primarily small programs

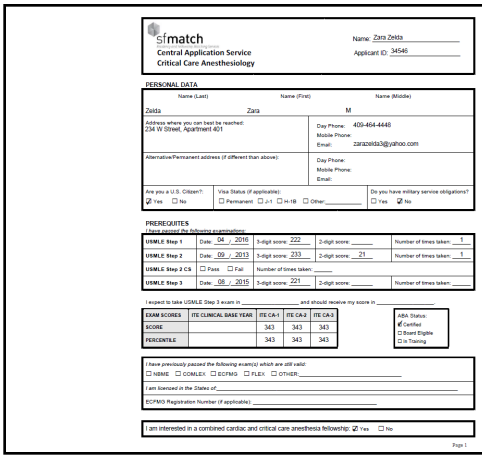
CAS Applicant Fees

Distribution Fees

CAS Application distribution fees increase progressively according to the number of applications chosen. CAS ***initial*** distribution list fees are as follows:

# of CAS Distributions	Fees
1 - 10	$60 total
11 - 20	$10 per program
21 - 30	$15 per program
31 - 40	$20 per program
41 or more	$35 per program

Supplemental distributions cost **$35 per program** regardless of how many programs you have selected on your initial distribution. All distribution fees can be paid by a Visa or a MasterCard.



sfmatch
Central Application Service
Critical Care Anesthesiology

Name: Zara Zelda
Applicant ID: 34546

PERSONAL DATA

Name (Last)	Name (First)	Name (Middle)
Zelda	Zara	M

Address where you can best be reached:
234 W Street, Apartment 401

Day Phone: 409-464-4448
Mobile Phone:
Email: zarazelda3@yahoo.com

Alternative/Permanent address (if different than above):

Day Phone:
Mobile Phone:
Email:

Are you a U.S. Citizen?: ☑ Yes ☐ No
Visa Status (if applicable): ☐ Permanent ☐ J-1 ☐ H-1B ☐ Other:
Do you have military service obligations?: ☐ Yes ☑ No

PREREQUITES
I have passed the following examinations:

USMLE Step 1	Date: 04 / 2016	3-digit score: 222	2-digit score:	Number of times taken: 1
USMLE Step 2	Date: 09 / 2013	3-digit score: 233	2-digit score: 21	Number of times taken: 1
USMLE Step 2 CS	☐ Pass ☐ Fail	Number of times taken:		
USMLE Step 3	Date: 08 / 2015	3-digit score: 221	2-digit score:	Number of times taken:

I expect to take USMLE Step 3 exam in _____ and should receive my score in _____

EXAM SCORES	ITE CLINICAL BASE YEAR	ITE CA-1	ITE CA-2	ITE CA-3
SCORE		343	343	343
PERCENTILE		343	343	343

ABA Status:
☑ Certified
☐ Board Eligible
☐ In Training

I have previously passed the following exam(s) which are still valid:
☐ NBME ☐ COMLEX ☐ ECFMG ☐ FLEX ☐ OTHER:_____

I am licenced in the States of_____

ECFMG Registration Number (if applicable) _____

I am interested in a combined cardiac and critical care anesthesia fellowship: ☑ Yes ☐ No

Page 1

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Residency and Fellowship Matching Services
Central Application Service
Critical Care Anesthesiology

Name: Zara Zelda
Applicant ID: 34546

EDUCATION
List your college, medical school and graduate level experience in chronological order (most recent first)

School/Medical Facility/Institution	Major/Specialty	Dates Attended From (mo/yr) to (mo/yr)	Degree/Date Granted	GPA (if noted on transcript)
Harvard Cole Porter School of Medicine	Medicine	04/17 to Present	MD	4.0

List any honors (such as AOA) obtained in medical school:
AOA achieved 2015

TRAINING:

INTERNSHIP Program Name, City, State	Type of Internship	Dates Attended	Program Director
Harvard University SOM	Clinical Interns	04/15 to 04/17	Hubert M. Humphrey MD FACS
RESIDENCY Program Name, City, State	**Type of Residency**	**Dates Attended**	**Program Director**
FELLOWSHIP Program Name, City, State	**Type of Fellowship**	**Dates Attended**	**Program Director**

Have you ever been discharged/terminated/failed to have a contract renewed by a training program? ☐ Yes ☑ No
Have you ever resigned from a training program? ☐ Yes ☑ No
Please explain any "Yes" answers to the above as well as any gaps in training:

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Critical Care Anesthesiology

Name: Zara Zelda
Applicant ID: 34546

LETTERS OF REFERENCE
*Three letters of reference are required. **One letter from your training Program Director or Chair is required**. The other letters should be from objective physicians (with one preferably from an intensivist) who have direct personal knowledge of your skills and ethics.*
Please indicate below the letters of reference that are part of your application.

Letter of Reference #1 (Training Program Director or Chair)
First Name: Gaundabert | M.I.: M | Last Name: Humperdink | Credentials: MD, FACP
Institution Name: Lucile Packard Childrens Hospit | Street:
City: Sarnia | State: ontario | Zip: H3B F4R | Country (If Outside US):
Phone: | Email: jamesfergusonmd45719@comcast.net
Check one: ☑ I have waived access to this letter and have informed the author of this confidentiality
☐ I desire access to this above letter and have informed the author.

Letter of Reference #2 (Intensivist preferred but not required)
First Name: David | M.I.: M | Last Name: Hurst, III | Credentials: MD, FACOG
Institution Name: Brown University School of Med | Street: 23 Holmes
City: Spark | State: Rhode Island | Zip: 91911 | Country (If Outside US):
Phone: 407-444-4444 | Email: davidhurstthethird@yahoo.com
Check one: ☑ I have waived access to this letter and have informed the author of this confidentiality
☐ I desire access to this above letter and have informed the author.

Letter of Reference #3
First Name: Carlos | M.I.: M | Last Name: Fantera III | Credentials: MD
Institution Name: Yale University | Street: 23 W Street
City: Culver City | State: CA | Zip: 91499 | Country (If Outside US):
Phone: 407-444-4444 | Email: earljamesthethird@yahoo.com
Check one: ☑ I have waived access to this letter and have informed the author of this confidentiality
☐ I desire access to this above letter and have informed the author.

PAST AND PRESENT EMPLOYMENT

Employer and Activity	City and State	Dates Employed From (mo/yr) to (mo/yr)
Walmart Stores Inc.	Wayne, NJ	04/14 to 05/17

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Critical Care Anesthesiology

Name: Zara Zelda
Applicant ID: 34546

RESEARCH ACTIVITIES, PAPERS AND/OR ADDITIONAL INFORMATON:
List authors and complete reference in chronological order (most recent first)

Publications:
Research published on various topics. Some Research on other topics in Medicine. Research published on various topics. Some Research on other topics in Medicine Research published on various topics. Some Research on other topics in Medicine. Research published on various topics. Some Research on other topics in Medicine. D Research published on various topics. Some Research on other topics in Medicine.

Grants or Other Research Activities:
Research published on various topics. Some Research on other topics in Medicine. Research published on various topics. Some Research on other topics in Medicine Research published on various topics. Some Research on other topics in Medicine. Research published on various topics. Some Research on other topics in Medicine. D Research published on various topics. Some Research on other topics in Medicine. Research published on various topics. Some Research on other topics in Medicine. Research published on various topics. Some Research on other topics in Medicine Research published on various topics. Some Research on other topics in Medicine. Research published on various topics. Some Research on other topics in Medicine. D Research published on various topics. Some Research on other topics in Medicine. Research published on various topics. Some Research on other topics in Medicine. Research published on various topics. Some Research on other topics in Medicine Research published on various topics. Some Research on other topics in Medicine. Research published on various topics. Some Research on other topics in Medicine. D Research published on various topics. Some Research on other topics in Medicine.

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Residency and Fellowship Matching Services
Central Application Service
Critical Care Anesthesiology

Name: Zara Zelda
Applicant ID: 34546

Have you ever been named in a malpractice suit? ☐ Yes ☑ No

Name of Agency	Date	Circumstances	Final Action	Under Appeal? (Yes/No)

Have you ever had your medical license suspended/revoked/or voluntarily terminated? ☐ Yes ☑ No
Have you ever been convicted of or pled guilty/no contest to a felony? ☐ Yes ☑ No
Have you ever been charged with use or possession of illegal drugs? ☐ Yes ☑ No
Is there anything in your past that would limit your ability to obtain a medical license or receive hospital privileges?
☐ Yes ☑ No
Please explain any "Yes" answer to the above questions:

sfmatch
Residency and Fellowship Matching Services
Central Application Service
Critical Care Anesthesiology

Name: Zara Zelda
Applicant ID: 34546

PERSONAL STATEMENT
Please explain what inspired you to enter the field of Critical Care Anesthesiology.
What are your ultimate career goals?

The story is presented as a first-person narrative using an unreliable narrator. He is a condemned man at the outset of the story.[3] The narrator tells us that from an early age he has loved animals. He and his wife have many pets, including a large, beautiful black cat (as described by the narrator) named Pluto. This cat is especially fond of the narrator and vice versa. Their mutual friendship lasts for several years, until the narrator becomes an alcoholic. One night, after coming home completely intoxicated, he believes the cat to be avoiding him. When he tries to seize it, the panicked cat bites the narrator, and in a fit of rage, he seizes the animal, pulls a pen-knife from his pocket, and deliberately gouges out the cat's eye. From that moment onward, the cat flees in terror at his master's approach. At first, the narrator is remorseful and regrets his cruelty. "But this feeling soon gave place to irritation. And then came, as if to my final and irrevocable overthrow, the spirit of perverseness." He takes the cat out in the garden one morning and ties a noose around its neck, hanging it from a tree where it dies. That very night, his house mysteriously catches fire, forcing the narrator, his wife and their servant to flee the premises. The next day, the narrator returns to the ruins of his home to find, imprinted on the single wall that survived the fire, the apparition of a gigantic cat, with a rope around the animal's neck. At first, this image deeply disturbs the narrator, but gradually he determines a logical explanation for it, that someone outside had cut the cat from the tree and thrown the dead creature into the bedroom to wake him during the fire. The narrator begins to miss Pluto, feeling guilty. Some time later, he finds a similar cat in a tavern. It is the same size and color as the original and is even missing an eye. The only difference is a large white patch on the animal's chest. The narrator takes it home, but soon begins to loathe, even fear the creature. After a time, the white patch of fur begins to take shape and, to the narrator, forms the shape of the gallows. This terrifies and angers him more, and he avoids the cat whenever possible. Then, one day when the narrator and his wife are visiting the cellar in their new home, the cat gets under its master's feet and nearly trips him down the stairs. Enraged, the man grabs an axe and tries to kill the cat but is stopped by his wife- whom, out of fury, he kills instead. To conceal her body he removes bricks from a protrusion in the wall, places her body there, and repairs the hole. A few days later, when the police show up at the house to investigate the wife's disappearance, they find nothing and the narrator goes free. The cat, which he intended to kill as well, has also gone missing. This grants him the freedom to sleep, even with the burden of murder. On the last day of the investigation, the narrator accompanies the police into the cellar. They still find nothing significant. Then, completely confident in his own safety, the narrator comments on the sturdiness of the building and raps upon the wall he had built around his wife's body. A loud, inhuman wailing sound fills the room. The alarmed police tear down the wall and find the wife's corpse, and on its rotting head, to the utter horror of the narrator, is the screeching black cat. As he words it: "I had walled the monster up within the tomb!"

sfmatch
Residency and Fellowship Matching Services
Central Application Service
Critical Care Anesthesiology

Name: Zara Zelda
Applicant ID: 34546

ADDITIONAL INFORMATION
Please provide any additional information that you would like us to know about yourself and/or any supplementary information regarding any of the questions. What interests do you have outside medicine?

The story is presented as a first-person narrative using an unreliable narrator. He is a condemned man at the outset of the story.[3] The narrator tells us that from an early age he has loved animals. He and his wife have many pets, including a large, beautiful black cat (as described by the narrator) named Pluto. This cat is especially fond of the narrator and vice versa. Their mutual friendship lasts for several years, until the narrator becomes an alcoholic. One night, after coming home completely intoxicated, he believes the cat to be avoiding him. When he tries to seize it, the panicked cat bites the narrator, and in a fit of rage, he seizes the animal, pulls a pen-knife from his pocket, and deliberately gouges out the cat's eye. From that moment onward, the cat flees in terror at his master's approach. At first, the narrator is remorseful and regrets his cruelty. "But this feeling soon gave place to irritation. And then came, as if to my final and irrevocable overthrow, the spirit of perverseness." He takes the cat out in the garden one morning and ties a noose around its neck, hanging it from a tree where it dies. That very night, his house mysteriously catches fire, forcing the narrator, his wife and their servant to flee the premises. The next day, the narrator returns to the ruins of his home to find, imprinted on the single wall that survived the fire, the apparition of a gigantic cat, with a rope around the animal's neck. At first, this image deeply disturbs the narrator, but gradually he determines a logical explanation for it, that someone outside had cut the cat from the tree and thrown the dead creature into the bedroom to wake him during the fire. The narrator begins to miss Pluto, feeling guilty. Some time later, he finds a similar cat in a tavern. It is the same size and color as the original and is even missing an eye. The only difference is a large white patch on the animal's chest. The narrator takes it home, but soon begins to loathe, even fear the creature. After a time, the white patch of fur begins to take shape and, to the narrator, forms the shape of the gallows. This terrifies and angers him more, and he avoids the cat whenever possible. Then, one day when the narrator and his wife are visiting the cellar in their new home, the cat gets under its master's feet and nearly trips him down the stairs. Enraged, the man grabs an axe and tries to kill the cat but is stopped by his wife- whom, out of fury, he kills instead. To conceal her body he removes bricks from a protrusion in the wall, places her body there, and repairs the hole. A few days later, when the police show up at the house to investigate the wife's disappearance, they find nothing and the narrator goes free. The cat, which he intended to kill as well, has also gone missing. This grants him the freedom to sleep, even with the burden of murder. On the last day of the investigation, the narrator accompanies the police into the cellar. They still find nothing significant. Then, completely confident in his own safety, the narrator comments on the sturdiness of the building and raps upon the wall he had built around his wife's body. A loud, inhuman wailing sound fills the room. The alarmed police tear down the wall and find the wife's corpse, and on its rotting head, to the utter horror of the narrator, is the screeching black cat. As he words it: "I had walled the monster up within the tomb!"

I certify that the information in this application is true and complete and that I have not withheld information that might significantly affect my qualifications for residency training. I authorize any training program that receives this application to contact any or all of my former employers, educational institutions and/or other persons or organizations who may have information relevant to my application. I understand that any information obtained will be treated as confidential information. I authorize SF Match to use any information I have provided to SF Match, in any study approved by SF Match, provided that no information clearly and uniquely identifiable with me is disclosed in reports resulting from such study. I intend to complete all prerequisites before the start of my fellowship training. I understand that any contract or match result will be void if I do not satisfactorily complete my prerequisite training or if I fail to meet other requirements that have been explicitly stated to all applicants.

Signature: Zara Zelda Date: 10/20/2016

Task force reports

- Out Reach
- CAS/ Standardized Letter
- Critical Care Ultrasound
- Critical Care Anesthesiology Jobs
- SOCCA Interchange

Updates from oversight orgs

- ACGME/RRC
- ABA

Match Timeline

	Date
Applicant Registration Begins	November 1, 2017
Rank List Submission Deadline	May 24, 2018
Results Released to Programs	May 31, 2018
Results Released to Applicants	May 31, 2018
Post-match vacancies posted	June 1, 2018
Fellowship Training Begins	July/August 2018

Meeting Dates 2018

- SCCM: San Antonio, February 24
- SOCCA/IARS: Chicago, April 27
- SAAAPM/AASPD: Chicago, November 2/3

Issues for discussion

- Joint efforts with CT anesthesiology fellowships
- Last-minute drop-outs
- August start date
- Change the Fellowship Title
- Others

HANDOUT

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Subspecialty Breakout – Obstetric

Rebecca D. Minehart, MD, MSHPEd

11/03/2017
3:45pm – 5:30pm

AASPD 2017: OB Anesthesia Fellowship Breakout Session

Rebecca D. Minehart, MD, MSHPEd
Program Director, Massachusetts General Hospital Obstetric Anesthesia Fellowship
Chair, SOAP OB Fellowship Committee
Chair, SOAP Strategic Task Force Initiative for OB Anesthesia Fellowships

I have no relevant financial disclosures.

DISCUSSION TOPICS

1) Review NRMP Match Strategy and contingency planning
2) ACGME Program Requirements Review and process for updating requirements
3) Webinar Series Review
4) Twitter Journal Club
5) Other business as required

HANDOUT

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Subspecialty Breakout – Pain Medicine

Scott A. Brancolini, MD, MPH
Timothy Furnish, MD
Glenn E. Woodworth, MD

11/03/2017
3:45pm – 5:30pm

THE ASSOCIATION OF PAIN PROGRAM DIRECTORS
ADVANCING EDUCATION IN MULTIDISCIPLINARY PAIN MEDICINE

SAAA 2017 Meeting

TIMOTHY FURNISH, MD
CLINICAL ASSOCIATE PROFESSOR, UCSD
PRESIDENT, APPD

SCOTT BRANCOLINI, MD, MPH
ASSOCIATE PROFESSOR, UPMC
VICE PRESIDENT, APPD

11.3.17

FINANCIAL DISCLOSURES

- DR. FURNISH – NONE
- DR. BRANCOLINI – NONE

LEARNING OBJECTIVES

- Welcome/Introductions
- APPD Election results
- Review 2017 Match data.
- Review potential changes in the ACGME Pain Medicine Fellowship Program Requirements
  - Review/discuss feedback from the Pain Medicine Fellowship Program Directors
- Review Medical Knowledge content resources newly available
  - APPD Website
  - Anesthesia Toolbox
    - Glenn Woodworth, MD, Associate Professor and Director of Regional Anesthesia, Oregon Health and Science University
- Discuss updates on the Universal Letter of Recommendation
- PD Compensation Survey results
- Future Meetings – Audience Response Polling: "Everything You Always Wanted to Know but Were Afraid to Ask"

APPD Leadership Elections

- President
- Vice President
- Secretary/Treasurer
- Board Members
- Past President

Pain Medicine NRMP Match Data Appointment Year 2018

Program Statistics	Number	%
Enrolled Programs	98	
Withdrawn Programs	0	
Certified Programs	98	
Programs Filled	95	96.9%
Programs Unfilled	3	3.1%
Certified Positions	335	
Positions Filled	331	98.8%
Positions Unfilled	4	1.2%

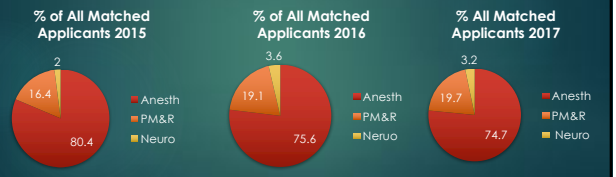
Pain Medicine Match Data Appointment Year 2018

Applicant Statistics	Number	%
Matched Applicants	331	
U.S. Grad	231	69.8%
U.S. Foreign	27	8.2%
Osteopathic	48	14.5%
Foreign	24	7.3%
Canadian	1	0.3%
Applicants Preferring this Specialty	437	
Matched to this Specialty	331	75.7%
Matched to Different Specialty	1	0.2%
Did not Match to any Program	105	24%

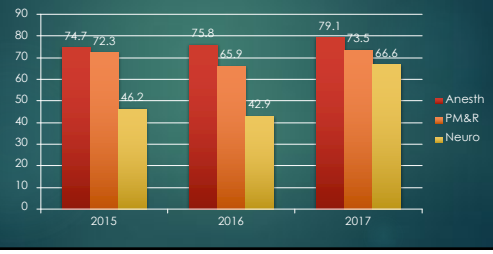
Pain Medicine Applicants' Residency Specialties
Appointment Years 2015-2017

Residency Specialty	2015		2016		2017	
	All Applicants	Matched Applicants	All Applicants	Matched Applicants	All Applicants	Matched Applicants
Anesthesiology	308	230	302	229	292	231
Emergency Medicine					3	<3
Family Medicine	4	<3	<3	<3		
Internal Medicine	<3		<3		<3	
Neurology	13	6	16	11	15	10
Child Neurology					<3	<3
Pediatrics	<3					
PM&R	65	47	88	58	83	61
Psychiatry	<3		7	3	4	<3
Radiology - Diagnostic	<3		<3	<3		
Internal Medicine/Psychiatry	<3	<3				
Pediatrics/Anesthesiology					<3	<3
Pediatrics/PM&R	<3	<3				
Diagnostic Radiology/Nuclear Medicine/Nuclear Radiology					<3	<3
Total	**397**	**286**	**416**	**303**	**401**	**309**
Percent unmatched		**28%**		**27%**		**23%**

Pain Medicine NRMP Data: % of matched fellows by specialty



Pain Medicine NRMP Data: % of each specialty who matched



ACGME Pain Medicine Program Requirement Changes

- Child Neurology
- Elimination of required numbers (CT/MRI readings, rehab plans, mental status exam, neuro exams)
- Anesthesia changes
  - IV experience eliminated
  - Basic airway management with mask ventilation
  - LMA added; intubations not needed
  - Local anesthetic toxicity
- Risk mitigation/opioid management/addiction added
- Elimination of required procedure numbers
  - Discography?

ACGME Program Directors Feedback

- Discussion

APPD Website Updates

Let's Take a Tour!

Resident Chronic Pain Curriculum

GLENN WOODWORTH, MD
OREGON HEALTH AND SCIENCE UNIVERSITY

Disclosures

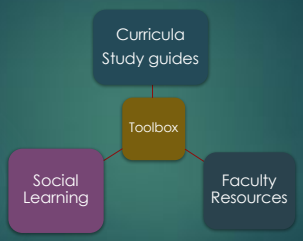
- **No Financial Disclosures**
- **Current Editor for the Anesthesia Toolbox**

Learning Objectives

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

- Understand the goals and objectives of the resident curriculum project and the participation of the pain program directors
- Describe the curriculum development and review process
- Identify the resources for learners and faculty in the Anesthesia Toolbox
- Describe how to utilize the Toolbox to implement a chronic pain curriculum

Goals of the Project



Resident Rotation Experience

- Highly variable experience
  - Clinical cases vary
  - Clinical teaching varies

Gruppen LD et al. The consistency and educational benefits of clinical experiences during an ambulatory care internal medicine rotation. Acad Med. 1993;68:674-680.

Resident Rotation Experience

- Take a specific rotation
- What knowledge, skills and behaviors should be mastered?

Toolbox Curricula

- National faculty experts define curriculum
- Sequenced exposure to topics
- Learner and faculty driven

Sample CP Week 1 Curriculum

Topic	Topic	
Self-Directed	Joint Pain	Podcast
	History taking in the pain patient	Podcast
	Physical exam of the spine	Video
	Week 1 Quiz	
Faculty-Driven	Exam of the Spine	Hands on skills
	Applied Anatomy of Pain pathways	PBLD
	Back and Neck Pain	Lecture

Toolbox Curricula Elements

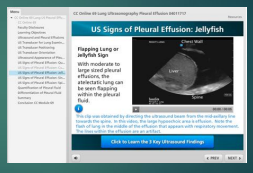
- **Self Directed**
  - Podcast
  - Online module
  - Video
  - Reading
  - Lecture archive
  - Quiz bank
- **Faculty directed**
  - Lectures
  - PBLDs
  - In-room teaching
  - SIM

Content Development

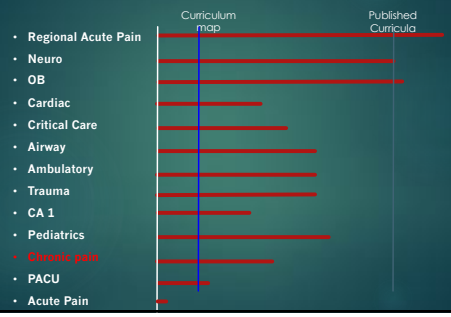
- Call to authors
- All volunteer army

Author Support

- Instructions, templates, examples
- Medical art/Stock Photography
- Computer programmer for e-learning modules
- Instructional design review
- Peer review



Progress



Education Platforms

Online LMS

- Course-based study
- Create and assign curricula
- Quiz bank
- Track learner progress

Community Portal

- Wiki Cases
- Ask a clinical question
- Clinical pearls
- Online PBLDs and Journal Clubs
- What's new
- What's trending

Toolbox Community

Create a social community of learning

- Use modern social knowledge management technology
- Capture and distribute key knowledge
  - Crowd-sourced knowledge
  - Collaborative learning
- Better alignment with the way current trainees communicate and learn

Toolbox LMS

Course or Rotation-based Learning

- Create Curricula
- Self-enroll or be assigned curricula
- Track learner progress
- Self-guided access
- Quiz bank

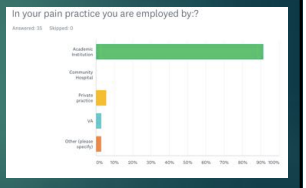
Strategic Partners

- Society for Education in Anesthesia
- World Federation of Anesthesiologists
- Society for Ambulatory Anesthesia
- Trauma Anesthesia Society
- Society for Airway Medicine
- Association of Peds Program Director
- **Association of Pain Program Directors**
- SAAA?
- ASA?

