2018
Annual Meeting Syllabus

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

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

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 2017 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 2018 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 5, 2018. After October 5, 2018, 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 15.75 *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 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.

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 5, 2018. 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:

- Chairs will be able to decide which behaviors to adopt.
- Fellowship directors will be able to identify which topics/skills are important to obtain jobs for graduating fellows.
- Residency directors will be able to identify which education techniques are successful.
- Participants will be able to recognize burnout and develop tools to increase resilience.
- Participants will have a greater understanding of how to change their departmental culture.

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.

Name	Commercial Interest	Nature of Relationship
Brenda G. Fahy, MD, MCCM	American Board of Anesthesiology	Self; Other Material Support
Jeff Gadsden, MD, FRCPC, FANZCA	Pacira Pharmaceuticals	Self; Funded – Research; Consulting Fees
	Mallinckrodt Pharmaceuticals	Self; Funded
James P. Rathmell, MD	American Board of Anesthesiology	Self; Honoraria
Peter Rock, MD, MBA, FCCM	NIH	Self; Funded Research
	Zygood, LLC	Self; Funded Research
	Department of Defense	Self; Funded Research
	Johns Hopkins School of Medicine	Self; Honoraria; Other Material Support
	The American Board of Anesthesiology	Self; Honoraria; Other Material Support
Douglas C. Shook, MD	Edwards Lifesciences	Self; Consulting Fees; Honoraria
	Boston Scientific	Self; Honoraria
Betty Leslie Warner, C-TAGME	Cleveland Clinic Florida	Self; Salary

All others, including editor, authors, reviewers and staff for the SAAAPM 2018 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 2018 Annual Meeting has gone mobile using Guidebook!

We strongly encourage you to download our mobile guide to enhance your experience at the SAAAPM 2018 Annual Meeting. You'll be able to plan your day with a personalized schedule and download all the meeting materials.

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 http://guidebook.com/browse/.

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Directions for Claiming CME Credit

Please note: Participants must claim credits for this course by December 31, 2018. 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 COURSES" to view the link to the SAAAPM 2018 Annual Meeting.
3. Download the latest syllabus PDF.
4. Select the link to access the course evaluation and claim credit.
5. To retrieve a username or password, enter your email address at: http://education.asahq.org/user/password

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

If you have any questions, please contact the ASA at jpmeetings@asahq.org.

Parking

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

SAVE THE DATES

2019 Annual Meeting
November 8-9, 2019
Swissôtel Chicago
Chicago, Illinois

2020 Annual Meeting
November 6-7, 2020
Swissôtel Chicago
Chicago, Illinois

2021 Annual Meeting
November 5-6, 2021
Swissôtel Chicago
Chicago, Illinois

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AAAC Concurrent Session

Friday, November 2 *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	**Session 1** *Moderator: Ronald G. Pearl, MD, PhD*
8:00 – 10:00am	**The "Life Cycle of a Chair"**
8:00 – 8:20am	**Preparing to be a Chair** Juhan Paiste, MD, MBA
8:20 – 8:40am	**Negotiating Your Chair Package** Steven L. Lisco, MD, FCCM, FCCP
8:40 – 9:00am	**The First Two Years as a Chair** Ruben J. Azocar, MD, MHCM, FASA, FCCM
9:00 – 9:20am	**Sustaining the Department** B. Scott Segal, MD, MHCM
9:20 – 9:40am	**Succession Planning and Exiting as a Chair** Gerard Manecke, MD
9:40 – 10:00am	**Q&A**
10:00 – 10:30am	**Break** *(Zurich Pre-Function)*
10:30 – 11:45am	**Mistakes Made; Lessons Learned** *Moderator: Ronald G. Pearl, MD, PhD*
10:30 – 10:42am	Michael P. Eaton, MD
10:42 – 10:54am	Meg A. Rosenblatt, MD, FASA
10:54 – 11:06am	Talal W. Khan, MD, MBA
11:06 – 11:18am	Vesna Jevtovic-Todorovic, MD, PhD, MBA
11:18 – 11:30am	Johan P. Suyderhoud, MD
11:30 – 11:45am	**Q&A/Panel Discussion**
11:45 – 12:00pm	**Alternate Entry Path (AEP) ABA Certification** James P. Rathmell, MD
12:00 – 1:15pm	**Box Lunch & Business Meeting** *(Ticket Required – Pick Up Lunch in Zurich Pre-Function)*
12:45 – 1:15pm	**AAAC Business Meeting & Introduction of All New and Interim Chairs**

Afternoon Session

1:15 – 5:00pm	**Session 3** *Moderator: Peter Rock, MD, MBA, FCCM*
1:15 – 2:00pm	**Perfect Storm** Charles W. Whitten, MD
2:00 – 2:10pm	**Q&A**
2:10 – 3:20pm	**The Need for Chairs to Take Care of Themselves First / How Have Long Serving Chairs Sustained Their Interest Passion and Engagement?**
2:10 – 2:30pm	Roberta L. Hines, MD
2:30 – 2:50pm	Donald D. Prough, MD
2:50 – 3:10pm	Ellise Delphin, MD, MPH
3:10 – 3:20pm	**Q&A**
3:20 – 3:50pm	**Break** *(Zurich Pre-Function)*
3:50 – 5:00pm	**Culture Change**
3:50 – 4:10pm	Michael C. Lewis, MD, FASA
4:10 – 4:30pm	Cynthia A. Wong, MD
4:30 – 4:50pm	Cynthia A. Lien, MD
4:50 – 5:00pm	**Q&A**
5:30 – 7:30pm	**SAAAPM Reception** *(Zurich Pre-Function)*

AACPD Concurrent Session

Friday, November 2 *All AACPD presentations held in Lucerne Ballroom unless otherwise noted.*

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

Morning Session

8:00 – 9:00am	**RRC & ABA ITE Updates** *Moderator: Manuel Pardo, Jr., MD*
8:00 – 8:15am	**RRC Updates** Cynthia A. Wong, MD Anne Gravel Sullivan, PhD
8:15 – 8:25am	**Q&A**
8:25 – 8:50am	**ABA Updates** Brenda G. Fahy, MD, MCCM Robert Gaiser, MD
8:50 – 9:00am	**Q&A**
9:00 – 10:00am	**Problem Resident Success Stories** *Moderator: Herodotos Ellinas, MD*
9:00 – 9:12am	Demicha D. Rankin, MD
9:12 – 9:24am	Harendra Arora, MD, MBA, FASA
9:24 – 9:36am	Timothy W. Martin, MD, MBA, FASA
9:36 – 9:48am	Russell K. McAllister, MD, FASA
9:48 – 10:00am	**Q&A/Panel Discussion**
10:00 – 10:30am	**Break** *(Lucerne Pre-Function)*
10:30 – 11:00am	**Best Practices and New Approaches in Wellness** *Moderator: John D. Mitchell, MD* Lauren Katherine Licatino, MD Daniel C. Sizemore, MD Jed Wolpaw, MD, MEd
11:00am – 12:00pm	**Mistakes Made; Lessons Learned as a Program Director** *Moderator: Manuel Pardo, Jr., MD*
11:00 – 11:10am	Manuel Pardo, Jr., MD
11:10 – 11:20am	Jerome M. Klafta, MD
11:20 – 11:30am	Mark J. Harris, MD, MPH
11:30 – 11:40am	Sujatha Ramachandran, MD, MACM
11:40am – 12:00pm	**Q&A/Panel Discussion**

12:00 – 1:30pm	**Box Lunch & Business Meeting** *(Ticket Required – Pick Up Lunch in Zurich Pre-Function)*
12:15 – 1:00pm	**AACPD Business Meeting**
1:00 – 1:30pm	**AACPD Meet & Greet with New Program Directors**

Afternoon Session

1:30 – 3:00 pm	**Panel with AAPAE on Resident Recruitment, Administration and Interview Formats** *Moderator: Charles A. Napolitano, MD, PhD*
1:30 – 1:55pm	**The Program Administrator Perspective** Amy DiLorenzo, MA
1:55 – 2:10pm	**Simulation** Kyle S. Ahn, MD, FASA
2:10 – 2:25pm	**Video Interviews** Jason W. Gatling, MD
2:25 – 2:50pm	**The Resident's Perspective** Rohit Choudhary, MD Danisa Daubenspeck, DO Derek Rizzo, MD, MHSA Lara R.I. Rosewicz, MD
2:50 – 3:00pm	**Q&A**
3:00 – 3:30 pm	**Break** *(Lucerne 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)*

AASPD Concurrent Session

Friday, November 2

All AASPD presentations held in Zurich DEFG unless otherwise noted.

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

8:00 – 8:05am — **Welcome and Announcements**

Morning Session

8:05 – 9:00am — **Panel 1**
Moderator: Ellen Y. Choi, MD

8:05 – 8:25am — **Succession Planning for the Fellowship Program Director**
Annemarie Thompson, MD

8:25 – 8:45am — **Mentoring Junior Faculty**
Gary J. Brenner, MD, PhD

8:45 – 9:00am — **Q&A**

9:00 – 10:00am — **Panel 2**
Moderator: Mark Stafford-Smith, MD, CM, FRCP(C)

9:00 – 9:20am — **Scholarly Productivity with a Fellowship**
Edward R. Mariano, MD, MAS

9:20 – 9:40am — **Quality Assurance Performance Improvement**
Thomas Caruso, MD, MEd

9:40 – 10:00am — **Q&A**

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

10:30 – 12:00pm — **Breakouts and Reporting**

10:30 – 11:30am — **Breakout 1 – Methods to Promote Diversity in Fellows** *(Vevey 1)*
Moderators: Mark Stafford-Smith, MD, CM, FRCP(C) and John Eck, MD

Breakout 2 – Mentoring New Fellowship Directors in Your Department: Are the Critical Elements in Place and Occurring? *(Vevey 2)*
Moderators: Charles Brock, MD and Magdalena Anitescu, MD, PhD

Breakout 3 – Scholarly Productivity and Fostering Research Opportunities of Subspecialty Program Directors – How to Enhance the Careers of Busy PDs and Fellows *(Zurich DEFG)*
Moderators: Erin Hennessey, MD and Rebecca D. Minehart, MD, MSHPEd

Breakout 4 – Ways to Maximize Preparing Fellows for the Boards – Subspecialty and OSCE *(Vevey 3)*
Moderators: Edward R. Mariano, MD, MAS and Kevin Thornton, MD

11:30 – 11:40am — **Report Back to General Session Room**

11:40 – 12:00pm — **Begin Breakout Reporting**
Moderator: Charles Brock, MD

12:00 – 1:30pm — **Box Lunch / Business Meeting / Breakout Reporting** *(Ticket Required – Pick Up Lunch in Zurich Pre-Function)*

12:00 – 12:30pm — **Lunch**

Afternoon Session

12:30 – 1:00pm — **AASPD Business Meeting**
Moderator: Charles Brock, MD

1:00 – 1:30pm — **Finish Breakout Reporting**
Moderator: Charles Brock, MD

1:30 – 2:15pm — **Updates from the Subspecialties**
Moderator: Charles Brock, MD

Regional Anesthesiology and Acute Pain Medicine
Edward R. Mariano, MD, MAS

Critical Care Medicine
Nicholas Sadovnikoff, MD, FCCM

Pain Medicine
Magdalena Anitescu, MD, PhD

Pediatric Anesthesiology
Franklyn P. Cladis, MD

ACTA
Douglas C. Shook, MD

OB Anesthesia
Rebecca D. Minehart, MD, MSHPEd

2:15 – 2:45pm — **Break (Zurich Pre-Function)**

2:45 – 5:30pm — **Subspecialty Breakout Sessions**

Adult Cardiothoracic *(Vevey 1)*
Douglas C. Shook, MD

Critical Care Medicine *(Vevey 2)*
Nicholas Sadovnikoff, MD, FCCM

Obstetric *(Vevey 4)*
Rebecca D. Minehart, MD, MSHPEd

Pain Medicine *(Zurich DEFG)*
Scott Brancolini, MD, MPH;
Renee Przkora, MD, PhD

Pediatric *(Vevey 3)*
Franklyn P. Cladis, MD

Regional Anesthesia *(Monte Rosa)*
Jeff Gadsden, MD, FRCPC, FANZCA;
Christina L. Jeng, MD, FASA

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

AAPAE Concurrent Session

All AAPAE presentations held in St. Gallen unless otherwise noted.

FRIDAY, NOVEMBER 2

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

Morning Session

7:15 – 8:00am — **Pre-Session for Educators and Scholars**
Moderator: Lara Zisblatt, EdD, MA, PMME

8:00 – 9:00am — **Session 1 – RRC & ABA ITE Updates**
Joint session with AACPD *(Lucerne Ballroom)*
See AACPD Schedule

9:00 – 9:15 am — **AAPAE Move to St. Gallen**

9:15 – 10:00 am — **Welcome**
Leslie Coker Fowler, MEd

10:00 – 10:30am — **Break** *(St. Gallen Pre-Function)*

10:30 – 12:00pm — **Session 2**
Moderator: Amy Miller Juve, Ed, MEd

10:30 – 11:30am — **Milestones**
Laura Edgar, EdD, CAE

11:30 – 12:00pm — **Practical Strategies for Engaging Faculty in Evaluation and Assessment Completion**
Lara Zisblatt, EdD, MA, PMME

12:00 – 1:30 pm — **Box Lunch & Business Meeting**
(Ticket Required – Pick Up Lunch in Zurich Pre-Function)

12:45 – 1:15pm — **AAPAE Business Meeting**

Afternoon Session

1:30 – 3:00pm — **AAPAE Members Choose from Two Options:**

OPTION 1 (PROGRAM DIRECTOR TRACK): ***See AACPD Schedule*** *(Lucerne Ballroom)*

OPTION 2 (SUBSPECIALTY PROGRAM DIRECTOR TRACK): ***See AASPD Schedule*** *(Zurich DEFG)*

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

7:00 – 9:00pm — **AAPAE Member Social**
Cash Bar & Desserts
(Lizzie McNeil's – 400 N McClurg Ct, Chicago, IL 60611)

SATURDAY, NOVEMBER 3

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

Morning Session

7:00 – 9:30am — **Wellness Roundtables**

Administrator Wellness
Moderator: Priyanka Dwivedi, MA, MEHP Fellow

Tools for Wellness (Identifying and Addressing Wellness Issues)
Moderator: Elisabeth A. Hudson, BS, C-TAGME

Responses to Wellness Crisis (Suicide, Substance Use)
Moderator: Amy DiLorenzo, MA

Cultivating Resiliency in Ourselves and Others
Moderator: Lara Zisblatt, EdD, MA, PMME

Addressing Systems Issues that Lead to Burnout
Moderator: Amy Miller Juve, EdD, MEd

Roundtable Timetable:
7:30 – 7:55am
8:00 – 8:25am
8:30 – 8:55am
9:00 – 9:25am

9:30 – 10:00am — **Break** *(St. Gallen Pre-Function)*

10:00 – 12:00pm — **Faculty Development**
Moderator: Amy DiLorenzo, MA

10:00 – 10:30am — **Introduction to the Faculty Development changes in the Core Requirements**
Amy DiLorenzo, MA

10:30 – 11:15am — **Panel Discussion About Current Support of Faculty Development**

Large Program: Chris Ashley Fox, PhD

Medium Program: Jane R. Maugeri, C-TAGME

Small Program: Betty Leslie Warner, C-TAGME

11:15 – 11:30am — **Q&A**

11:30 – 12:00pm — **Integration of Technology Tools to Improve Education**
Chris Ashley Fox, PhD & Ashley Grantham, PhD

12:00 – 1:00pm — **Box Lunch – Join SAAAPM** *(Ticket Required – Pick Up Lunch in Zurich Pre-Function)*

Afternoon Session

1:00 – 2:30pm — **Afternoon Session – Join SAAAPM** *(Zurich)*

2:30pm — **EVENT ENDS**

SAAAPM Presentations

Saturday, November 3

All SAAAPM presentations held in Zurich unless otherwise noted.

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

Morning Session

7:00 – 12:00pm — **Morning Session**
Moderator: Jeanine P. Wiener-Kronish, MD

7:00 – 7:10am — **Update on Clinical Research Consortium**
Jeanine P. Wiener-Kronish, MD

7:10 – 8:40am — **Approaches to Residency and Research**

7:10 – 7:30am — Dawn Dillman, MD

7:30 – 7:50am — Aaron Norris, MD, PhD

7:50 – 8:10am — Judith Hellman, MD

8:10 – 8:30am — Vivianne L. Tawfik, MD, PhD

8:30 – 8:40am — **Q&A**

8:40 – 9:30am — **How to Successfully Apply for a T-32**

8:40 – 8:55am — Yan Xu, PhD

8:55 – 9:10am — Thomas J. Ebert, MD, PhD

9:10 – 9:25am — David S. Warner, MD

9:25 – 9:30am — **Q&A**

9:30 – 9:45am — **ASA Update**
Linda J. Mason, MD, FASA

9:45 – 10:00am — **Break** *(Zurich Pre-Function)*

10:00 – 11:00am — **Using Technology to Help with Quality, Staffing and Economics**

10:00 – 10:15am — **Command Center**
Adam Sapirstein, MD

10:15 – 10:30am — **Pre-Ops at Home**
Nirav V. Kamdar, MD, MPP

10:30 – 10:45am — **Monitoring Postoperative Patients Remotely**
Kyan C. Safavi, MD, MBA

10:45 – 11:00am — **Q&A**

11:00 – 12:10pm — **Innovative Ways of Using Simulation as a Development Tool**
Moderator: Peter Rock, MD, MBA, FCCM

11:00 – 11:20am — **Selecting a New Chair**
Berend Mets, MB, ChB, PhD, FRCA, FFA(SA)

11:20 – 11:40am — **Using Simulation to Educate Anesthesia Providers' Loved Ones/Support Persons About Anesthesia to Improve Relatedness to Providers**
Susan M. Martinelli, MD, FASA

11:40 – 12:00pm — **Using Simulation to Improve Leadership Skills**
Arna Banerjee, MD, FCCM

12:00 – 12:10pm — **Q&A**

12:10 – 12:25pm — **Box Lunch** *(Ticket Required – Pick Up Lunch in Zurich Pre-Function)*

Afternoon Session

12:25 – 2:30pm — **Equity and Inclusion**
Moderators: Jeffrey R. Kirsch, MD, FASA and Amy Miller Juve, Ed, MEd

12:25 – 12:45pm — **Identifying Implicit Bias & Introduction to Group Activity**
Ellise Delphin, MD, MPH

12:45 – 1:25pm — **Group Activity and Discussion of Scenarios/ Vignettes**
Facilitator: Destiny Peery, JD/PhD

1:25 – 2:10pm — **Practical Approaches to Strengthening Equity and Inclusion within Your Department Panel**
Ronald L. Harter, MD
Michael H. Wall, MD, FCCM
Michael A. Gropper, MD, PhD

2:10 – 2:30pm — **Q&A**

2:30pm — **EVENT ENDS**

2:45pm — **SAAAPM HOSTED BUSES DEPART FOR AIRPORTS**

Back to Schedule

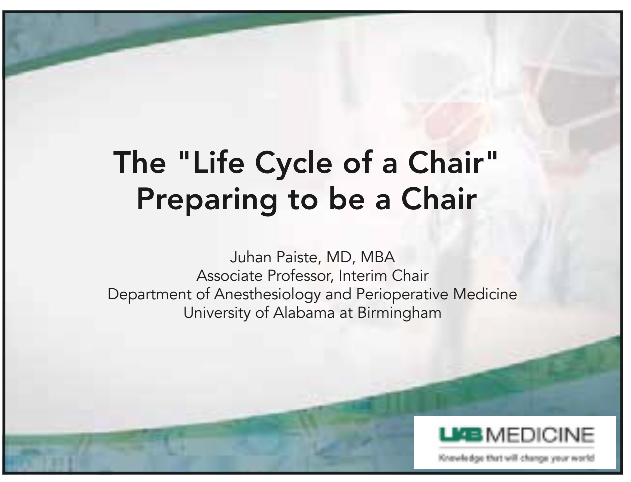
HANDOUT

The "Life Cycle of a Chair" – Preparing to be a Chair

Juhan Paiste, MD, MBA

11/02/2018
8:00am – 8:20am

Back to Schedule



Outline

1. You want to become an Academic Chair
   - Why? When? Where?
2. What helps you to prepare to serve as an Academic Chair?
   - What is the Dean expecting?
   - What are the CEO's needs?
   - What does the faculty want?
   - What motivates you?

You Want to Become an Academic Chair…

- Why?
  - What motivates you?
- When?
  - Are you ready? Are you prepared?
- Where?
  - What kind of academic department?

Know Yourself – Why? Where? When?

- What are you known for?
- What do you want to be known for?
- What are your areas of expertise?
- What past experiences have you had that have helped shape who you are today?
- What kind of problems have you solved?
- How have you demonstrated impact?
- What makes you different?
- How recognizable are you?

Academic Department Chair

The department **chair** is the executive officer of the unit and reports to and advises the dean of the college.

The **chair** provides leadership and direction in the planning, development, and delivery of academic programs and promotes excellence in **teaching**, **research**, and **service**.

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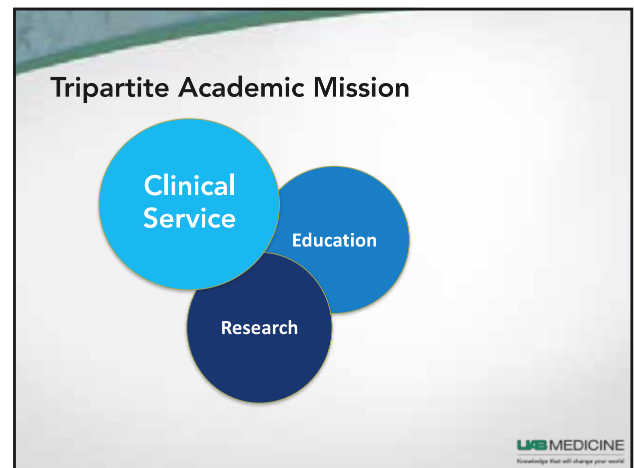
Tripartite Academic Mission



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CEO's Expectations

- Quality Care
- Efficiency
- Consistency
- 24/7/365
- High OR Utilization (and other service lines)
- Budget
- Growth (academic and community)

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Successful Clinical Mission

- Efficient Clinical Operations
- Clinical Sites & Service to be Balanced with the Number of Faculty FTEs, GME trainees and CRNAs (modelling)
- Recruitment of Talent
- Maintain Faculty Work-Life Balance
- Leadership Development / Succession Planning
- Growth
- Budget

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Dean's Expectations

- Funded Research / NIH rankings
- Educational Programs
- Clinical Mission
- Recruiting (clinical and research faculty)
- Leadership Development / Succession Planning
- Budget

UAB MEDICINE

Research Mission

- Talent Recruitment
- Talent Development
- Tenured Faculty
- Endowments
- Start-up Packages / Internal Grants
- Research Support Budget
- Space / Support Staff
- Leadership Development / Succession Planning

UAB MEDICINE

Back to Schedule

Education Mission

- Accreditation Council for Graduate Medical Education (ACGME) - Program Requirements
- Resident/Fellow Recruitment
- Curriculum Development / Didactics
- Mentoring (Residents & Faculty)
- Work-Life Balance (Residents & Faculty)
- Leadership Development / Succession Planning

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Faculty Expectations

- You are "Their" Chair
- "You Need to Walk the Talk"
- Professional Development
- Work-Life Balance
- Compensation
- Generational Differences
- Fairness / Visibility / Access

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Success Factors

- Mentoring (both directions, internal & external)
  - Develop & Maintain Strong Mentoring Relationships
  - Have a "Fellow Chair to Call for Advice"
- Team Building
  - Develop your Leadership Team, Motivate and Empower them
- Relationships ("Bank of Good Will")
- Negotiation Skills & Politically Savvy
- Financial Management

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Can the Chair Do it all?

- Manage and Grow Clinical Enterprise
- Conduct Funded Research
- Lead Educational Programs
- Recruit, Develop and Mentor Faculty
- Manage Budgetary and HR Issues
- Stay Clinically Active
- Maintain your Work-Life Balance

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Yes and No. It Depends.

- Your Personality
- Your Organization Size
- Your Organization Governance Structure
- Your Organization Financial Situation
- Your Department Credibility and Ability to Influence within the Organization

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The First 90 Days

"STARS"
S - Startup
T - Turnaround
A - Accelerated Growth
R - Reorganization
S - Sustaining Excellence

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The First 90 Days

- Listen and Learn
  - Present day academic departments are highly interdependent and complex enterprises
- Networking and Establishing Relationships – Internal and External
- Learn, Learn, Learn
- Be Visible
- Start Conceptualizing How to Implement Your Vision – but Articulate it with the Right Speed

Ultimately Dean/CEO Will Decide…

- Internal vs External Candidate
  - Pro's and Con's for Both
- Departmental (and Institutional) Needs and Priorities
- Start-Up Package Expectations
- Potential Candidate Retention Offers
- Personal Chemistry
- Sometimes - Timing and Luck

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Positivity & Reality

- Sometimes You Win, Sometimes You Don't
- Competitive Marketplace
- It's Not Personal, It's Business
- You Learn a Lot in the Process

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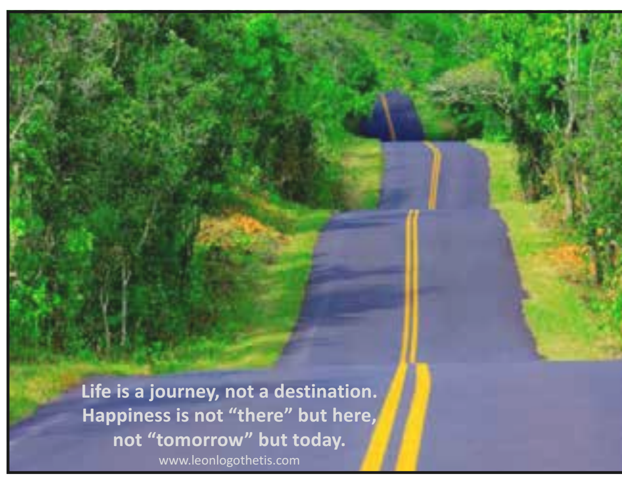

THANK YOU!

Juhan Paiste
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205-934-7424

UAB MEDICINE

Back to Schedule

HANDOUT

The "Life Cycle of a Chair" – Negotiating Your Chair Package

Steven J. Lisco, MD, FCCM, FCCP

11/02/2018
8:20am – 8:40am

Back to Schedule

Disclosures

I have no relevant financial relationships to disclose

Objectives

- Define the components of the Chair's Package
- Appreciate the role congruency with hospital and COM leadership plays in your success
- Recognizing and addressing barriers to achieving your vision

Basic Assumptions

- Unlikely you will have as much information or as much time as you would like to make a commitment to your new position
- You cannot anticipate everything needed to be successful over the next 5-10 years
- Do not discuss your own specific needs until you have an offer
- Get a sense of what cannot be negotiated

Components of the Chair's Package

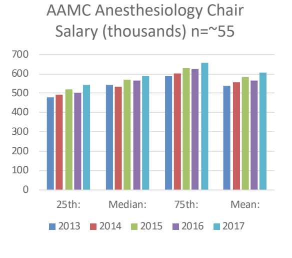
The Personal Package
- Compensation
- Benefits

The Leadership Package
- Program Vision
- Resources Required
- Development

The Department Package
- People
- Space and Infrastructure
- Timeline

Back to Schedule

The Personal Package: Compensation



- Obtain information on competitive salaries for Anesthesiology Chairs
- Best source likely department administrator
- AAMC vs. SAAA
- Upward adjustments for high cost of housing
- Is there incentive tied to leadership performance?

The Personal Package: Benefits

Things to negotiate outside basic benefits

Start Date
Interim pay for work performed during transition
Interim insurance (Cobra)
Relocation costs
Office / Laboratory renovations
Computers / Cell phone
Interim housing and travel between acceptance and relocation
Interim travel if your family doesn't relocate at the same time you commence your new role
Leadership coaching support

The Leadership Package: Vision

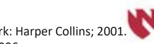
Chair's responsibility: the tripartite mission of academic medicine

Souba W. Acad Med. 2002;77:2

The Leadership Package: Vision

Goals of your Departmental Vision

- A vision is different than a strategic plan
- It should recognize and define a core focus
- It should establish congruency in expectations of the chair, the dean, and the CEO of the teaching hospital
- It should articulate both general and specific plans and timeline for accomplishment



Collins J. Good to Great. New York: Harper Collins; 2001.
Lobas JG. Amer J Med, 119(7), 2006

The Leadership Package: Resources

Articulate vision > Share vision > Obtain resources

- Avoid "Package Envy"
  - Whatever you do get it now and get it in writing
  - More is better and a lot more is a lot better
- Pin down the measures of success
- Secure resources necessary for achieving them
- Don't Columbo the Dean

The Leadership Package: Resources

Consider

You cannot anticipate everything so agree in writing to the principle that, within reason, resources needed to be successful that are not committed to as a part of the offer will be provided in good faith in the future, to the degree that the institution can respond at that time.

Focus on accomplishments and not just a large package of resources for the sake of bragging rights

Back to Schedule

The Leadership Package: Development

Leadership Skills

Professional development in managerial arena is critical
- Formal training opportunities
- Leadership coaching

Walking around funds

Consider creating a development account
- Unanticipated expenses or opportunities
- Contribution of Dean or CEO to chair's / department development account
- For use at chair's discretion to achieve mission driven goals

The Department Package: People

Commitment to Incremental Resources

- Obtain a list of all faculty by discipline, rank, and age (yup)
- Get sense of likelihood of staying on with department
- Understand the flexibility you have to adjust appointments
- Define how many new FTEs you will need, including administrative support
- Do not forget the educational mission

The Department Package: Space

Necessary to Recruit and Retain Faculty

- Inventory all space
  - Location
  - Condition
  - Age
- Walk the space with facilities expert and obtain their opinion on
  - Current condition
  - Consistent with intended use
  - Dollars allocated sufficient to get the upgrade/expansion done
- Same exercise for clinical, educational, and research space

The Department Package: Timeline

Schedule of Resources for positions, space, equipment and recurring and non-recurring funds

- Know
  - what now exists
  - what will be added
  - when this will occur
- How specific you define timelines depends in the culture
- of the institution
- The culture will define what you will need to be comfortable when making your decision whether to
- accept the offer

Biebuyck JF, Mallon WT. The Successful Medical School Department Chair (Volume 3): Performance, Evaluation, Rewards,Renewal. Washington, DC: Association of American Medical Colleges Publications, 2003.

Barriers to Success

- Elements proven to be barriers to success:
  - Relationship between the chair and CEO of hospital
  - Organizational structure and funds flow of the institution
  - Presence or lack of work-life balance
  - Selection process for leaders
- Unless the CEO shares a common vision for the future of the AHC and values medical education and research as much as patient care an adversarial relationship may develop
- Use chair package to establish congruency of vision

Summary

The Chairs Package should reflect

Your Chairs package defines the resources for your personal, departmental, and institutional success

Congruency of vision with the Dean and CEO are essential to that success

The package should reflect the principle that we as chairs serve in the interest of our faculty

Careful and thoughtful negotiations of the package will pay dividends for years to come

Back to Schedule

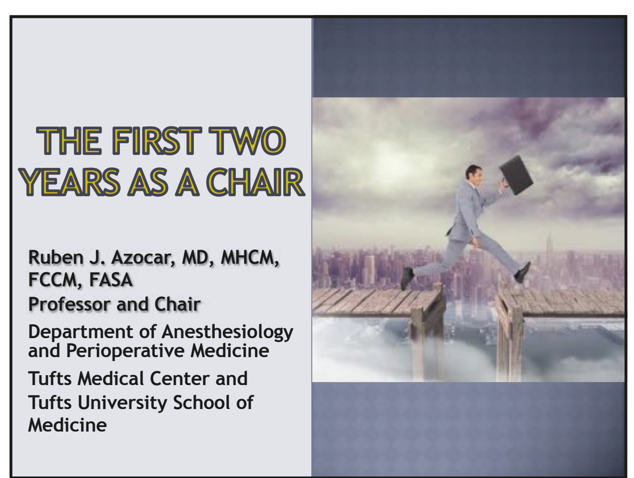
HANDOUT

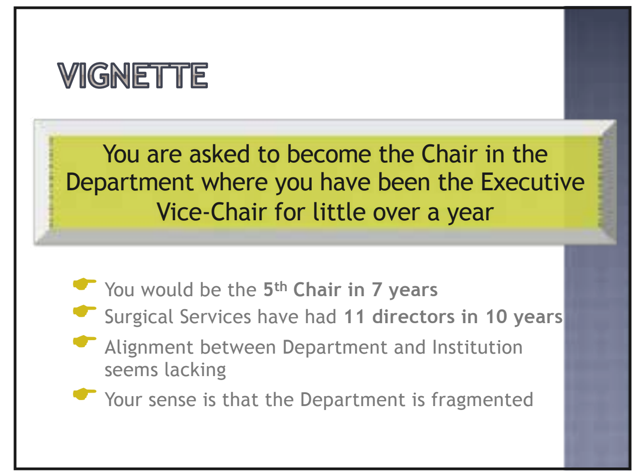
The "Life Cycle of a Chair" – The First Two Years as a Chair

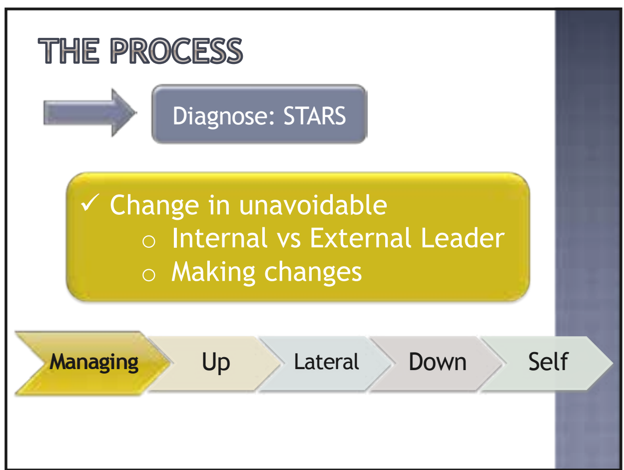
Ruben J. Azocar, MD, MHCM, FASA, FCCM

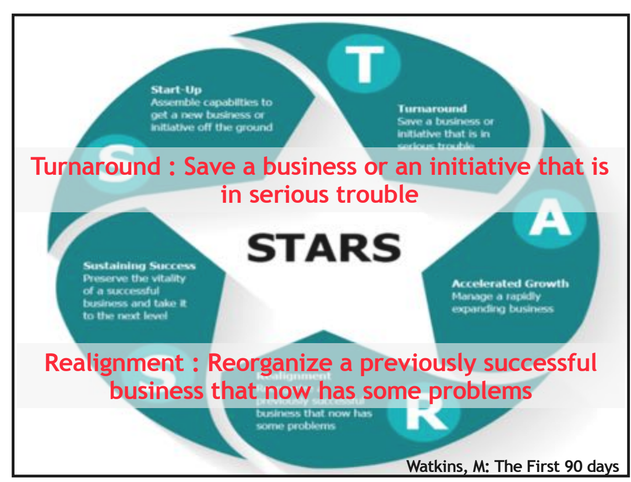
11/02/2018
8:40am – 9:00am

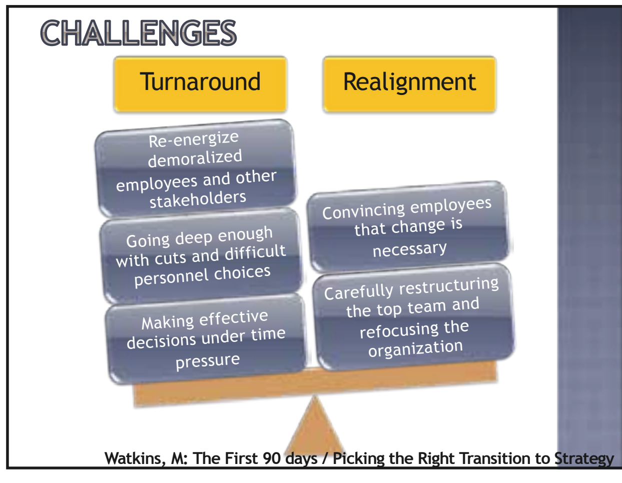
Back to Schedule

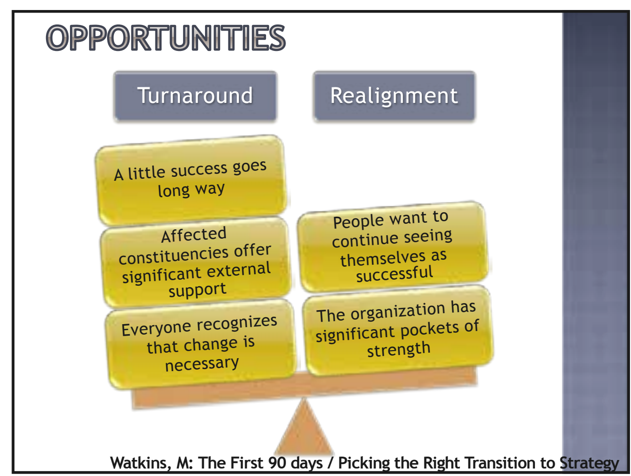


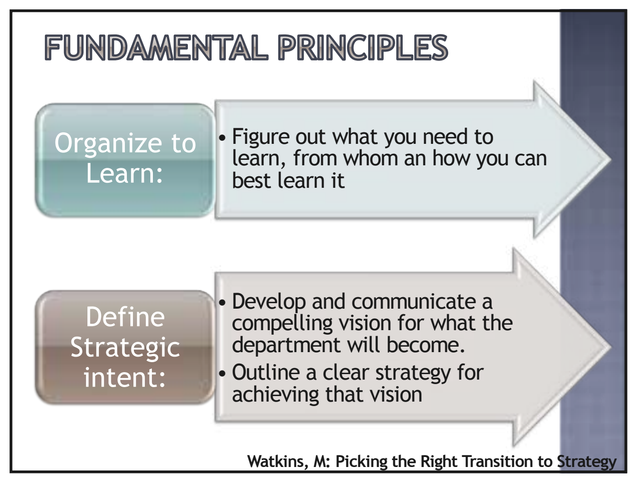


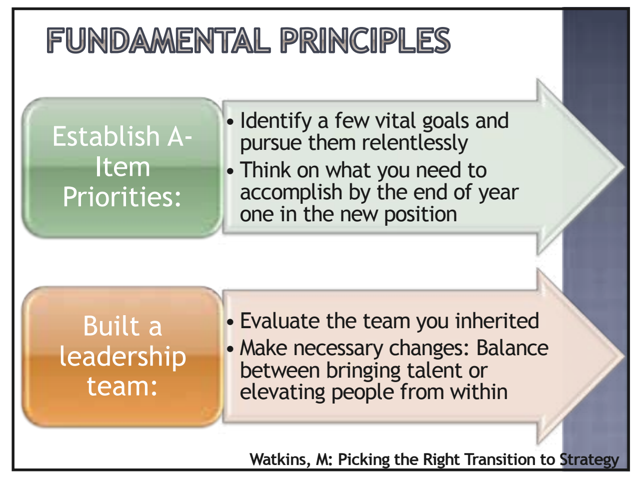


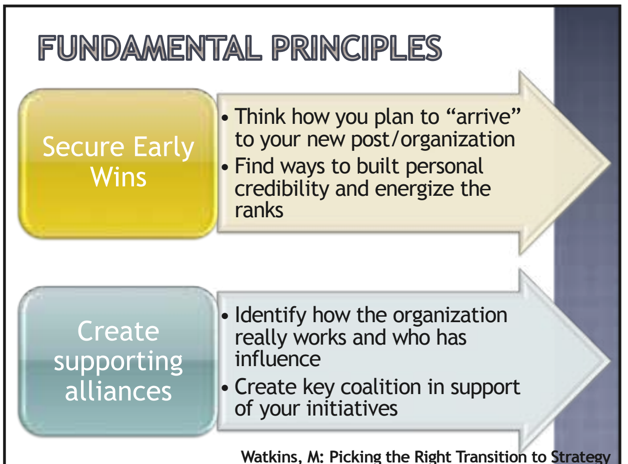


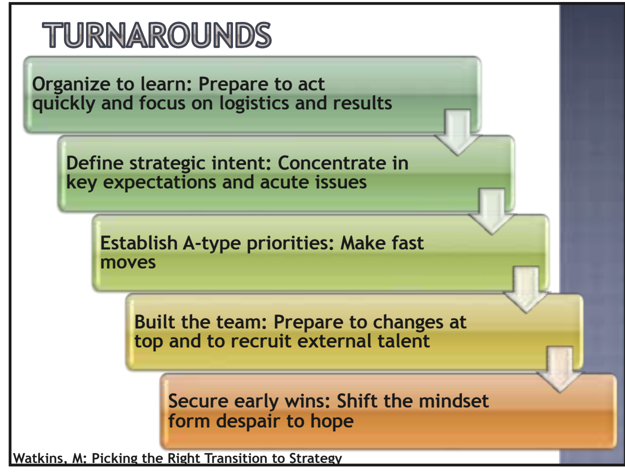


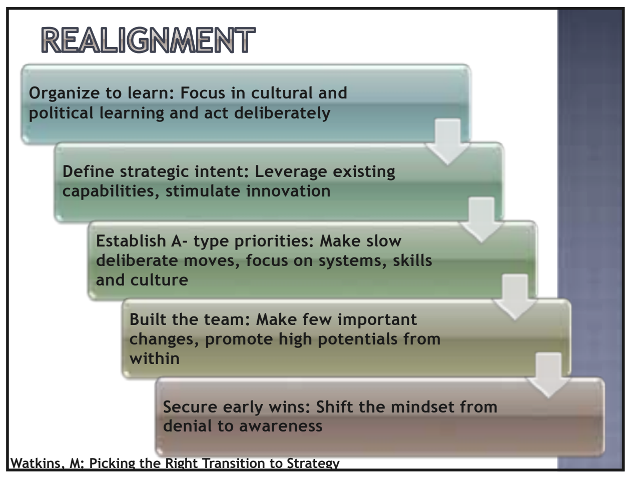


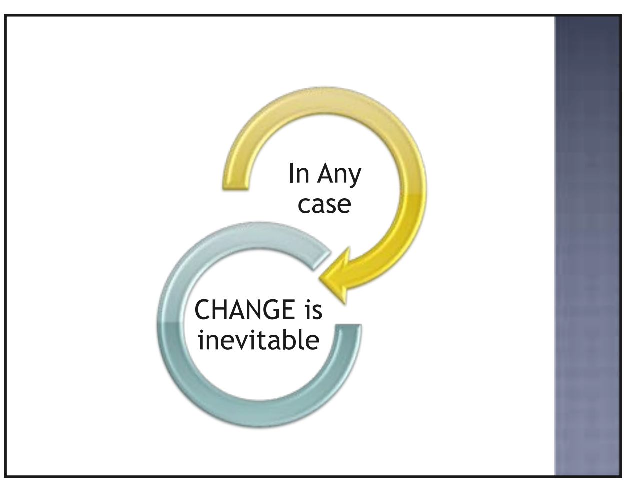

FUNDAMENTAL PRINCIPLES
Organize to Learn:
• Figure out what you need to learn, from whom an how you can best learn it
Define Strategic intent:
• Develop and communicate a compelling vision for what the department will become.
• Outline a clear strategy for achieving that vision
Watkins, M: Picking the Right Transition to Strategy