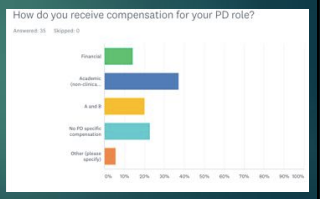
ASK

- Help finish the resident month 1 and 2 curricula (we need a few authors)
- Desperate for Peer Reviews
- Tackle the fellow curricula

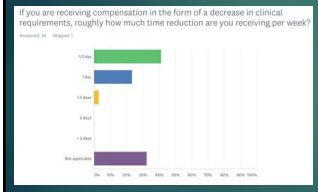
Program Director Compensation Survey

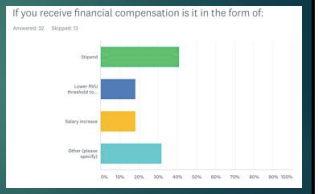


Program Director Compensation Survey

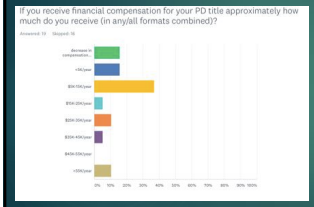


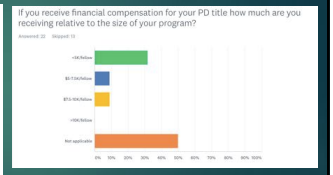
Program Director Compensation Survey



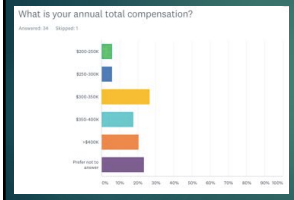


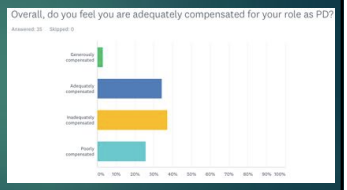
Program Director Compensation Survey





Program Director Compensation Survey



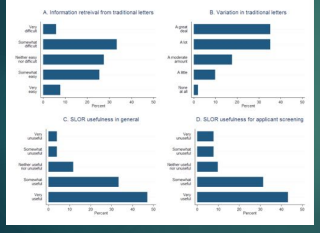


Universal Letter of Recommendation

- Rationale:
  - Letters of recommendation vary widely in content and comparability
  - Provide some consistency for at least the pain PDs letters of rec
- Survey of PDs

PD Survey Regarding LOR

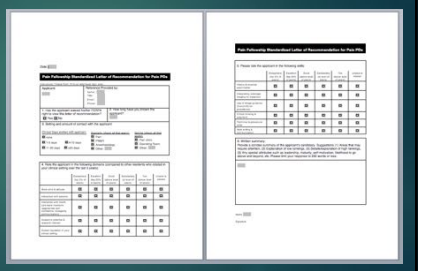
Perspectives on Current and Ideal Practice Re: LOR



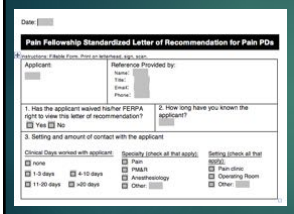
Pain Fellowship Applicant Screening Process		
Characteristic	**Yes n (%)**	**No n (%)**
Applications are screened on standardized criteria	42 (82%)	9 (18%)
Letter of recommendation is currently part of the screening process	18 (43%)	24 (57%)

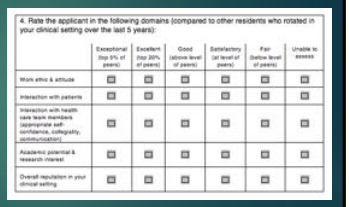
PD Letter of Recommendation

- Standardized, fillable Word Document
- Print on letterhead
- Compare similar letters across institutions
- Applicants graded on defined skills and domains
- **Voluntary**

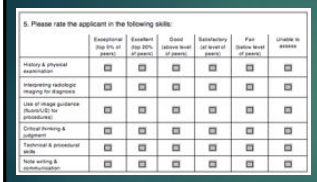


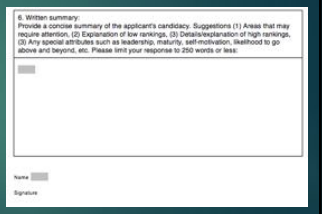
PD Letter of Recommendation





PD Letter of Recommendation





Future Topics: Everything you Want to Know but are Afraid to Ask

- Anonymous polling
- Sample questions:
  - Nonclinical time?
  - Do you use ERAS to screen board scores?
  - Do you prefer some subspecialties over others?
  - Do you do dedicated "fellow clinics"?
  - How do you meet requirements for various experiences (psychiatry, neurology, PM&R, anesthesiology, palliative care, etc)?

HANDOUT

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Subspecialty Breakout – Pediatric

11/03/2017
3:45pm – 5:30pm

Identifier	Title	Author	Curriculum	Week	Type	Description	Notes
Peds Reading/Podcast 1.1	Neonatal and Infant Physiology	Belani	Basic	Week 1	Reading/Podcast	Developmental physiology of neonates, infants and children	This could be readingor podcast, that is then paired with a clinical to focus on clinical correlates
Peds Reading/Podcast 1.2	Physiologic Effects of Anesthestic Agents		Basic	Week 1	Reading/Podcast	Review the effect of anesthetic agents on infants and children including the impact on the airway and the cardiovascular system	
Peds Reading/Podcast 1.3	Pediatric Pharmacology	Nicole Rovinson	Basic	Week 1	Reading/Podcast		
Peds Online 1	Setting up a pediatric room	Tammy Wang	Basic	Week 1	Online module	Video	
Peds Assessment 1	Quiz Week 1	Meredith Kato	Basic	Week 1			
Peds Mini PBLD 1	Neonatal and infant Physiology	Belani	Basic	Week 1	Mini PBLD		
Peds Mini PBLD 2	Physiologic Effects of Anesthestic Agents	Ehie	Basic	Week 1	Mini PBLD		
Peds Mini PBLD 3	Pediatric Pharmacology: NMB	Afroze	Basic	Week 1	Mini PBLD	Clinical correlates for peds pharamaco dynamics and pharmaco kinetics.	Designed for in room teaching
Peds Lecture 1	Neonate, Infant and Child Airway Anatomy	Lisa Lynch	Basic	Week 1	Lecture		
Peds Lecture 2	Techniques for the induction of general anesthesia in infants and children	Kelly Ryan	Basic	Week 1	Lecture		
Peds SIM 1	Techniques for the induction of general anesthesia in infants and children		Basic	Week 1	SIM		
Peds Reading/Podcast 2.1	Thermoregulation in infants and Children	Gail Shibata/Andrew Infosin	Basic	Week 2	Reading/Podcast		
Peds Reading/Podcast 2.2	PONV in infants and Children		Basic	Week 2	Reading/Podcast		
Peds Assessment 1	Quiz Week 2	Sandr Gonzalez	Basic	Week 2	Assessment	asked Rae	
Peds Mini PBLD 4	Thermoregulation	Gail Shibata/Andrew Infosin	Basic	Week 2	Mini PBLD		
Peds Mini PBLD 5	PONV in infants and children		Basic	Week 2	Mini PBLD		
Peds Mini PBLD 6	Physiologic Effects of Anesthestic Agents - Volatile Agents	Sandra Gonzalez	Basic	Week 2	Mini PBLD		
Peds Lecture 3	Pediatic Airway Management	Masood Memarzadeh/infos	Basic	Week 2	Lecture		
Peds Sim/ Hands-on 2	Pediatic Airway Management	Jennifer Chiem	Basic	Week 2	Hands-on Skill Session		
Peds Lecture 4	Fluid and electrolytes in infants and children	Faith Ross	Basic	Week 2	Lecture		
Peds Sim/Hands-on 3	Intravenous access in infants and children	Jamie Rubin	Basic	Week 2	Hands-on Skill Session		
Peds Reading/Podcast 3.1	Social and Emotional Milestones	Kristin Pappas	Basic	Week 3	Reading/Podcast		
Peds Reading/Podcast 3.2	Parent presence during induction of anesthesia	pinyavat	Basic	Week 3	Reading/Podcast		
Peds Reading/Podcast 3.3	Neuraxial anatomy in infants and children	Anita Akbar	Basic	Week 3	Reading/Podcast		
Peds Assessment 3	Basic Quiz 3	Helena Oechsner	Basic	Week 3	Assessment		
Peds Mini PBLD 7	Parent presence during induction	Pinyavat	Basic	Week 3	Mini PBLD		
Peds Mini PBLD 8	Neuraxial anatomy in infants and children	Janice Man	Basic	Week 3	Mini PBLD		
Peds PBLD 1	Social and Emotional Milestones	Seiden	Basic	Week 3	PBLD		
Peds Lecture 5	Respiratory Infection in the Perioperative Period	Groenewald	Basic	Week 3	Lecture		
Peds Lecture 6	Methods of distraction and premedication in infants and children	Deverman	Basic	Week 3	Lecture		

Peds Reading/Podcast 4.1	laryngospasm	Anita Akbar	Basic	Week 4	**Reading/Podcast**
Peds Online 2	Caudal Anesthesia	Dooley	Basic	Week 4	**Online Module**
Peds Assessment 4	Basic Quiz 4	Adria Boucherel	Basic	Week 4	**Assessment**
Peds Mini PBLD 9	Laryngospasm	Anita Akbar	Basic	Week 4	**Mini PBLD**
Peds Lecture 7	Caudal Anesthesia	Adam Adler	Basic	Week 4	**Lecture**
Peds Hands-on 3 ????	Caudal Anesthesia		Basic	Week 4	**Hands-on Skill Session**
Peds SIM 2	Difficult communiction	Elizabeth Yun	Basic	Week 4	**SIM**
	Advanced Curriculum				
Peds Reading/Podcast 5.1	Neonatal Surgical emergencies CDH	Tina Dong/infosino/shibata	Adv	Week 5	**Reading/Podcast**
Peds Reading/Podcast 5.2	Common congential neonatal abnormalities: omphalocele	Neon	Adv	Week 5	**Reading/Podcast**
Peds Assessment 5	Adv Quiz 1	Farzana Afroze	Adv	Week 5	**Assessment**
Peds Mini PBLD 10	Neonatal surgery 1 -		Adv	Week 5	**Mini PBLD**
Peds Mini PBLD 11	Neonatal surgery 2 -		Adv	Week 5	**Mini PBlD**
Peds Lecture 8	Common congenital neonatal abnormalities		Adv	Week 5	**Lecture**
Peds PBLD 2	Neonatal surgical emergencies	Jason Bryant	Adv	Week 5	**PBLD**
Peds PBLD 3	Common congenital neonatal abnormalities	Ona Dachsangvorn	Adv	Week 5	**PBLD**
Peds Reading/Podcast 6.1	Common congenital heart disorders	Saab	Adv	Week 6	**Reading/Podcast**
Peds Reading/Podcast 6.2	Pyloric stenois	Kapoor	Adv	Week 6	**Reading/Podcast**
Peds Assessment 6	Adv Quiz 2	asked Melissa Ehlers	Adv	Week 6	**Assessment**
Peds Mini PBLD 12	Common congenital heart disorders	Saab	Adv	Week 6	**Mini PBLD**
Peds Mini PBLD 13	Common congenital heart disorders 2	Saab	Adv	Week 6	**Mini PBLD**
Peds Mini PBLD 14	Pyloric stenosis	kapoor	Adv	Week 6	**Mini PBLD**
Peds Lecture 9	Common congenital heart disorders	Schwartz	Adv	Week 6	**Lecture**
Peds Lecture 10	Pediatric regional anesthesia	See Regional Lecture 14	Adv	Week 6	**Lecture**
Peds Lecture 11	Pediatirc pain management	Lisgelia Santana	Adv	Week 6	**Lecture**
Peds Reading/Podcast 7.1	Trisomy 21	Sinskey/Infosino	Adv	Week 7	**Reading/Podcast**
Peds Reading/Podcast 7.2	Peds Anesthesia emergencies		Adv	Week 7	**Reading/Podcast**
Peds Assesssment 7	Adv Week 3 Quiz		Adv	Week 7	**Assessment**
Peds Mini PBLD 15	Peds difficult airway	Hedwig Schroeck	Adv	Week 7	**Mini PBLD**
Peds Mini PBLD 16	Peds difficult airway 2 - foreign body	Debnath Chatterjee	Adv	Week 7	**Mini PBLD**
Peds Mini PBLD 17	Peds anesthesia emergencies		Adv	Week 7	**Mini PBLD**
Peds Mini PBLD 18	Peds anesthesia emergency 2		Adv	Week 7	**Mini PBLD**
Peds Lecture 12	Peds difficult airway	Hemanth Baboobal	Adv	Week 7	**Lecture**
Peds SIM 4	Peds Anesthesia Emergencies		Adv	Week 7	**SIM**
Peds Lecture 13	Peds anesthesia emergencies		Adv	Week 7	**Lecture**
Peds Reading/Podcast 8.1	Major spine surgery in the peds patient	Chris Glover	Adv	Week 8	**Reading/Podcast**
Peds Reading/Podcast 8.2	Neuromuscular disorders	Greg Latham	Adv	Week 8	**Reading/Podcast**
Peds Assessment 8	Adv Week 4 Quiz		Adv	Week 8	**Assessment**
Peds Mini PBLD 19	Peds neuromuscular disorders	Rani Sunder		Week 8	**Mini PBLD**
Peds Mini PBLD 20	Downs syndrome patient			Week 8	**Mini PBLD**

Peds Mini PBLD 21	Peds PALS	Wajia Rajeev		Week 8	**Mini PBLD**
Peds PBLD 5	OSA in the pediatric population	Arvind Chandrakantan	Adv	Week 8	**PBLD**
Peds Lecture 15	Learning the signs of a very sick child	Rae Brown	Adv	Week 8	**Lecture**

Supplemental Content

Peds Pocast 9	HFOV for peds patients		Adv		**Reading/Podcast**
Peds Online 3	Uptake and distribution of anesthetic gas in the newborn.				**Online**
Peds PBLD 4	Peds OOR anesthesia		Adv	Week 8	**PBLD**
Peds Lecture 16	Peds Trauma		Adv	Week 8	**Lecture**

Effects of Anesthetics on the control of breathing	
Anesthesia for the Newborn (ask Myron Yaster)	pocast
Anesthesia for the Newborn (ask Myron Yaster)	lecture

Resident Peds Anesthesia Curriculum

Glenn Woodworth, MD
Oregon Health and Science University

Disclosures

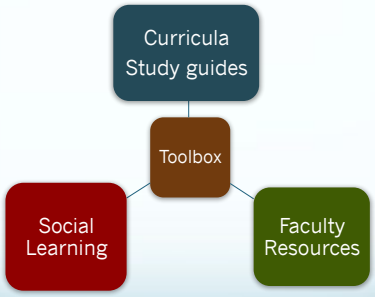
- **No Financial Disclosures**
- **Current Editor for the Anesthesia Toolbox**

Learning Objectives

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

- Understand the goals and objectives of the resident curriculum project and the participation of the Peds program directors
- Describe the curriculum development and review process
- Identify the resources for learners and faculty in the Anesthesia Toolbox
- Describe how to utilize the Toolbox to implement a Peds anesthesia curriculum

Goals of the Project



Resident Rotation Experience

- Highly variable experience
  - Clinical cases vary
  - Clinical teaching varies

Gruppen LD et al. The consistency and educational benefits of clinical experiences during an ambulatory care internal medicine rotation. Acad Med. 1993;68:674-680.

Resident Rotation Experience

- Take a specific rotation
- What knowledge, skills and behaviors should be mastered?

Toolbox Curricula

- National faculty experts define curriculum
- Sequenced exposure to topics
- Learner and faculty driven

Sample CP Week 1 Curriculum

Topic	Topic	
Self-Directed	Physiologic effects of anesthetic agents	Podcast
	Developmental pharmacology	Podcast
	Setting up a pediatric room	Video
	Week 1 Quiz	
Faculty-Driven	Neuromuscular blockers	Mini PBLD
	Neonatal physiology	Mini PBLD
	Physiologic effects of anesthetic agents	Mini PBLD
	Infant and child airway anatomy	Lecture
	Techniques for induction	Lecture
	Techniques for induction	SIM

Toolbox Curricula Elements

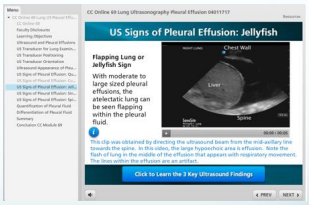
- **Self Directed**
  - Podcast
  - Online module
  - Video
  - Reading
  - Lecture archive
  - Quiz bank
- **Faculty directed**
  - Lectures
  - PBLDs
  - In-room teaching
  - SIM

Content Development

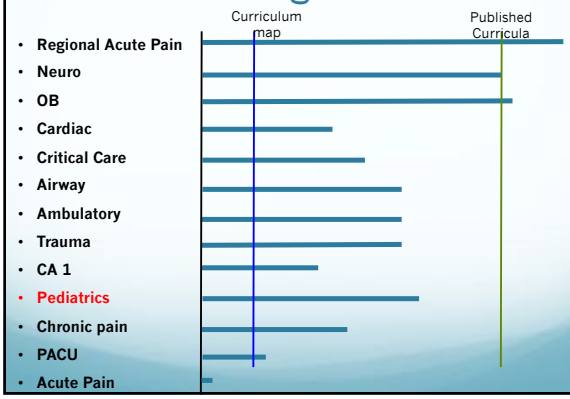
- Call to authors
- All volunteer army

Author Support

- Instructions, templates, examples
- Medical art/Stock Photography
- Computer programmer for e-learning modules
- Instructional design review
- Peer review



Progress



Education Platforms

Online LMS

- Course-based study
- Create and assign curricula
- Quiz bank
- Track learner progress

Community Portal

- Wiki Cases
- Ask a clinical question
- Clinical pearls
- Online PBLDs and Journal Clubs
- What's new
- What's trending

Toolbox Community

Create a social community of learning

- Use modern social knowledge management technology
- Capture and distribute key knowledge
  - Crowd-sourced knowledge
  - Collaborative learning
- Better alignment with the way current trainees communicate and learn

Toolbox LMS

Course or Rotation-based Learning

- Create Curricula
- Self-enroll or be assigned curricula
- Track learner progress
- Self-guided access
- Quiz bank

Strategic Partners

- Society for Education in Anesthesia
- World Federation of Anesthesiologists
- Society for Ambulatory Anesthesia
- Trauma Anesthesia Society
- Society for Airway Medicine
- Association of Peds Program Director
- **Association of Pain Program Directors**
- SAAA?
- ASA?

ASK

- Help finish the resident month 1 and 2 curricula (we need a few authors)
- Desperate for Peer Reviews
- Tackle the fellow curricula

HANDOUT

AAPAE
ASSOCIATION OF ANESTHESIOLOGY PROGRAM ADMINISTRATORS AND EDUCATORS

Just Say No! Developing Assessment Tools Beyond the Milestone Progression

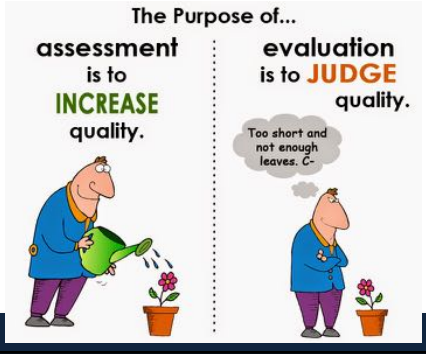
Mandi Mizuta, MA
Lara Zisblatt, EdD, MA, PMME

11/03/2017
8:30am – 8:55am

UNIVERSITY OF MICHIGAN

Just Say No! Developing Assessment Tools Beyond the Milestone Progression

Lara Zisblatt, EdD, MA, PMME



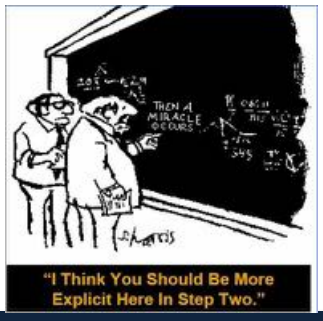
Background

Why do we care about Assessment?

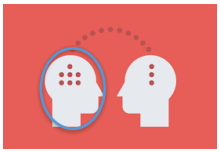
What is CBME?

Competency-based Medical Education

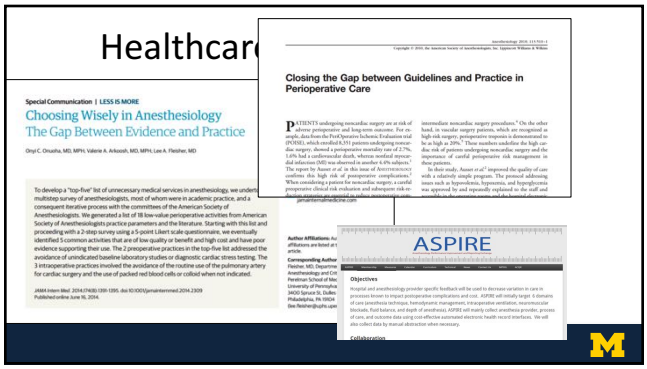
MILESTONES



Apprenticeship Model



Healthcar

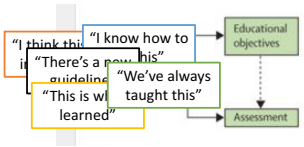

Special Communication | LESS IS MORE

Choosing Wisely in Anesthesiology
The Gap Between Evidence and Practice

Closing the Gap between Guidelines and Practice in Perioperative Care

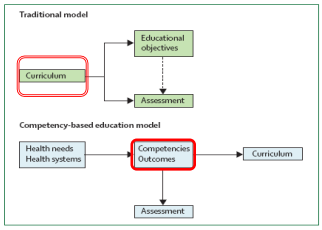
ASPIRE

Traditional Educational Model



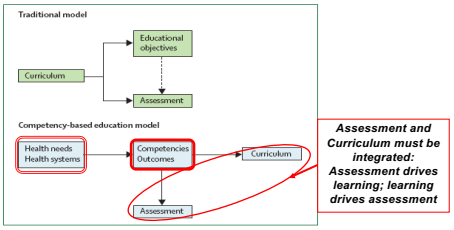
Frenk J, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet. 2010

CBME: Start with System Needs



Frenk J, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet. 2010

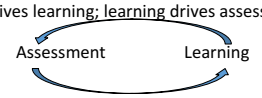
CBME and Assessment

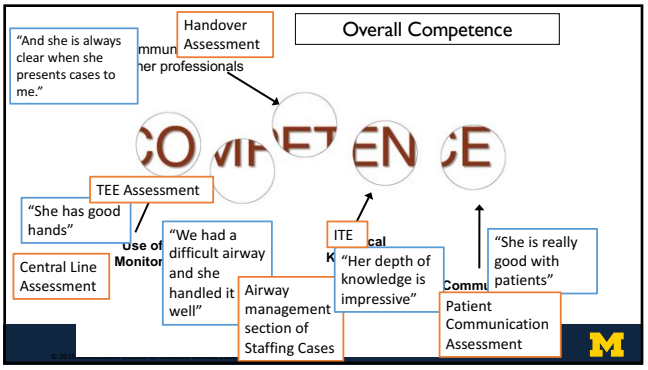


Frenk J, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet. 2010

Fundamental Premise

- Assessment and learning (curriculum) do not function independently
- The nature of the learning will substantially affect the quality of the assessment:
  - Assessment drives learning; learning drives assessment:





Assessment = Education

HANDOUT

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ASSOCIATION OF ANESTHESIOLOGY PROGRAM ADMINISTRATORS AND EDUCATORS

Data Overload: Best Practices for Reporting Assessment Data to the CCC

Faye Haggar, EdS
Elisabeth Anne Hudson, BS
Kristin A. Johnson, MS

11/03/2017
9:00am – 9:25am

Data Overload: Best Practices for Reporting Assessment Data to the CCC
Voices from 3 Programs

Elisabeth Hudson, B.S., Administrative Manager, Vanderbilt University Hospital

Kristin Johnson, M.S., Medical Education Program Manager, Maine Medical Center

Faye Haggar, Ed.S., Instructional Designer, University of Nebraska Medical Center

Objectives:
Following this session, participants will be better able to:

1. Identify program need for Clinical Competency Committee best practices.
2. Compare the characteristics of three Clinical Competency Committee programs (Vanderbilt, Univ of Nebraska Medical Center, Maine Medical Center).
3. Discuss how program best practices can enhance efficiency and effectiveness of the Clinical Competency Committee process.

Overall, our hope is to provide attendees with real life examples of, and tools from, programs that utilize innovative ways to provide CCCs with data used to assess learners.

Presentation Content:
25 minutes

Questions for this panel session (presented by Leslie)

1. How are you involved in data collection for your program's CCC?
2. After all the data is collected, what are efficient practices for organizing your program's CCC?
3. How do you assist in ensuring effective communication between CCC members?
4. How is data presented during the CCC meetings?