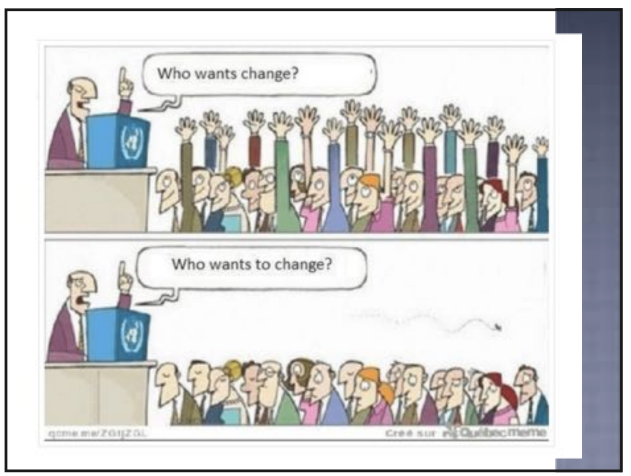

FUNDAMENTAL PRINCIPLES
Establish A-Item Priorities:
• Identify a few vital goals and pursue them relentlessly
• Think on what you need to accomplish by the end of year one in the new position
Built a leadership team:
• Evaluate the team you inherited
• Make necessary changes: Balance between bringing talent or elevating people from within
Watkins, M: Picking the Right Transition to Strategy

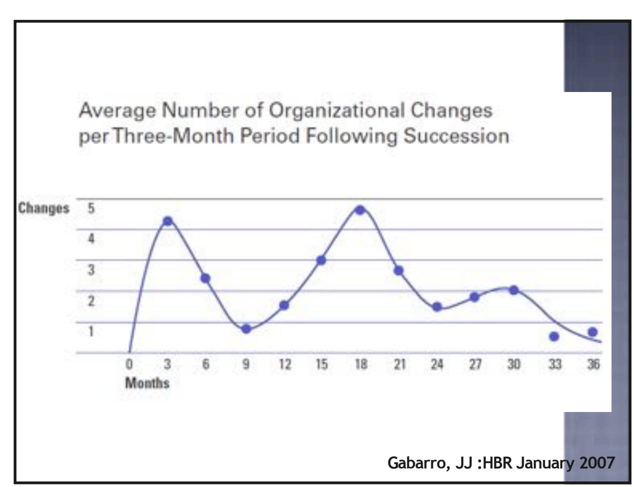

FUNDAMENTAL PRINCIPLES
Secure Early Wins
• Think how you plan to “arrive” to your new post/organization
• Find ways to built personal credibility and energize the ranks
Create supporting alliances
• Identify how the organization really works and who has influence
• Create key coalition in support of your initiatives
Watkins, M: Picking the Right Transition to Strategy

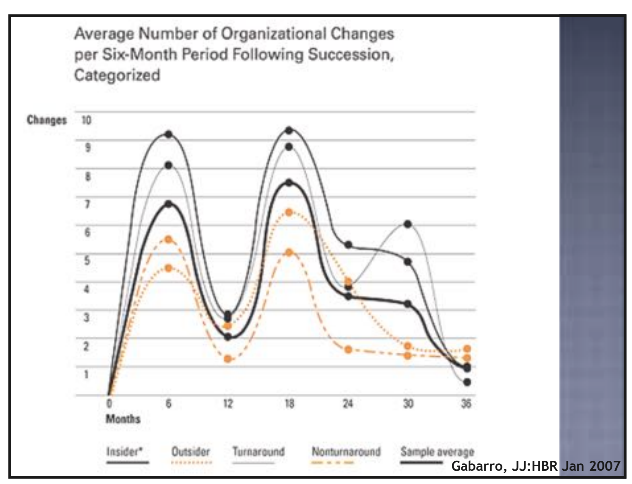

TURNAROUNDS
Organize to learn: Prepare to act quickly and focus on logistics and results
Define strategic intent: Concentrate in key expectations and acute issues
Establish A-type priorities: Make fast moves
Built the team: Prepare to changes at top and to recruit external talent
Secure early wins: Shift the mindset form despair to hope
Watkins, M: Picking the Right Transition to Strategy

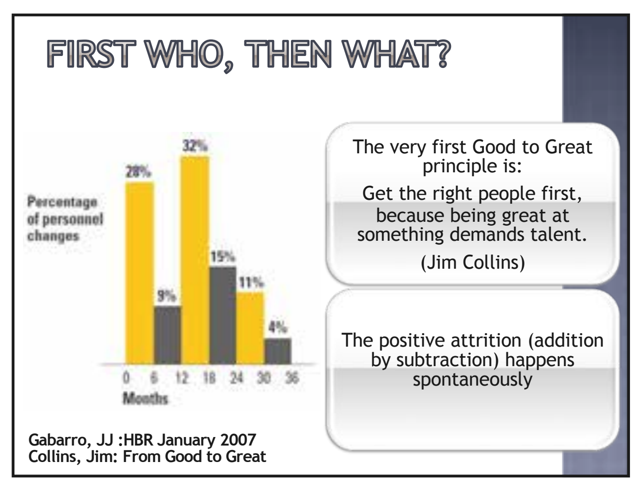

REALIGNMENT
Organize to learn: Focus in cultural and political learning and act deliberately
Define strategic intent: Leverage existing capabilities, stimulate innovation
Establish A- type priorities: Make slow deliberate moves, focus on systems, skills and culture
Built the team: Make few important changes, promote high potentials from within
Secure early wins: Shift the mindset from denial to awareness
Watkins, M: Picking the Right Transition to Strategy

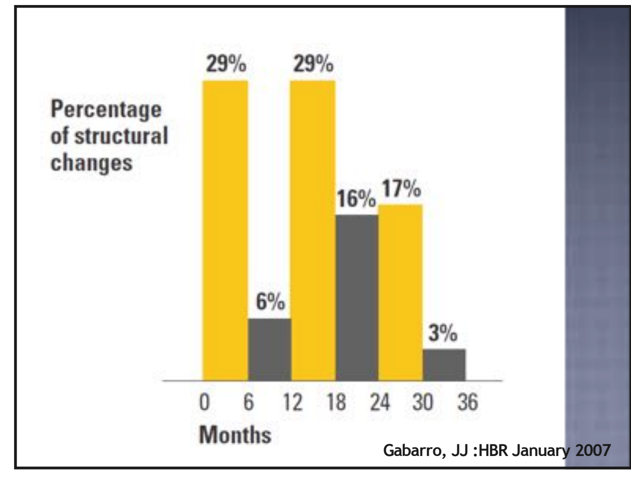

In Any case
CHANGE is inevitable

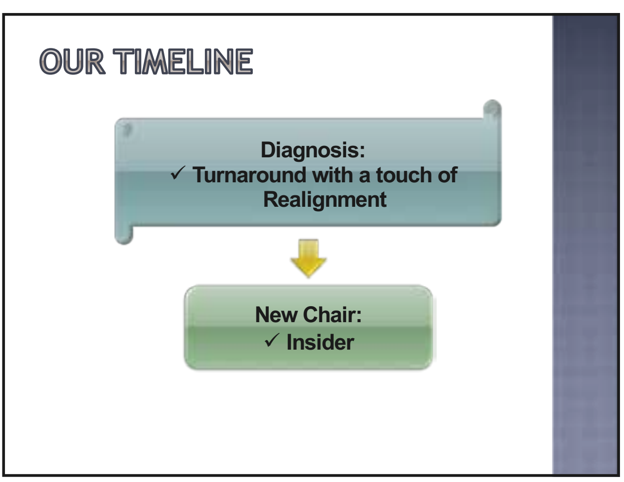

Who wants change?
Who wants to change?


Average Number of Organizational Changes per Three-Month Period Following Succession
Changes
5
4
3
2
1
0 3 6 9 12 15 18 21 24 27 30 33 36
Months
Gabarro, JJ :HBR January 2007

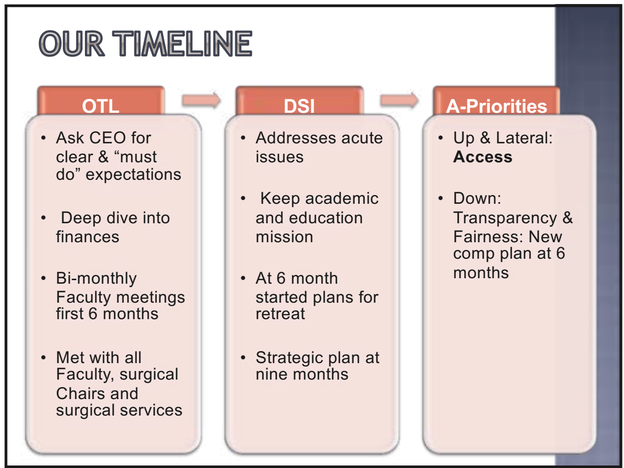

Average Number of Organizational Changes per Six-Month Period Following Succession, Categorized
Changes
0 6 12 18 24 30 36
Months
Insider*
Outsider
Turnaround
Nonturnaround
Sample average
Gabarro, JJ:HBR Jan 2007

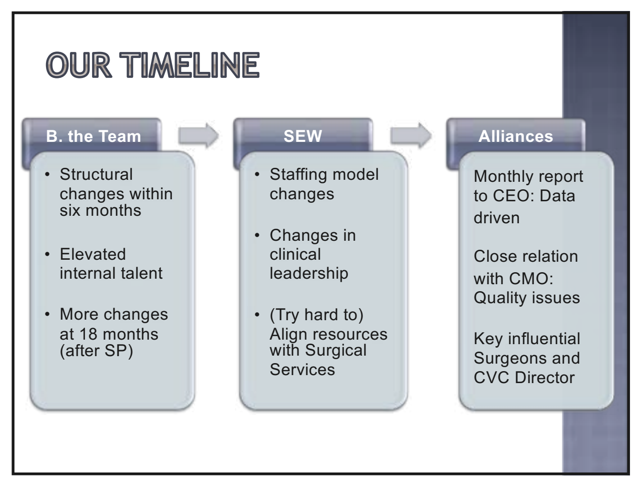

FIRST WHO, THEN WHAT?
Percentage of personnel changes
28%
32%
9%
15%
11%
4%
0 6 12 18 24 30 36
Months
The very first Good to Great principle is:
Get the right people first, because being great at something demands talent.
(Jim Collins)
The positive attrition (addition by subtraction) happens spontaneously
Gabarro, JJ :HBR January 2007
Collins, Jim: From Good to Great

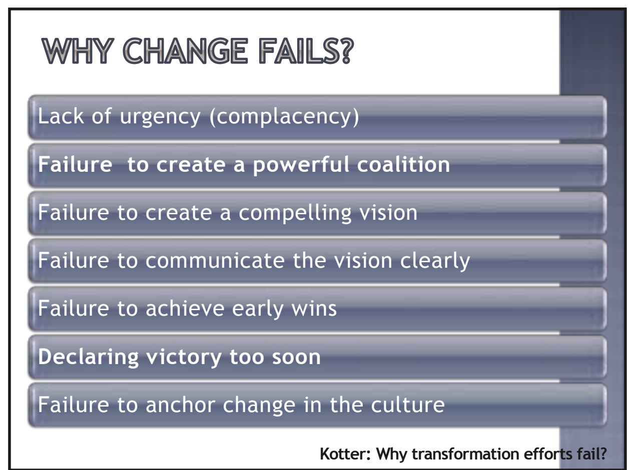

Percentage of structural changes
29%
29%
6%
16%
17%
3%
0 6 12 18 24 30 36
Months
Gabarro, JJ :HBR January 2007

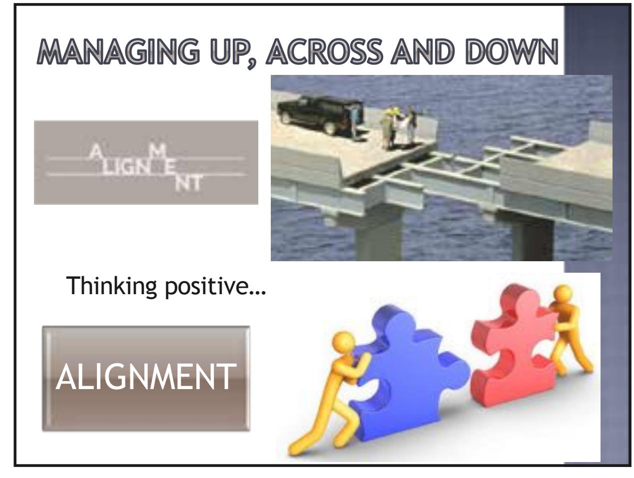

OUR TIMELINE
Diagnosis:
✓ Turnaround with a touch of Realignment
New Chair:
✓ Insider

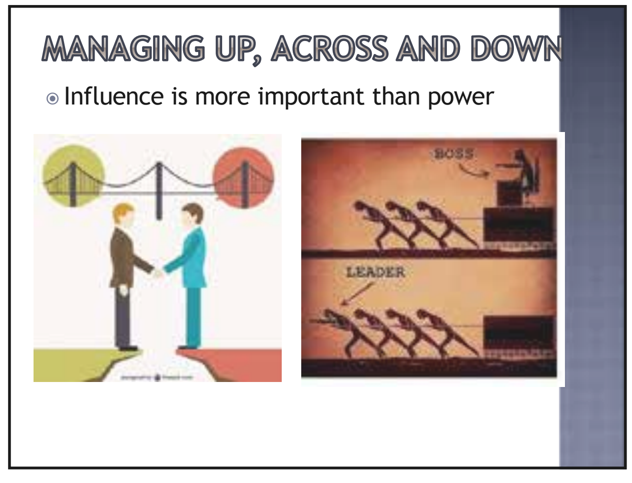
Back to Schedule

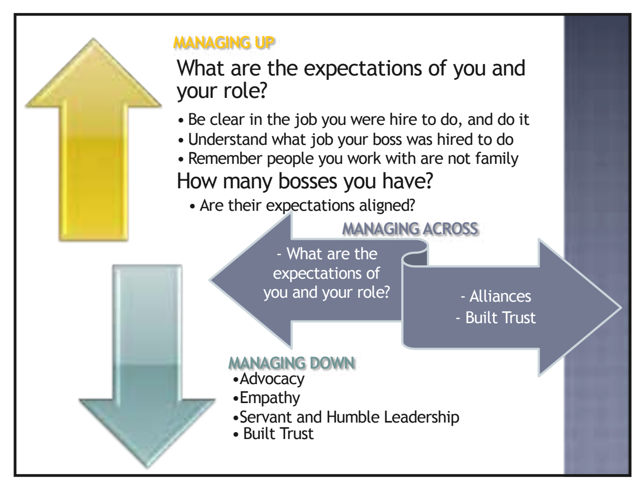




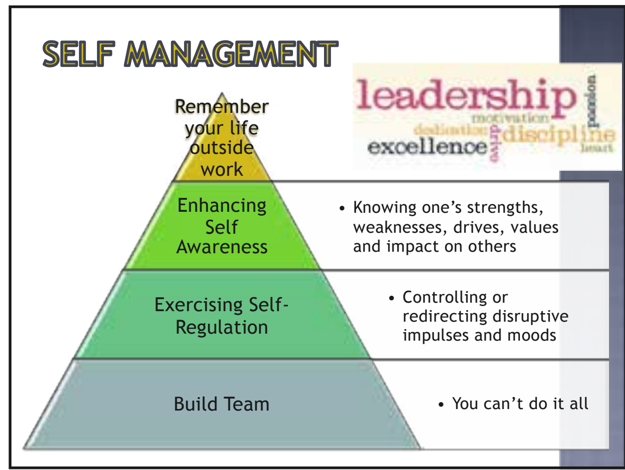


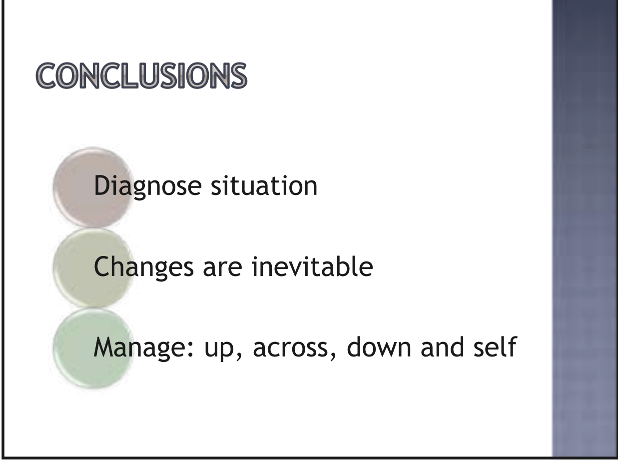


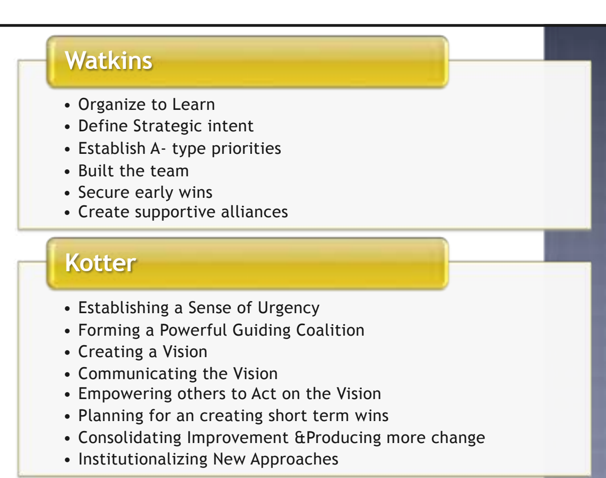




"I don't want to change. I want all of you to change!"







HANDOUT

The "Life Cycle of a Chair" – Sustaining the Department

B. Scott Segal, MD, MHCM

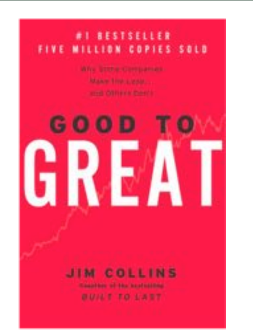
11/02/2018
9:00am – 9:20am

Back to Schedule

LIFE CYCLE OF A CHAIR: SUSTAINING THE DEPARTMENT

Scott Segal, MD, MHCM
Wake Forest school of Medicine

Now this is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning.



Sustaining vs. pursuing greatness

"Good is the enemy of great. And that is one of the key reasons why we have so little that becomes great. We don't have great schools, principally because we have good schools. We don't have great government, principally because we have good government. Few people attain great lives, in large part because it is just so easy to settle for a good life." --Jim Collins

Seven principles of "great companies"

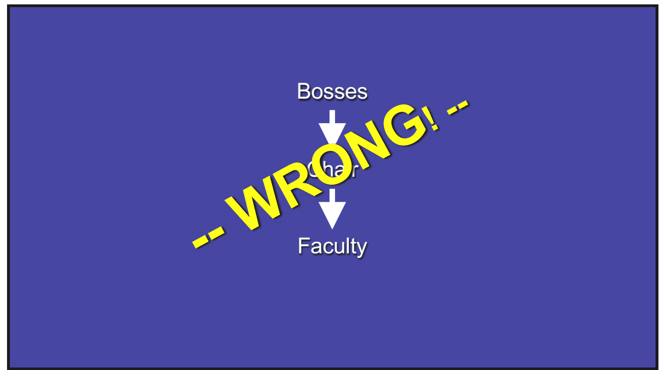
- Level 5 Leadership
- First Who, Then What
- Confront the Brutal Facts (Yet Never Lose Faith)
- The Hedgehog Concept
- A Culture of Discipline
- Technology Accelerators
- The Flywheel

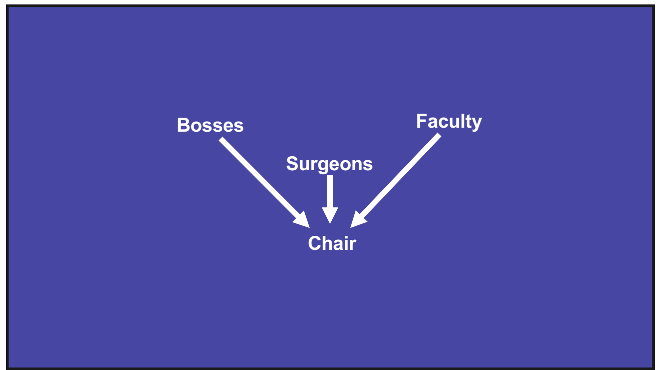
Leadership

Intense determination, profound humility, organizational success over personal advancement

Focus on high level of performance during tenure

Back to Schedule





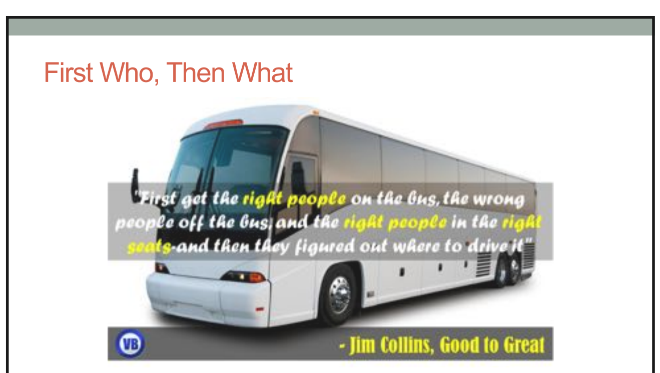
Leadership development

- Executive coaching
- Seek feedback
  - Formal: annual reviews, 360° evals, engagement surveys
  - Informal: trusted faculty (Exec VC, VC Clinical Affairs, VC Education), faculty meetings, Administrative Director, other Chairs
  - MBWA (*gemba walk)*
- Self study (books, HBR, blogs)
- Mindfulness, work-life balance, pre-retirement hobbies

Leadership development (aspirational!)