TABLE CODE: Maine Medical Center, Vanderbilt University Hospital, University of Nebraska Medical Center

Collecting Data:	Organizing meeting:	Communication	Discussion of Milestones
Residents complete self milestones 6 weeks prior, they are provided a copy of their previous milestones Advisors are given a sheet with the previous milestone and the resident self assessment. They also receive: 1. Milestones spreadsheet 2. Notations on Quality Improvement, Scholarly Activity, SCU rotation, RCA Attendance, Test scores, Pain rotation, RB rotation for that review period 3. NI Documentation- showing evaluation comments, conference attendance, some milestones, and rotations scheduled 4. ABA Milestones notations (if applicable) 5. Supplemental Documentation- Pain etc. 6. Internal Performance Documentation (ie. Emails received about performance) 7. Advisor Meeting Minutes from previous meeting 8. On demand evaluations 9. Sim Session Evaluations (not created yet) 10. QI Project update 11. NI Scatter Plot – showing where they compared to peers The CCC members receive all of the above as well as the New Innovations Scatter plot and the agenda. The CCC's documentation is on the google site. CCC members go to a (secured) Google sheet and complete their evaluation using comments from evaluations, coordinator notes done independently	Coordinator combines CCC independent assessment into one document One meeting scheduled for each class over series of months =	All assessments done via google site CCC members given ipads to use for assessment and meeting All documentation loaded on google site for reference at later time	Mentors are scheduled to present their mentee Milestones where all assessors agree are reviewed quickly so discussion can be focused where assessors have different opinions

Collecting Data:	Organizing meeting:	Communication	Discussion of Milestones
Fellows are asked to complete self-report milestones 2 weeks prior as well as complete a Scholarly Activity Form Fellows are asked to also make sure their Case Logs are up to date Data collected: • Fellow self-reported milestones • Case Log Report (Minimum and actuals) • Fellow Scholarly Activity a. Papers, manuscripts b. QI projects and status c. Research, etc. d. Presentations/Lectures • Attendance during conferences • Evaluations reports from Faculty, Rotation, NPs, Techs • Duty Hour Compliance • Previous Milestones if applicable • Rotations	Meetings are scheduled quarterly, coordinator arranges location and invite Coordinator combines collected data on all fellows into a PDF document 1 week prior to CCC Meeting and distributes to all faculty via email	Each faculty member is randomly assigned one fellow's data and is asked to review all data and complete the milestones prior to the meeting	Faculty members present on their assigned fellow and discuss any issues or concerns gleaned from the data and then reviews milestone scores and asks for input from other CCC members Coordinator pulls up NI on conference room AV and enters milestones for each fellow as reviewed as well as any comments necessary Post CCC Meeting, the coordinator schedules quarterly reviews for each fellow with the PD and APD to review milestones and CCC report
Coordinator collects all data, all is eventually uploaded to NI **We just made a shift to this, after struggling with paper and email for far too long. Data includes: data sheet (license info, compliance completion, duty hours, meeting attendance, etc), case logs, rotations Summative report generated from NI (monthly evals, 360 evals, praise/concern cards) Resident Self assessment on milestones **This is new for us	Coordinator combines CCC data, all uploaded to NI One meeting scheduled for each class each month, so each class has 2 CCC meetings each year (we try to take the summer months off from CCC meetings)	Each faculty member is randomly assigned two residents to review Review scores are due to coordinator PRIOR to the CCC meeting, the coordinator compiles the scores	During the CCC meeting, scores are projected on screen and also printed for each team member Milestones where all team members agree are reviewed quickly so discussion can be focused where assessors have different opinions CCC chair sends letter to resident after the meeting, sharing the scores and any deficiencies

HANDOUT

AAPAE
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Time for Wellness: Current Physician Wellness Models Within Our Programs and Institutions

Janine Roberts, BS

11/03/2017
10:30am – 11:00am

Peer support and Resiliency In Medicine: Current Resident Wellness Model at Stanford University

Janine Roberts
Anesthesiology Program Manager
Stanford University
Department of Anesthesiology, perioperative and pain medicine

Stanford | MEDICINE

Stanford Anesthesiology Residency

- Large Program
  - 95+ Residents
    - Categorical
    - Advanced
    - Combined Peds/Anesthesiology
    - Combined IM/Anesthesiology
  - 200+ Faculty
  - 4 hospitals and 2 surgery centers
  - Stanford Duck Syndrome

Why??

- 30-60% of physicians have symptoms of burnout (depression, substance abuse, divorce, suicide, increased medical errors, decreased patient satisfaction and job satisfaction.
- Some proven solutions:
  - Mindfulness Training
  - Self Care
  - Increase Social Connectivity
- Now a requirement of the ACGME!

Stanford Anesthesia PRIME

Peer support and Resiliency In MEdicine

- Founded by Dr. Emily Ratner, Founding Co-Director Dr. Tara Cornaby
- Initiated in 2010, planning began in 2008
- Current Co-Directors: Drs. Tara Cornaby and Natalya Hasan
- Team of 4 additional faculty facilitators

Goals of the PRIME Program

- Create an environment to support and promote the well-being of residents
- Build community
- Teach/expose residents to skills to promote resiliency
- Prevent burnout in those who aren't already
- Intervene early, prevent progression and devastating consequences

Core Components

- **Wellness Retreat**
  - Elective, off-site weekend retreat in August of the CA1 year led by four training facilitators. Modeled after Jon Kabat-Zinn's MBSR Program.
- **Wellness Sessions**
  - Two hour, facilitator led, experiential sessions held every six weeks during protected didactic time.
- **PRIME Scholarship Program**

Wellness Retreat Goals

- **Individual**
  - Teach mind-body techniques shown to increase self-awareness, reduce perceived and measured stress, promote resiliency, and improve performance.
  - Acknowledge and address signs and symptoms of physician burn-out.
  - Break from Early first-year stressors.
- **Community**
  - Build peer support groups.
  - Outline ongoing available resources.

PRIME Retreat
Wellness Retreat Details

- Verbalized commitment to confidentiality and respect
- Non judgmental feedback with a focus on attentive listening, rather than problem solving
- Experiential exercises including guided compassion, walking, eating, and forgiveness meditations, silent meditations, "3 good things" journaling, and daily yoga
- Opportunity for self-reflection, attention training through a mindfulness practice, and development of a core peer support group
- Group meals, rooming with peers, limited unstructured free time

PRIME Program
Wellness Session Details

- Meet every 8 weeks for 1 ½ to 2 hours.
  - Held during protected didactic time.
  - All residents are expected to attend.
- Two groups from retreat are usually kept with the same M.D./Ph.D. Facilitator.
- Experiential meetings include a check-in, meditation and usually a short interactive lecture on a "wellness" topic.

PRIME Program
Surveys

- Post-Retreat Evaluations
- Annual Wellness Session Evaluation
- Maslach Burnout Inventory
- NIH PROMIS - Social Isolation Survey
- Maslach - Six Areas of Work-life Stressor Survey

PRIME Program
Scholarship Program

- Philanthropic gift from the family of Amy Wang M.D., now self-sustaining.
- Intended to support initiatives that promote resident wellness and resiliency.
- Activities:
  - -Attend a meeting and present information
  - -Implement a program, including outcome data
  - -Participate in research, new or ongoing
  - -Other approved activity

PRIME Program
Scholarship Details

- Annual scholarships given to selected residents in the amount of $1500.
- Residents must submit a one-page proposal that includes a designated faculty mentor.
- Proposals approved by the Selection Committee.
- A final report is presented to the Education Committee once the project is completed.

Christina Maslach, Ph.D.
-Professor Emerita U.C. Berkeley

"What we found is that people's health, well-being, everything in life, is way better if you're connected with other people. That social network, that each of you have each other's back, that they're there for you and you're there for them, that's like money in the bank. That's a precious, precious resource."

- Dr. Natalya Hasan
- Dr. Tara Cornaby
- Dr. Emily Ratner
- Dr. Alex Macario, Program Director
- Dr. Ron Pearl, Chairman

HANDOUT

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Place Your Own Oxygen Mask Before Helping Others! Crowdsourcing and Small Group Activity: Barriers to Our Own Wellness

Amy Miller Juve, EdD, MEd

11/03/2017
11:00am – 11:50am

In small groups

- How do you define work/life balance
- What challenges do you have in achieving your ideal wellness goals
- What have you done to overcome your challenges

Crowdsourcing activity

Best practices for wellness

Directions

- On your card write 1 way in which you support your own wellness
- Walk around the room and introduce yourself to one person
- Exchange cards
- Rank the idea on the card from 1-3
  - 1 = best idea I've ever seen…I'm incorporating this into my life
  - 2 = this is ok..I might give it a try someday…if I have time
  - 3 = I would never do this

In a small group: Discuss the ideas you read on the cards

HANDOUT

AAPAE
ASSOCIATION OF ANESTHESIOLOGY PROGRAM ADMINISTRATORS AND EDUCATORS

Guiding Zen

Vuslat E. Willey, MS

11/03/2017
11:50am – 12:00pm

GUIDING ZEN

Vu Willey, M.S.

Some Barriers to Meditation

1. "***I've never meditated before, and I don't know how or where to start***."
2. "***I can't find the time to meditate. I'm just too busy!***"
3. "***I'm terrible at meditation. My mind wanders all over the place when I meditate.***"Patrick, 2012

- Background music

Resources

- Sample 5-Minute meditation
- Sample 10-Minute meditation

- Simply search YouTube for "guided meditation for___" or "___ minute guided meditation"

HANDOUT

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

ASA Update

Linda J. Mason, MD

11/04/2017
7:00am – 7:15am

American Society of Anesthesiologists®

ASA® Working for You

Linda J. Mason, M.D.
ASA President Elect

asahq.org

Disclosures & Objectives

- Nothing to disclose.
- Objectives: Participants will learn –
  - Key trends and challenges facing the specialty in the market, legislature and regulatory, nationally and in the states.
  - How ASA is working with members nationally and in the states to address current and emerging opportunities.

AAAC Officers

Peter Rock, M.D., M.B.A., FCCM,
President
University of Maryland School of Medicine

Jeanine P. Wiener-Kronish, M.D.,
President-Elect
Massachusetts General Hospital

AAAC Officers

Ronald G. Pearl, M.D., Ph.D.,
Secretary
Stanford University School of Medicine

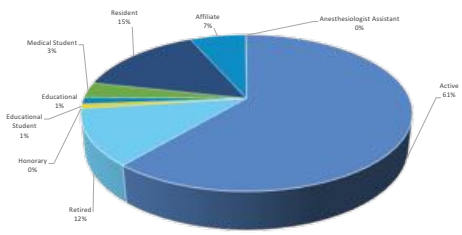
Jeffrey Kirsch, M.D.,
Past President
Oregon Health & Sciences University

Academic Anesthesiology Affiliated Subspecialty of ASA

Jeffrey Kirsch, M.D., FASA
Director

Michael Lewis, M.D., FASA
Alternate Director

2016 ASA Membership – 53,000 members



Impact of Changing Marketplace on Your Practice and ASA

- Dramatic increase in hospital employment and practice consolidation.
- Trend to consolidation is affecting diverse types of practices in both academic and private settings.
- ASA is committed to maintaining relevance to large practices as rapid consolidation continues.

American Society of Anesthesiologists®

Education

asahq.org

ASA Education Center and My Learning App

Current courses on the app:
- 2016-2017 ACE, SEE
- SAM Pediatrics
- SAM Obstetrics
- Journal CME and more

Track all CME and MOCA credit in one place.

ASA Self-Assessment Programs

- Anesthesiology Continuing Education (ACE) Program
- Self- Education and Evaluation (SEE) Program
- Self-Assessment Modules (SAM), developed w/sub-specialties
  - Pain Medicine
  - Pediatrics
  - Obstetrics

ASA Supports Quality and Patient Safety

ASA activities approved for MOCA Part 2 Patient Safety requirements:
- Fundamentals of Patient Safety
- Patient Safety Highlights
- MRI Advisory
- Cardiac Arrest and Spinal Anesthesia
- Cardiac Tamponade
- Intraoperative Awareness
- Smoking Cessation in Surgical Patients
- Neuromuscular Blockade

New Innovative ASA Education Offerings

Safe Sedation Training – Moderate

Launched August, 2015

asahq.org/sst-moderate

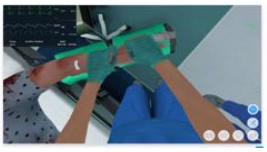
Safe Sedation Training – Deep

Launched July, 2017

asahq.org/sst-deep

Anesthesia SimSTAT – Now Approved for 5 Patient Safety and ABA MOCA Part IV Credits

- Initial modules will include:
  - Pulseless Electrical Activity (PEA) Trauma (**Now Available**)
  - Postoperative Myocardial Infarction (Coming soon)
  - Malignant Hyperthermia (Coming soon)
  - Anaphylaxis (2018)
  - Local Anesthetic Systemic Toxicity (2018)



ASA Education Concierge

- The Education Concierge is a learning platform for health care organizations that provides a private label, custom educational experience with access to ASA's quality CME education, for physicians and care teams.

Features and benefits:

- Curriculum meets accreditation and certification requirements
- View education outcome reports with easy data capture, historical record keeping and report generation of learner progress
- Available on any device, anytime- compatible across all platforms

American Society of Anesthesiologists®

Advocacy

Pain Medicine and Prescription Opioid Abuse

asahq.org

Addressing the Opioid Epidemic- ASA's Key Policy Issues

- Increase patient access to multimodal and multidisciplinary pain management, including insurance coverage of non-opioid therapies and team-based care
- Enhance physician education on multimodal, multidisciplinary pain management, including safe and effective opioid prescribing
- Encourage safe storage and disposal of opioid medications by increasing patient access to drug "take back" programs
- Support research for decreasing opioid use in the postoperative period

AMA Task Force to Reduce Prescription Opioid Abuse

- Supports the goals to:
  - Increase physicians' registration and use of effective PDMPs.
  - Enhance physicians' education on effective, evidence-based prescribing.
  - Reduce the stigma of pain and promote comprehensive assessment and treatment.
  - Reduce the stigma of substance abuse and enhance access to treatment.
  - Expand access to naloxone in the community and through co-prescribing.

Controlled Substances Stakeholder's Coalition

- Organized by the National Association of Boards of Pharmacy (NABP), ASA and other organizations meet 1-2 times a year to address common issues and collaboration between physicians and pharmacists.
- Previously collaborated on a resource addressing red flag warning signs for opioid prescribing and dispensing.
- Last met in December 2016, with plans to meet in spring 2017.
- Working together to develop slides to illustrate roles pharmacists/physicians play in opioid prescribing and dispensing, to be utilized for presentations at national conventions.

Collaboration with Premier Inc.Safer Post-Operative Pain Management: Reducing Opioid-Related Harm Pilot

- 6-month pilot program: September 2017- March 2018
- ASA and Premier will work together with 30 hospitals
- Goals:
  - Measurably reduce adverse drug events and harm associated with opioids among select adult surgical patient populations including elective hip and knee arthroplasty and colectomy procedures.
  - Limiting opioid use in these surgeries; thereby decreasing opioid use at discharge and lowering readmission rates
- ASA members will serve as expert faculty on educational webinars with the participating hospitals

Resident International Anesthesia Scholarship Program 2018-19 Application Details

The ASA Committee on Global Humanitarian Outreach (GHO) is pleased to announce the application cycle for the 2018-19 scholarship program for U.S. anesthesiology residents to spend a month in a resource-poor setting. The site for the rotation will be a CURE Hospital in Ethiopia, Uganda, Malawi or Kenya, or a GHO-affiliated site in Rwanda or Guyana. Residents will have the opportunity to experience the challenges of delivering safe anesthesia in a low-resource, underserved area in a developing country as well as participate in the training and education of local anesthesia providers. With appropriate planning, the resident will be eligible to receive ABA credit. Covered expenses include travel, lodging, meals, visa, vaccinations and medical insurance.

Application requirements and details:

- Applicants must be CA-2 residents at time of application and must have completed a pediatric anesthesia rotation, and should be CA-3 residents at the time of the rotation.
- Must be a resident in good standing in a U.S. anesthesiology residency training program.
- Application requirements include a letter of motivation, letter of support from program director, CV and one additional letter of recommendation.
- The first available month for the rotation is approximately September 2018, with start dates and rotation dates flexible based on needs of the home institution.
- **Applications are due by January 31, 2018.**

Send application materials or questions to:

Elizabeth T. Drum, M.D., FAAP, FCPP
Medical Director, Radiology Anesthesia Sedation Services
Medical Director, Anesthesiology Global Health Initiatives
The Children's Hospital of Philadelphia
Associate Professor of Clinical Anesthesiology and Critical Care
Perelman School of Medicine, University of Pennsylvania
U.S. Program Director for Scholarship program
drumet@temple.edu

HANDOUT

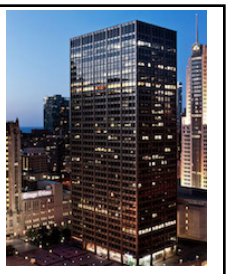
SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

RRC Update

Robert R. Gaiser, MD, MSEd
Anne Gravel Sullivan, PhD

11/04/2017
7:20am – 7:40am

Anesthesiology RC Update



Robert Gaiser, MD
Chair, Anesthesiology Review Committee
Anne Gravel Sullivan, PhD
Executive Director, Anesthesiology Review Committee

Disclosures

Dr. Gaiser has no conflicts of interest

Dr. Gravel Sullivan works for the ACGME

Objectives

- Introduce new RC members
- Update on New and Osteopathic Programs
- Pain Medicine Program Requirement Revision Timeline
- Core Anesthesiology Program Requirement Revisions (proposed)
- Review ACGME and RC Initiatives in 2018
- Answer questions

New RC Members

Manuel Vallejo, Jr., MD (2018)
DIO, Dept. of Obstetric Anesthesiology
West Virginia University

Anne Marie McKenzie-Brown, MD, (2018)
Associate Professor, Dept. of Anesthesiology
Director, Division of Pain Management and Pain Center
Emory University

New Programs in 2017

Core Residencies	9
Adult Cardiac	3
Critical Care Anesthesiology	2
OB Anesthesiology	1
Pain Medicine	2
Regional Anesthesiology	12
TOTAL	**31**

Osteopathic Programs

Residencies

- 10 of 13 AOA Anesthesiology Programs on Initial Accreditation
- One merged with existing ACGME-accredited program
- 1 on Continued Pre-Accreditation
- 1 not applying

Pain Medicine fellowships applying

Fellows, faculty may be boarded by AOBA or Osteopathic Conjoint Pain Medicine Examination Committee

Multidisciplinary Pain Medicine PR Revision

Proposed Requirements posted for Review & Comment……TBD (late 2017)

Review & Comment ends……TBD

Committee on Requirements review……March 2, 2018

Effective Date (tentative)……July 1, 2018

Anesthesiology Core PR Revision

Proposed Requirements posted for Review & Comment……TBD

Committee on Requirement review……March 2, 2018

Anticipated Effective Date……July 1, 2018

Anesthesiology Core PR Revision

IV.A.5.a).(2).(m) patients undergoing a variety of diagnostic or therapeutic procedures outside the surgical suite. This must include: (Outcome)

IV.A.5.a).(2).(n) use of surface ultrasound, and transesophageal and transthoracic echocardiography to guide the performance of invasive procedures and to evaluate organ function and pathology as related to anesthesia and critical care, and resuscitation

IV.A.5.a).(2).(n).(i) Must understand the principles of ultrasound including: the physics of ultrasound transmission, ultrasound transducer construction and transducer selection for specific applications; be able to obtain images with with an understanding of limitations and artifacts.

Anesthesiology Core PR Revision

IV.A.5.a).(2).(n).(ii) Be able to obtain standard views of the heart and inferior vena cava with transthoracic echocardiography allowing the evaluation of myocardial function, estimation of central venous pressure, and gross pericardial/cardiac pathology (e.g. large pericardial effusion)

IV.A.5.a).(2).(n).(iii) Be able to obtain standard views of the heart with transesophageal echocardiography allowing the evaluation of myocardial function and gross pericardial/cardiac pathology (e.g. large pericardial effusion)

IV.A.5.a).(2).(n).(iv) Be able to use transthoracic ultrasound for the detection of pneumothorax and pleural effusion

IV.A.5.a).(2).(n).(v) Be able to use surface ultrasound to guide vascular access (both central and peripheral) and to guide regional anesthesia procedures.

IV.A.5.a).(2).(n).(vi) Be able to describe techniques, views, and findings in standard language.

Anesthesiology Core PR Revision

IV.A.5.b).(1).(a).(vi) healthcare finance, legislative and regulatory issues; and, (Outcome)

IV.A.5.b).(1).(b) management skills to include basic knowledge of organizational culture, decision making, change management, conflict resolution, and negotiation and advocacy.(Outcome)

IV.A.5.b).(1).(c) knowledge of the care of the patient in the continuum of the perioperative period, including collaboration with medical and surgical colleagues to:

IV.A.5.b).(1).(c).(i) optimize preoperative patient condition. (Outcome)

IV.A.5.b).(1).(c).(ii) optimize recovery. (Outcome)

Core Program Board Pass Rate

- Basic Exam not included in program Board Pass Rate
- Calculation will be made by graduation rather than calendar year

Academic Calendar

Other RC Activities

- Implementation of Final Adult Cardiac Case Logs (required as of 7/1/2017)
- Revision of Core Requirement FAQs
- Changes to Pediatric Anesthesiology Case Logs

Updates to Pediatric Case Log Classifications

Proposed RC Changes:

- Specific locations of peripheral nerve blocks and catheters (upper or lower) added
- Blood transfusion patients will be tracked
- Number of CVCs dropped to 6

ACGME Initiatives

- CPR Revision Task Force
  - Section VI implemented July 1, 2017*
  - Other Sections currently under revision
- Program Coordinator Advisory Council
  - Third meeting Sept 2017
  - Coordinator Position Description and Manual
- New Educational resources available through Distance Learning in ACGME's Bridge LMS (www.tiny.cc/acgme)

RC Presentations & Outreach

- Annual Education Conference - March 2018
- American Osteopathic Colleges of Anesthesiology Meetings - March & September 2018
- New Program Coordinator Workshop - August 2018

Questions?

Anne Gravel Sullivan, PhD
Executive Director, RC for Anesthesiology
Director of Distance Learning
(312) 755-7032
asullivan@acgme.org

Gladys Banfor
Accreditation Administrator
(312) 755-5493
gbanfor@acgme.org

HANDOUT

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

ABA Update

James P. Rathmell, MD

11/04/2017
7:50am – 8:20am

The American Board of Anesthesiology

2017 ABA REPORT

SOCIETY OF ACADEMIC ANESTHESIOLOGY ASSOCIATIONS

BRENDA G. FAHY, M.D.
Vice President, American Board of Anesthesiology

University of Florida Health Shands Hospital
Gainesville, FL

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Margaret Pisacano, BSN, J.D.
UK Healthcare

James P. Rathmell, M.D.
Brigham and Women's Hospital

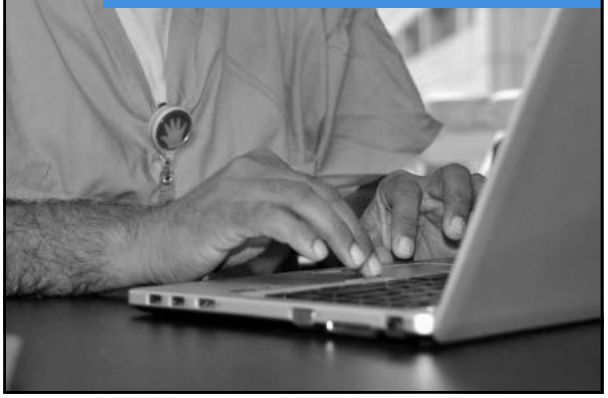
David O. Warner, M.D.
Mayo Clinic

DISCUSSION OVERVIEW

- RTID Reporting Update
- Primary Certification Updates
- Subspecialty Certifications
- Program Directors' Meetings
- MOCA 2.0®
- MOCA 2.0 New Features

3

RTID REPORTING UPDATE



RTID REPORTING REQUIREMENTS

- Programs should complete the following activities every six months (**Jan. 31** and **July 31**):
  - Resident Enrollment Forms
  - Clinical competency assessments
  - Program Director Reference Forms
- Assess at end of training whether resident can **independently practice** in the specialty without accommodation or with reasonable accommodation

5

CERTIFICATE OF CLINICAL COMPETENCY (CCC) REPORT

- Required for each resident who has spent any portion of six-month reporting period in training
- Complete CCC Reports at the end of each reporting period
- If you validate CCC reports for residents taking the BASIC Exam before getting their results, your reports may reflect an incorrect overall grade for those who failed

6

PRIMARY CERTIFICATION

7

STAGED EXAMINATIONS

- Move to staged exams
  - Complements ACGME movement toward competency-based training and promotion
  - Encourages residents to engage in more sustained study during training

- In 2017, launched the APPLIED Exam, the last exam in the staged exam series
- In 2018, adding the Objective Structured Clinical Examination (OSCE) component to the APPLIED Exam for candidates who complete(d) their residency training on or after Oct. 1, 2016

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SUBSPECIALTY CERTIFICATION

SUBSPECIALTY CERTIFICATION

- The ABA currently offers subspecialty certification in:
  - Critical Care Medicine
  - Pain Medicine
  - Sleep Medicine
  - Hospice & Palliative Medicine
  - Pediatric Anesthesiology
- Must have completed an ACGME-accredited fellowship program
- Fellows must be certified in anesthesiology prior to registering for a subspecialty exam

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PROGRAM DIRECTOR MEETINGS

PROGRAM DIRECTOR MEETINGS

- Hosted Program Directors' meetings in 2017 to share updates on the APPLIED Exam launch with OSCEs in 2018
- Topics for discussion included:
  - Rationale for OSCEs
  - OSCE Content Outline and exam structure
  - Scoring rubric
  - Tour OSCE rooms
  - Pilot test of OSCE scenarios

PROGRAM DIRECTOR FEEDBACK

- Heard during the meetings that you wanted more information on OSCEs
  - Created exemplars of OSCE scenarios
  - Published TEE resource links
- OSCE pilot testing continues with early career diplomates
- Full-scale run-through scheduled for late November
- Dedicated email for program director feedback: PDfeedback@theABA.org

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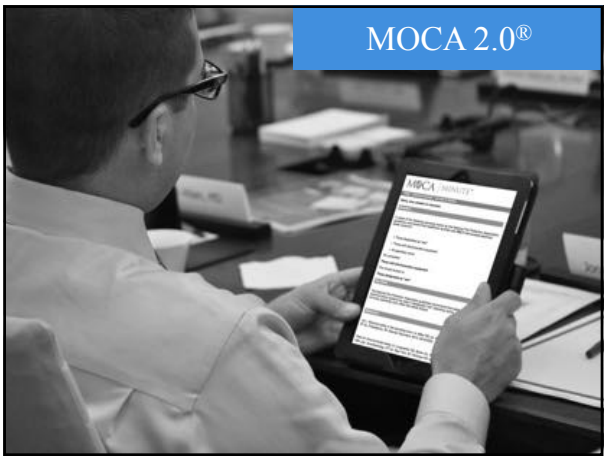

MOCA 2.0® GOAL

Create a web-based, **lifelong learning** platform that promotes and supports **personalized knowledge acquisition**, **assessment** and demonstration of proficiencies

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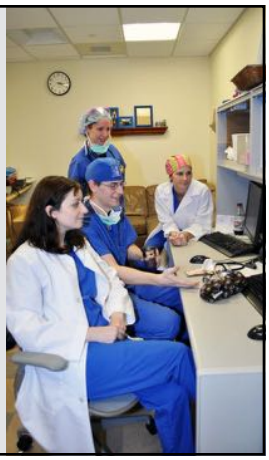
MOCA 2.0®
Promotes continuous lifelong learning
Relevant to diplomates' practices
Professionally and publicly credible
Ongoing continuous assessment
Encourages group discussion
Incorporates principles of adult learning theory
Facilitates Quality Improvement and Safety
Integrates all program components



SPECIFIC OBJECTIVES

- Identify knowledge gaps among diplomates, as a group and as individuals
- Connect them to targeted educational opportunities based upon knowledge gaps
- Utilize continuous longitudinal assessment and dynamic education tools to improve diplomates' fund of knowledge
- Integrate and simplify MOCA components
- Generate a learning and assessment resource that is relevant to many different practice types

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MOCA MINUTE® PILOT OBJECTIVES

- Incorporate features of adult learning theory
  - Provide a continuous, dynamic assessment of knowledge using questions similar to those on the MOCA exam
  - Provide focused content that can be accessed and reviewed later to refresh knowledge
  - Allow diplomates to quickly assess their knowledge and then guide them to resources to strengthen their expertise

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MOCA 2.0® REQUIREMENTS

Medical License	Unrestricted medical licensure – No change
CME	250 Category 1 CME Credits (including 20 Patient Safety) • Self-Assessment CMEs no longer required • Diplomates who previously completed Self-Assessment CMEs will get credit for them in MOCA 2.0
MOCA Minute®	MOCA Minute longitudinal assessment is being piloted to replace the exam
Quality Improvement	Variety of options provide greater flexibility to complete relevant activities • Point System weights activities based on the time and effort • Simulation is an option; not a requirement, although the ABA strongly encourages participation
Fee:	$210 annual fee for first certificate maintained, $100 annual fee for each additional certificate maintained

MOCA MINUTE® RESEARCH

- Diplomates have told us how important it is to provide evidence about impact of our programs
- We are researching the efficacy of MOCA Minute and plan to share the results
- We are also hosting a research summit to identify and prioritize our certification and MOCA research efforts

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2016 MOCA SURVEY FEEDBACK

Not perfect, but getting better

Praise

"Our board is very forward thinking and moving in a great direction for keeping its (diplomates) active, educated and striving to learn and grow with their practice."

"It is doing its best to tailor the methodology to the 21st century requirements yet maintaining high professional standards in our specialty."

"The ABA is leading our specialties in terms of promoting ongoing learning with the MOCA Minute and the new MOCA program rather than cramming for a test every 10 years like some of my peers."

Criticism

"…clinical requirements for clinical improvement is time consuming and not always feasible in practice. I believe the educational questions and CME are more worth your time. Why are we making it more cumbersome for anesthesiologists? … Please consider what the true objective."

"It seems complicated."

"Dump it (Part 4)."

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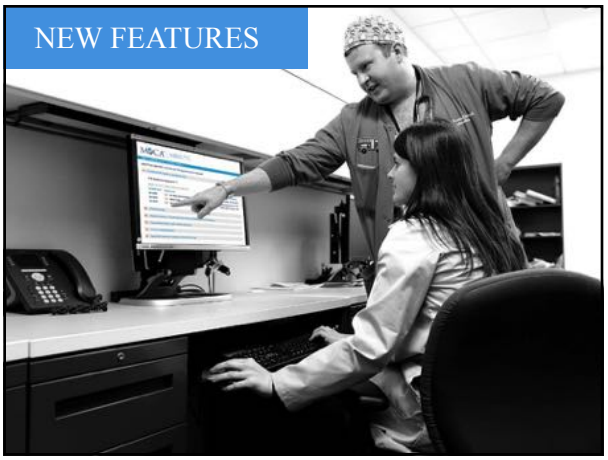
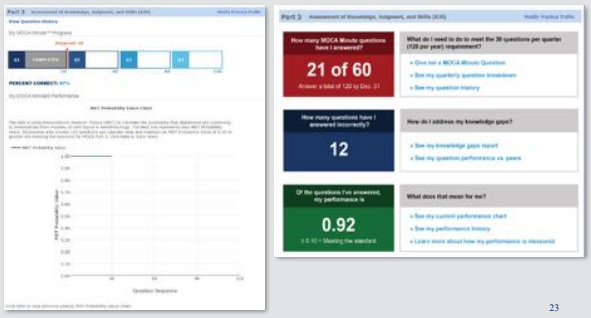
NEW FEATURES



MOCA PROGRESS REPORT: PART 3

OLD NEW



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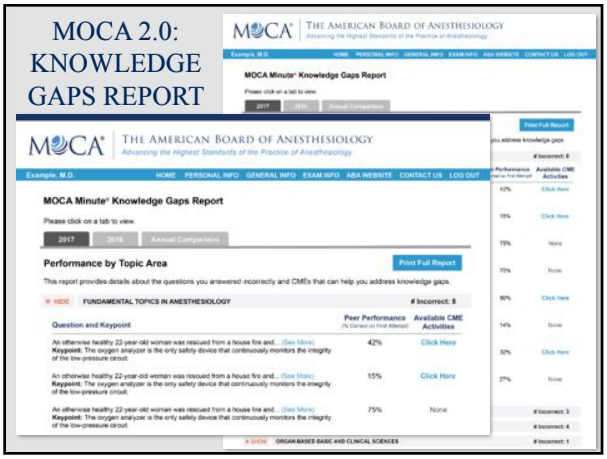
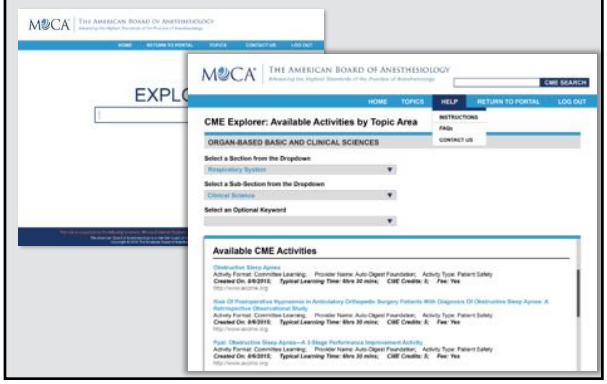
MOCA 2.0: KNOWLEDGE GAPS REPORT



CME EXPLORER



PERSONAL PORTFOLIO

PERSONAL PORTFOLIO

ABA The American Board of Anesthesiology

QUESTIONS?

COMMUNICATIONS CENTER
Phone: (866) 999-7501
Fax: (866) 999-7503
Email: coms@theABA.org

MAIL CORRESPONDENCE
ABA Secretary
4208 Six Forks Rd, Suite 1500
Raleigh, NC 27609-5765

FOLLOW US

HANDOUT

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

ABA ITE Update

David O. Warner, MD

11/04/2017
8:30am – 8:50am

The American Board of Anesthesiology

2017 ABA Exams Report

Society of Academic Anesthesiology Associations

DAVID O. WARNER, M.D.
Chair, ABA Assessments & OSCE Committees

Mayo Clinic
Rochester, MN

QUESTION EDITORS

ITE/BASIC/ADVANCED/PART 1 EXAMS

76 JUNIOR EDITORS
10 were selected in 2016
Write questions (18/year)
Revise questions based on feedback

43 SENIOR EDITORS & COMMITTEE MEMBERS
Edit questions
Mentor junior editors

2

QUESTION DEVELOPMENT

- Question generation for the examinations: BASIC, ADVANCED, Part 1 and ITE
  - Approximately **1,400** questions generated
  - Three senior editors meetings and 8 webinars to review items
  - ITE and BASIC Exam forms reviewed by exams committees in August and September 2016
  - ADVANCED form was reviewed in January 2017

3

2018 IN-TRAINING EXAM (ITE)

- Internet-based, secure, proctored exam delivered via vendor
  - Exam may be delivered any time from **12 a.m. ET on Thursday, Feb. 15,** to **11:59 p.m. ET on Tuesday, Feb. 20,** with multiple administrations
- Every computer used must pass complete systems check; administration guides delivered in December
- Questions may include graphics, including still shots of a monitor screen and ultrasound images

4

ITE-PAIN MEDICINE (ITE-PM)

- In 2017, **86** programs administered the exam to nearly **320** fellows
- 2018 ITE-PM will be administered at fellowship program sites on **Friday, March 16**
- ITEs for Critical Care Medicine and Pediatric Anesthesiology are expected to be added in **2019**

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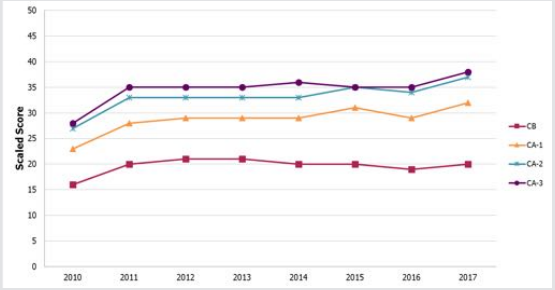
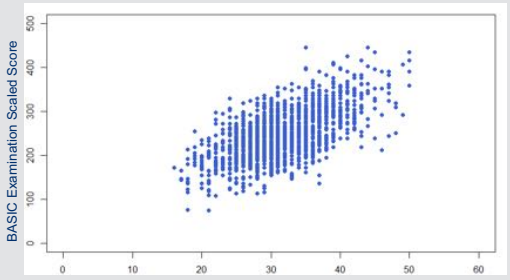
IN-TRAINING EXAM PERFORMANCE

BY TRAINING LEVEL & EXAM YEAR



6

RELATION OF SCORES
2017 ITE TO 2017 JUNE BASIC EXAMINATION



The correlation between the 2017 ITE scaled scores and 2017 June BASIC Exam scaled Scores is 0.622, p < 0.001

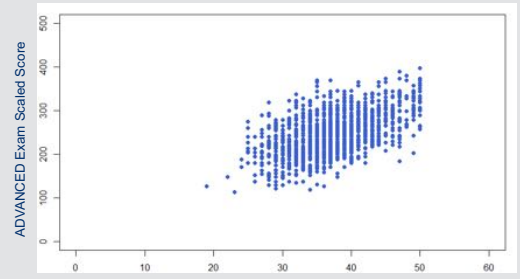
7

RELATION OF SCORES
2017 ITE TO 2017 JUNE BASIC EXAM

Scaled Score	N	2017 June BASIC Scaled Score Mean (S.D.)	BASIC Pass Rate
≤25	217	201 (44)	64%
26-30	524	228 (41)	85%
31-35	508	250 (43)	94%
36-40	306	283 (45)	99%
41-45	89	325 (47)	100%
≥46	20	341 (61)	100%

8

RELATION OF SCORES
2017 ITE TO 2017 JULY ADVANCED EXAMINATION



The correlation between the 2017 ITE scaled scores and 2017 July ADVANCED Exam scaled Scores is 0.540, p < 0.001.

9

RELATION OF SCORES
2017 ITE TO 2017 JULY ADVANCED EXAM

Scaled Score	N	2017 ADVANCED Scaled Score Mean (S.D.)	ADVANCED Pass Rate
≤25	15	197 (46)	73%
26-30	126	210 (41)	81%
31-35	392	232 (41)	94%
36-40	562	249 (37)	98%
41-45	310	272 (36)	100%
≥46	120	305 (41)	100%

10

EXAMINATION SCORING

- Standard-setting study conducted every five years
- Following exam administration, preliminary item analysis conducted (difficulty & discrimination)
- Key validation for items
  - negative discrimination
  - no clear correct answer

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2017 JUNE BASIC EXAM RESULTS

- Candidates were assigned to examine on Friday or Saturday
- Key validation eliminated nine items from two forms
- 88.4% of candidates passed

N	Mean Scaled Score	Standard Deviation	Pass Rate	Reliability
1,696	247.6	54.0	88.4%	0.80

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2017 JULY ADVANCED EXAM RESULTS

- Candidates were assigned to examine on Friday or Saturday
- Key validation eliminated 10 items from two forms
- 95.2% of candidates passed

N	Mean Scaled Score	Standard Deviation	Pass Rate	Reliability
1,610	248.9	47.4	95.2%	0.75

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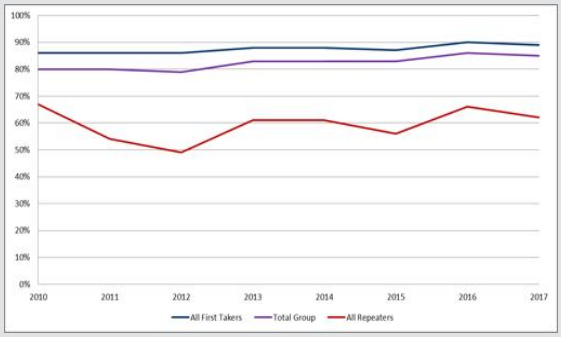
PART 2/APPLIED EXAMINATION

SUCCESS RATES



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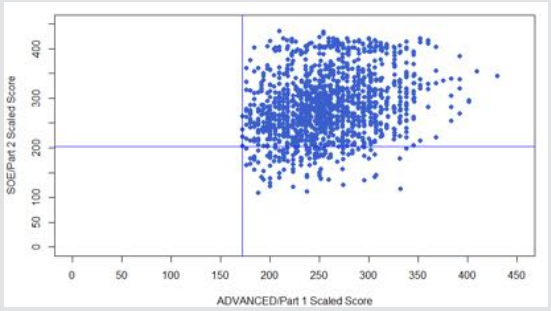
RELATION OF SCORES

2017 SOE/PART 2 EXAM TO FIRST ATTEMPT ON 2016 ADVANCED/PART 1 EXAM



The correlation between the 2017 SOE/Part 2 Exam scaled scores and first attempt on 2016 ADVANCED/Part 1 Exam scaled scores is 0.266, $p < 0.001$

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STAGED EXAMINATIONS

- Staged exams launched in 2014 to replace the traditional Part 1 and Part 2 Exams
  - Candidates who completed residency training on or after Oct. 1, 2016, take the staged exams – BASIC, ADVANCED and APPLIED Exams

- In 2018, the Objective Structured Clinical Examination (OSCE) component will be added to the APPLIED Exam, completing the staged exams rollout

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APPLIED EXAM: WHY ADD OSCES?

- OSCES are intended to assess two major domains that are difficult to assess in written or oral exam formats, such as
  - **Communication and Professionalism**
  - **Technical skills related to patient care**
- Evidence that these domains are important in physician performance after training

OSCE FORMAT

- Candidates will participate in a **seven-station circuit** that will evaluate their proficiency in seven of the nine skills from the OSCE Content Outline:
  - Six Communication & Professionalism skills
  - Three Technical skills
- Each station will be **eight minutes long** with four minutes between stations to review their next scenario

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OSCE FORMAT

- In some stations the candidate will interact with a **standardized patient actor** as part of the scenario
- In others, the candidate will interact directly with an examiner, but examiners will not be in most exam rooms

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WHY ARE WE DOING THIS?

- **Assessment**
  - To better assess competencies important for diplomates to possess; better align with expansion of competencies reflected by the ACGME milestones
  - Desire to improve the discrimination and external validity of our overall assessment process and assess whether there is significant collinearity with the SOE
- **Training**
  - To drive improved training in these domains within residency programs

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PREPARATION FOR OSCES?

- Extensive exam prep/training should not be necessary
  - **Communication & Professionalism scenarios:** Based on OSCE formats that medical school grads have experienced – enter a room and talk with a standardized patient/clinician
  - **Technical Skills scenarios:** Mimic common clinical teaching settings (e.g., explaining what the candidate sees on a monitor, showing faculty relevant U.S. anatomy, interpreting an echo)

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HOW WILL OSCES BE SCORED?

- Scoring method similar to that used for the current Structured Oral Examination
- Standards for passing the OSCE component will account for the novel nature of the exam

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OSCE RESOURCES

- Published these resources on the ABA website to help programs help residents prepare for the first OSCE administration in 2018:
  - OSCE Content Outline
  - OSCE administration schedule
  - OSCE example scenarios with links to TEE resources
  - OSCE overview video

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ABA The American Board of Anesthesiology

QUESTIONS?

COMMUNICATIONS CENTER
Phone: (866) 999-7501
Fax: (866) 999-7503
Email: coms@theABA.org

MAIL CORRESPONDENCE
ABA Secretary
4208 Six Forks Rd, Suite 1500
Raleigh, NC 27609-5765

FOLLOW US

HANDOUT

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Professional Citizenship

Jeffrey Scott Plagenhoef, MD

11/04/2017
9:30am – 9:50am

Professional Citizenship…

Teaching it is essential to advancing OUR specialty and securing OUR future.

Annual Meeting of
Society of Academic Associations of Anesthesiology and Perioperative Medicine
November 4 , 2017

Jeffrey S. Plagenhoef, MD, FASA
ASA Immediate Past President
Chairman Depart of Anesthesiology
Baylor Scott & White Hillcrest Med Ctr

COI Disclosure

- No conflicts

Learning Objectives

Not the same as usual for this presentation

What is the 50K Foot View?

❖**Major and rapid change**
- in public policy
- in employment models
- in payment policy
- in care delivery models

❖**Major threats**
- to patient safety and quality of care
- SOP no longer Ed-based
- inadequate insurance
- pervasive apathy and complacency

❖**Major challenges**
- EMRs
- quality and outcomes reporting
- data registry/QCDR
- technologic advances
- lack of unity and consensus
- Need for additions to residents' education
- How to prevent the "scatter effect"

A professional view not so aligned with the facts

Great science

Great research

+ Great education

= "*Advancing the specialty AND securing the future*"

Definitions

Professionalism

Vs.

Professional Citizenship

Definition of Professionalism

- The conduct, aims, or qualities that characterize or mark a profession or a professional

ACGME Requirements

Professional responsibilities defined by "*The Charter on Professionalism*"

- Commitment to professional competence
- Commitment to honesty with patients
- Commitment to patient confidentiality
- Commitment to maintaining appropriate relations with patients
- Commitment to improving quality care
- Commitment to improving access to care
- Commitment to a just distribution of finite resources
- Commitment to scientific knowledge
- Commitment to maintaining trust…
- Commitment to professional responsibilities

"Active Citizenship"

- Assertion that members of companies or nation-states have certain roles and responsibilities at a higher level than their primary job
- Societally, easier to define "rights" than "responsibilities"
- Active citizens - fulfill both rights and responsibilities in a balanced way (simple distillation = take & give back)

Is Doing Your Primary Job Enough?

Always do your best at what's expected of you… *and then some*!

What's in Your Personal Profile?

- **Honesty**
- **Leadership**
- **Neat Appearance**
- **Proper Conduct**
- **Ethical Behavior**
- **Compassion**
- **Courtesy**
- **Collaboration**
- **Highest standards**

- **QI Efforts**
- **Trust**
- **Integrity**
- **Availability**
- **Accountability**
- **Altruism**
- **Responsibility**
- **Ownership**
- **Innovative**

Variable jargon out there…

- Professionalism
- Professional Development
- Active Citizenship
- Corporate Citizenship
- Leadership Development

So, What is "Professional Citizenship"?

- Willingness to accept personal responsibility and ownership for the present and future state of *"X"*
- Team player
- Pulling your fair share of the load - ALWAYS
- Leading by example in EVERYTHING!
- Standing up for and doing what is right – ALWAYS!
- Not just taking – but at all levels GIVING BACK
- Supporting the mission with one's time, energy and money

So, why discuss this?

1) Our future truly depends upon a transformation from within
2) We have too many takers and not enough givers!
3) Not everyone had good parents – missed out on "The Dad/Mom Talk"!
4) Solid professional citizenship can readily be taught through effective leadership and mentorship

Teaching Professionalism

- Set expectations – policies
  Must include consequences of noncompliance
- Assess compliance and performance
- Reward good behavior, remediate inappropriate
- Goals - preventing inappropriate behaviors and implementing a cultural change.

But, does teaching professionalism do any good?

- Certain behaviors early in medical education have been found to correlate with unprofessional behavior later in careers. We need to be vigilant in looking for those behaviors and let our trainees know why we're so concerned about them.

YES, it does!

Teach who?

- Residents and fellows, of course
- But also junior faculty… and some senior faculty!
- Mentorship – not just clinically, but also in professional citizenship - for junior faculty HUGE importance and value!
- All senior department members should play a leadership role in mentoring others

When it comes to organized medicine, need to teach to **NEVER** say…

- *"The medical staff needs to do blah, blah, blah…"*
- *"The XSA needs to do this, that or the other"*
- *"The ASA needs to do X, Y or Z…"*
- And for sure do not ever prove your consummate lack of awareness of the facts by saying…

"Those organized medical associations don't do anything for me or my specialty."

Come on… Really?

Advocacy

A Huge Shared Responsibility

Definition: noun – recommendation, support, championing, backing, promotion, campaigning for, upholding, advancement, pleading for, propagation, spokesmanship

(Not a "dirty word" but an essential mission)

ASA Leading in "COMPREHENSIVE Advocacy"

Educational – ASA members and the public
GME Funding
Research Funding
Scientific
Regulatory
PR/Marketing/branding
Health Policy
Out of Network billing/payment
Legislative
And yes, political

Not Just Political Advocacy!

What is Your ASA doing for Academic Anesthesiologists?

***** 2017 Focus Items *****

- Scope of Practice Expansion
- New Payment Models/reductions
- Periop Surgical Home
- GME Funding
- Research Funding
- Insurance Gaps & OONB
- Quality Reporting((AQI/NACOR)
- Quality Measure Development
- Pediatric Dental Anesthesia
- Patients Bill of Rights
- PR, marketing, education about our specialty

*If not your ASA, then who?

*If not you, then who?

*Whose responsibilities?

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Why should all anesthesiologists be thankful for their State Society and the ASA?

→ AN IRREFUTABLE VALUE PROPOSITION AND HUGE ROI!

American Society's Mission Statement:

"To advance the specialty and secure its future"

Really, shouldn't it be EVERY anesthesiologist's professional mission?

A Few Big Problems

- 1) 80% don't support comprehensive advocacy
- 2) 99% Don't support FAER!
- Why? Because we graduate residents, year-in-and-year-out, that cannot articulate the importance of either.

School of Pharmacy University of Maryland

- INSTRUCTIONAL DESIGN AND ASSESSMENT Effective Leadership and Advocacy: Amplifying Professional Citizenship

  Cynthia J. Boyle, PharmD, Robert S. Beardsley, PhD, and Margaret Hayes, MS; American Journal of Pharmaceutical Education 2004; 68 (3) Article 63.

Their Introduction…

"The profession of pharmacy (anesthesiology?) is governed by legislation and regulations that are constantly changing. By bringing their expertise as medication specialists into legislative and regulatory negotiations, pharmacists (anesthesiologists) can influence decisions to promote safe and effective health care policy and delivery. Therefore, it is important for student pharmacists (residents) to develop leadership and expertise in advocacy, as they meet the Accreditation Council for Pharmacy Education curricular outcomes for the doctor of pharmacy degree…."

Cont'd…

"… as part of this professional citizenship, pharmacists must intervene for patients and communicate with individuals and groups that are not health professionals, such as managers, legislators, payers, and society at large."

"The more anesthesiologists take part in government, the less government will take a part of anesthesiologists."

If you want us to have a seat at the table – please help make the reservation!

Bi-partisan & non-ideological political voice of the ASA.

Founded in 1991 to advocate on behalf of ALL anesthesiologists and their patients.

American Society of Anesthesiologists Political Action Committee
ASAPAC

Why ASAPAC?

- A "*Plagenhoefism*" – politicians' hearing aides.
- It is the way government is played in the U.S. -- we cannot win a game without playing in it.
- One cannot talk about advancing anesthesiology without including advocacy – it is crucial to all that is patient safety, quality of care, and our business.
- Basic entry level professional citizenship expected of everyone!!!

OR… at least serve as supporting cast

- A HUGE opportunity that any anesthesiologist who wants to be a part of the solution can do.
- Talk about this in your group/dept.
- "The Legacy of Gopal"
- Pay your dues – be a member!!!

On the Scope of Practice Front…

VA's *PROPOSED* New Nursing Handbook → → ***VHA Final Rule → Veterans Won!***

Clear demonstration that professional citizenship is an absolute essential requirement if we are to execute effectively in the current world.

We reversed the preexisting pitiful level of apathy

- Best ever in past: 4,000 responses / 7-8% of membership
- Needed 500% increase
- Achieved a 2600% increase
- 104K responses/, but ONLY ~57% of all Anesthesiologists! Why?