- Executive coaching
- Seek feedback
  - Formal: annual reviews, 360° evals, engagement surveys
  - Informal: trusted faculty (Exec VC, VC Clinical Affairs, VC Education), faculty meetings, Administrative Director, other Chairs
  - MBWA (*gemba walk)*
- Self study (books, newsletters, magazines, blogs)
- Mindfulness, work-life balance, pre-retirement hobbies

First Who, Then What

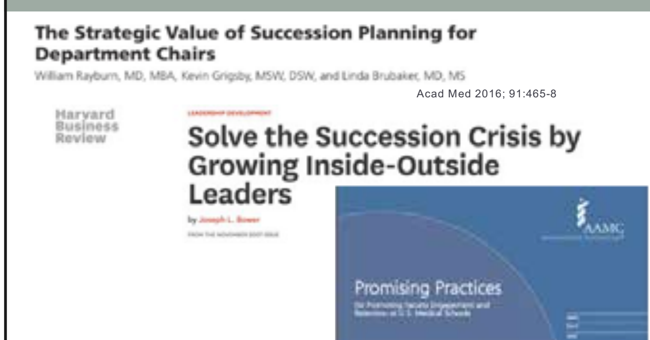


Faculty development

- Incentives: nonclinical productivity, citizenship
- Coaching: developmental and “remedial”
- Office of Women in Medicine and Science
- Peer-review of proposed departmental investments
  - Faculty development committee
  - Research committee
  - Global Health committee
- Faculty engagement initiative
- Succession planning

Critical importance of succession planning

- Many businesses have no plan
  - 2007 large US companies: 60% no plan
  - 2017 small businesses: 58% no plan
    - “Enjoy running the company…transition too far in the future…too busy…no obvious successor”
- Academic medicine: even worse, but equally important (Acad Med 2016; 91:465-8)
- AAMC Faculty Forward survey: highest engagement scores correlate with succession planning and affirmative faculty development

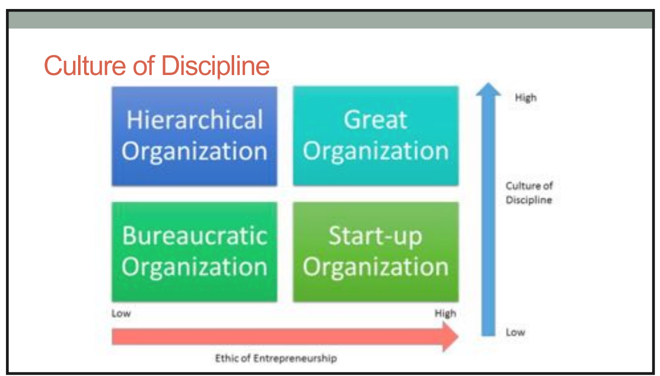


Confront the Brutal Facts (Yet Never Lose Faith)

- “Stockdale paradox”
- Fortunately, no crises (so far!)
- Significant financial pressures, vigorous expansion
  - Budget pressure, but pressure to grow
  - Acquisitions of two hospitals
  - Growing pains for new Pain Medicine section
  - New clinical services (OB)
- Faculty meetings, MBWA, balance institutional and departmental loyalties
- Investments in the future (departmental facelift, endowments)

The Hedgehog Concept

Culture of Discipline



Focus and discipline

- Hard for me personally!
- Use senior advisors, faculty to vet ideas before pursuing them
  - But encourage creativity, entrepreneurship
- CSU model for faculty effort: supports flexibility
- Some “hedgehog discipline” decisions
  - Focus residency on clinical excellence > academic productivity
  - Expand clinical footprint with CRNAs, not residents
  - Accept some financial loss to bolster institutional priorities (PSH)

Technology accelerators

- Hedgehog/discipline: choose tech that accelerates, not creates greatness
- Examples we chose
  - qGenda: not just schedules, business intelligence tools, faculty effort accounting, accountability
  - Activity Insight: faculty activity reporting; drives annual reports, CV maintenance, Dean’s report, academic incentive program
  - MPOG, data scientist: drives QI, process improvement, research
  - Office renovation: high end conference room, display screens

Flywheel

Our flywheel

- Maintain a thoughtful, selective quest for big new initiatives
- Steady increase in clinical footprint, services offered
- Steady increase in academic output, research $
- Promote faculty development and engagement
- Succession plan for all major leadership positions
- Continual celebration of wins

Back to Schedule

HANDOUT

The "Life Cycle of a Chair" – Succession Planning and Exciting as a Chair

Gerard Manecke, MD

11/02/2018
9:20am – 9:40am

Succession Planning and Exiting as a Chair

Gerard Manecke, M.D.
University of California San Diego

Serving as Anesthesiology Chair can be very exciting and rewarding. It certainly was for me. The opportunity to build innovative new programs, provide high quality education and training to trainees and students, assure excellent clinical care, mentor junior faculty while supporting senior ones, and creatively problem-solve were all highlights for me. All earthly things, however, be they good or less-good, must come to an end. There are a few ways in which Chair appointments can end. The possibilities include unceremonious sudden firing by the Dean or Health System CEO, multiple screaming matches followed by "I quit!", and organized departure with a succession plan that is agreeable to all parties. Reasons for voluntary exit (stepping "down" or "away") may include taking a similar or higher administrative position at the same or another institution, retirement, semi-retirement, or change in career direction (research, teaching, writing, consulting, clinical work). [1]

Succession planning, which can be defined as "a deliberate process designed to promote organizational stability during changes in leadership" is now discussed and embraced both in the hospital leadership structure and in schools of medicine. [2,3] The importance of achieving stability during leadership changes serves to preserve and develop the legacies of the current Chair, retain the knowledge assets of the current Chair, maintain organizational efficiency, and control cost. "Planned transitions" or "planned exits" occur when leadership changes are determined proactively with a defined timeline, whereas "Unexpected departures" invoke an emergency transition plan.[3] Each Department should have an emergency transition plan. A long-term mechanism to manage planned transitions is now recommended as well. Such a mechanism involves faculty mentorship, development of leaders, and sometimes an eye toward recruiting from outside to fill leadership gaps.

This presentation focuses on the planned exit, since the presenter has personal experience with it. Herein is described one Chair's experience with exiting the position in a controlled way with considerable planning.

One and one half years prior to stepping away from the Chair position in April of 2018, my approach to my work appeared to be shifting. I had served as Chair for more than 11 years, and I began to feel apathy toward some of the day-to-day but important aspects of the role. My role had not changed substantially, but the more mundane aspects of the position, including routine sign-offs on expenses, proposals, and human resource actions seemed to be taking over my entire professional life. Joint Commission visits, pharmacy audits, OR efficiency complaints, interpersonal conflicts, requests by proceduralists for surgical block time without enough cases to fill the time (with the requisite "politics" mixed in), all appeared to be much more important to the Health System than developing a strong, innovative

perioperative team and Department of Anesthesiology. This may not have been the case, but this is what I was feeling.

The term "burnout" came to mind, and Chairs have been identified as being particularly prone to it.[4] I made sure I "checked the boxes" to address "burnout": I was physically and psychiatrically healthy, getting enough sleep, getting exercise, spending some personal time on non-professional things such as family, baseball and music, and was still engaged in teaching and clinical work in the Operating Room. Nonetheless, the office component of the job was no longer causing me to jump up out of bed in the morning with excitement. I was disinclined, at this later stage of my career, to try to force myself to "like" something that I did not enjoy anymore. Three things came to mind:

1. Maybe "burnout" is a normal process for some people who have been in a position for an extended period. "Burnout" may not mean there is anything wrong with me or the position; it may simply be a signal that it's time to "move on" to some new endeavors.

2. Change can be good. Perhaps stepping away from the Chair position would be good for me, and good for the Department.

3. Finding myself searching Amazon for an "I DON'T CARE" rubber stamp for the paperwork coming across my desk might mean that it would be better for the Department, Health System, and me to hand the baton off to someone else.

Two main things needed to be done:

1. Prepare the Department for a leadership change

2. Work with the Dean, CEO and Health System to assure a smooth transition.

PREPARING THE DEPARTMENT

Much of the preparation for transition overlaps the general function of the Chair. The stronger and more stable the Department, the better it will tolerate a leadership change, and the better your reputation will be after the change. Importantly, any programs and legacies you have created will be more likely to survive and develop further after your departure if you have prepared the Department and its leaders for the transition. If, throughout her tenure, the Chair strives for healthy clinical, teaching, and research enterprises, transition will be much easier. It is recommended that succession planning begin early in the Chair tenure. The following steps and principles are recommended:

1. **BE QUIET** until you are ready to make an announcement about the coming change. This announcement must be coordinated with the Dean and the CEO of the Health System. This can be challenging, but is extremely important. Gossip, rumors,

and true juicy stuff travel very quickly, and the game of "telephone" (exaggeration with each iteration of a story) is played very well in academic centers. Any anticipated significant change, with the rumors that accompany it, can be very disruptive and destabilizing. **Make the plans first, then talk**.

2. **Develop leaders** in the Department. Choose people you can trust, and if you have weak leaders in some areas, make changes. We had two divisions with weak, aging leadership. Although the process was painful, new "next generation" leaders were appointed. This had a very positive effect on those divisions and the Department. As with any time in the Chair tenure, do not let weak leaders drag down the Department. The following are examples of leaders who should be in place and functional:

a. VC for Clinical Affairs and/or Clinical Director
b. Academic Leaders: VC for Education/Program Director, VC for Research, faculty development leaders
c. Division Heads: Cardiac, Pain, Acute Pain, Critical Care, Obstetrics, General, Vascular, Pediatrics, Perioperative Medicine

3. If possible, **"groom" someone** or a small group of talented, energetic individuals for the interim Chair and/or Chair position. Introducing a talented, motivated faculty with leadership potential to the senior leadership of the Health System by expanding their role and profile, allowing them latitude to grow, and bringing them into the sphere of your responsibilities can make the transition quite easy. Introducing them to your responsibilities also allows them to determine if the Chair role is to their liking. Providing some time, resources, and educational opportunities (e.g. "Leadership Academy") improves their readiness and can introduce them to other members of the leadership group of the organization. At UC San Diego we were blessed to have a very talented, motivated, and energetic Clinical Director. Bringing her into the hospital leadership circle was, perhaps, the most important maneuver to facilitate the transition. She is now functioning exceedingly well as our Interim Chair, and it took her a very short time to acclimate to the position.

4. Make the Departmental Business Office as functional as possible. Financial management, information technology support, and administrative support for departmental programs are all critical.

5. Before making a general announcement, have private communications with department members closest to you (e.g. Vice Chairs, Program Directors, division chiefs, key administrative personnel). Be firm in your decision-there are those who will want to dissuade you.

6. Radiate and communicate confidence that the Department is doing well, it will continue to do well, and that its future is very bright. There are always reasons to be optimistic, and these should be emphasized.

PLANNING WITH THE DEAN, CEO, HEALTH SYSTEM, AND SCHOOL OF MEDICINE

1. **Be quiet and discrete** until you are ready to "pull the trigger". On the day you first communicate about this to senior management, you should be prepared to move your belongings out of your office (their response may not be predictable).

2. Have your Departmental plans in place, and a strategy in place for communicating with senior Health System leadership. Prepare to **be firm** in your decision. As within the Department, there are those who will want to dissuade you.

3. Have a **firm timeline** for the transition in mind. If you don't, a timeline will be created for you. Perhaps the shortest timeline is the best. The Dean may want to keep you in your position as he addresses other issues. The question of having an Interim Chair *vs.* an immediate formal recruitment for a permanent Chair may come up. Not wanting to spend an extended period as an ineffectual or "lame duck" Chair, my preference was for an Interim Chair, appointed as soon as possible. A short timeline was one of the few things I was "pushy" on. I spoke with the Dean in January 2018, and our transition date was April 1, 2018. That interval was sufficient time for the Health System and Department to navigate the change, but not excessive.

4. Prior to an official announcement from the Dean, communicate with leaders in the Health System and School of Medicine who are closest to you. Examples might include the Chair of Surgery and other chairs, Chief Operating Officers, and Nursing Directors.

5. You may not be able to choose your successor, but you will likely be asked for suggestions. Be ready with a short list of people you think will do well as Interim Chair or as your successor in the permanent position. If you plan to stay on with your Department as faculty, it is best to avoid appearing overly biased in this process.

6. You may have serious, deep differences with the Dean or members of the Health System management. It may be helpful to the Department for you to express some concerns, but **creating or encouraging ill will helps no one**. Keep it cordial and professional. Your criticisms, if you have them, should be constructive, aimed it improving the status and function of the Department, the Health System, or the School of Medicine.

7. Once the transition begins in earnest, step far into the background and be as supportive as possible to the next Chair and to the Department.

CONCLUSION

Transitioning away from the Chair position can be difficult and emotionally draining. Try to be alert to the signs that the job is really not working for you. When the time comes, be decisive, and recognize that the change, if done for the right reasons, will be good for you, the Department, and the Health System. The preparatory steps are very similar to the steps one ordinarily takes to strengthen a Department. Most of them, particularly in faculty development, are things that one should do throughout the Chair tenure. It can be argued that the entire Chair period is preparatory for the future of the Department and its next Chair. When the Department does well in the transition, your own reputation is enhanced and your legacies can be preserved. Once the transition begins, step back and be supportive of the new Chair and those attempting to navigate the transition and move your Department into the next era.

REFERENCES

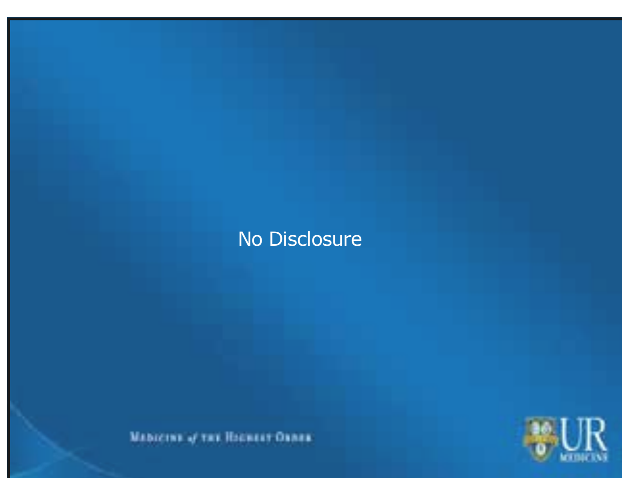
1. Zweig S, Matson C, Magill M. Stepping Through: The Transition from Department Chair. Annals of Family Medicine 2016;14.
2. Rayburn W, Grigsby K, Brubaker L. The Strategic Value of Succession Planning for Department Chairs. Acad Med 2016;91:465-8.
3. Thorndike L, Grigsby K. The Need for Succession Planning. Academic Physician and Scientist 2005.
4. De Oliveira GS, Jr., Ahmad S, Stock MC, et al. High incidence of burnout in academic chairpersons of anesthesiology: should we be taking better care of our leaders? Anesthesiology 2011;114:181-93.

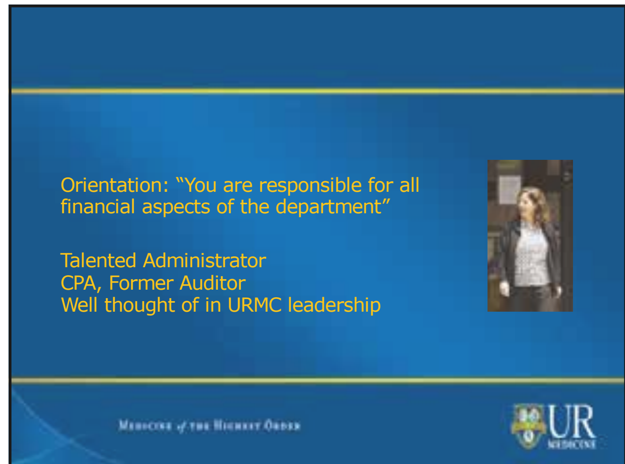
HANDOUT

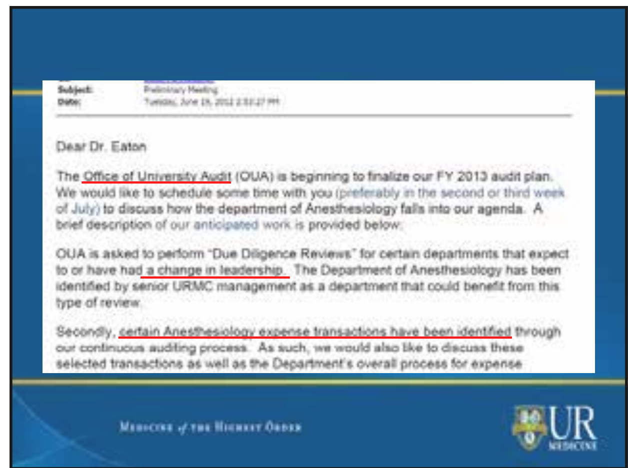
Mistakes Made; Lessons Learned

Michael P. Eaton, MD

11/02/2018
10:30am – 10:42am





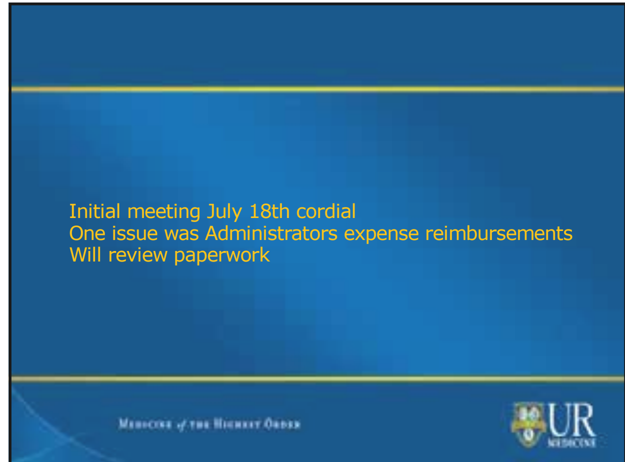

Subject: Preliminary Meeting
Date: Tuesday, June 19, 2012

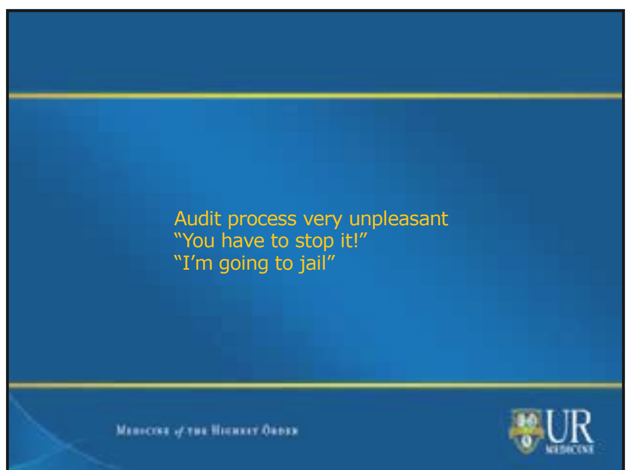
Dear Dr. Eaton

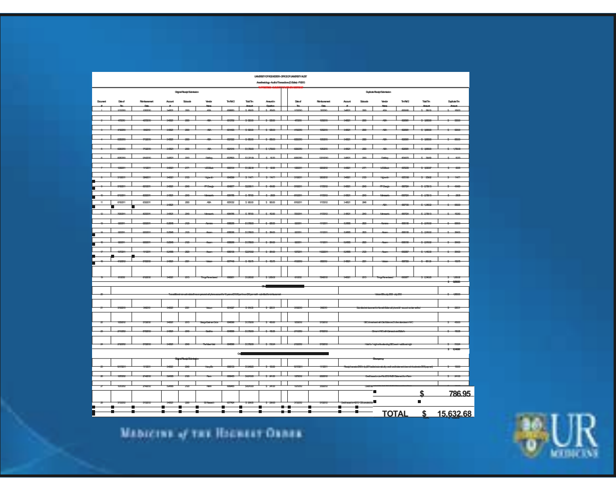
The Office of University Audit (OUA) is beginning to finalize our FY 2013 audit plan. We would like to schedule some time with you (preferably in the second or third week of July) to discuss how the department of Anesthesiology falls into our agenda. A brief description of our anticipated work is provided below:

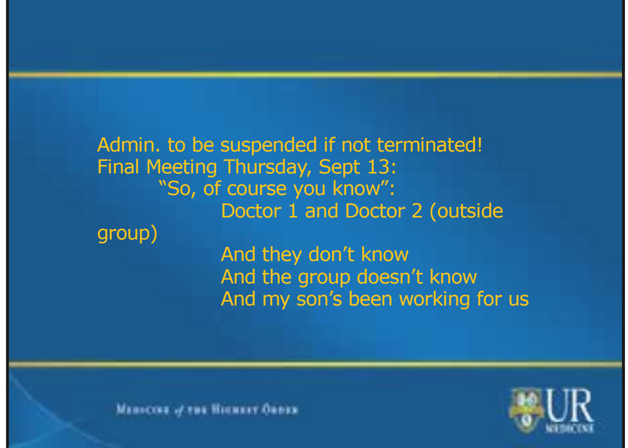
OUA is asked to perform "Due Diligence Reviews" for certain departments that expect to or have had a change in leadership. The Department of Anesthesiology has been identified by senior URMC management as a department that could benefit from this type of review.

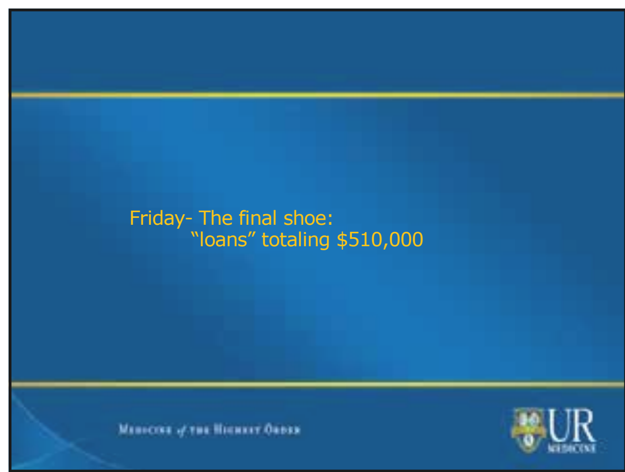
Secondly, certain Anesthesiology expense transactions have been identified through our continuous auditing process. As such, we would also like to discuss these selected transactions as well as the Department's overall process for expense











IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA,

-vs-

DEBRA

Defendant.

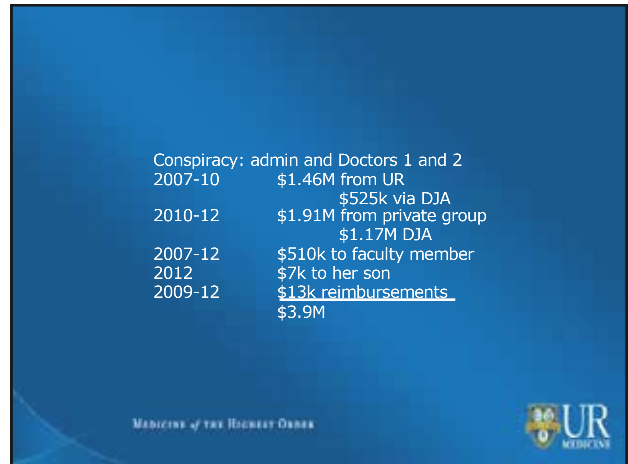
INFORMATION
(Felony)

COUNT 1
(Conspiracy to Commit Mail Fraud)

The United States Attorney Charges That:

THE CONSPIRACY

1. From in or about May 2007 to in or about September 2012, in the Western District of New York, the defendant, DEBRA [illegible] did knowingly, willfully and unlawfully [illegible]



Back to Schedule

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA,

v. 13-CR-6103

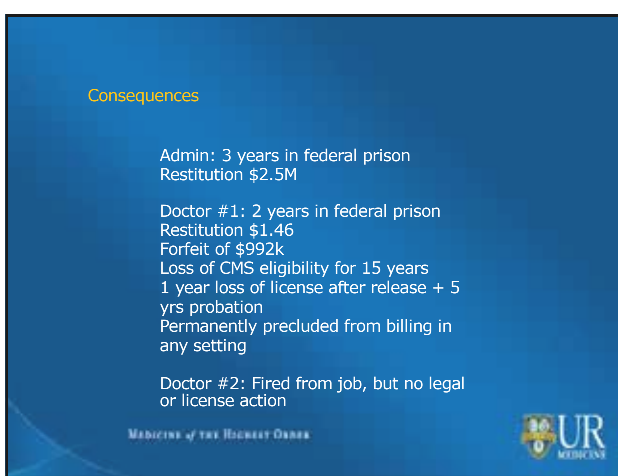
DEBRA

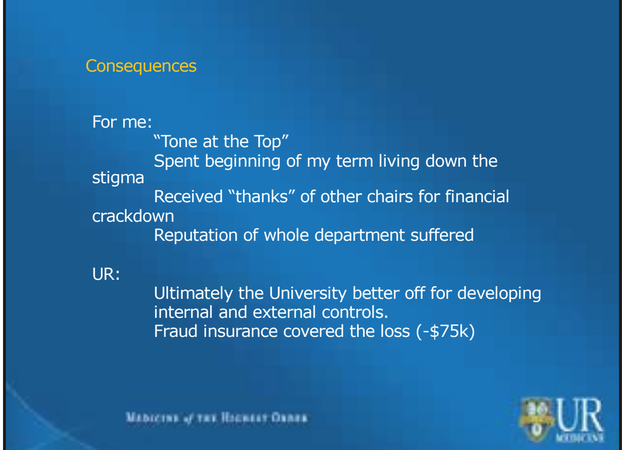
Defendant.

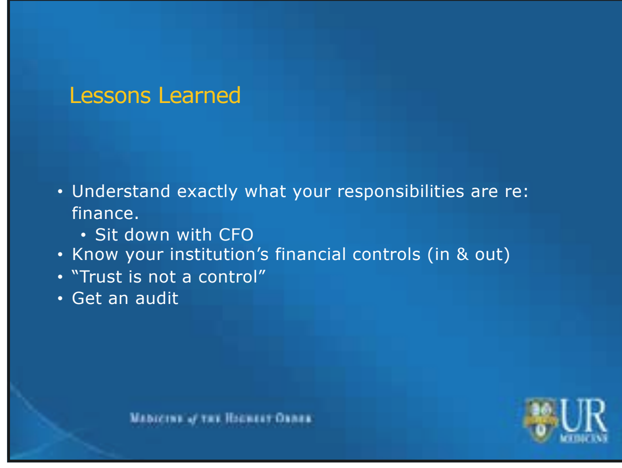
PLEA AGREEMENT

The defendant, DEBRA and the United States Attorney for the Western District of New York (hereinafter "the government") hereby enter into a plea agreement with the terms and conditions as set out below.

I. THE PLEA AND POSSIBLE SENTENCE





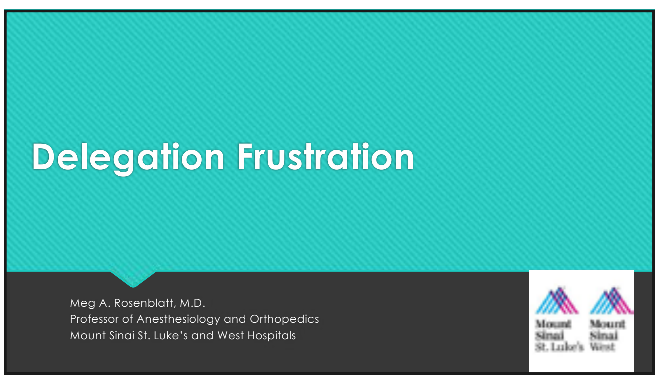


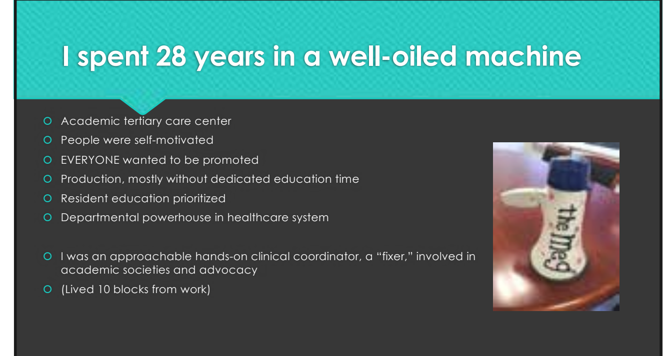
HANDOUT

Mistakes Made; Lessons Learned

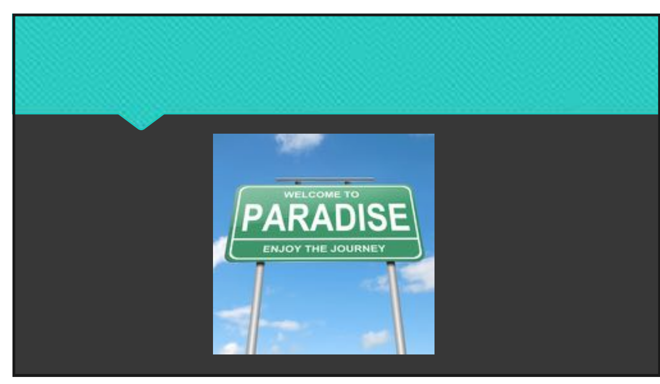
Meg A. Rosenblatt, MD, FASA

11/02/2018
10:42am – 10:54am

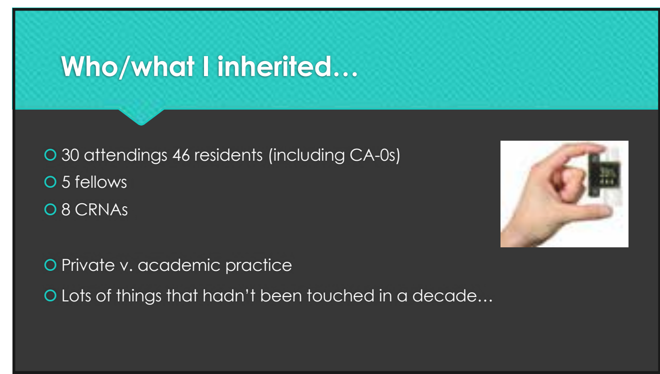

Delegation Frustration
Meg A. Rosenblatt, M.D.
Professor of Anesthesiology and Orthopedics
Mount Sinai St. Luke's and West Hospitals
Mount Sinai St. Luke's
Mount Sinai West


I spent 28 years in a well-oiled machine
Academic tertiary care center
People were self-motivated
EVERYONE wanted to be promoted
Production, mostly without dedicated education time
Resident education prioritized
Departmental powerhouse in healthcare system
I was an approachable hands-on clinical coordinator, a "fixer," involved in academic societies and advocacy
(Lived 10 blocks from work)
the Meg

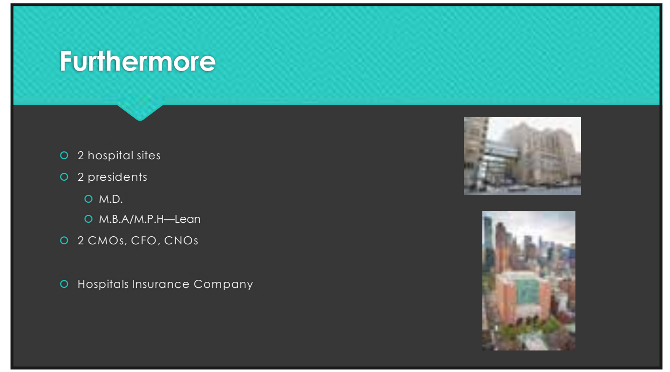
Our healthcare system bought a failing healthcare system
I agreed to Chair the only hospital that had its own residency
St. Luke's Roosevelt
Continuum Health Partners, Inc.

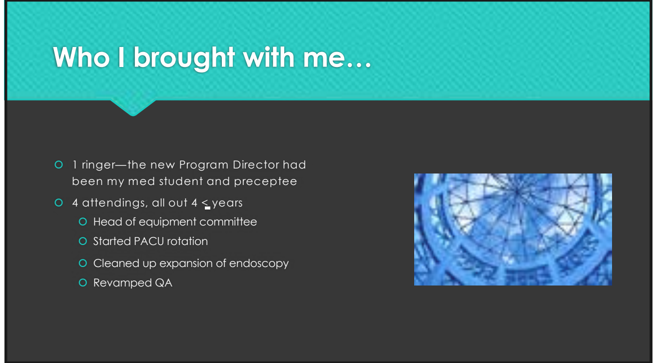

WELCOME TO
PARADISE
ENJOY THE JOURNEY

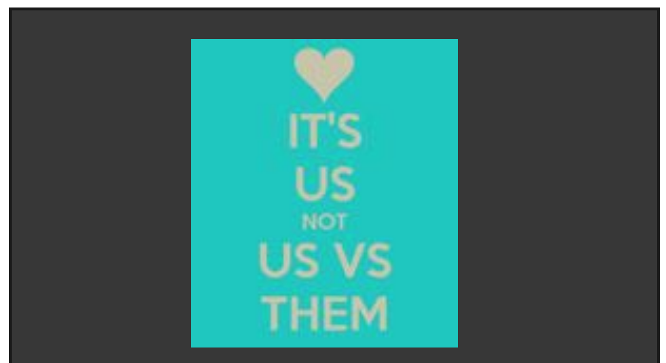
EXPECTATIONS
REALITY


Who/what I inherited…
30 attendings 46 residents (including CA-0s)
5 fellows
8 CRNAs
Private v. academic practice
Lots of things that hadn't been touched in a decade…

Back to Schedule

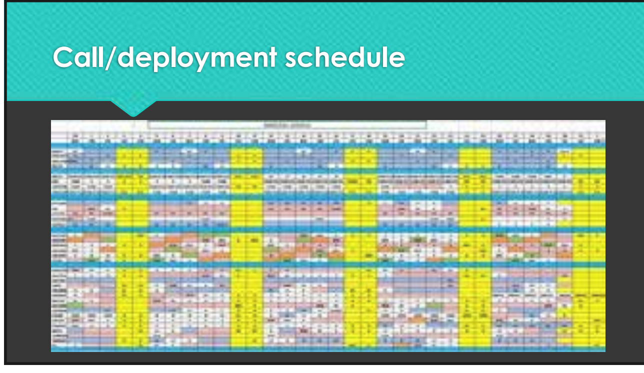






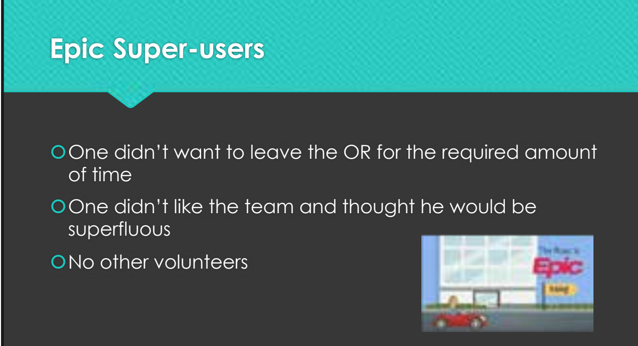
IF I FOUND A TASK UNPLEASANT, I DID IT MYSELF

I went from being a pretty good clinician to a pretty mediocre administrator…



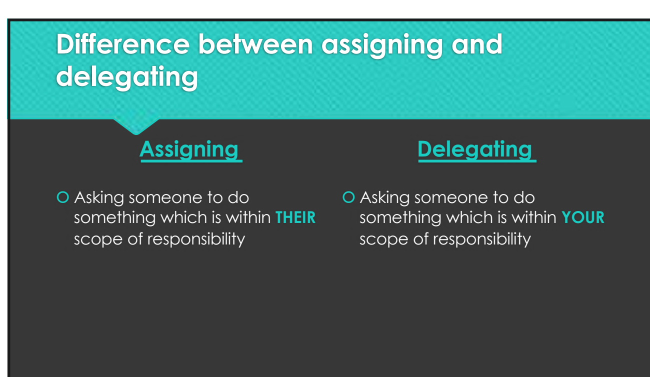
Organize a Preadmission Testing Unit

- One refused
- One was dismissed from the assignment
- One expired



Delegating consists of:

- Assigning work
- Assigning responsibility
- Assigning authority



Afraid of losing power?
Be a hero?

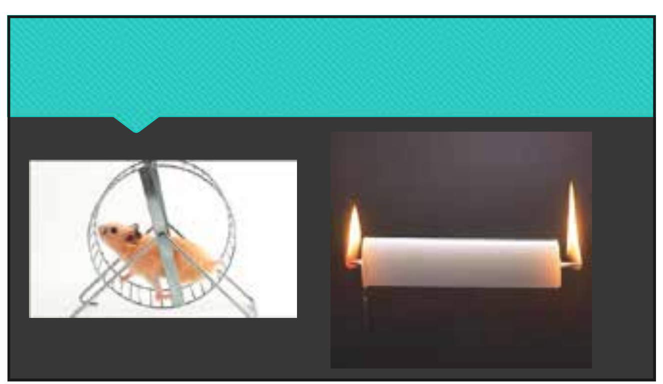
I didn't have confidence they would perform to my expectations.

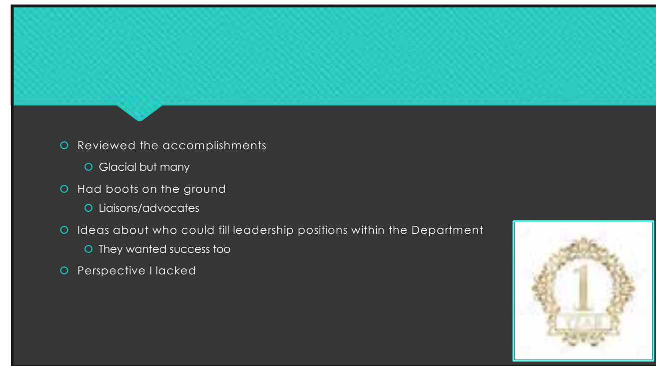
Seven Strategies for Delegating Better and Getting More Done

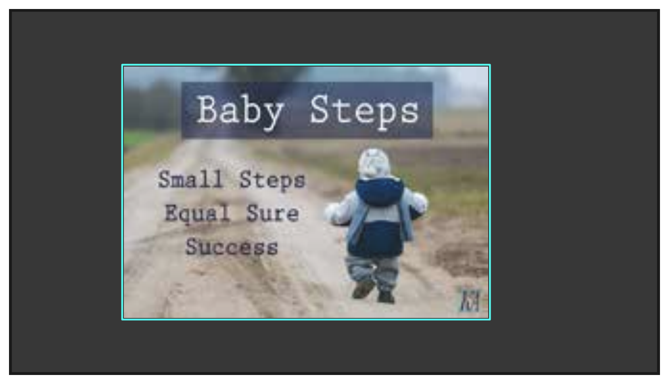
- Learn to let go
- Establish a firm priority system
- Play to you work strength
- Include instruction
- Teach new skills
- Trust, but verify
- Use feedback

De Mers, Inc. 2015

Back to Schedule







Back to Schedule

Lessons Learned: Delegation Cooperation

- You can't do everything yourself and do it well
- Getting into the operating room is great for your own morale, but may not lead to truth
- Find people with like vision
  - Encourage
  - Listen
- "Modified Oligarchy" = SUCCESS

Back to Schedule

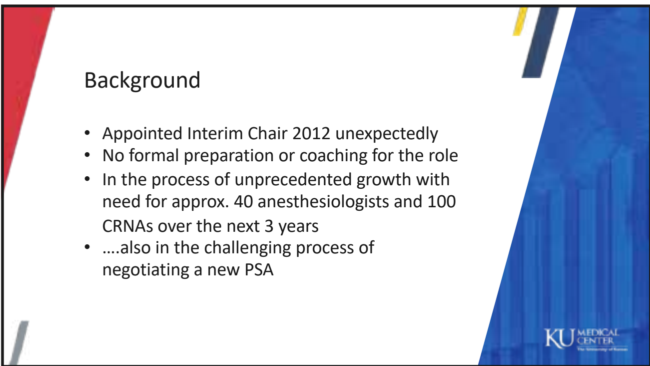
HANDOUT

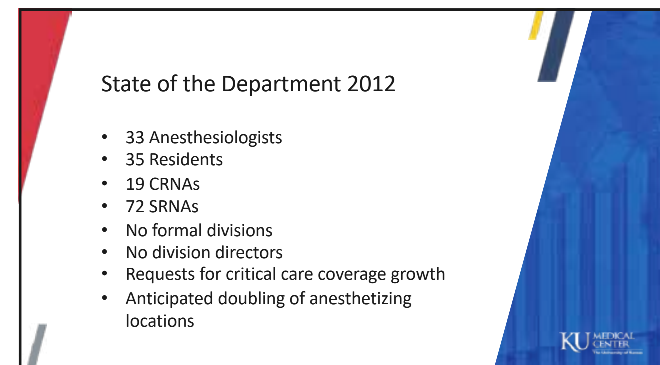
Mistakes Made; Lessons Learned

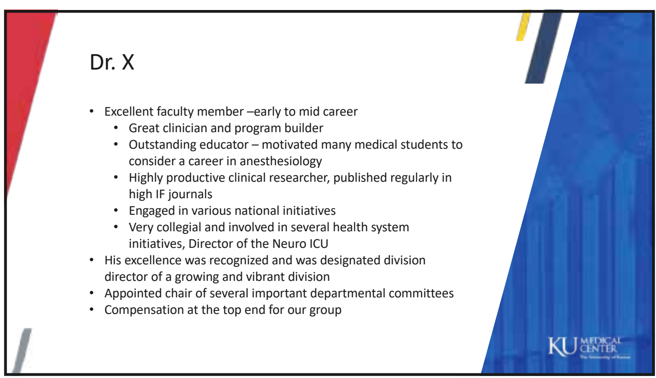
Talal W. Khan, MD, MBA

11/02/2018
10:54am – 11:06am

Back to Schedule







Back to Schedule

Factors Affecting Faculty Attrition

- Faculty morale
- Perceptions of work-life balance
- Perceived support from the institution
- Faculty development
- Recognition and rewards
- Protected time
- Relationship with superiors
- Role clarity