Opt-out Legislation Does **NOT** Improve Access or Costs

- Four articles published in 2016-2017:
  - Sun EC, Miller TR, Halzack NM
  - Sun EC, Dexter F, Miller TR
  - Sun EC, Dexter F, Miller TR, Baker LC
  - Schneider JE, Ohsfeldt RL, Li P, Miller TR, Scheibling CM
- Using four different national datasets
- Access measured in multiple ways:
  - Growth in anesthesia use rates
  - Increase in procedures related to emergent diagnoses
  - Change in travel patterns
  - Change in surgical utilization or costs

ANESTHESIOLOGY
The Journal of the American Society of Anesthesiologists, Inc.

ANESTHESIA & ANALGESIA

A&A CASE REPORTS
Clinical Care. Education. Perioperative Services. Global Health. Patient Safety.

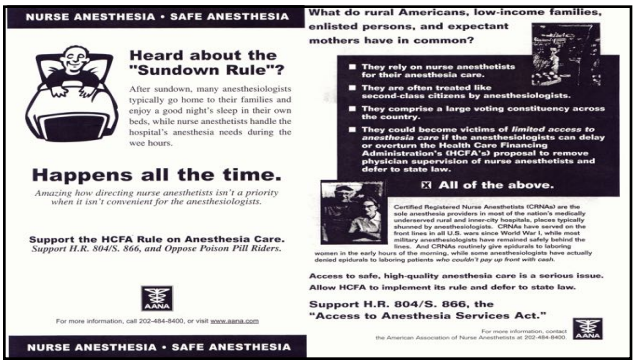
Health Economics Review
a SpringerOpen Journal

What's in your vocabulary?
"APRN Consensus Model" and "APRN Compact"

- ***Better learn it!!!***
- The VA's pro-nursing action--> straight from this House of Nursing's SOP advancement play book!
- Enlighten your awareness of reality by "Googling" this topic
- ASA cannot win SOP battles without YOU doing your part too!

CAMPAIGN FOR APRN CONSENSUS

APRN COMPACT



Our messaging is crucial

- Assuring representation at all discussions where our specialty may be impacted is key
- Our opponents show up in large numbers
- What is your personal contribution to our counter narrative?

Must Teach to Give

- Of One's Time
- Of One's Effort
- Of One's Money – *the easiest contribution!*

OR… at least to serve as supporting cast

- A HUGE opportunity that any anesthesiologist that wants to be a part of the solution can do.
- Talk about this in your department.
- "The Legacy of Gopal"

American Society's Plan of Action

- A reason I agreed to serve as an ASA officer.
- Ad Hoc Committee on Residents' Essential Professional Development
- Strategic Dialogue Summit: Redesigning for the Best Future

"Design Thinking" / "Collaborative Design"

- Originally only used for the physical – commercial products
- Then, user interface/customer experience
- Now core to development of business strategies, interventions and major change management of companies, small –> mega

How Certainty Transforms Persuasion

ZL Tormala, DD Rucker, Harvard Business Review, Sept. 2015

"Certainty profoundly shapes our behavior. The more certain we are of a belief – regardless of its objective correctness -- the more durable it will be and the greater its influence on what we do."

What is certainty?

- Confidence in our beliefs, including the sense that something "feels" just right
- Cannot create certainty about professional citizenship within all anesthesiologists without consensus and unity in core values & responsibilities and teaching the same consistently

"Certainty" profoundly shapes human behavior

- Subjective, but can be measured
- The Four Levers of Certainty
  - Consensus
  - Repetition
  - Ease
  - Defense

"Social Reengineering"

- Is it needed?
- Is it possible?
- How to accomplish? Apply…
  - Systems Theory
  - Human Factors Science
  - Create greater "certainty" among us

"Example is not the MAIN thing in influencing others - it is the ONLY thing!"
ALBERT SCHWEITZER

"The world will not be destroyed by those who do evil, but by those who watch them and do nothing."
ALBERT EINSTEIN

Applied to Current Events…
Plagenhoef's Corollary

"Patient safety and anesthesiology will not be destroyed by those unaware of what is required for optimal patient safety and quality of care, but by those totally aware - through education and experience - who watch them and elect to say or do nothing to lead in the right direction."

Contact Info

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HANDOUT

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Philanthropic Creativity for Anesthesiology Departments

James Boyle
Aaron Conley, EdD

11/04/2017
9:50am – 10:10am

Philanthropic Creativity for Anesthesiology Departments

SAAAPM Annual Meeting

November 4, 2017

Jim Boyle
Vice President

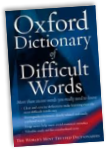
Aaron Conley
Senior Vice President

Grenzebach Glier and Associates
200 S. Michigan Avenue
Suite 2100
Chicago, Illinois 60604
tel 312.372.4040

GG+A

Understanding Philanthropy and Donor Motivation

Understanding Philanthropy & Donor Motivation

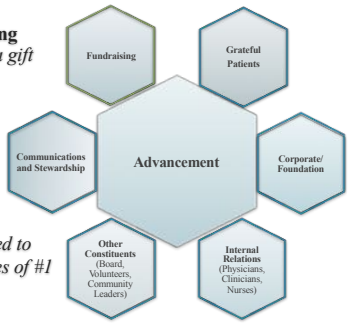


#1 – Fundraising *…asking for a gift*

#2 – Development / Advancement
…everything needed to improve the chances of #1

Understanding Philanthropy & Donor Motivation

#1 – Fundraising
…asking for a gift



#2 – Advancement
…everything needed to improve the chances of #1

Understanding Philanthropy & Donor Motivation

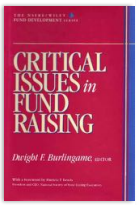
If you're new to fundraising, donors think differently about…

Annual Gifts	Major Gifts
Transactional	**Well-Thought**
• *Routine or little thought given*	• *How do I feel about this organization?*
Impulsive	**Contemplative**
• *Response to disaster/crisis*	• *Exploration of long-term impact*
Impersonal	**Highly Personal**
• *May not know anyone*	• *Close relationship(s)*
Collective	**Individual Impact**
• *Crowdfunding/social media*	• *Single purpose/project*

Creativity: The Next Ice Bucket Challenge?

Source: anesthesiology.duke.edu/?p=830010

Understanding Philanthropy & Donor Motivation



- **Identification Model**
  - Communities of Participation
  - Frameworks of Consciousness

Understanding Philanthropy & Donor Motivation

1. Think of one of your top prospects who has not yet made a major gift.
2. Identify their…
   - + Engagement Driver(s) (Communities of Participation)
   - + Emotional Driver(s) (Frameworks of Consciousness)
3. How will these guide your solicitation strategy?

Tools for Emotional and Engagement Drivers

- **One-on-one initial visits** by development professionals, eventually accompanied by relevant institutional or volunteer partners
- Systematic, **personal communications** that are natural follow-ups to conversations, providing "insider" information about areas of interest or on topics of interest to the prospective donor (*"I saw this and it reminded me of our conversation about…"*)
- Broader, **public communications** such as alumni magazines, school or department newsletters, annual reports and similar vehicles that consistently include information about gifts received, donor profiles, campaign updates and similar news that helps build a greater institutional "philanthropic identity"
- **Events or topical programming** that feature institutional partners, volunteers, and/or include other prospective donors at similar levels
- Invitations to participate in appropriate levels of **volunteer activities**
- Invitations to **off-site briefing meetings** led by institutional leadership, designed to elicit feedback in small groups

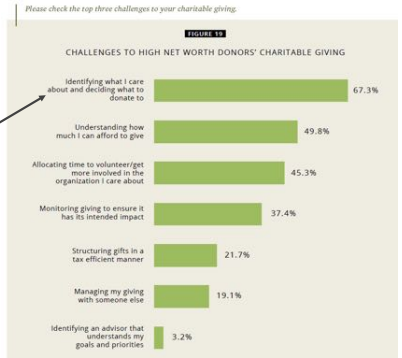
Understanding Philanthropy & Donor Motivation

- Available at: **philanthropy.iupui.edu/research/current-research**
- Conducted in 2006, 2008, 2010, 2012, 2014, 2016
- Criteria include:
  - Minimum household income of $200,000 and/or net worth of $1 million (excl. home)
  - 1,435 study participants
  - Average income $331,156 and net worth $16.8 million.

Understanding Philanthropy & Donor Motivation

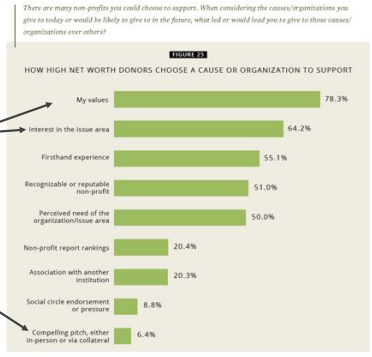
- High net worth individuals admit their top challenge…

How do I decide what to support?



Understanding Philanthropy & Donor Motivation

- Importance of **beliefs**, **values** and **interests**…
- "The Ask" is less important than getting to **Donor Readiness**

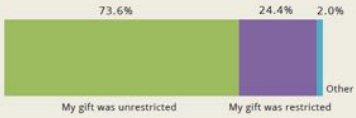


Understanding Philanthropy & Donor Motivation

Was your largest gift in 2015 restricted or unrestricted?

FIGURE 9

OBJECTIVES OF LARGEST GIFTS MADE IN 2015



Understanding Philanthropy & Donor Motivation

In general, do you prefer restricted or unrestricted gifts?

FIGURE 10

HIGH NET WORTH DONORS' PREFERENCES FOR RESTRICTED OR UNRESTRICTED GIVING

Raising Philanthropic Support for your Anesthesiology Department

How Do I Get Started?

1. **Case** – What do I need? Your vision/Strategic Plan
2. **Prospects** – Who are my potential donors?
3. **Plan** – How do I engage my donors?
   - Individualized/specific to each person

Using Your Strategic Plan in Priority Setting

- **Critical Points** in Communicating Your Priorities to Donors
  - **Brevity**: *Challenge yourself to articulate your plan as if it was a text message.*
  - **Focus**: *Decide what are the two or three most important priorities in your plan?*
  - **Outcomes**: *How will your department/unit be better if this plan is executed?*
  - **Appearance**: *Academic writing doesn't work outside of academe.*
  - **Messengers**: *Who is carrying your message? Can your volunteers, development staff and other non-medical staff effectively translate your plan?*

Grateful Patients – Mine are all passed out!

- **Make fundraising a team sport –** involve physicians, nurses, receptionists, family service coordinators and anyone who interacts with patients. Build a common vision and goal.
- **Educate, Educate, Educate** – outreach to the community, service clubs, 'lunch and learns', and the larger medical community on the role anesthesiology plays in exceptional patient care. Don't forget about the clinic or hospital.
- **Listen** – donor clues can be subtle and they may not be aware of their interest.
- **Develop an Advisory Board** – people who volunteer their time give more and can serve as Ambassadors.
- **Donate** – set an example for your team, your patients and your community.

WHAT COULD POSSIBLY GO WRONG?

More about "what we need"	Assume emotional commitment that's not there
Decide for them what their interest "should" be	Emphasize recognition and reward when it doesn't matter
Focus on size rather than impact of the gift	Evidence of fear, negativity or desperation

PARTING ADVICE

Do your homework, know your facts, but it is passion that matters…

Our mission is advancing yours.

GG+A

Thank You and Best Wishes for Fundraising Success

Jim Boyle
jboyle@grenzglier.com

Aaron Conley
aconley@grenzglier.com

www.grenzebachglier.com

HANDOUT

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Improving Your Bottom Line to Support Research and Education: The Duke Experience

Joseph P. Mathew, MD, MHSc, MBA

11/04/2017
10:10am – 10:30am

HANDOUT

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Entrepreneurship in Anesthesiology: The Utah Experience

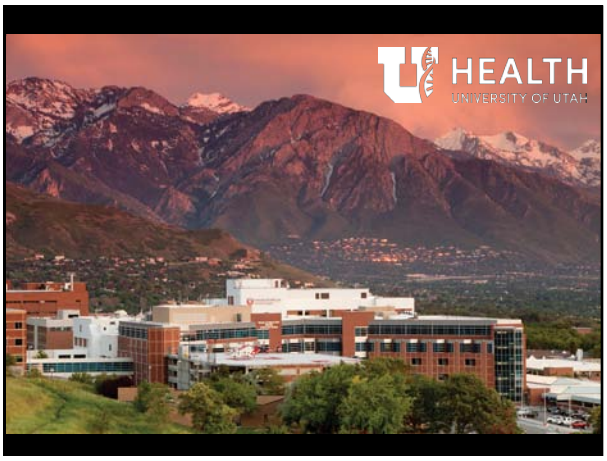
Talmage D. Egan, MD

11/04/2017
10:30am – 10:50am

HEALTH
UNIVERSITY OF UTAH

Entrepreneurship in Anesthesiology: The University of Utah Experience

Talmage D. Egan, MD
Department of Anesthesiology



Disclosures

Outline

- Main Challenges of Commercialization
- Assets Required for Success
- Non-Traditional Funding Sources
- University of Utah Model
  - State, University, Department Assets
  - Profile of Anesthesiologist-Entrepreneur
  - Profiles of Entrepreneurial Projects

An Ongoing Revolution…

Old Model

- Publications
- Grants
- Awards
- Faculty-centric

Culture of Knowledge

New Model

- Innovation
- Spinoffs
- Products
- Student-focus

Culture of Impact

Prestwich GD. Culture of impact: faculty as mentors for student entrepreneurs. Sci Transl Med. 2013 Jan 23;5(169)

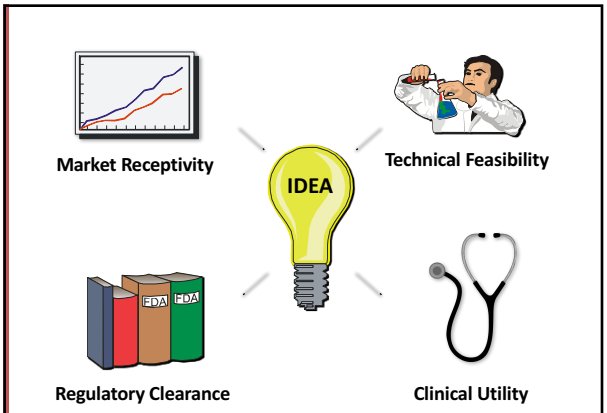
Key Point

Successful device or drug commercialization requires victory in four key battles.

Four Main Challenges

1. Technical Feasibility
2. Clinical Utility
3. Regulatory Clearance
4. Market Receptivity

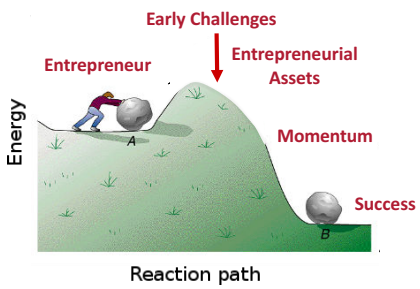
Egan (*Br J Anaesth* 2010)



Key Point

Assets at many levels are usually needed for the faculty entrepreneur to succeed.

Activation Energy



https://en.wikipedia.org/wiki/Activation_energy
https://socratic.org/questions/how-do-enzymes-catalyze-reactions

Assets at Three Levels

State

University

Department

Assets at Three Levels

State

- Business Talent Pool
- Tax Incentives
- Funding Programs
- Culture of Innovation

Assets at Three Levels

University

- Scientific Collaborators
- Incentive Programs
- Tech Transfer Assistance
- Culture of Innovation

Assets at Three Levels

Department

- Supportive Leadership
- Proximate Partners
- Seed Funding
- Culture of Innovation

Key Point

Non-traditional sources are usually needed to jumpstart faculty entrepreneurial research.

Non-Traditional Funding

- Government (Non-R,K,T)
- NGOs - Philanthropic
- Institutional
- Angel - Personal

NIH & NGOs don't typically fund projects aimed at commercialization…

Assets at Three Levels

State

University

Department

Assets at Three Levels

Utah

State

THE UNIVERSITY OF UTAH

University

HEALTH UNIVERSITY OF UTAH

Department

Assets at Three Levels

Utah

State

THE UNIVERSITY OF UTAH

University

HEALTH UNIVERSITY OF UTAH

Department

Seven Economic "Mega" Regions

Parag Khanna, "A New Map for America", *New York Times* (15 April 2016)

A Pro Business Innovation Climate

Forbes

"Best States for Business" 2010 to 2016

#1 Utah – 2010, 2011, 2012, 2014, 2015, 2016
#3 Utah – 2013

Forbes

"Best Places for Business and Careers" 2016

#2 Provo, Utah
#7 Salt Lake City, Utah
#8 Ogden, Utah

Silicon SLOPES UTAH

Forbes Magazine, various issues *2014-2016*

A Pro Business Innovation Climate

U.S. Chamber of Commerce

Entrepreneurial Zeitgeist…

Utah Rankings in 2014 Report:

#1 for "Innovation and Entrepreneurship"
#2 for "High Tech Performance"
#3 for "Overall Economic Performance"

Published Supplemental Report:

"Utah: Collaboration as the Foundation for Growth"

US Chamber of Commerce Foundation: "Enterprising States" Report, 2014

USTAR
Turning innovation into industry.

Utah Governor's Office of Economic Development

State – Public University Partnership

- Initial Funding of $200M in 2006
- Ongoing funding of $20M/year

Assets at Three Levels

Utah
State

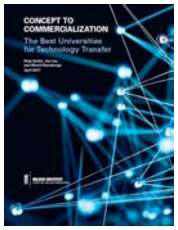
THE UNIVERSITY OF UTAH
University

HEALTH
UNIVERSITY OF UTAH
Department

TECHNOLOGY & VENTURE COMMERCIALIZATION
THE UNIVERSITY OF UTAH
WWW.TVC.UTAH.EDU

THE UNIVERSITY OF UTAH'S

#1 for Commercialization in Milken Institute report, Top 20 for Innovation in Nature Index report



2017

2017

TECHNOLOGY & VENTURE COMMERCIALIZATION
THE UNIVERSITY OF UTAH
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Stage-gated & Milestone-driven Commercialization Process

Go/No Go/Iterate | Go/No Go/Iterate

Technology Commercialization Path

Initial Assessment	Incubate	License and Accelerate
What is it? What is the Opportunity? Can/Should we Protect it?	Validate Value Propositions in the Market Define Milestones	Build the Team Identify Funding Execute on Milestones

Additional Resources

Funding – Grant Writing – Management – Sponsored Research – Facilities – Prototyping

http://www.tvc.utah.edu/tco/engine_process.php

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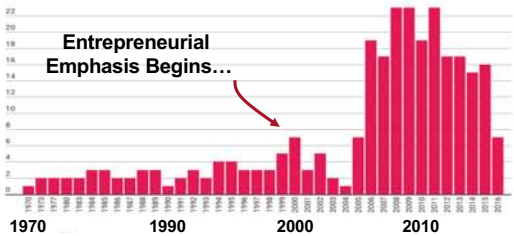
Commercialization Impact

of Startups Since 1970



TECHNOLOGY & VENTURE COMMERCIALIZATION
THE UNIVERSITY OF UTAH
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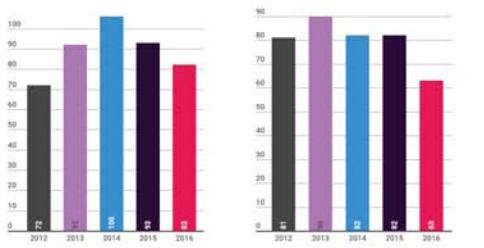
THE UNIVERSITY OF UTAH'S®

Licenses and Issued Patents

Licenses ≈ 90/yr

Issued Patents ≈ 76/yr



TECHNOLOGY & VENTURE COMMERCIALIZATION
THE UNIVERSITY OF UTAH
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THE UNIVERSITY OF UTAH'S®

Commercialization Successes

BIOFIRE™

myriad
WHEN DECISIONS MATTER

ARUP LABORATORIES

LINEAGEN

NPS Pharma.

For more successes see:
http://www.tvc.utah.edu/tco/successes.php

TECHNOLOGY & VENTURE COMMERCIALIZATION
THE UNIVERSITY OF UTAH
WWW.TVC.UTAH.EDU

Competitions

B2B Bench to Bedside

Games 4 Health

THE UTAH ENTREPRENEUR CHALLENGE

PARTNERSHIPS FOR PROPELLING CLINICAL TRANSLATION

Educational Events

LASSONDE ENTREPRENEUR INSTITUTE
THE UNIVERSITY OF UTAH

Mentoring

Entrepreneurial Faculty Scholars
AT THE UNIVERSITY OF UTAH

LASSONDE ENTREPRENEUR INSTITUTE
THE UNIVERSITY OF UTAH

Assets at Three Levels

Utah
State

THE UNIVERSITY OF UTAH
University

HEALTH
UNIVERSITY OF UTAH
Department

History of Innovation

ZARS PHARMA

KORR™ Medical Technologies Inc.

THROUGHTHECHORDS

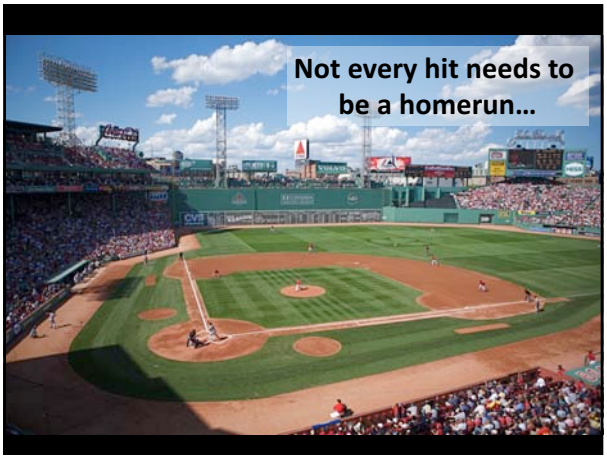
medvis
applied medical visualizations

anecare.

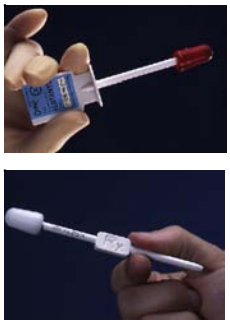
Dynasthetics

REDDYPORT

History of Innovation



ANESTA



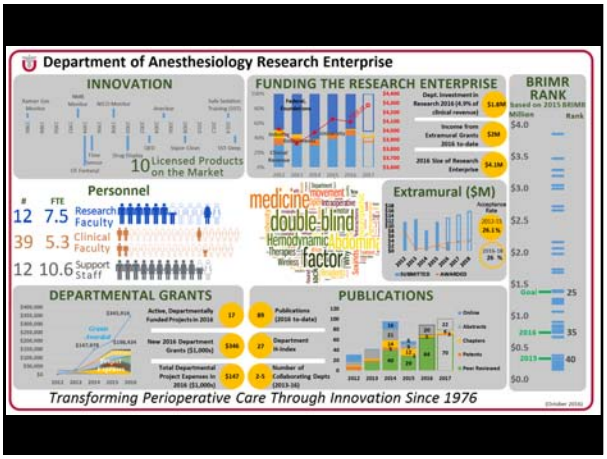
Theodore Henry Stanley

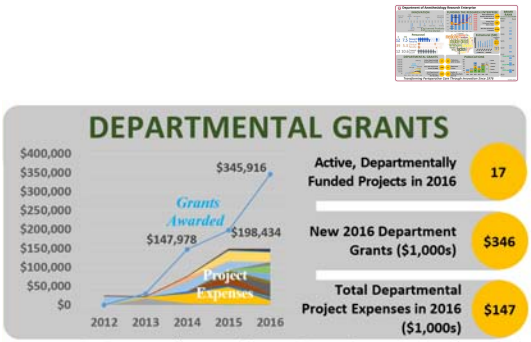
1940 - 2017

Success breeds success!

STANLEY CHAIR
& RESEARCH FUND

- Numerous Endowed Chairs
- Endowed Research Fund
- "Quasi" Endowment Fund





- Integrated Unit
- Graduate Students
- Gadget Knowhow
- Project Management

Division of Bioengineering

Dr. Dwayne Westenskow

Dr. Kai Kuck

Faculty Entrepreneur Profile

Derek Sakata, MD

anecare.

Dynasthetics

It's in their blood!

- Professor in anesthesiology, adjunct in bioengineering
- Engineering background, engineer collaborators, many patents
- Director of ambulatory anesthesia (vice-chair)

Entrepreneurial Project Profile

"Human Powered Oxygen Concentrator"

Unmet Need = Reliable O_2 Source for Infant Pneumonia

Lara Brewer, PhD

- Infant pneumonia common cause of death in poor countries
- Reliable oxygen source estimated to save 500K lives/year
- Example of "extremely affordable" technology for global market

Entrepreneurial Project Profile

"Universal Vital Sign Simulator"

Unmet Need = Vital Sign Emulator for any Monitor

Joe Orr, PhD

SBIR·STTR America's Seed Fund

Dynasthetics

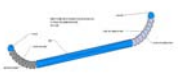
- "In situ" simulation requires use of "native" monitors
- Current technology limited to "non-native" monitor
- Targets burgeoning simulation training market

Entrepreneurial Project Profile

"Airway Management Tools Designed for the Video Laryngoscope"

Unmet Need = Affordable Difficult Airway Management Tools

Sean Runnels, MD



LASSONDE ENTREPRENEUR INSTITUTE THE UNIVERSITY OF UTAH

Utah Governor's Office of Economic Development

CORPS

- Airway tools that fully harness the superior view of VLS
- Cost effective (affordable, easy to master)
- Targets: prehospital, ED, and ICU markets

Outline

Culture is #1!

- Main Challenges of Commercialization
- Assets Required for Success
- Non-Traditional Funding Sources
- University of Utah Model
  - State, University, Department Assets
  - Profile of Anesthesiologist-Entrepreneur
  - Profiles of Entrepreneurial Projects

HANDOUT

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Entrepreneurship in Anesthesiology: Should Anesthesiology Innovators Work Under the University Umbrella or Start Their Own Company and Logistics for Taking the Best Approach

Douglas Eric Raines, MD

11/04/2017
10:50am – 11:10am

SHOULD ANESTHESIOLOGY INNOVATORS WORK UNDER THE UNIVERSITY UMBRELLA OR START THEIR OWN COMPANY?

LOGISTICS FOR TAKING THE RIGHT APPROACH

Douglas Eric Raines, M.D.
Massachusetts General Hospital

CASE STUDY: ANNOVATION BIOPHARMA

- Startup Company I founded in late 2009
- Singular focus: Developing new IV sedative-hypnotic agents
- Based on technology developed in my laboratory and funded by NIH grants (P01 and R01)
- Subsequent commercial funding provided by institutional and external VCs, angel investors, and a strategic partner
- Acquired by the strategic investor in early 2015

ANNOVATION

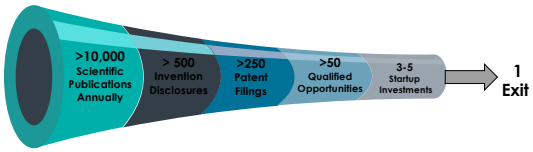
WHY FOUND A STARTUP COMPANY?

- Existing companies wont license it
  - Too risky
  - Unproven market
  - Need to "derisk" the project
- Maintain control of the development process
- Financial upside
- Great learning experience
- Meet new people
- It's really fun!

WHY NOT?

- Time commitment
- Potential financial commitment
- Employ staff (e.g. CEO, project manager, consultants)
- Negotiate for a license agreement with the institution (the existing company will do that)
- Hire attorneys to incorporate the company and distribute company stock
- Raise capital for technology development
- High risk as the large majority of startups fail

PARTNERS HEALTHCARE ANNUAL PIPELINE



Exit = An acquisition or IPO

WHY DO BIOMEDICAL TECHNOLOGY STARTUPS FAIL?

- Weak team, poor leadership
- Inability to raise capital ("failure to launch")
- Poor use of capital
- No exit strategy
- Technology failure

STARTUP 101: HIRING A CEO

- This was the first step because I had a day job and no business experience
- Nick Barker Ph.D.: serial entrepreneur who had previously run a company based on MGH technology
- No upfront salary (future salary contingent on raising capital)
- Stock in the company that would vest over 4 years

STARTUP 101: NEGOTIATING THE LICENSE AGREEMENT WITH MGH

- Although I invented the technology, MGH owns it
- Annovation BioPharma needed to sign a license agreement with MGH to develop and commercialize the technology
- MGH wanted
  - Upfront cash payment
  - Reimbursement for patent costs
  - Equity in the startup
  - Milestone and royalty payments
- Compromise: 1 year option at no cost

STARTUP 101: HIRING A LAW FIRM

- Cooley LLP
  - Headquartered in Palo Alto
  - 12 offices (including Boston)
  - 900 attorneys
  - Annual revenue ~ $1B (but not in 2009!!)
- Agreed to work on a contingency basis

STARTUP 101: RAISING CAPITAL

- **Angel Investors**
  - Individuals or groups of individuals
  - Invest their own money
  - Relatively small investments (typically < $100k/angel)

- **Venture Capital Firms**
  - Companies
  - Raise funds from investors
  - Earn a management fee (plus a share of profits)
  - Larger investments ($1M – >10M)

- **Strategic Partners**
  - Mid-size to large companies
  - Invest with company funds
  - Potential buyer of the start-up

STARTUP 101: RAISING CAPITAL

- **Seed Round: $750,000**
- **Angel Investors**
  - 9 Angel Investors (Mass Medical Angels)
  - $10 – 35k in seed round
- **Venture Capital Firms**
  - Partners Innovation Fund
    - Established in 2008 with $35M from MGH and BWH
    - Currently funded with
      - $100M from MGH and BWH
      - $65M from pharma and other strategic investors
    - Focus: Funding startups based on Partners Healthcare technology
  - Atlas Venture
    - Boston-based VC firm with a focus on biomedical technology

STARTUP 101: RAISING CAPITAL

- UCLA VC fund (UCLA)
- NYU Innovation Venture Fund (NYU)
- BVR –BR Venture Fund (Cornell Univ)
- Simon School Venture Capital Fund (Univ of Rochester)
- Triton Technology Fund (UC, San Diego)
- The Garber Venture Capital Center (Penn State Univ)
- CSU Ventures (Colorado State Univ)
- OSU Venture Fund (Oregon State Univ)
- Innovate Indiana Fund (University of Indiana)
- The Engine (MIT)
- UVA Seed Fund (Univ of VA)

UNIVERSITY VENTURE CAPITAL FUNDS

- Invest in startups based on university technologies
- Provide guidance wrt company formation
- Connect with external venture capital firms
- Demonstrate institutional support for the startup
- Interface with the licensing group
- Answer questions and provide "reality checks" as the process advances

SHOULD ANESTHESIOLOGY INNOVATORS WORK UNDER THE UNIVERSITY UMBRELLA OR START THEIR OWN COMPANY?

LOGISTICS FOR TAKING THE RIGHT APPROACH

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Massachusetts General Hospital

SHOULD ANESTHESIOLOGY INNOVATORS WORK UNDER THE UNIVERSITY UMBRELLA ***AND*** START THEIR OWN COMPANY?

LOGISTICS FOR TAKING THE RIGHT APPROACH

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STARTUP 101: RAISING CAPITAL

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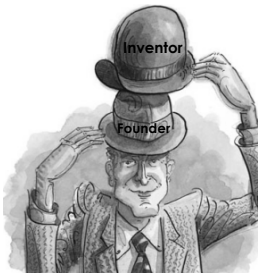
    - Focus: Funding startups based on Partners Healthcare technology
  - Atlas Venture
    - Boston-based VC firm with a focus on biomedical technology

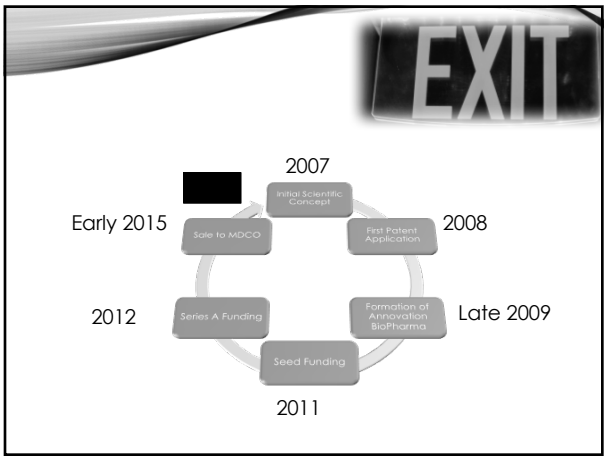
STARTUP 101: RAISING CAPITAL

- **Series A Round: $10,000,000**
- **Angel Investors**
  - 9 Angel Investors
- **Venture Capital Firms**
  - Partners Innovation Fund
  - Atlas Venture
- **Strategic Partner:**
  - The Medicines Company
  - Option to acquire Annovation BioPharma
    - Upfront payment
    - Milestone payments
    - Royalties

TWO HATS

- Inventor and Company Founder
- Stockholder
- Potential conflicts of interest
  - Partners Healthcare
  - Harvard
  - NIH
- Consultant
- Disclosed my conflicts





WHAT DO I TELL PEOPLE?

- You should start a company (under the University umbrella)!
  - Learn a lot
  - Meet new people
  - Have fun
  - Have more control of the development process
  - Opportunity to make more money
  - Even if you fail, it'll make a good story
  - <u>There are a few negatives</u>
    - You'll spend more time (hiring staff, raising capital)
    - Conflicts of interest

HANDOUT

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Funding Sources for Education Research: FAER

James C. Eisenach, MD

11/04/2017
11:20am – 11:35am

Funding education research: FAER

James C. Eisenach, MD
President & CEO

FAER
Foundation for Anesthesia Education and Research

Objectives

- Understand how FAER's mission overlaps with yours
- Review current FAER grants to support research in education
- Partner with FAER to help us transform these offerings

FAER
Foundation for Anesthesia Education and Research

FAER's Mission

To develop the next generation of physician-scientists in anesthesiology

FAER Foundation for Anesthesia Education and Research

To develop the next generation of physician-scientists in anesthesiology

	MRTG	REG
Areas	Basic/Clinical Sci	Education
Why	Develop skills to independence	Improve quality & impact of research
Who	<10 yr from training	Any rank
Time	2 years; **75%** effort	2 years; **40%** effort
$$$	$175,000	$100,000

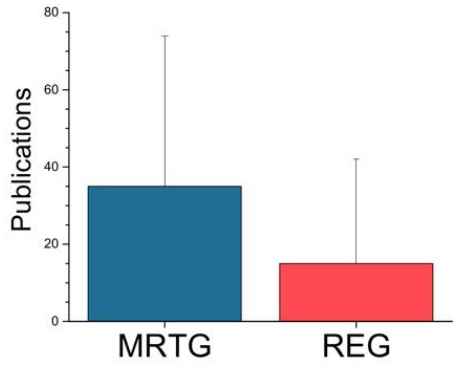
FAER Foundation for Anesthesia Education and Research

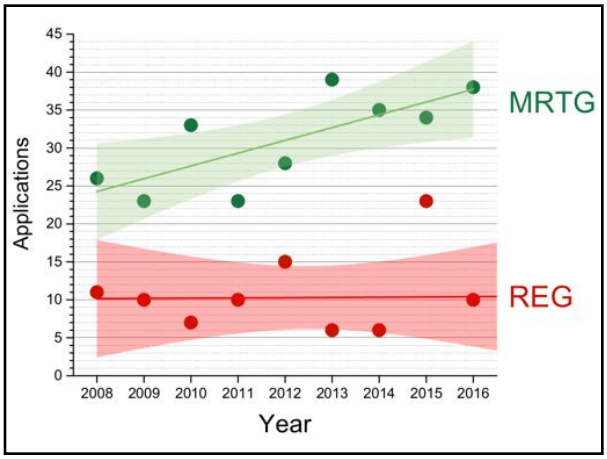
To develop the next generation of physician-scientists in anesthesiology

MRTG	REG
Individual Publication	Project Publication

FAER Foundation for Anesthesia Education and Research

To develop the next generation of physician-scientists in anesthesiology





FAER
Foundation for Anesthesia Education and Research

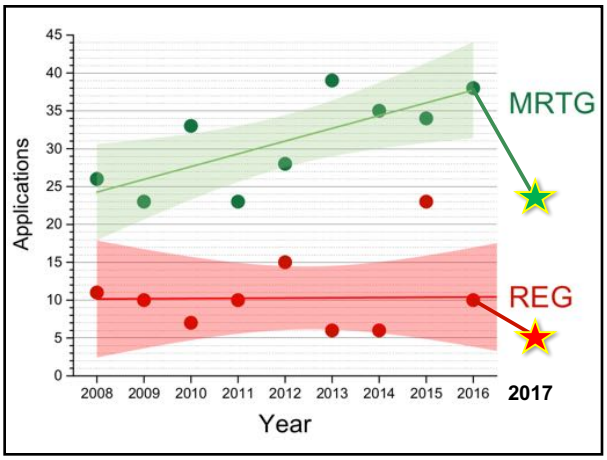
Partnering with FAER to transform these awards

FAER
Foundation for Anesthesia Education and Research

To develop the next generation of physician-scientists in anesthesiology

Research Career	Single Question
Paradigm shifting Generalizable Go far	Direct application Local Go fast

What does this have to do with education?



FAER
Foundation for Anesthesia Education and Research

To develop the next generation of physician-scientists in anesthesiology

tinyurl.com/FAERsurvey

FAER
Foundation for Anesthesia Education and Research

To develop the next generation of physician-scientists in anesthesiology

Partnering

1. *Our missions overlap*
2. *We are eager to know your needs*
3. *Research is central to the specialty*
4. *Careers and projects are important in different ways*

FAER
Foundation for Anesthesia Education and Research

To develop the next generation of physician-scientists in anesthesiology

tinyurl.com/FAERsurvey

HANDOUT

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Funding Sources in Education Research: IARS

Beverley Orser, MD, PhD, FRCPC

11/04/2017
11:35am – 11:50am

Funding Sources for Education Research
IARS

SAAAPM 2017

Beverley A. Orser, MD, PhD, FRCPC, FACH
Chair, Department of Anesthesia
Professor of Anesthesia and Physiology
University of Toronto

IARS
International Anesthesia Research Society

Department of Anesthesia, University of Toronto

Objectives

- IARS mission
- Opportunities for funding education research
- Previous funded project
- Indirect support through educational events
- Discussion

Mission

The IARS mission is to encourage, stimulate, and fund ongoing anesthesia-related research projects that will enhance and advance the specialty, and to disseminate current, state-of-the art, basic and clinical research data in all areas of clinical anesthesia, including perioperative medicine, critical care, and pain management.

IARS
International Anesthesia Research Society

Board Members

Laura E. Niklason, MD, PhD
New Haven, Connecticut

Christian P. Werner, MD
Mainz, Germany

IARS Direct Support of Research

- Frontiers in Anesthesia Research Award
- IARS Mentored Research Awards
- SmartTots Research Funding

Applications are reviewed and selected by panels that are independent of the IARS Board of Trustees.

Evaluations are based on scientific merit and the specific objectives of the funding program.

IARS
International Anesthesia Research Society

Frontiers in Anesthesia Research Award

- $750,000 grant, awarded triennially
- Fosters innovation and creativity by an individual investigator
- Projects must have significant originality, a direct relevance to anesthesiology, and play a critical role in the scientific evolution of a novel concept.
- Applicants must demonstrate commitment to research and the potential for leadership.
- Applications must address one of the following areas of research:
  - Fundamental Neuroscience Unknowns
  - Immune, Inflammatory and Metabolic Consequences of Trauma, Surgery and Critical Care
  - Best Use of Systems-Based Practice to Enhance Patient Safety & Quality

IARS International Anesthesia Research Society

2015 Frontiers in Anesthesia Research Award

Judith Hellman, MD
Professor, Department of Anesthesia and Perioperative Care
Vice Chair for Research, Department of Anesthesia and Perioperative Care
University of California, San Francisco

Endothelial inflammatory pathways in septic vasculopathy and organ injury

IARS International Anesthesia Research Society

Frontiers in Anesthesia Research Award

- Applications for the 2018 Frontiers Award will open on November 13, 2017
- Application deadline is January 31, 2018
- Info and complete guidelines at www.iars.org/awards/fara/

IARS International Anesthesia Research Society

IARS Mentored Research Awards

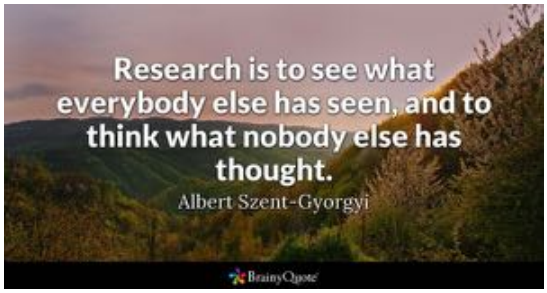
- $175,000 grants, 4 awarded annually
- Support investigations that further the understanding of clinical practice in anesthesiology and related sciences
- Support applicants who have yet to establish substantial independent research funding or who are initiating a new area of research.
- Applications are reviewed on the basis of scientific merit, adequate preliminary data, career potential of the investigator, and a supportive research environment.

IARS International Anesthesia Research Society

2016 SAAA-IARS Research Grant - $150,000

The Society of Academic Anesthesiology Associations (SAAA) provided a one-time contribution of $75,000 to support of research in the area of anesthesiology and perioperative medicine education.

The IARS matched the contribution to create a $150,000 educational grant.



Spencer Foundation (modified)

www.spencer.org

- proposals are expected to be hypothesis-driven, and have a strong research designs and rigorous analytic methods
- give a clear and compelling account of how the research proposed may be significant for educational policy and practice
- conceptual framework to show the research will contribute to understanding in ways that go beyond the study at hand and impact anesthesiology

Spencer Foundation's funding guidelines: No Funding

- Scholarships or studentships
- Curriculum or program development and implementation
- Evaluations of curriculum or programs
- Professional development activities

2016 IARS Mentored Research Awards

Eric Vu, MD, Baylor College of Medicine
Predictive Analytic Tool for Diagnosis of Coronary Allograft Vasculopathy

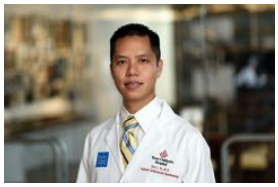
Daniel Mclsaac, M.D., M.P.H., F.R.C.P.C., The Ottawa Hospital Research Institute
A PSH for the Frail Elderly (Phase 3): Prehabilitation of Frail Elderly

Angela Meier, MD, PhD, University of California, San Diego
Anesthesia and Sex Specific, Immune Dependent Impact on Cancer Progression

Wei Zhou, MD, PhD, UC San Francisco Medical Center/UCSF Children's Hospital
The Roles and Applications of Orexin/Hypocretin System in Anesthesia

IARS International Anesthesia Research Society

Predictive Analytic Tool for Diagnosis of Coronary Allograph Vasculopathy



Eric Vu
Baylor College of Medicine, Houston, Texas

Indirect support for Early-Stage Scholars

Scholars Program at IARS Annual Meeting (AUA, SOCCA, IARS, eSAS)

- Co-Sponsored by IARS, AUA, eSAS
- Funded in part by an NIH Conference Grant

IARS International Anesthesia Research Society

NIH-Funded Conference Series:
"Securing the Future of Academic Anesthesiology"

NIH NIGMS

- NIGMS R13 grant to Mashour & Avidan will support multiple conferences for emerging anesthesiology scholars
- Integrate all 15 T32 programs in nanesthesiology
- Inaugural R13-funded event:
  - **2017 IARS / eSAS Scholars' Program**

NIH-Funded Conference Series: Intended audience and goals

NIH NIGMS

Specific Aims

Aim 1: Organize a series of meetings that empower junior academic anesthesiologists to create impact through translational research

Aim 2: Improve mentorship practices ries of meetings and provide broader access to mentors for junior academic anesthesiologists

eSAS early-stage anesthesiology scholars

Early-Stage Anesthesiology Scholars (eSAS) is a nascent community of junior anesthesiologist-scientists who are interested in pursuing academic careers. It is open to all junior faculty, fellows, residents and medical students who identify as "early stage" and who are interested in contributing to the future of our specialty.

http://esashq.org/

2017 IARS Annual Meeting

SAAA Society of Academic Anesthesiology Associations

IARS

FAER Foundation for Anesthesia Education and Research

AUA Association of University Anesthesiologists

eSAS early-stage anesthesiology schola

- Principles of translational research
- Reproducibility across the translational spectrum
- Commercialization, innovation, and entrepreneurship
- Precision medicine
- Diversity in academic anesthesiology programs
- NIH funding
- Mentors and mentees – discussions and feedback

Objectives

- IARS Mission
- IARS sponsored opportunities for supporting education research
- Indirect support through educational events
- Discussion

Thank you

IARS International Anesthesia Research Society

HANDOUT

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Mentoring Faculty Members: Gender Differences are Important

F. Kayser Enneking, MD

11/04/2017
1:00pm – 1:30pm

MENTORING FACULTY: GENDER DIFFERENCES ARE IMPORTANT

F. Kayser Enneking, MD
November 4, 2017

MENTORING FACULTY: GENDER DIFFERENCES ARE IMPORTANT

F. Kayser Enneking, MD
Professor of Anesthesiology, Orthopaedics and Rehabilitation
Interim Chairman of Dermatology

I am important

November 4, 2017

MENTORING FACULTY: GENDER DIFFERENCES ARE IMPORTANT

F. Kayser Enneking, MD
Professor of Anesthesiology, Orthopaedics and Rehabilitation
Interim Chairman of Dermatology

November 4, 2017

Learning Objectives

- Expand your knowledge base regarding gender differences in the workplace
- Develop retention strategies around work family conflict reduction
- Sponsor women to expand their strategic and business acumen to develop leaders
- Provide insights into improving the work environment for all faculty

Its How you Look: What to wear if you want a job??

YES

NO

- Rounded silhouettes
  curved lines
  light colors
- Straight silhouettes
  angular lines
  dark colors

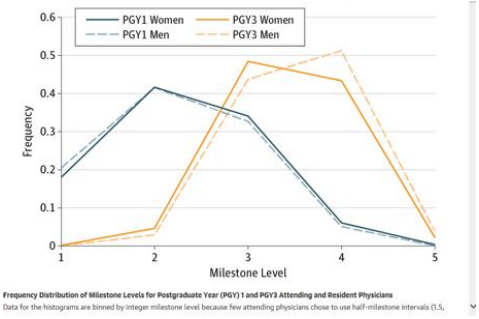
Forsythe J Applied Social Psych 1990

Its How you Act: Body Language

Wonder Woman Pose

Its How you Act: Body language

Gender Differences in >33,000 EM Resident Evaluations



Frequency Distribution of Milestone Levels for Postgraduate Year (PGY) 1 and PGY3 Attending and Resident Physicians

Data for the histograms are binned by integer milestone level because few attending physicians chose to use half-milestone intervals (1.5,

Dayal JAMA Int Med 2016

Its How you communicate: Talking points

Men tend to

- Discuss facts
- Use direct and powerful language
- Use conversation as means of exchanging information
- Hardball negotiators

Women tend to

- Ask questions
- Use indirect language and give fewer directives
- Use conversation as a means of establishing a connection
- Empathetic negotiators

Why do you want to help them?

What is the pay gap between genders?

In 2015, female full-time workers made only **80 cents** for every dollar earned by men, a gender wage gap of 20 percent. Women, on average, earn less than men in virtually every single occupation for which there is sufficient earnings data for both men and women to calculate an earnings ratio.

OCTOBER 26,2017

Journal Article Review

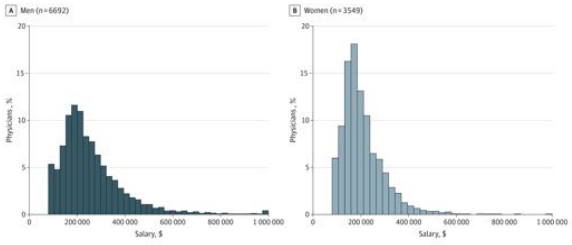
Original Investigation

Sex Differences in Physician Salary in US Public Medical Schools

Anupam B. Jena, MD, PhD; Andrew R. Olenski, BS; Daniel M. Blumenthal, MD, MBA

JAMA Internal Medicine September 2016 vol 176; 1294-1304.

Figure 1. Salary Distribution by Sex in 24 Public Medical Schools

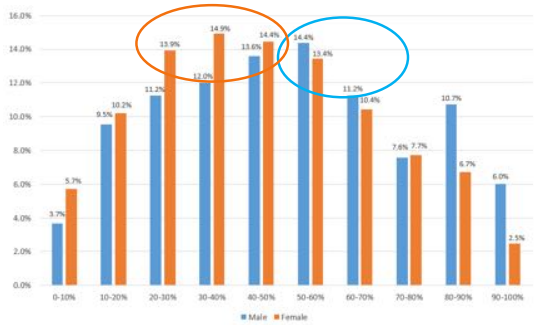


- Female graph skewed leftward toward lower salaries; more women receiving lower salaries

Anupam JAMA Int Med 2016

Percentile Distribution for UF Faculty

By Percent of Gender



AAMC 2015 %ile

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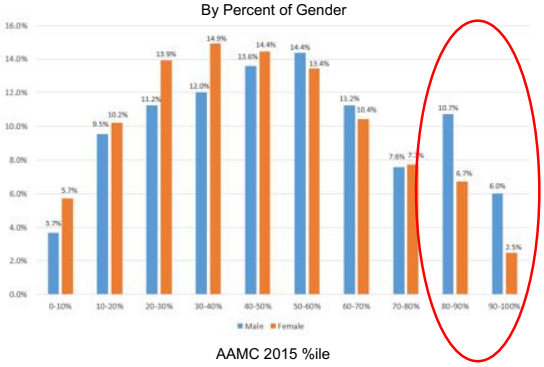

AAMC 2015 %ile

Early career development

1. Start with equal salary for equal work.
2. Develop clear obtainable yearly objectives to work towards promotion
3. Have tissues in your top drawer
4. Don't assign them

to solve world peace

Three ways to improve faculty retention

1. Increase control over work time and schedule
2. Increase supervisor social support
3. Examine organizational culture and job design processes

Kelly Am Sociol Rev 2014
Changing work and work-family conflict: Evidence from the work, family, and health network

Increase control over work time and schedule

- Many ways to accomplish this
  - Buying and selling call
  - Partial FTEs
  - Smaller group scheduling
  - Increase predictability of day end
    - You can do this for ARNPs/PAs/CRNAs why can't you do this for faculty?

Increase supervisor social support

- Listen listen listen listen then listen some more
- DO NOT INTERPUPT THEM
  - In a meeting if an interruption occurs 87% of the time it occurs to a women

SCOTUS "Manterruption"

Jacobi Schweers Time Magazine May 2017

24% Female Justices on SCOTUS
32% interruptions occurred to female Justices
4% interruptions made by female Justices

Female Justices were 3X more likely to be interrupted than male Justices

Increase supervisor social support

- In meetings ask their ideas and validate them

That's an excellent suggestion Miss Triggs.
Perhaps one of the men here would like to make it.

Increase Supervisor social support

Be consistent in how you address your faculty.
If you refer to them all by first name that is OK.
If you refer to them all as Doctor that is OK.
But….
do not call the women by their first name and the men by their title.