Jeanmonod R. Retaining talent at academic medical centers. Int J Acad Med [serial online] 2016 [cited 2018 Oct 7];2:46-51

KU MEDICAL CENTER

The Case for Strategic Talent Management in Academic Medicine – AAMC 2011

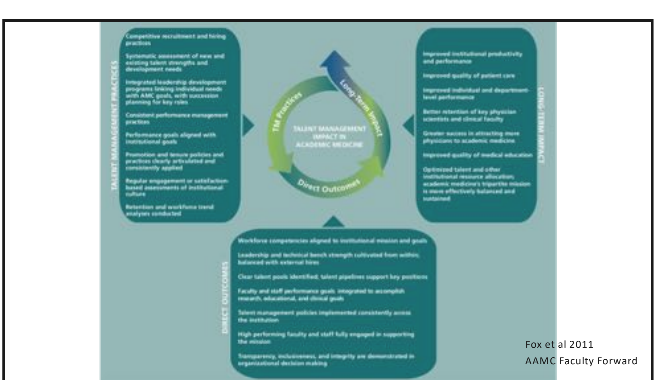
- Human capital – academic medicine's workforce talent – can represent a key driver of transformation within academic medical centers
- An evidence-based approach to attracting, developing, and retaining talent is a necessary foundation for supporting transformative change
- Activities
  (1) engage the workforce as a key driver of organizational performance, including quality of healthcare
  (2) promote a strategic and systemic approach to building and sustaining the workforce as a critically important organizational resource

KU MEDICAL CENTER

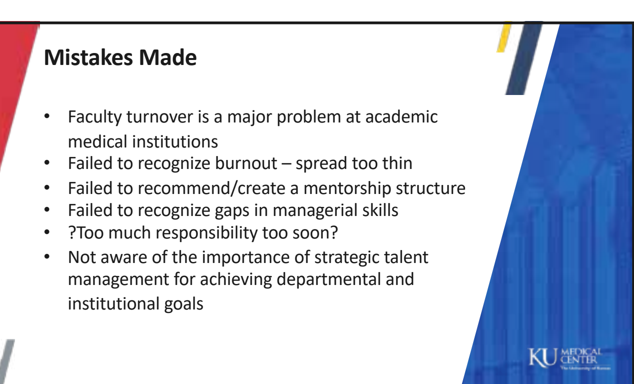
Impact of Strategic Talent Management

- **High levels of employee engagement and retention**
  - These are important intermediate outcomes that have been linked to positive organizational performance, defined by productivity or financial measures
- **Positive individual-level performance of faculty and staff, including job performance and organizational citizenship behaviors**
  - Robust talent management practices in recruitment, employee development and morale-building can directly improve individual performance
- **Positive organizational-level performance**
  - including quality of patient care, hospital mortality rates, customer service quality, productivity, and various measures of nancial performance

KU MEDICAL CENTER



Fox et al 2011
AAMC Faculty Forward



Lessons Learned

- Recruit with intention to retain – Strategic Talent Management
- Mentoring Program
  - Career Development Programs appear to offer retention advantage *Chang 2016*
- Faculty Fulfilment
  - Purpose, autonomy, escalating levels of responsibility,
- Burnout Recognition
  - Focus on Wellness, "Wellness Committee"
- "Work-Life Balance"
- Recognition and reward programs
- Formal faculty development – VC Fac Development
- Attention to faculty professional and personal goals – annual assessments

KU MEDICAL CENTER

Back to Schedule

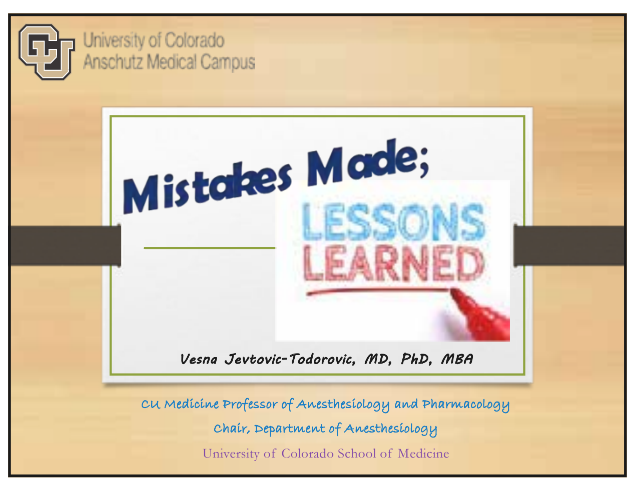
HANDOUT

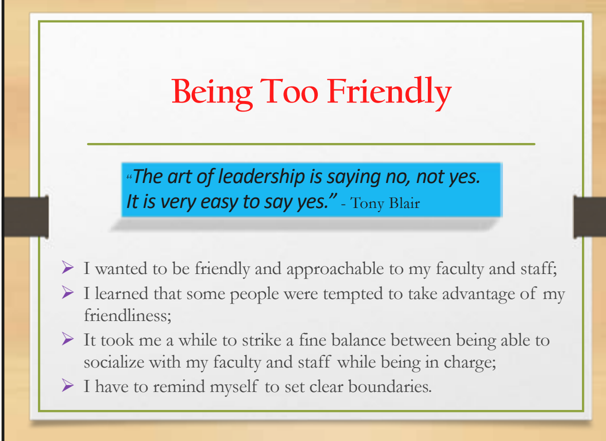
Mistakes Made; Lessons Learned

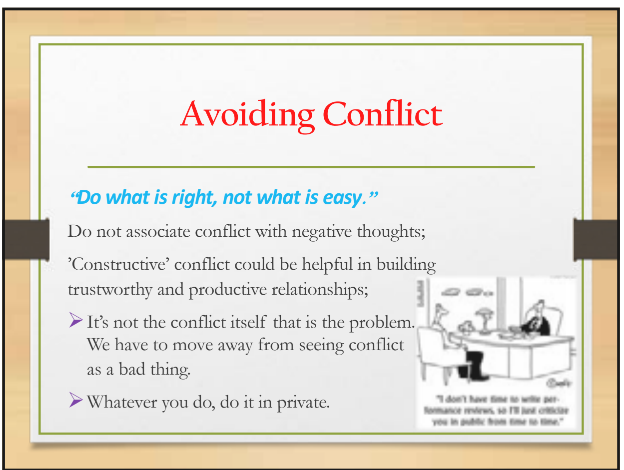
Vesna Jevtovic-Todorovic, MD, PhD, MBA

11/02/2018
11:06am – 11:18am

Back to Schedule







Not Delegating Enough

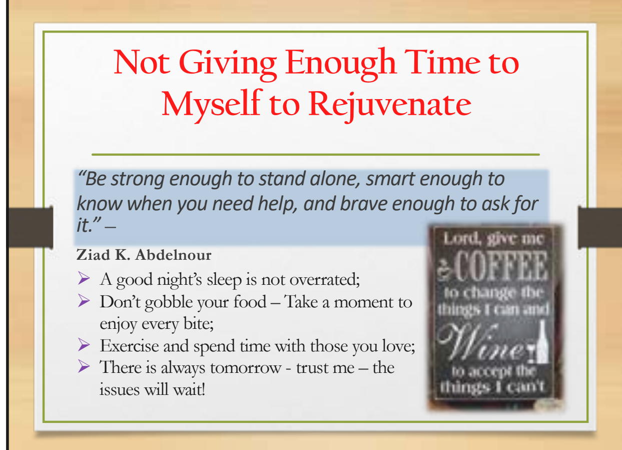
"*Don't tell people how to do things, tell them what to do and let them surprise you with their results.*" - George Patton

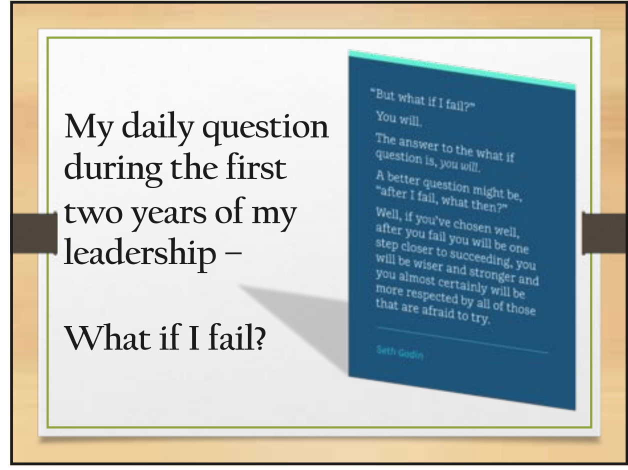
"*The best executive is the one who has sense enough to pick good men (women) to do what he (she) wants done, and self-restraint to keep from meddling with them while they do it.*" -Theodore Roosevelt

Giving Feedback in Real Time - It is Crucial!!!

- **Culture of Transparency and Trust** - Provide honest and helpful feedback and trust that it will be used in a positive way.
- **Improve Employee Performance** - Address and document performance issues in real time so that the faculty can quickly course correct. Performance issues no longer surface as surprises during formal performance reviews.
- **Increase Motivation by Offering Recognition and Encouragement** - Faculty should be called out for their strengths and accomplishments, reinforcing strong performance and positive contributions.
- **Reduce the Amount of Time Required to Prepare for Formal Performance Reviews** - The chair and the faculty can easily review performance for the entire period and create goals for the future.

Back to Schedule





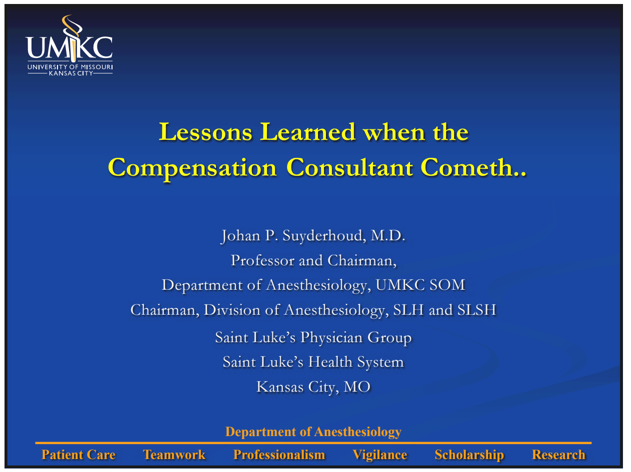
Back to Schedule

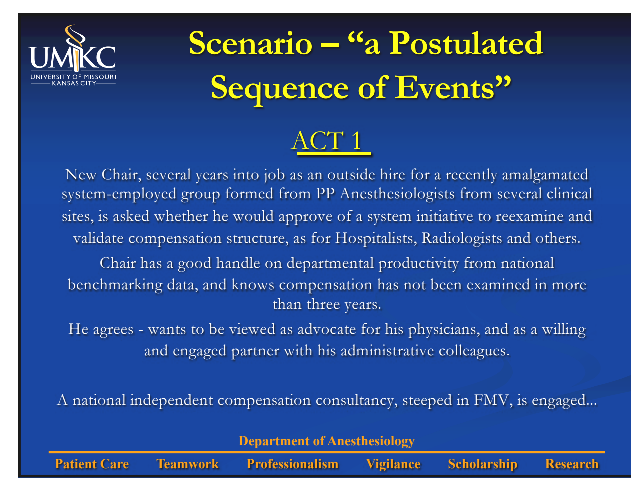
HANDOUT

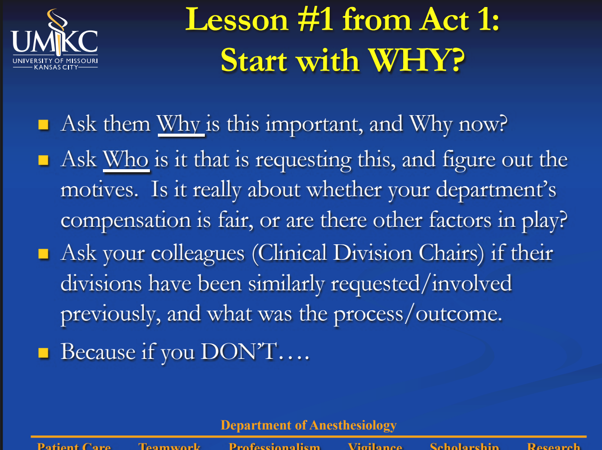
Mistakes Made; Lessons Learned

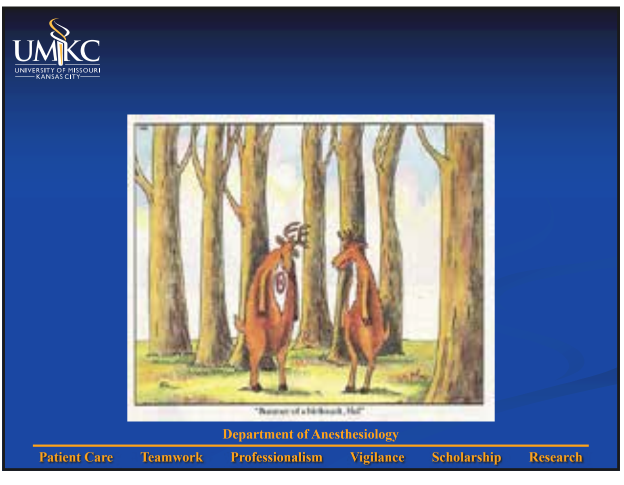
Johan P. Suyderhoud, MD

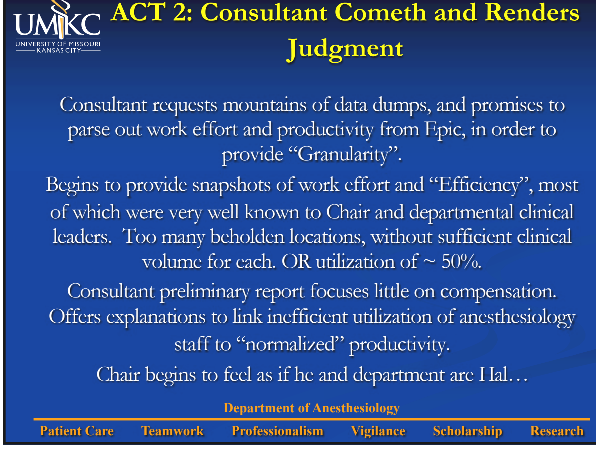
11/02/2018
11:18am – 11:30am

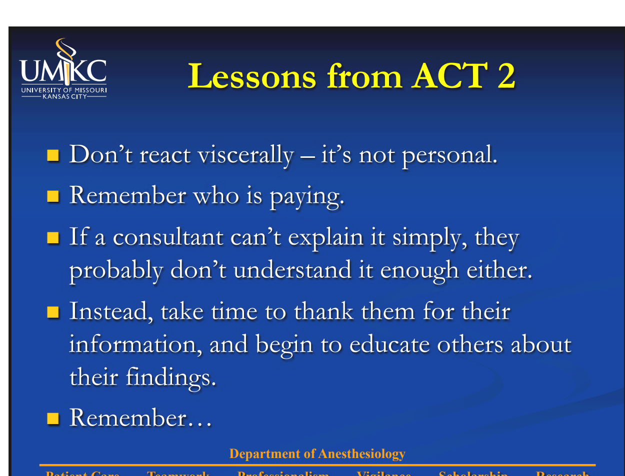

UMKC
UNIVERSITY OF MISSOURI KANSAS CITY
Lessons Learned when the Compensation Consultant Cometh..
Johan P. Suyderhoud, M.D.
Professor and Chairman,
Department of Anesthesiology, UMKC SOM
Chairman, Division of Anesthesiology, SLH and SLSH
Saint Luke's Physician Group
Saint Luke's Health System
Kansas City, MO
Department of Anesthesiology
Patient Care Teamwork Professionalism Vigilance Scholarship Research

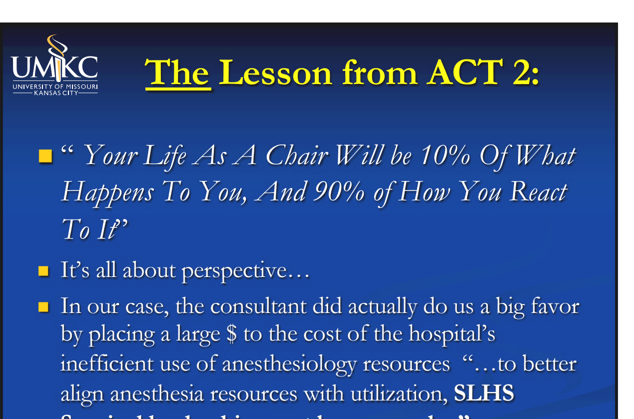

UMKC
Scenario – "a Postulated Sequence of Events"
ACT 1
New Chair, several years into job as an outside hire for a recently amalgamated system-employed group formed from PP Anesthesiologists from several clinical sites, is asked whether he would approve of a system initiative to reexamine and validate compensation structure, as for Hospitalists, Radiologists and others.
Chair has a good handle on departmental productivity from national benchmarking data, and knows compensation has not been examined in more than three years.
He agrees - wants to be viewed as advocate for his physicians, and as a willing and engaged partner with his administrative colleagues.
A national independent compensation consultancy, steeped in FMV, is engaged...
Department of Anesthesiology
Patient Care Teamwork Professionalism Vigilance Scholarship Research

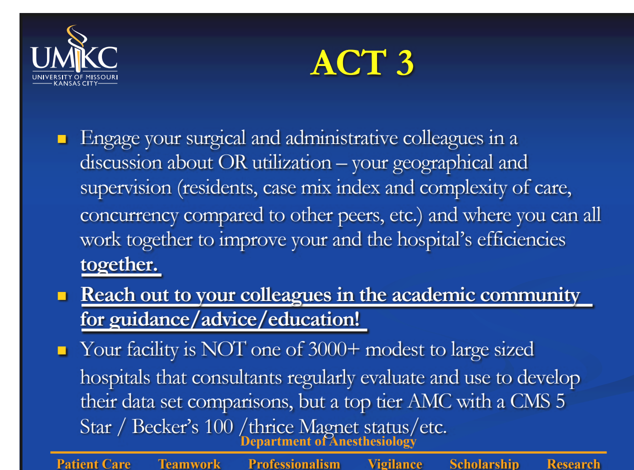

UMKC
Lesson #1 from Act 1: Start with WHY?
Ask them Why is this important, and Why now?
Ask Who is it that is requesting this, and figure out the motives. Is it really about whether your department's compensation is fair, or are there other factors in play?
Ask your colleagues (Clinical Division Chairs) if their divisions have been similarly requested/involved previously, and what was the process/outcome.
Because if you DON'T….
Department of Anesthesiology
Patient Care Teamwork Professionalism Vigilance Scholarship Research


UMKC
Department of Anesthesiology
Patient Care Teamwork Professionalism Vigilance Scholarship Research


UMKC
ACT 2: Consultant Cometh and Renders Judgment
Consultant requests mountains of data dumps, and promises to parse out work effort and productivity from Epic, in order to provide "Granularity".
Begins to provide snapshots of work effort and "Efficiency", most of which were very well known to Chair and departmental clinical leaders. Too many beholden locations, without sufficient clinical volume for each. OR utilization of ~ 50%.
Consultant preliminary report focuses little on compensation. Offers explanations to link inefficient utilization of anesthesiology staff to "normalized" productivity.
Chair begins to feel as if he and department are Hal…
Department of Anesthesiology
Patient Care Teamwork Professionalism Vigilance Scholarship Research


UMKC
Lessons from ACT 2
Don't react viscerally – it's not personal.
Remember who is paying.
If a consultant can't explain it simply, they probably don't understand it enough either.
Instead, take time to thank them for their information, and begin to educate others about their findings.
Remember…
Department of Anesthesiology
Patient Care Teamwork Professionalism Vigilance Scholarship Research





UMKC

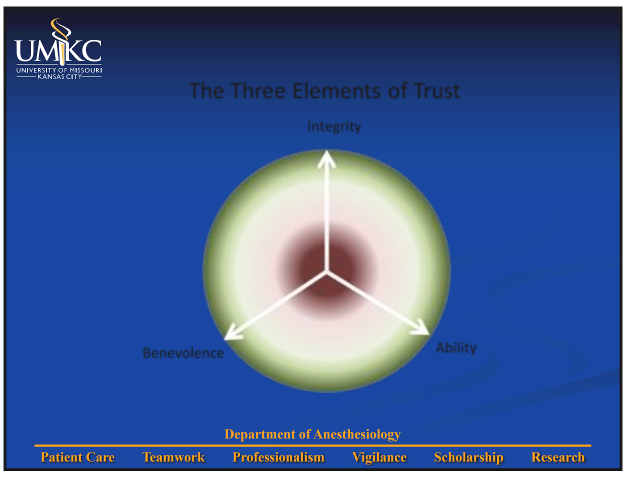
UNIVERSITY OF MISSOURI KANSAS CITY

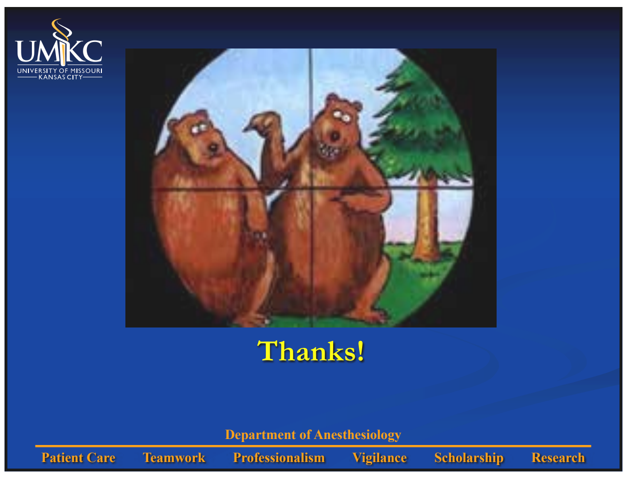
ACT 4

- Department offered to staff new locations with saved resources.
- OR utilization rates have improved markedly to above 60-70%
- Remember that the rate of System leadership change is far greater than that of physicians.
- Consultant findings focused on facility inefficiencies, resulting in…..nationally prominent OR Efficiency Consultant!
- **"…geography is the primary challenge to the efficient delivery of operative care…"**
- Department is engaged in helping to implement OR efficiency project, co-championed by both anesthesiology and surgery Chairs…scheduling, preference cards, vendor selection, standardization, etc.