> And while female introducers identified male speakers with the title of doctor 95 percent of the time, male introducers only did the same for their female colleagues 49 percent of the time. Male doctors were less formal, in general, but still referred to male colleagues as doctors 72 percent of the time.

Files Journ Women's Health 2017

Increase supervisor social support

- Do not make every interaction factual, information driven,

have a conversation

its how women communicate.

  - Are you enjoying your life?
  - Is your family well?
  - Have you settled into life in _____ ?
  - Is there anything I can help you with?

Increase supervisor social support

- Measure them by their productivity not their face time
  - Who cares if they get stuff done on Thursday at 3 or Sunday at 3
- If they have a .8 appointment do not expect 110% productivity.
- Always encourage production that will lead to promotion
  - Encourage doing academic things on academic time not "volunteering " to do extra clinical work, or things that don't demonstrate leadership or scholarship.

Increase supervisor social support

- Listen listen listen listen then listen some more
- DO NOT INTERPUPT THEM
- In meetings ask their ideas and validate them
- Be consistent in addressing them by name or degree.
- Do not make every interaction factual, information driven, have a conversation.
- Measure their productivity not their face time
- Always encourage production that will lead to promotion
- Remember it is a marathon not a sprint
  - Not retaining a good academician is lose/lose for everyone

Examine organizational culture and job design processes

- Is everyone "encouraged" to pitch in help by "volunteering" to do extra clinical work when the department is short?
  - Is extra work overvalued in your department?
- Is there a " Mommy " track in your department?
  - Is there one in your mind?
- Have you assigned a female faculty member to work on any budget development task?

Examine organizational culture and job design processes

- Institutional Promotion criteria

The gender gap is present in

- ↓ Resident evaluations
- ↓ Attending teaching evaluations
- ↓ Lecture evaluations
- ↓ Professionalism assessment by patients
- ↓ Grant funding, outside visiting professor invitations
- ↑ Rate of unpaid work assignment

The gender gap is present in

- ↓ Resident evaluations
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- ↓ Professi essment by patients
- ↓ Grant fu ng, outside visiting professor invitations
- ↑ Rate of unpaid work assignment

Every way we evaluate for promotion

Issues in promotion for women

- Poor negotiating skills
  - Assignments
- Lack of role models
- Lack of networking/sponsorship

Gender Differences in Negotiations

- Women set less aggressive or aspirational goals
- Women don't ask for as much as men do
- Women don't choose to negotiate in situtations where men do

Prof Leigh Thompson https://m.youtube.com/watch?v=bMWLimhNfTI

Why are there Gender Differences in Negotiations?

- Women believe that assertive behavior will elicit a negative response
- "Women who ask" are not perceived as positively
  - Male evaluators penalize female candidates > male for initiating negotiations*
  - Are seen as less nice and more demanding
  - They are less inclined because they are more nervous going against culture stereotypes

* Women evaluators penalize all candidates for asking

Improving Women's negotiating skills

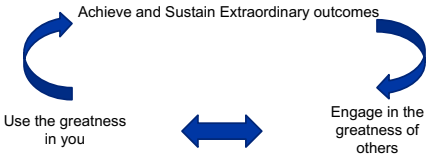
- Acknowledge that you are in a negotiation, don't be ambiguous, and give them permission to ask and aspire
- Have them negotiate on behalf of someone else
- Remind them that negotiating is really a female strength because its about communicating and coming to a Win/Win

Closing the Leadership Gender Gap: Susan Colantuono TedXBeaconStreet

https://www.ted.com/talks/susan colantuono
the career advice you probably didn t get

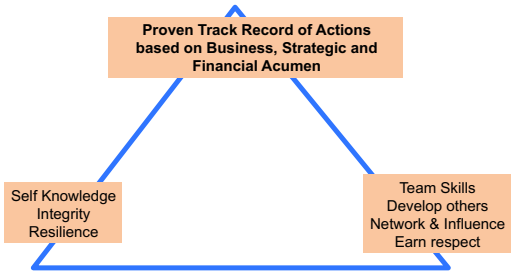
3,443,651 views as of 11/4/17

Moving Women from Middle Management to the Executive Level



Susan Colantuono Closing the leadership gap. Tedx: Beacon Street

Moving Women from Middle Management to the Executive Level



Susan Colantuono Closing the leadership gap. Tedx: Beacon Street

Women are mentored

Men are sponsored

"Success has many fathers, but failure is an orphan.
Before I can promote you, you'll need to take a paternity test."

Sponsorship vs. Mentorship

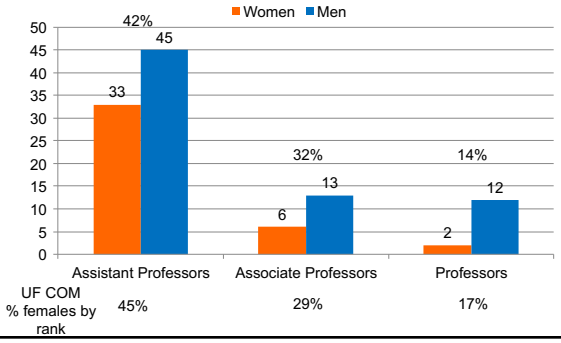
Sponsor	Mentor
▪ Must be senior leader	▪ Leadership position not required
▪ Provide developmental assignments	▪ Provide benevolent advice
▪ Raise profile of sponsee among senior level	▪ Passive role in development
▪ Communicate talent/skill set of sponsee to decision makers	▪ Failure to promote is failure of mentee
▪ Failure to promote is failure of sponsor	

Ibarra 2010 HBR

To reiterate

1. Start with equal salary for equal work.
2. Develop clear obtainable yearly objectives to work towards promotion
3. Have tissues in your top drawer
4. Be wary of gender bias **everywhere**
5. Examine your culture, not the one in your policies, the real culture.
6. Allow them to be “Women who ask”
7. Identify future leaders and develop their strategic thinking, their business understanding and financial acumen.
8. Be a sponsor not a mentor

UF COM Departures 2016-17



HANDOUT

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Value in Anesthesiology: How to Survive in the World of Value

Michael H. Wall, MD, FCCM

11/04/2017
1:30pm – 2:00pm

Value in Anesthesiology: How to Survive in the World of Value?

Michael H Wall, MD, FCCM
JJ Buckley Professor and Chair

University of Minnesota Medical School

University of Minnesota Driven to Discover℠

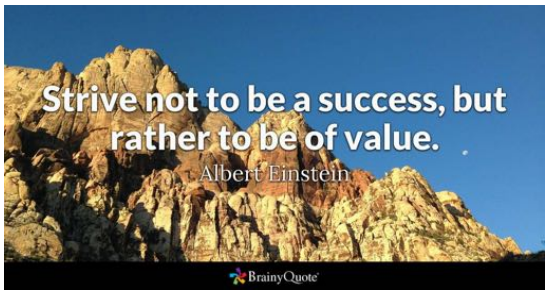
Disclosures

- None

Objectives

- What is value anyway?
- What can anesthesiologists do to increase value?
  - Pre-procedural assessment centers
  - Standardize perioperative care
  - Pain management services
  - Sedation services
  - Critical care

Value



What is Value? (Noun)

- The regard that something is held to deserve; the importance, worth, or usefulness of something.
  - "your support is of great value"
  - The material or monetary worth of something.
    - "prints seldom rise in value"
  - The worth of something compared to the price paid or asked for it.
    - "at $12.50 the book is a **good value**"

Google Dictionary

What is Value? (Noun)

- A person's principles or standards of behavior; one's judgment of what is important in life.
  - "they internalize their parents' rules and values"
- The numerical amount denoted by an algebraic term; a magnitude, quantity, or number.
  - "the mean value of x"

Google Dictionary

What is Value?

- Depends who's asking…
- CMS/IHI
- Hospitals and hospital systems
- Patients
- Surgeons

What is Value? (Institute for Healthcare Improvement)

- Improve and optimize the "Triple Aim"
  - Patient experience
  - Health care costs (i.e. decrease)
  - Population health
- Quadruple aim
  - The work life of healthcare providers including physicians and staff

What is Value for Patients, Hospitals and Physicians ?

- The triple aim applies to all of us…
- Improve and optimize the "Triple Aim"
  - Improve patient experience
  - Health care costs (i.e. decrease)
  - Population health

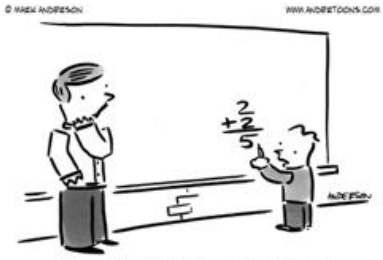
What is Value?

- Improve Patient experience ("Patient centered")
  - Make care more convenient, predictable and timely
  - Decrease pain
  - Decrease nausea and vomiting
  - Do more as out patients
  - If in the hospital, go home sooner and don't come back!!
  - Decrease costs

What is Value?

- Decrease health care costs
  - Decrease length of stay
  - Decrease readmissions
  - Standardize care
  - Improve perioperative processes and systems
- Population health
  - Do all of above (and more) for the population you serve

What Can Anesthesiologists do to Increase Value?



"I prefer to think of it as added value."

Is Anesthesiology Ready for 21st Century

Longnecker Anesth 1997;86;736

- Anesthesiologists must engage in a broader role-
  - Preop evaluation
  - Acute/chronic and cancer pain
  - Critical care
  - Palliative/hospice and home care
- *Should we stay in OR or have a greater commitment to new forms of clinical practice, education and research?*

What Can Anesthesiologists do to Increase Value?

- Pre-procedural assessment centers
- Perioperative care
  - Perioperative surgical home
  - Enhanced recovery
- Pain management services
- Sedation services
- *Critical care services (Topic for another day!)*

Pre-procedural Assessment Centers

"Yes, tobacco counts as a leafy vegetable. But only if you're eating it as a salad."

Pre-procedural assessment centers **1949!?**

- Lee first described the notion of an outpatient PAT clinic in **1949**.....
- However, Lee proposed that:
- *" the patient should rather be seen as soon as the surgeon schedules the patient and the PAT clinic should facilitate the patient arriving in the operating room medically optimized."*

Lee JA. The anaesthetic out-patient clinic. Anaesthesia. 1949;4(4):169–174.

Value of Preop Clinics

- Great Infographic in Anesthesiology
  - Wanderer et al *Anesthesiology* August 2016
- (1996) *Development and effectiveness of an anesthesia preoperative clinic in a teaching hospital.*
  - Fischer et al Anesthesiology 1996, 196-206
  - First to show reduction in testing and case cancelations

Wanderer et al Anesthesiology August 2016

Value of Preop Clinics

- (1998) *Anaesthesia preadmission assessment: A new approach through use of a screening questionnaire.*
  - Badner et al CJA, 1998, 87-92
  - First to describe a tool to screen pts who do NOT need to be seen

Wanderer et al Anesthesiology August 2016

Value of Preop Clinics

- (2002) *How preoperative assessment programs can be justified financially to hospital administrators.*
  - Gibby et al Int Anesth Clin 2002, 17-30
  - Great template to use when talking with your hospital

Wanderer et al Anesthesiology August 2016

Value of Preop Clinics

- *Preoperative Evaluation Clinic Visit Is Associated with Decreased Risk of In-hospital Postoperative Mortality*
  - Blitz et al, Anesthesiology 2016; 125:280-94
- A retrospective review.
- 46 deaths from 64,418 patients (0.07%):
  - 22 from 35,535 patients (0.06%) seen in PEC and 24 from 28,883 patients (0.08%) not seen in PEC.

Value of Preop Clinics

- **Results:** A visit to PEC was associated with a reduction in mortality (odds ratio, 0.48; 95% CI, 0.22 to 0.96, *P* = 0.04
  - sub analysis suggested that the proportion of deaths attributable to an unanticipated surgical complication was not significantly different between the two groups (*P* = 0.141).
- **Conclusions:** An in-person assessment at the PEC was associated with a reduction in in-hospital mortality.

Blitz et al, Anesthesiology 2016; 125:280-94

Value of Preop Clinics

- Other opportunities
  - Medication reconciliation
  - Pain management consults
  - Nutrition
  - Frailty assessments
  - "prehabilitation"
  - Pulmonary prehabilitation
  - Discharge planning, social work, etc.
  - Smoking cessation
  - Anemia evaluation and treatment

Value of Perioperative Management

Enhanced recovery after surgery in the setting of the perioperative surgical home

Paiste et al, Int Anesth Clinics 2017, 135-137

- ERAS
  - "evidence-based, fast tracked-approach to surgery…relies upon perioperative protocols to attenuate the stress response during the entire perioperative period…early and optimal recovery"

Enhanced recovery after surgery in the setting of the perioperative surgical home

Paiste et al, Int Anesth Clinics 2017, 135-137

- PSH
  - *"Physician-championed, institution –supported, well coordinated, patient centered, interdisciplinary model of care"*
  - 3 keys:
    - Entire episode of care
    - Patient-clinician shared decision making
    - Patient centered

Value of Perioperative Management

- *ERAS*
  - 1995-early recovery after lap colon surgery
  - Multiple studies have shown
    - Decrease in LOS
    - Decreased complications
    - Earlier return to work
    - Improved self reported quality of life
  - (Excellent review on how to actually do this)

Paiste et al, Int Anesth Clinics 2017, 135-137

A case management report: a collaborative perioperative surgical home paradigm and the reduction of total joint arthroplasty readmissions

Alem et al Perioperative Medicine 2016, 5:27

- 2 year follow up after implementation of PSH
  - 328 elective TJA
    - 72% ASA 3

Group4.6%	30d-Readmit %	95% CI	P-value
Pts after PSH	2.1	0.4-3.8	
Meta-analysis (9 trials)	5.5	4.5-6.7	0.014
Medicare estimate	4.6		

The perioperative surgical home: improving the value and quality of care in total joint replacement.

Chimento et al, Curr Rev Muskskel Med 2017, 365-369

- Several studies have shown:
  - Improved preop discharge planning
  - Improved analgesia
  - Improved OR efficiency
  - Decreased LOS
  - Decreased costs

The perioperative surgical home: improving the value and quality of care in total joint replacement.

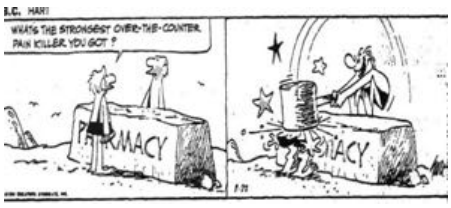
Chimento et al, Curr Rev Muskskel Med 2017, 365-369

- *"The PSH pathway is a safe and effective method of providing value based care to patients undergoing hip and knee arthroplasty"*

Value of Perioperative Management

- *Evolving healthcare delivery paradigms and optimization of "value" in anesthesiology*
  - Alem and Kain, Cur Opin in Anesth 2016, 223-229
  - Comprehensive review and bibliography of this topic
- *"..the scope of anesthesiology education and clinical practice should diversify to further integrate perioperative care of surgical patients"*

Value of Pain Management



Value of Pain Management

- Great Infographic in Anesth Analg
  - Wanderer et al *Anesth Analg* October 2017
- Optimize the triple aim!
- Chronic post-surgical pain (CPSP)
  - $638 Billion/yr in US
  - Incidence 10-80%
  - Risk factors
    - Preop pain, anxiety, depression, catastrophizing

Wanderer et al *Anesth Analg* October 2017

Value of Pain Management

- Value of a periop pain service:
  - Identify at risk patients
  - Reduce variability in treatment of pain
  - Integrate ALL periop care

Wanderer et al *Anesth Analg* October 2017

The perioperative surgical home: a new role for the acute pain service

Zaccagnino Anesth Analg 2017, 1394-1402

- Current perioperative pain management is fragmented
- Anesthesiologist led PPS take lead in reducing the opioid epidemic
- The authors propose
  - Preoperative assessment and risk stratification
  - Standardized intra AND post op protocols
  - Post discharge planning
    - ?Started preop for highest risk

The perioperative surgical home: a new role for the acute pain service

Zaccagnino Anesth Analg 2017, 1394-1402

- How do you pay for it?
- Leverage existing Preop clinic and pain services
- The authors (Brigham and Women's)
  - Billed for preop pts at risk for CPSP
  - Billed for in-hospital rounding
  - Billed for coordinating discharge plans
  - Billed for follow up (pain) visit

Opioid-free analgesia in the era of ERAS and the PSH: Implications for population health

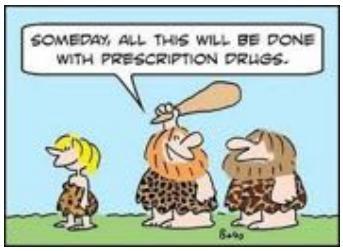
Kamdar Anesth Analg 2017, 1089-1091

- Opioid overdose leading cause of accidental death….19,000 cases a year in US
  - Perioperative physicians responsible for some
- Opioid sparing or opioid-free analgesia should become a key part of PSH/ERAS

Opioid-free analgesia in the era of ERAS and the PSH: Implications for population health
Kamdar Anesth Analg 2017, 1089-1091

- *"A unified voice from anesthesiologists and surgeons…to commit to OFA, beginning with ERAS protocols…will demonstrate that our specialty is addressing national public health epidemics…"*

Value of Sedation Services



Growth in an Anesthesiologist- and Nurse Anesthetist-Supervised Sedation Nurse Program Using Propofol and Dexmedetomidine
Thomas et al A & A Case Reports 402-10, 2016

- 2008-propofol and dexmedetomidine administration by nurses was approved in Iowa
- 11,038 elective sedation cases done between January 1, 2007, and June 30, 2014.
- Caseload increased from 170 to 470 cases/quarter.
- Propofol use increased from 0% to approximately equal to 70% of cases
- Dexmedetomidine from 0% to approximately equal to 25% of cases.

Growth in an Anesthesiologist- and Nurse Anesthetist-Supervised Sedation Nurse Program Using Propofol and Dexmedetomidine
Thomas et al A & A Case Reports 402-10, 2016

- The number of nurses working each day (on average) increased from 2.2 to 4.7
- Supervising providers remained at 1/day.
- There were no changes in general anesthesia or monitored anesthesia care cases performed for comparable procedures.
- Trained, supervised nurses can safely administer propofol or dexmedetomidine to selected patients for a wide variety of procedures.

Value of sedation services

- SCAI/CCAS/SPA Expert Consensus Statement for Anesthesia and Sedation Practice: Recommendations for Patients Undergoing Diagnostic and Therapeutic Procedures in the Pediatric and Congenital Cardia Catheterization Laboratory
  - Odegard et al. Anesth and Analg 2016, 1201

SCAI/CCAS/SPA Expert Consensus Statement

- Provider expertise needed
- CRISP score 0-1
  - Sedation team (non-anesthesiologist)
- CRISP score 2-4
  - Anesthesiologist with expertise in CHD
- CRISP score >4
  - Pediatric cardiac anesthesiologist

Odegard et al. Anesth and Analg 2016, 1201

What Can Anesthesiologists do to Increase Value?

We can (and are) doing a lot!

- Pre-procedural assessment centers
- Perioperative care
  - Perioperative surgical home
  - Enhanced recovery
- Pain management services
- Sedation services
- *Critical care services (Topic for another day!)*

HANDOUT

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Finding the Best Fellowship Applicants Debate: Required Documentation for Fellowship Applicants

Michael L. Ault, MD, FCCP, FCCM
Christopher E. Swide, MD

11/04/2017
2:00pm – 2:30pm

Northwestern Medicine

Disclosures:
No Financial Disclosures
No Grants, Patents, or Industry Support
No Conflicts of Interest

Objectives:
Review the data available for applicant assessment
Debate the pro/con of maximal information

Northwestern Approach

Central Application Service (SF Match)
- USMLE Scores
- Letters of Recommendation

Supplemental Application (NUFSM)
- ITE Scores
- AOA Designation
- Medical Student Performance Evaluation (MSPE)
- Residency Performance Evaluation

Multi-faculty Interview

Northwestern Medicine

Available Data for Cognitive Indicators

- USMLE Scores
  - Cognitive performance correlation but negative correlation with manual dexterity (*Wood et al, Invest Radiol, 1990)*
  - Correlates with ITE scores but not with faculty evaluations (*Bell et al, Am J Obstet Gynecol, 2002*)
  - Correlates with selection committee scores *(Metro et al, Anesth Analg 2005)*
    - Halo Effect?
  - USMLE Step 1 but not Step 2 correlates with faculty resident performance evaluations *(Bhat et al, J Emerg Med, 2015)*
  - Negative correlation b/t high scores & perform *(Neely et al, JGME, 2010)*

Northwestern Medicine

Available Data for Cognitive Indicators

- ITE Scores
  - Correlation with board certification
- AOA Designation
  - Correlation with 1st attempt at board certification *(Shellito et al, Am J Surg, 2010)*
  - Correlation with resident performance *(Daly et al, J Am Coll Surg, 2006)*

Northwestern Medicine

Available Data for Performance Predictions

- Medical Student Performance Evaluation
  - Medical school ranking best predictor *(Neely et al, JGME, 2010)*
  - Student class rank second best predictor *(Neely et al, JGME, 2010)*
  - Specialty rotation performance *(Bhat et al, J Emerg Med, 2015)*
- Letters of Recommendation
  - PD's feel they are important *(Love et al, Acad Emerg Med, 2014)*
  - No correlation with performance *(Bhat et al, J Emerg Med, 2015)*

Northwestern Medicine

Available Data for Performance Predictions

- Interviews
  - PD's feel they are important
  - Standardized interviews greater interrater reliability
    - Not shown to be better predictor of performance *(Bandiera et al, Acad Emerg Med, 2004; Blouin et al, JGME, 2011)*

Northwestern Medicine

Mathematical Modeling for Performance Predictions

[4 x school rank (1-5)] + [0.2 x overall rank (10-90%tile)] + 0.05 x medicine rank (10-90%tile)] + board score number (>250=1, >240=2, >230=3, >220=4, >200=5)

A student from a 2nd tier school with an overall rank of 20%tile, a medicine grade of 40%tile and a board score of 235

8 + 4 + 2 + 3 = 17 (Most applicants b/t 10 & 25)

(Neely et al, JGME, 2010)

Northwestern Medicine

Pro/Con Debate

Northwestern Medicine

The Program Director's Perspective

Christopher E. Swide, M.D.
Department of Anesthesiology & Perioperative Medicine
Oregon Health & Science University

Why did I become Interested in this topic?

Role of ITE

Confidentiality of CCC process

Role of residency program
advocate or objective evaluator??

Validated predictors of Fellowship success?

THE AMERICAN BOARD OF ANESTHESIOLOGY, INC.
A MEMBER BOARD OF THE AMERICAN BOARD OF MEDICAL SPECIALTIES
Advancing the Highest Standards of the Practice of Anesthesiology

SENT VIA EMAIL
February 16, 2017

ABA ID: 3583-0310

Christopher Swide, M.D.
Oregon Health & Science University
6431 SW Dolph Drive
Portland, OR 97219-4947

Dear Dr. Swide:

Thank you for your February 9 email expressing your concerns about the growing trend among fellowship programs asking that residents provide their ITE scores as part of their fellowship application processes. We know that many other core program directors share your concern and the ABA does as well.

The issue has been brought to our attention in the last several years during our meetings with the core program directors. We have told all our program directors – core and subspecialty – that the ITE is intended only as a measure of the resident's increasing command of the anesthesiology residency curriculum over the 4-year period of residency training and its use as an appropriate marker of likely future success in fellowship training has never been validated; therefore, ITE scores should never be part of the fellowship admissions decision making process. But clearly, the practice continues.

We have passed your email on to the ABA's Assessments Committee and they will discuss what further steps the ABA can and should take to discourage the practice and reinforce this message among all the stakeholders involved, including core and subspecialty program directors, as well as fellowship applicants. The Assessments Committee next meets on April 21. I will follow up with you about their discussions after that.

Sincerely,

Deborah J. Culley, M.D.
Secretary

4208 Six Forks Road, Suite 1500, Raleigh, NC 27609-5765 | Phone: (866) 999-7501 | Fax: (866) 999-7503 | www.theABA.org

So what should fellowship programs receive ?

Milestones?

LORs?

Maybe a "MSPE" written by the PD or CCC chair?

Performance Summary for Fellowship Applicants

The evaluation and assessment process for resident advancement at OHSU is robust involving multiple raters, confidential evaluation tools, and a quarterly review and assessment by the Clinical Competency Committee. The process is both formative and summative and is designed to provide a complete evaluation of each resident. The program does not release individual faculty comments or individual evaluations to fellowship programs to maintain the confidentiality and educational value of our evaluation processes. Information utilized in preparing this form represents a composite of performance evaluations submitted by Attending Physicians during the training period and includes comments from the Program Director. This evaluation covers all aspects of the resident's training experience through the dates specified below.

NAME: RESIDENT NAME DOB: XX/XX/XXXX

DATES OF RESIDENCY TRAINING:

RESIDENCY PROGRAM EVALUATION	Satisfactory	Unsatisfactory
Patient Care	X	
Medical Knowledge	X	
Practice-Based Learning and Improvement	X	
Interpersonal and Communication Skills	X	
Professionalism	X	
Systems-Based Practice	X	

COMMENTS:

RECOMMENDATION
Without Reservation With Reservation (see comments) Do Not Recommend

No definitive answers but lots of questions!!

Finding the best fellowship applicants
Required Documentation for Fellowship applicants

Christopher E. Swide, MD

1. Define the criteria that define a “perfect” fellow and how programs can identify these qualities in applicants. Are these criteria validated?

2. Discuss the role of the ITE as a formative tool in anesthesiology training. Discuss the opinion of the American Board of Anesthesiology in using the ITE as an “admissions” examination.

3. Discuss the need to maintain confidentiality in the processes of Clinical Competency Committees vs the needs of fellowship programs to get “accurate” data.

4. Assess the role of ACGME Milestones for fellowship admissions.

5. Compare Letters of Recommendations vs a “Global” standardized Program Director Assessment for fellowship training.

6. What is the role of the residency program? Resident advocate vs “impartial and objective” evaluator of suitability for post residency training.

HANDOUT

AAPAE
ASSOCIATION OF ANESTHESIOLOGY PROGRAM ADMINISTRATORS AND EDUCATORS

ABA Updates and Q&A

James P. Rathmell, MD

11/04/2017
9:45am – 10:15am

The American Board of Anesthesiology

PROGRAM COORDINATOR UPDATE

SOCIETY OF ACADEMIC ANESTHESIOLOGY ASSOCIATIONS

JAMES P. RATHMELL, M.D.
Director, American Board of Anesthesiology

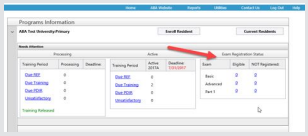
Brigham and Women's Hospital
Boston

DISCUSSION OVERVIEW

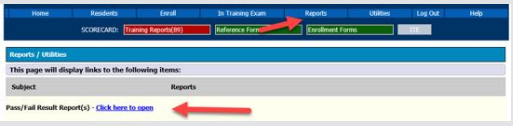
- RTID Features
- CCC Reports
- In-Training Exam
- BASIC Exam Date Assignments
- Board Communications

RTID FEATURES

- Track BASIC & ADVANCED Exam registration status

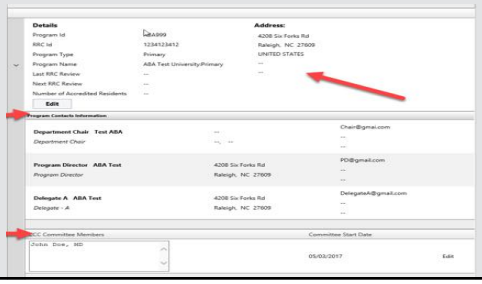


- View Part 1 & ADVANCED Exam Pass/Fail Results in Reports section



RTID FEATURES

- Review contact information for your program
- Change CCC Committee Members



RTID FEATURES

- Use the resident listing in RTID to identify residents who have not created an ABA portal account
  - Residents with an asterisk (*) beside their name have not created a portal account and need to do so immediately
  - We are launching a new RTID report soon that will list all of your residents who have not created a portal account

CCC REPORTS

- Programs should complete Certificate of Clinical Competency (CCC) Reports every six months (**Jan. 31** and **July 31**).
- Reports must include:
  - Seven essential attributes
  - BASIC Exam question (automatically displays exam result when programs select the default option)
  - Overall performance
  - Description for unsatisfactory grade

CCC REPORTS

- Required for each resident who has spent any portion of six-month reporting period in training
- Complete CCC Reports at the end of each reporting period
- If you validate CCC reports for residents taking the BASIC Exam before getting their results, your reports may reflect an incorrect overall grade for those who failed

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CCC REPORTS

- Final CCC report for graduating residents/fellows must:
  - Be approved by residency program director and CCC Chair before Program Director Reference Form (PDIR) can be approved
  - Answer the question "Will Continue?" with "No-Graduating" to remove the resident or fellow from the training roster

8

IN-TRAINING EXAMINATION

- Next exam will be administered Thursday, Feb. 15 – Tuesday, Feb. 20
- Registration is available Nov. 1 – Dec. 14 for $100 per resident
- Late registration is available Dec. 15 – Jan. 4 for $150 per resident
- ITE results are emailed to program directors in early April

9

BASIC EXAM DATE ASSIGNMENTS

- BASIC Exam dates assigned based on last number in resident's ABA ID number
- Reasons for permitting a date change:
  - Medical accommodations
  - Military responsibility
  - Religious observance

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BASIC EXAM DATE ASSIGNMENTS

Year	BASIC Exam	Last Number in ABAID	Date Assignment
2017	November	Odd	Second day
2017	November	Even	First day
2018	June	Odd	Second day
2018	June	Even	First day
2018	November	Odd	First day
2018	November	Even	Second day
2019	June	Odd	First day
2019	June	Even	Second day
2019	November	Odd	Second day
2019	November	Even	First day

Date assignment listing located in RTID Help tab

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ABA COMMUNICATIONS

- Residents should add their personal email address to their portal account to ensure they receive all ABA communications
  - We want to stay in contact after they graduate
  - Institutional servers may block mass communications
- Residents should also keep their mailing address up-to-date in their portal
  - All exam result letters are mailed, except for ITE result letters

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ABA
The American Board of
Anesthesiology
QUESTIONS?
COMMUNICATIONS CENTER
Phone: (866) 999-7501
Fax: (866) 999-7503
Email: coms@theABA.org
MAIL CORRESPONDENCE
ABA Secretary
4208 Six Forks Rd, Suite 1500
Raleigh, NC 27609-5765
FOLLOW US:

HANDOUT

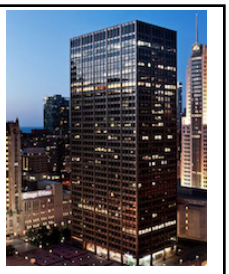
AAPAE
ASSOCIATION OF ANESTHESIOLOGY PROGRAM ADMINISTRATORS AND EDUCATORS

ACGME Updates and Q&A

Anne Gravel Sullivan, PhD

11/04/2017
10:15am – 11:15am

Anesthesiology RC Update



Anne Gravel Sullivan, PhD

Executive Director, Anesthesiology Review Committee

Disclosures

Dr. Gravel Sullivan works for the ACGME

Objectives

- Introduce new RC members
- Update on New and Osteopathic Programs
- Pain Medicine Program Requirement Revision Timeline
- Core Anesthesiology Program Requirement Revisions (proposed)
- Review ACGME and RC Initiatives in 2018
- Answer questions

New RC Members

Manuel Vallejo, Jr., MD (2018)
DIO, Dept. of Obstetric Anesthesiology
West Virginia University

Anne Marie McKenzie-Brown, MD, (2018)
Associate Professor, Dept. of Anesthesiology
Director, Division of Pain Management and Pain Center
Emory University

New Programs in 2017

Core Residencies	9
Adult Cardiac	3
Critical Care Anesthesiology	2
OB Anesthesiology	1
Pain Medicine	2
Regional Anesthesiology	12
TOTAL	**31**

Osteopathic Programs

Residencies

- 10 of 13 AOA Anesthesiology Programs on Initial Accreditation
- One merged with existing ACGME-accredited program
- 1 on Continued Pre-Accreditation
- 1 not applying

Pain Medicine fellowships applying

Fellows, faculty may be boarded by AOBA or Osteopathic Conjoint Pain Medicine Examination Committee

Multidisciplinary Pain Medicine PR Revision

Proposed Requirements posted for Review & Comment……TBD (late 2017)

Review & Comment ends……TBD

Committee on Requirements review…..March 2, 2018

Effective Date (tentative)…..……July 1, 2018

Anesthesiology Core PR Revision

Proposed Requirements posted for Review & Comment……TBD

Committee on Requirement review……March 2, 2018

Anticipated Effective Date……July 1, 2018

Anesthesiology Core PR Revision

IV.A.5.a).(2).(m) patients undergoing a variety of diagnostic or therapeutic procedures outside the surgical suite. This must include: (Outcome)

IV.A.5.a).(2).(n) use of surface ultrasound, and transesophageal and transthoracic echocardiography to guide the performance of invasive procedures and to evaluate organ function and pathology as related to anesthesia and critical care, and resuscitation

IV.A.5.a).(2).(n).(i) Must understand the principles of ultrasound including: the physics of ultrasound transmission, ultrasound transducer construction and transducer selection for specific applications; be able to obtain images with with an understanding of limitations and artifacts.

Anesthesiology Core PR Revision

IV.A.5.a).(2).(n).(ii) Be able to obtain standard views of the heart and inferior vena cava with transthoracic echocardiography allowing the evaluation of myocardial function, estimation of central venous pressure, and gross pericardial/cardiac pathology (e.g. large pericardial effusion)

IV.A.5.a).(2).(n).(iii) Be able to obtain standard views of the heart with transesophageal echocardiography allowing the evaluation of myocardial function and gross pericardial/cardiac pathology (e.g. large pericardial effusion)

IV.A.5.a).(2).(n).(iv) Be able to use transthoracic ultrasound for the detection of pneumothorax and pleural effusion

IV.A.5.a).(2).(n).(v) Be able to use surface ultrasound to guide vascular access (both central and peripheral) and to guide regional anesthesia procedures.

IV.A.5.a).(2).(n).(vi) Be able to describe techniques, views, and findings in standard language.

Anesthesiology Core PR Revision

IV.A.5.b).(1).(a).(vi) healthcare finance, legislative and regulatory issues; and, (Outcome)

IV.A.5.b).(1).(b) management skills to include basic knowledge of organizational culture, decision making, change management, conflict resolution, and negotiation and advocacy.(Outcome)

IV.A.5.b).(1).(c) knowledge of the care of the patient in the continuum of the perioperative period, including collaboration with medical and surgical colleagues to:

IV.A.5.b).(1).(c).(i) optimize preoperative patient condition. (Outcome)

IV.A.5.b).(1).(c).(ii) optimize recovery. (Outcome)

Core Program Board Pass Rate

- Basic Exam not included in program Board Pass Rate
- Calculation will be made by graduation rather than calendar year

Academic Calendar

Other RC Activities

- Implementation of Final Adult Cardiac Case Logs (required as of 7/1/2017)
- Revision of Core Requirement FAQs
- Changes to Pediatric Anesthesiology Case Logs

Updates to Pediatric Case Log Classifications

Proposed RC Changes:

- Specific locations of peripheral nerve blocks and catheters (upper or lower) added
- Blood transfusion patients will be tracked
- Number of CVCs dropped to 6

ACGME Initiatives

- CPR Revision Task Force
  - Section VI implemented July 1, 2017*
  - Other Sections currently under revision
- Program Coordinator Advisory Council
  - Third meeting Sept 2017
  - Coordinator Position Description and Manual
- New Educational resources available through Distance Learning in ACGME's Bridge LMS (www.tiny.cc/acgme)

RC Presentations & Outreach

- Annual Education Conference - March 2018
- American Osteopathic Colleges of Anesthesiology Meetings - March & September 2018
- New Program Coordinator Workshop - August 2018

Questions?

Anne Gravel Sullivan, PhD
Executive Director, RC for Anesthesiology
Director of Distance Learning
(312) 755-7032
asullivan@acgme.org

Gladys Banfor
Accreditation Administrator
(312) 755-5493
gbanfor@acgme.org

HANDOUT

AAPAE
ASSOCIATION OF ANESTHESIOLOGY PROGRAM ADMINISTRATORS AND EDUCATORS

Partnering with Your GME Office

Ann M. Baker
Jennifer T. Kuttenberg, BA

11/04/2017
10:45am – 11:15am

Partnering with your GME Department to Improve Your Program

Jenny Kuttenberg & Ann Baker
Loyola University Medical Center

Speakers

Jennifer Kuttenberg, BA
Residency/Fellowship Coordinator
Anesthesia Residency, Pain Medicine Fellowship, CT Fellowship
Department of Anesthesiology
Loyola University Medical Center

Ann M. Baker, BA
Institutional Coordinator for Surgical & Hospital-Based Programs
GME Office
Loyola University Medical Center

We have nothing to disclose

Presentation Objectives

- Demonstrate productive relationship between specialty programs and institutional GME office
- Identify programs & processes which the institutional GME office performs for all residency/fellowship programs to cut down on repetitive procedures done by individual programs

Loyola University Medical Center
Residency/Fellowship Community
www.loyolamedicine.org/gme

- 613 trainees in 23 resident programs & 36 fellow programs
- Our trainees represent 37 different countries with 35 holding some type of visa
- There are 28 GME program coordinators at Loyola, many covering multiple residency and fellowship programs

GME Staff

- **Greg Ozark, MD**
- Vice President for Graduate Medical Education & Assistant Dean
- **Anne Hartford, MBA**
  Designated Institutional Official & Administrative Director
- **E. Kelly Quinn**
  Administrative Secretary
- **Terry Leppellere**
  Data Analyst, Sr.
- **Jory Eaton, MBA, C-TAGME**
  Operations Manager for Graduate Medical Education
- **Ann Baker**
  Institutional Coordinator for Surgical & Hospital Based Programs
- **Kathy Vandlik**
  Institutional Coordinator for Medical Specialties

GME Sponsored Training, Resources and Support for Coordinators

Coordinator Training

- Professional Development Series for Coordinators
  - Meets monthly following GMEC
    - Topics discussed at GMEC are shared with coordinators
  - Topics vary by month and include:
    - Onboarding/Off-boarding, J-1 VISA sponsorship, Interview Season Do's and Don'ts, Privileging, etc.
  - Holiday lunch and annual "We Survived Onboarding" Celebration
- Quarterly New Innovations Drop-In Sessions for personalized program support and help with special projects
- High-Yield training sessions for licensure and ERAS
- 2-Week new coordinator boot camp with all members of GME staff
- AHME/ERAS/New Innovations webinars available to all coordinators

Coordinator Resources

- Password protected Program Director/Coordinator website with resource material, slides from Professional Development
- Standard tools for coordinators including monthly GME calendar and Coordinator Handbook
- Centralized onboarding of all newly matched trainees in the Spring, utilizing online checklists
- Ongoing institutional compliance reporting (flu shot, BLS/ACLS, etc.)

Coordinator and Program Development and Support

- Annual program reviews and WebAD reviews
- Annual Program Director/Coordinator institution-wide retreat with national speakers on timely topics
- Support for programs struggling with resident wellness, faculty engagement, accreditation issues
- Host conferences (CAMEG and AHME)
- Encourage programs to support coordinator attendance at specialty conferences, including ACGME and AHME

GME Sponsored Committees for Program Directors and Associate Program Directors

Monthly GMEC Committee Meetings include:

- Program Directors
- Resident representatives
- Coordinator representative
- GME staff

GMEC Subcommittees include:

- Resident Resiliency and Burnout
- Residents as Teachers Curriculum
- GME Dashboard Creation and Development
- Housestaff Handbook Committee
- GME Resource Allocation

Program Coordinators: Contact with your GME Office

- How much contact do you have with your GME office? Weekly, Daily, Monthly?
- Is the contact enough, too much?
- What kind of programs/meetings do they offer to you?
- What would you like to see offered from your GME office?

Any GME staff in the audience?

- What do you do with/for your institutional programs?
- What would like to do for/with your institutional programs
- Do you receive the support of your institutional management for your programs?

Thanks for listening

HANDOUT

AAPAE
ASSOCIATION OF ANESTHESIOLOGY PROGRAM ADMINISTRATORS AND EDUCATORS

Partnering with Your Program Evaluation Committee to Ensure a Robust Program Review

Christopher Zell, MS

11/04/2017
11:15am – 11:45am

I have no financial disclosures to report.

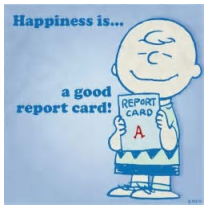
Upon completion of this learning activity, participants should be able to:

1. compile and produce the necessary data for the PEC meeting;
2. produce an outline to document the discussed education components and action items;
3. and develop a more active role in the PEC annua review process.

Why should there be an annual program evaluation?

Just like a **report card**, the PEC will assess what your program is doing well and where it needs to improve.

- ❑ Report on the four components dictated by the ACGME common program requirements:
  - ✓Graduation Performance
    - A-
  - ✓Resident Performance
    - B+
  - ✓Program Quality
    - B+
  - ✓Faculty Development
    - C+
- ❑ Assess improvements since last year
- ❑ Report on progress of identified deficiencies from last year
- ❑ Create improvement **action plans**



Northwestern Medicine

Preparing for the PEC meeting

What is our role?

We wear many hats...

- **Librarian**
- **Historian**
- **Organizer**
- **Researcher**
- **Analyzer**
- **Problem Solver**

...and we have to put on all of them to help the committee prepare for the annual program evaluation meeting.

Northwestern Medicine

Preparing for the PEC meeting

1. When should the meeting be scheduled?

- Ideally in **June** before the graduates leave
- Faculty and residents should complete a confidential **internal education program evaluation** in May (PR).
  - Create an anonymous evaluation form in New Innovations or similar program

2. Who should attend?

- At least **two faculty** and at least **one resident** (PR)
- The PD appoints the PEC (PR).
- Program Director or APD should attend.
- Committee Chair
  - This is likely a faculty member from the Education leadership
- Residents/Fellows
  - At least one resident from each class
- Coordinator/Administrator
  - Records discussion points and action items

Northwestern Medicine

Preparing for the PEC meeting

Additional ACGME program requirements (PR)

- The PEC must have a written description of its responsibilities (*example provided in future slide*)
- The PEC should participate actively in:
  - planning, developing, implementing, and evaluating educational activities of the program;
  - reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
  - addressing areas of non-compliance with ACGME standards; and
  - reviewing the program annually using evaluations of faculty, residents, and others
- The PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation.
- Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually

Northwestern Medicine

Preparing for the PEC meeting

Additional ACGME program requirements (PR)- *continued*

- The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program
- The PEC must document progress on the previous year's action plan(s).
- The PEC must prepare a written plan of action to document initiatives to **improve performance in one or more of the four areas**, as well as delineate how they will be measured and monitored
- The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes

Northwestern Medicine

Preparing for the PEC meeting

What information and documents do we need to obtain?

Librarian/Historian

We have to collect and compile a lot of information:

1. ABA Basic Exam results
2. ABA ITE results
3. ABA certification rates
4. Number/Percentage of graduates doing academics, private practice and fellowships
5. ACGME Resident and Faculty surveys results
6. Results from the internal evaluation of the Education Program by residents and faculty
7. Citations and areas for improvement (AFI) from annual accreditation notification letter
8. Results from the GME internal review, if applicable
9. A list of professional development courses, lectures, retreats that your faculty attended

Northwestern Medicine

Preparing for the PEC meeting

ACGME Component- Resident Performance

- Document how the residents performed on exams
  - Basic
  - ITE
  - *How do the scores compare from previous year(s)?*
- Document scholarly activity
  - Presentations at regional and national meetings
  - The number of residents doing research rotations
  - *How does the output compare to previous year(s)?*
- Include citations ,AFI, and survey results relating to resident performance
  - *Did any survey scores improve compared to the previous year?*
- *What other data could we include?*

❑ Describe plan of action to make improvements and how they will be monitored in at least **one** item from above (PR)

Northwestern Medicine

Preparing for the PEC meeting

ACGME Component- Graduate Performance

- Document board certification rates of graduates
  - At least 70% of a program's graduates who are eligible for board certification, averaged over five years, should pass on the first attempt (PR).
    - Access certification data on ABA RTID
    - *How do the percentages compare from previous year(s)?*
- Document categories of post graduate employment
  - Number of academic positions
    - *What is the total percentage from the last 3-5 years?*
  - Number of private practice positions
  - Number of fellowship positions
    - *How many graduates went to top 25 (competitive) programs?*
- Include citations, AFI, and survey results relating to graduate performance
  - *Did any survey scores improve compared to the previous year?*
- *What other data could we include?*

❑ Describe plan of action to make improvements and how they will be monitored in at least **one** item from above (PR)

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Preparing for the PEC meeting

ACGME Component- Program Quality

- Document educational components of the program and policy changes
  - Didactic (lecture schedule) changes
  - Rotation changes
  - Competency-based goals and learning objective changes (PR)
  - QI and Patient Safety changes
  - Wellness changes
  - Duty hour changes
- Include citations ,AFI, and survey results relating to graduate performance
  - *Did any survey scores improve compared to the previous year?*
- *What other data could we include?*

❑ Describe plan of action to make improvements and how they will be monitored in at least **one** item from above (PR)

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Preparing for the PEC meeting

ACGME Component- Faculty Development

- Document components relating to faculty performance
  - Professional development
    - *What courses, lectures, retreats did your faculty as a whole attend?*
  - *What is the faculty evaluation completion/compliance rate?*
    - *How do the percentages compare from previous year(s)?*
- Include citations, AFI, and survey results relating to graduate performance
  - *Did any survey scores improve compared to the previous year?*
- *What other data could we include?*

❑ Describe plan of action to make improvements and how they will be monitored in at least **one** item from above (PR)

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Preparing for the PEC meeting

Before the meeting occurs…

- Build the PEC outline (*see future slide for outline example*)
  - Because you should already know the meeting date, who is attending, the exam scores, graduation outcomes, and faculty professional development activities, add this information to the **draft of the PEC outline**
- Add ACGME and GME (action) items to the respective four categories of the outline
  - Include ACGME areas of non-compliance: citations, areas for improvement, and survey result components with a score of less than ??%.
    - Northwestern's GME requests action on scores of less than 80%, so your program may have a different threshold to reach.
  - Include GME internal review findings
- Send outline and hard copies/pdfs of supporting documentation to PEC Chair
- Ask the PEC Chair to identify 2-4 areas for improvement from the internal education program evaluation and add them as action items to the outline under the respective four categories
- Send final draft outline to PEC members in order to review before the meeting

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The PEC Evaluation and Improvement Meeting

During and after the meeting…

During

- The committee reviews the draft of the outline highlighting discussion points and areas for improvement in the four categories
- The committee provides an action plan and how it will be monitored for each item (PR)
- The committee reviews the action plan from the previous year and documents progress or resolution of each item (PR)
- The committee makes recommendations for revisions of competency-based curriculum goals and objectives (PR)
- The coordinator records any information to be added to the outline

After

- The coordinator incorporates new items, action plans, and progress report into the outline.
- The coordinator sends draft to PEC Chair to review, edit, and finalize.
- The PEC Chair and PD signs the final action plan outline.
- The coordinator forwards the signed copy to the other PEC members.

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Annual Program Evaluation and Plan of Action Meeting

Program: Anesthesiology
Date:

Purpose

To evaluate the Anesthesiology Program at McGaw Medical Center of Northwestern University, the Program Director and PEC Chair reviewed and assessed with key program faculty the following areas of outcomes: resident performance, graduate performance, program quality and faculty development. A written improvement plan was developed in response to the ACGME annual surveys, citations, areas for improvement and faculty and resident evaluation of the education program.

Time Period of Evaluation
July 2016 - June 2017

Review Participants (Must include at least one trainee)

Residents:
Faculty:

Discussion and Action Report

A. On Resident Performance

1.
   a. Plan of Action and monitoring:
2.
   a. Plan of Action and monitoring:

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A. On Graduate Performance and Certification Exam

1.
   a. Plan of Action and monitoring:
2.
   a. Plan of Action and monitoring:

A. On Program Quality

1.
   a. Plan of Action and monitoring:
2.
   a. Plan of Action and monitoring:

A. On Faculty Development

1.
   a. Plan of Action and monitoring:
2.
   a. Plan of Action and monitoring:

Progress on Previous Year's Action Plans

1.

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Education Program Evaluation Checklist (for meeting minutes)

- The educational effectiveness of the program was evaluated on 6/13/2017.
- The committee chair, representative faculty, and at least one resident were present.
- Potential changes to competency-based goals and objectives were reviewed.

- Comments, from the faculty, regarding the quality of the program were reviewed.
- The most recent report from the GMEC (Internal Review) was reviewed, if applicable.
- The most recent accreditation letter(s) from the RRC were reviewed, if applicable.
- Any recent communications from the ACGME or RRC were reviewed, if applicable.
- The results from the most recent ACGME resident survey were reviewed.
- Confidential written evaluations of the program submitted by the residents and faculty were reviewed.

- Resident/fellow performance and outcome assessment were used in the evaluation of the educational effectiveness, including but not limited to performance on certification exams.

- A specific Plan of Action to address areas for improvement was reviewed and approved by the faculty.

I hereby certify that all requirements have been met.

_____ _____6-20-17_____
Associate Program Director Signature

_____ _____6-20-17_____
Committee Chair Signature

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The Program Evaluation Committee (PEC) Responsibilities
-Evaluation and Improvement-

The PEC will actively plan, develop, implement, and evaluate the educational activities of the program; review and make recommendations for revision of competency-based curriculum goals and objectives; address areas of non-compliance with ACGME standards; and review the program annually using evaluations of faculty, residents, and others.

The PEC will document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation. The PEC is comprised of faculty and resident members.

The PEC will make sure that the program monitors and tracks resident performance, faculty development, program quality, progress on the previous year's action plan(s), and graduate performance, including performance of program graduates on the certification examination (As part of the overall evaluation of the program, the PEC will take into consideration the information provided by the ABA regarding resident performance on the certifying examinations over the most Anesthesiology recent five-year period. The Review Committee will also take into account noticeable improvements or declines during the period considered. Program graduates should take the certifying examination, and at least 70% of the program graduates should become certified).

The PEC will make sure that residents and faculty have the opportunity to evaluate the program confidentially and in writing at least annually. The PEC will use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program.

The PEC will prepare a written plan of action to document initiatives to improve performance in one or more of the above areas as well as delineate how they will be measured and monitored. The action plan will be reviewed and approved by the teaching faculty and documented in meeting minutes.

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In Conclusion

1. It requires a lot of time to collect, analyze, and prepare the documents for the PEC information, so make sure you give yourself plenty of time to work on it.
2. Your current role or input in the PEC may be minimum currently, but hopefully after viewing this presentation, you understand the importance of taking a more active role in the process.
3. Taking more ownership of the process is an opportunity for professional develop and to impress your Committee Chair and PD.

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