Department of Anesthesiology

Patient Care Teamwork Professionalism Vigilance Scholarship Research





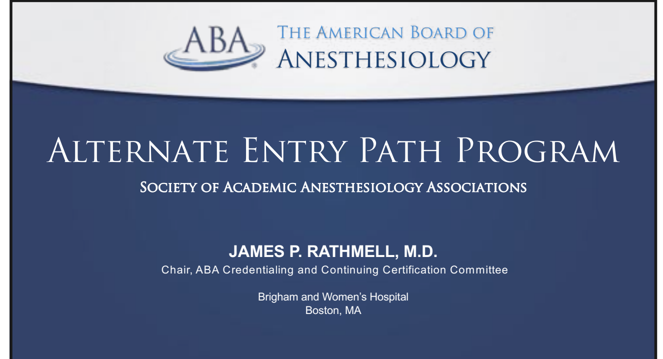
HANDOUT

Alternate Entry Path (AEP) ABA Certification

James P. Rathmell, MD

11/02/2018
11:45am – 12:00pm

Back to Schedule



Two AEP Pathways

Research & Fellowship Pathway

- Internationally-trained and certified
- Practicing in U.S.
- Pre-existing track record of scholarship as represented by the scholarship of discovery, dissemination and application
- Complete four years of continuous experience in one anesthesiology department
- Approved four-year plan of fellowship training, research or faculty experience
- Funding for K or R grants from NIH, FAER, AHA, APSF, IARS, DOD, VA merit

Clinician Educator Pathway

- Internationally trained in an ABA-approved training program with 4+ years (3+ years of anesthesiology-specific training) of post-graduate education in anesthesiology
- Letter of support from sponsoring program's chair & PD
- Valid unrestricted medical license for scope of practice
- Board certification in anesthesiology from an ABA-approved certifying body
- Clinically active with a faculty appointment for four continuous years in an ACGME-accredited anesthesiology program
- Academic rank of assistant professor or higher at the time of application
- Approved four-year mentoring plan for future academic development as a clinician educator

Training & Certification Systems

Australia & New Zealand
Canada
Europe (other than UK and Ireland)
Ireland
Singapore
South Africa
United Kingdom

How to Apply

- Collect the checklist items for the appropriate pathway
- Complete the online application
- Mail the application fee with the signed, mail-in form to the ABA

Back to Schedule

Questions?

7

What's changing?

Current Policy	Proposed Policy
• Up to 12 weeks (60 working days) of time away during CA1-3 years	• Up to 12 weeks (60 working days) of time away during CA1-3 years • Up to **8 additional weeks of leave** with ABA-approval (40 working days) during the CA1-3 years **without extending training**

Absences in excess of both the current and proposed policies will require lengthening total training time

Request for Feedback

- Surveying trainees, chairs and program directors to ensure policy meets their needs before it's effective on July 1, 2019
  - We've received 650+ responses so far, of which 600 indicated that the new policy meets their needs very well or fairly well
- The survey closes Nov. 9, so please submit your responses soon
  - Once we receive the survey data we will finalize and announce the policy
  - It will go into effect July 1, 2019

10

Feedback Themes

- Residents may experience significant personal concerns that require leave, but feel guilty about taking time off
- Residents need as much time as possible in training to meet the clinical competency standards
- This may cause division between residents
- *"This is an amazing and wonderful change to the policy! Especially as all specialties are moving towards a milestone based curriculum."*

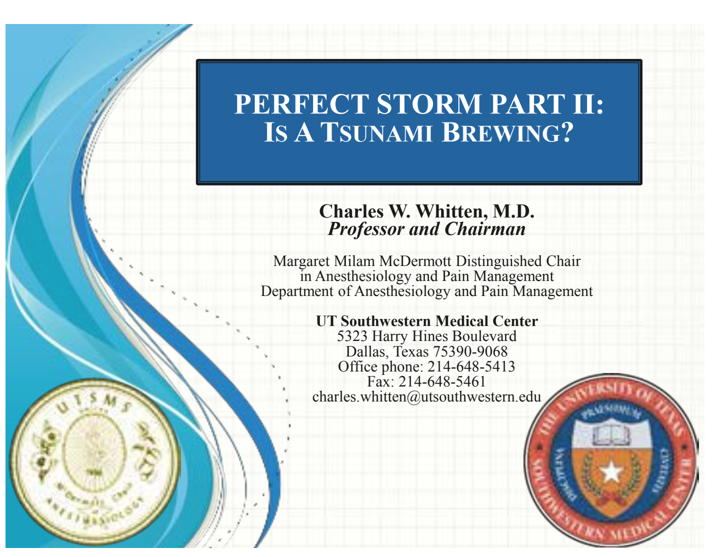
11

HANDOUT

Perfect Storm

Charles W. Whitten, MD

11/02/2018
1:15pm – 2:00pm



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 by Kevin Tremper and leaves a wonderful legacy for us in Academic Anesthesiology.

No data was presented in 2012 at the SAAA Meeting. I have presented 2012 data for completeness in some of the slides. I have compiled this data since 2013.

3

The Etiology of Perfect Storm Part I

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 2017- 1,630 Senior Residents. A total of 6,207 Anesthesiology Residents are enrolled in 150 Core Residency Programs graduated (**35% women enrolled in all training programs**).

Residency Production: Confounding Factors

- In 2017, we know that the following pursued ACGME fellowships:

Number of Programs (N)	Positions Filled	% Women
Critical Care Medicine (N=53)	150/202	28%
Pain Medicine (N=98)	331/335	22%
Pediatrics (N=55)	184/213	48%
Adult Cardiothoracic (N=64)	202/207	30%
OB (N=27)	38	59%
Clinical Informatics (N=0)	0	N/A

6

Back to Schedule

SAAA YEARLY SURVEY DATA 2017

7

2017 Average Department

	Mean	+/- SD	Median
Surgical Anesthesiologist FTE s	49.6	32	42.2
Acute Pain (In-Patient)	2.3	2.58	1.2
Chronic Pain (Out-Patient)	3.7	2.9	3.0
ICU	4.0	4.8	2.0

2017 Average Department Academic Rank

Chair	1.0
Professor	8.6
Associate Professor	13.9
Assistant Professor	38
Instructor	6.3
Non Academic Clinical	3.1
Total	70.9

8

National Clinical Coverage

	Mean	+/- SD	Median
How many OR s does your Department cover each day Monday- Friday?	46.6	27	42
How many Non-OR/Off Site locations does your Department cover each day Monday-Friday?	13	9.89	10
How many OB deliveries with anesthesia involvement does your Department have each year? *How do we staff OB at night and at what level of deliveries does it take to have a dedicated person covering this service?	3,038	2,248	2,424

9

National 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.			
OR	29.8	19.9	24
OB	1.5	1.03	1
ICU	2.0	2.09	1.8
Acute Pain	1.4	1.05	1
Pain Clinic	2.7	1.92	2
Pre-Op Clinic	1.0	0.76	1
Other	1.3	2.71	0
Total	39.7		

10

Average Department Clinical Sites Coverage Monday-Friday

	Mean	+/- SD	Median
ORs	46.6	27	42
Off Site	13	9.89	10
OB	1.5	1.03	1
ICU	2.0	2.09	1.8
APS	1.4	1.05	1
Pain	2.7	1.92	2.0
Pre-Op	1.0	0.76	1
Other	1.3	2.71	0
Total	69.5		
Faculty/Sites	*70.9/69.5= 1.02	(0.7953 in 2016)	

* Reflection of total faculty not clinical FTE

11

National Institutional Support

	Mean	+/- SD
Institutional Support	$ 11,063,270	$ 8,426,667
Institutional Support / FTE	$ 183,712	$ 130,961

12

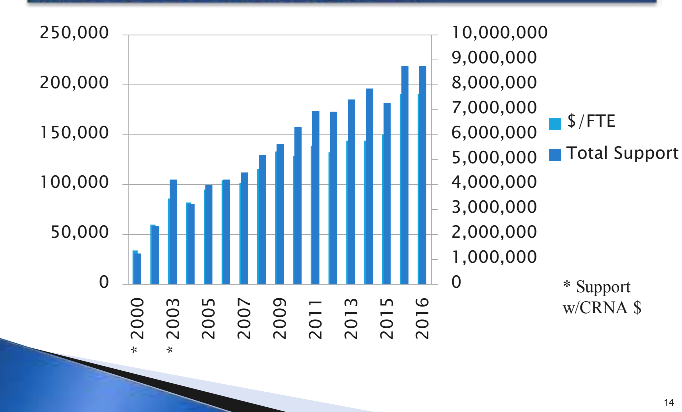
Back to Schedule

Total Support	25%	Median	75%
Total Support	$ 4,252,814	$ 8,924,693	$ 16,665,818
Total Support per FTE	$ 74,872	$ 167,473	$ 258,494

Mean National Institutional Support

Total Support/FTE		
	2017	$ 183,712
	2016	$ 190,584
	2015	$ 191,912
	2014	$ 196,441
	2013	$ 181,000

13



14

Comparison of Economic Status by Departmental Size

<40 (n=23) +88 (n=24)

15

<40 n= 23	Mean	+/- SD	Median
Institutional Support	$ 3,921,534	$ 3,643,429	$ 2,200,000
Institutional Support per FTE	$ 152,573	$ 142,234	$ 118,919

+88 n= 24	Mean	+/- SD	Median
Institutional Support	$ 14,947,231	$ 9,861,137	$ 11,958,610
Institutional Support per FTE	$ 135,214	$ 90,809	$ 111,951

16

National Department Clinical Revenue

	Mean	+/- SD
ASA Units	$ 36,301,401	$ 25,157,497
ICU Units	$ 1,888,944	$ 2,445, 233
Pain Units	$ 2,692,156	$ 3,452,932
Other	$ 1,020,986	$ 1,290,986
Total	**$ 41,903,487** ↑	

17

National Collection / FTE

	Mean	+/- SD
ASA Units	$ 588,325	$ 410,649
ICU Units	$ 24,442	$ 26,179
Pain Units	$ 49,375	$ 103,634
Other	$ 12,924	$ 14,724

Is it a true reflection of clinical FTE??

18

Back to Schedule

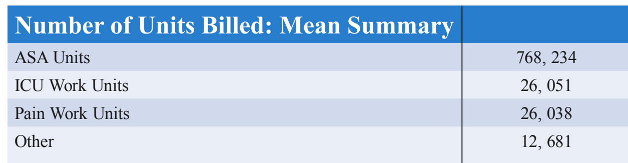
Billing Production National

	Mean	+/- SD
Total Anesthesia Units Billed	768,234	369,337
Total Anesthesia Units Billed Per FTE	12,317	36,666

Billing Data

	Mean	+/- SD
What is your gross unit value?	$121.00	$ 37.60
What is your average $ amount collected per unit?	$ 50.63	$ 37.69
What unit value do you receive from Medicaid?	$ 16.40	$ 5.84

19



Number of Units Billed: Mean Summary

ASA Units	768, 234
ICU Work Units	26, 051
Pain Work Units	26, 038
Other	12, 681

Billing – Collection Mean Summary

ASA (Base and Time) units billed for anesthesia service	$ 50.63
Work units in ICUs (wRVUs)	$ 67.32
Units for Pain (wRVUs)	$ 116.39
Any other billed services	$ 57.54

20

ASA Units – Collections for Anesthesia Services

n	Mean	SD	90%	75%	50%	25%
89	$50.63	$37.69	$110.00	$52.70	$38.23	$30.00

wRVUs – Collections in ICUs

n	Mean	SD	90%	75%	50%	25%
75	$67.32	$72.39	$131.16	$69.28	$55.18	$35.00

wRVUs – Collections for Pain

n	Mean	SD	90%	75%	50%	25%
80	$116.39	$173.08	$159.50	$118.58	$83.81	$57.26

21

ASA Units Billed: ASA Units/Year

n	Mean	SD	90%	75%	50%	25%
88	768,234	369,337	1,236,295	1,068,005	664,941	513,399

Units Billed: ICU wRVUs/Year

n	Mean	SD	90%	75%	50%	25%
74	26,051	26,145	63,920	34,460	18,048	5,299

Pain wRVUs/Year

n	Mean	SD	90%	75%	50%	25%
81	26,038	21,627	57,511	36,448	19,120	10,898

22

Number of ASA Units Billed/FTE: ASA Units

n	Mean	SD	90%	75%	50%	25%
88	12,317	3,666	16,632	14,859	12,513	10,117

23

SAAA 2017 Compensation Total Compensation Including Income Plus Pension Contributions

Compensation Includes Income Plus Pension Contribution	25%	Median	75%
Instructor	$ 224,197	$ 303,903	$ 327,950
Assistant Professor	$ 323,000	$ 351,040	$ 384,558
Associate Professor	$ 345,223	$ 386,517	$ 417,093
Professor	$ 368,245	$ 414,703	$ 437,631
Chair	$ 549,642	$ 600,000	$ 665,225

*Is not a reflection of C FTE

24

Faculty Benefits

	25%	Median	75%
Instructor	$ 0	$ 27,739	$ 53,515
Assistant Professor	$ 48,244	$ 62,115	$ 83,252
Associate Professor	$ 51,214	$ 70,510	$ 89,228
Professor	$ 52,128	$ 70,919	$ 96,002
Chair	$ 61,636	$ 91,432	$ 129,158

25

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

26

Understanding Anesthesia Clinical Productivity and Survey Results

Utilize the Following:

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

27

Clinical Productivity by Facility Type

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

2013 Survey of Clinical Productivity of Academic Anesthesiology Departments

Association of Academic Anesthesiology Chairs (AAAC) of Society of Academic Anesthesiology Associations (SAAA)

SAAA AAAC

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

28

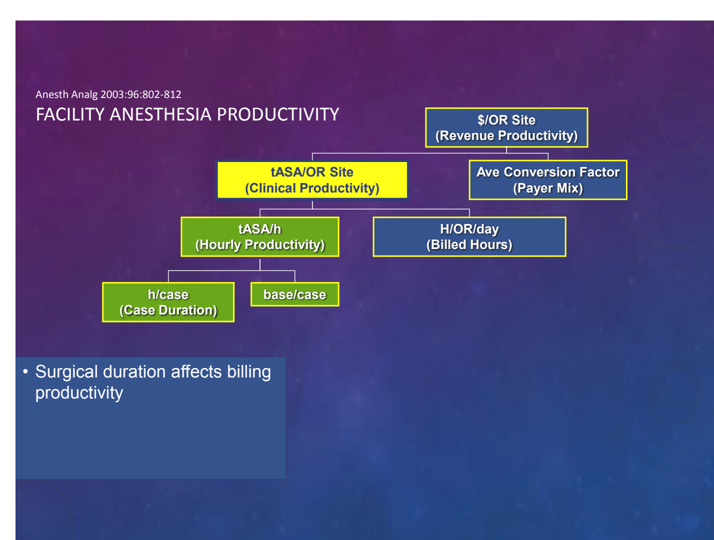
Benchmarks by Facility Type SAAA 2013

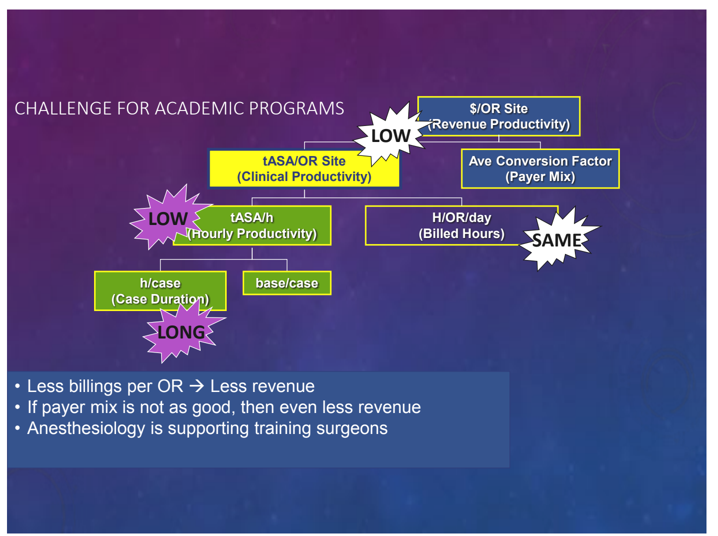
MEDIAN VALUES (50%)	All Groups (n=143)	All non ASC (n=111)	ASC (n=32)	AMC/ Indigent* (n=80)	Children (n=11)	Community (n=20)
Sites						
tASA/OR	tASA = Total ASA units billed, OR = Anesthetizing Site					
H/OR/d	H = 4 time units, d = 250 weekdays/year					
tASA/h	Hourly productivity					
Base/case		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

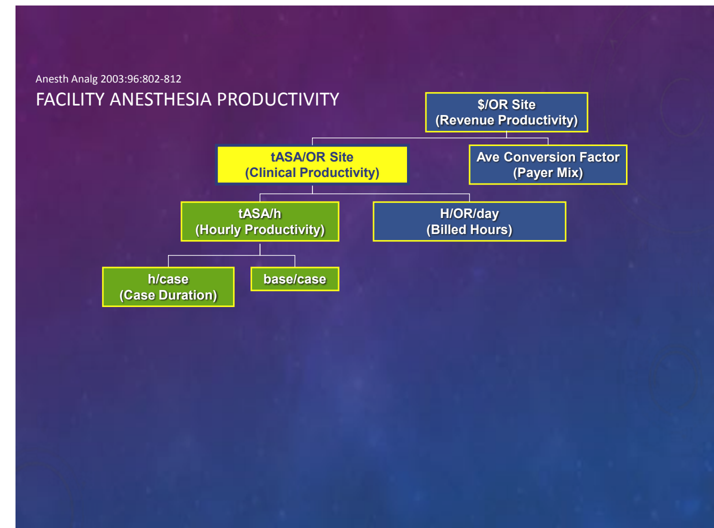
* Includes 1 Heart Hospital

2013 Survey of Clinical Productivity of Academic Anesthesiology Departments, ww2.SAAAhq.org

29







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						
H/OR/d						
tASA/h						
Base/case						
H/case						
Staffing Ratio						

What is Overall Clinical Productivity?

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

33

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

34

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	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

35

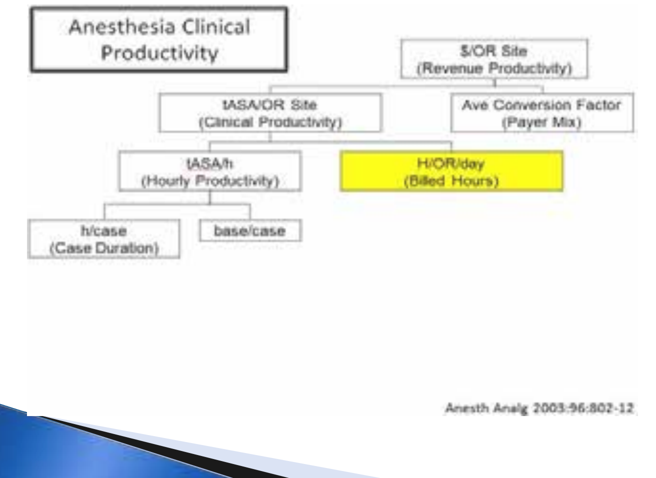
Benchmarks by Facility Type- SAAA 2013

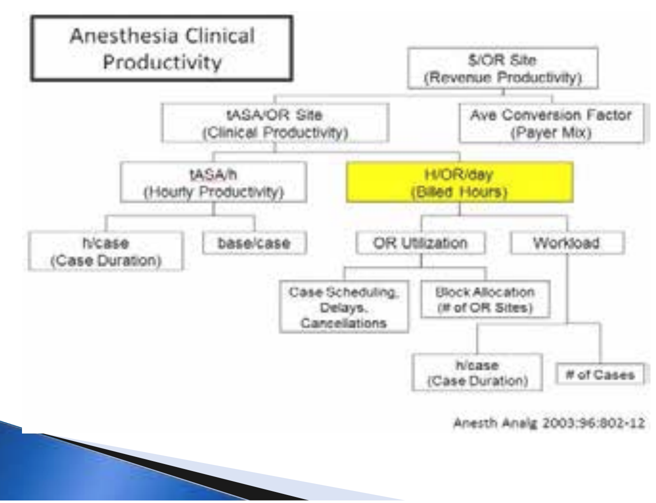
MEDIAN VALUES (50%)	All Groups (n=143)	All non ASC (n=111)	ASC (n=32)	AMC/ Indigent* (n=80)	Children (n=11)	Community (n=20)
Sites	21.0	26.0	4.0	31.4	18.0	14.5
tASA/OR	11,215	11,632	8,912	11,982	10,839	10,630
H/OR/d	6.5	6.9	4.3	7.3	6.0	6.0
tASA/h	6.7	6.7	7.4	6.5	7.3	7.1
Base/case	5.8	6.0	4.5	6.2	5.8	5.4
H/case	2.2	2.3	1.2	2.5	1.7	1.6
Staffing Ratio						

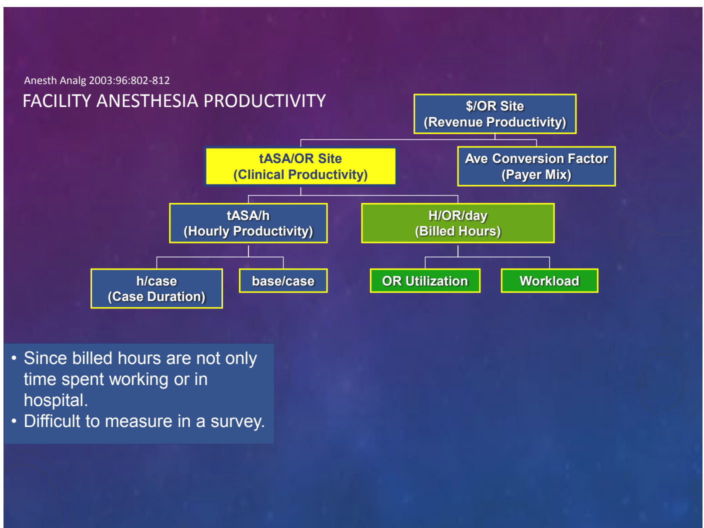
* Includes 1 Heart Hospital
2013 Survey of Clinical Productivity of Academic Anesthesiology Departments, www.SAAAhq.org

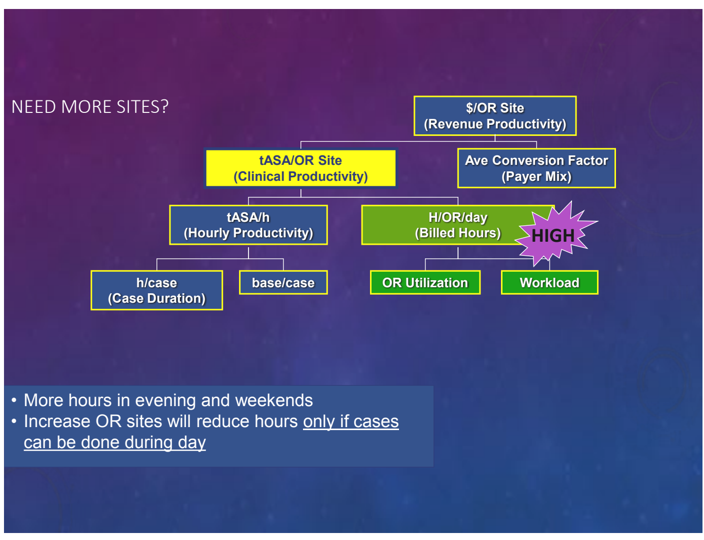
36

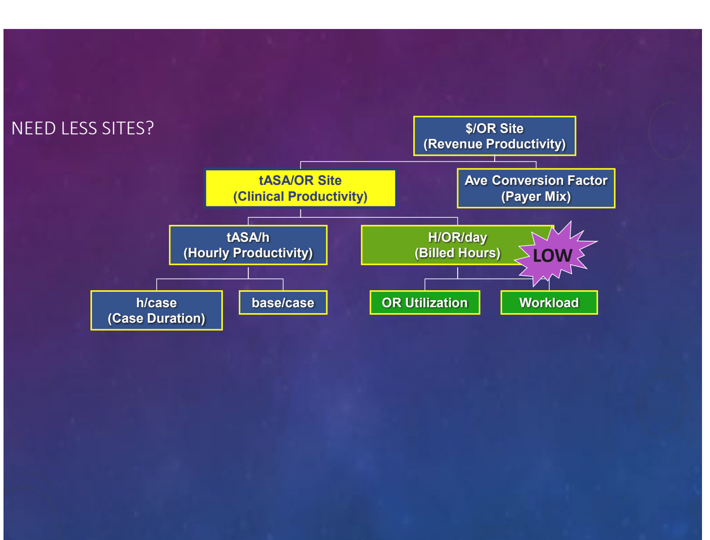
Back to Schedule











Benchmarks by Facility Type- SAAA 2013

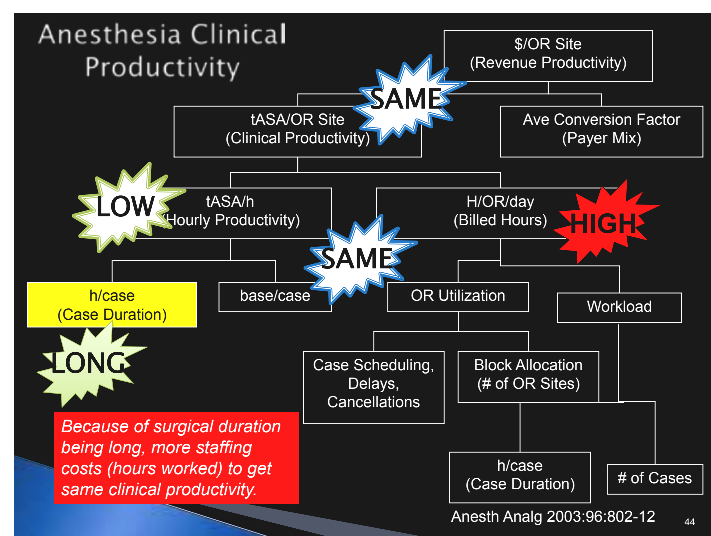
MEDIAN VALUES (50%)	All Groups (n=143)	All non ASC (n=111)	ASC (n=32)	AMC/ Indigent* (n=80)	Children (n=11)	Community (n=20)
Sites	21.0	26.0	4.0	31.4	18.0	14.5
tASA/OR	11,215	11,632	8,912	11,982	10,839	10,630
H/OR/d	6.5	6.9	4.3	7.3	6.0	6.0
tASA/h	6.7	6.7	7.4	6.5	7.3	7.1
Base/case	5.8	6.0	4.5	6.2	5.8	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

42

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



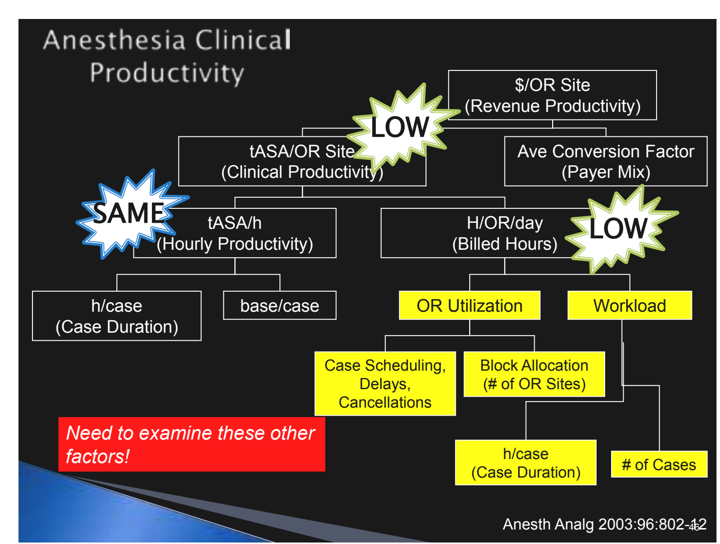
Benchmarks by Facility Type, SAAA 2013

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
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						

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

*Includes 1 Heart Hospital

45



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	6.5	6.9	4.3	7.3	6.0	6.0
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

47

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	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 n=3

48

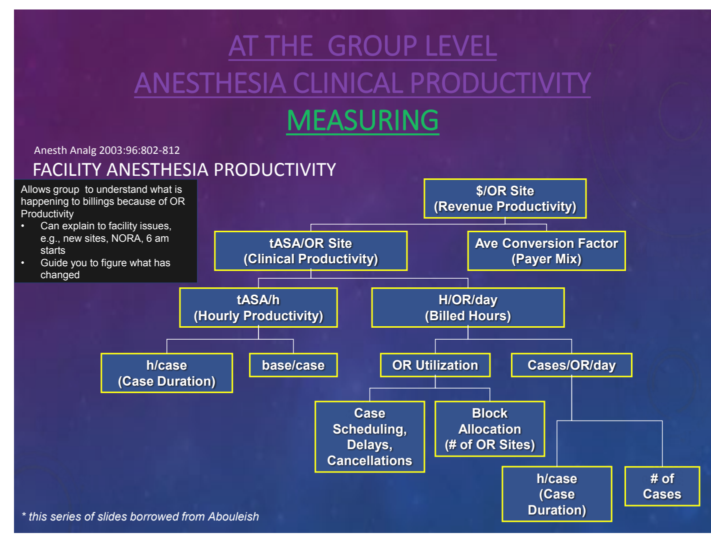
Back to Schedule

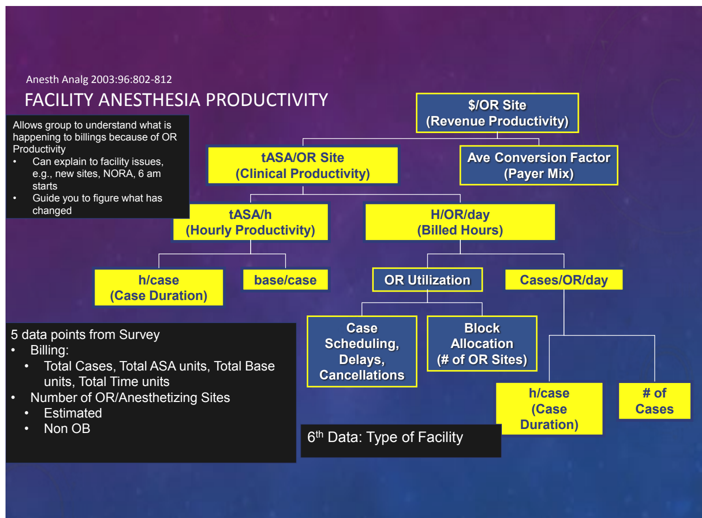
2013 AAAC/SAAA Clinical Productivity Report

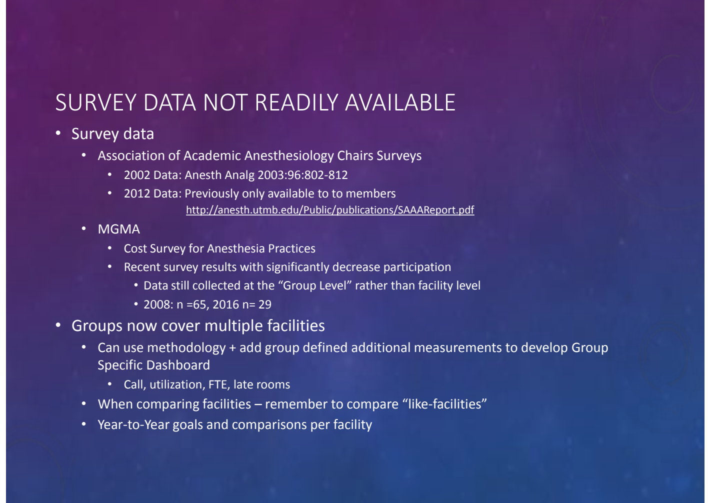
Key Findings:

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.

49



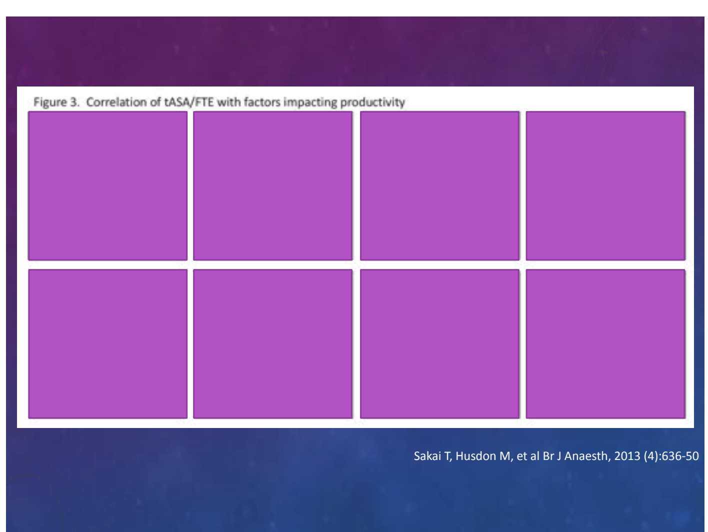




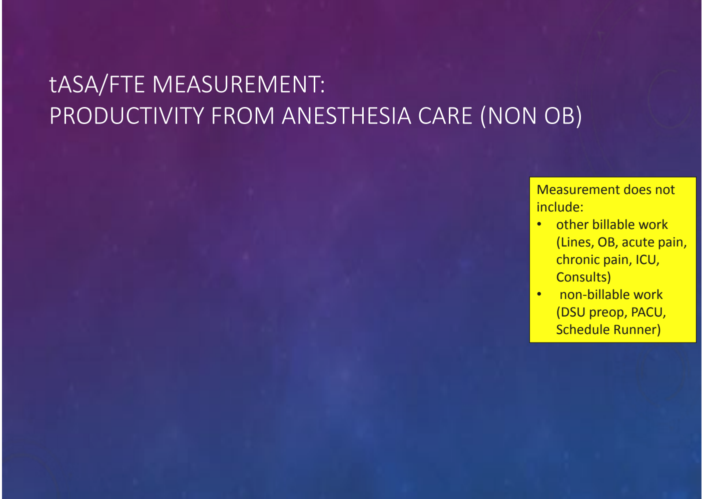
INTERNAL COMPARISONS: YOU DEFINE THE MEASUREMENT

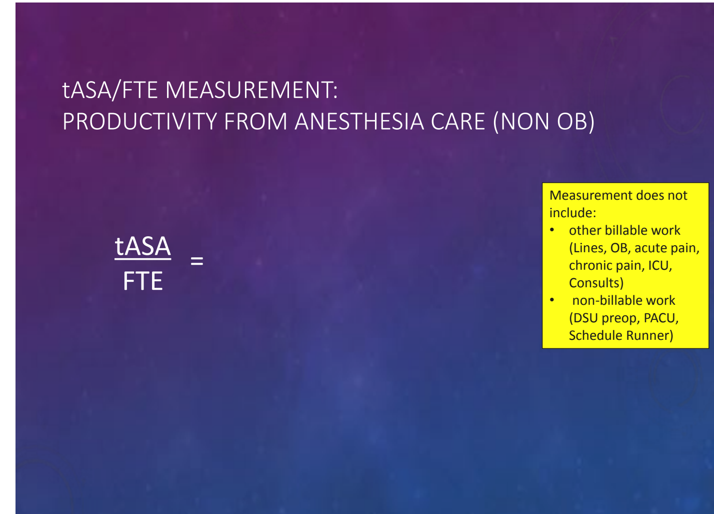
- Although "Per FTE" measurement is not meaningful when comparing productivity externally, you can use it internally.
- Hudson et al. describes UPMC experience in using
  - Must understand how calculate the FTE and apply same definition
  - Factors influencing
    - OR FTE rather than total FTE
    - Concurrency or staffing ratio
    - In house call or at home call

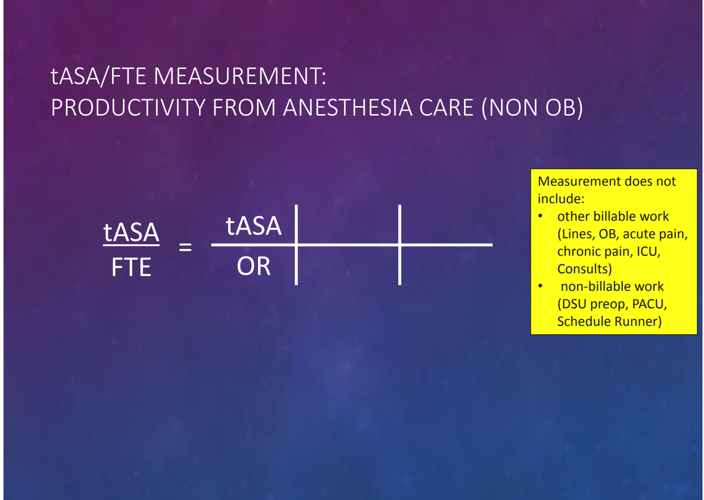
Hudson ME, Lebovitz. Anesthesiology Clinics, In Press 2018
Sakai T, Husdon M, et al Br J Anaesth, 2013 (4):636-50

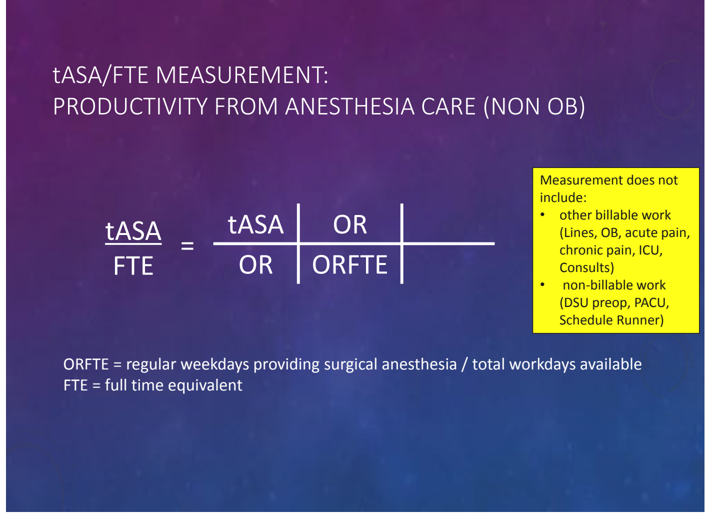


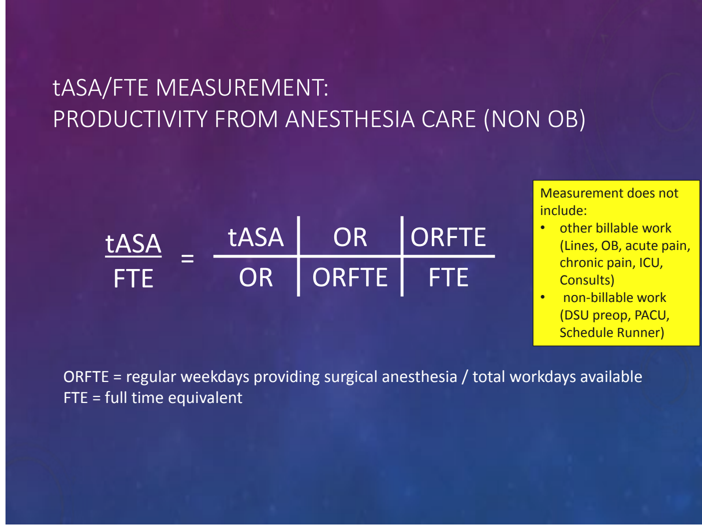
Back to Schedule

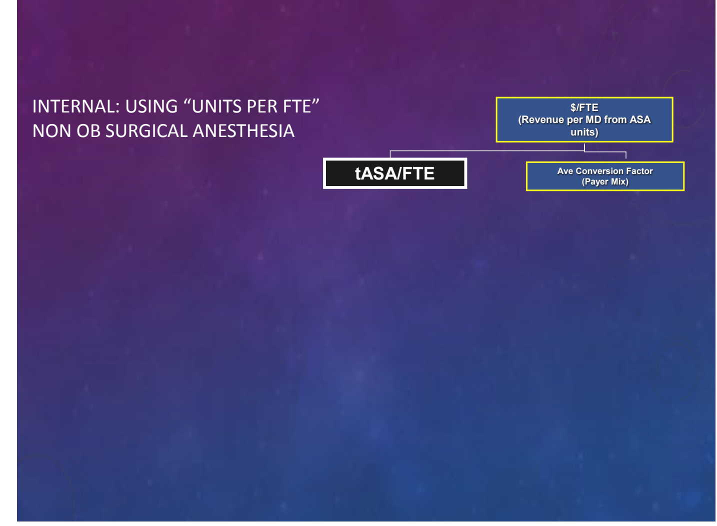




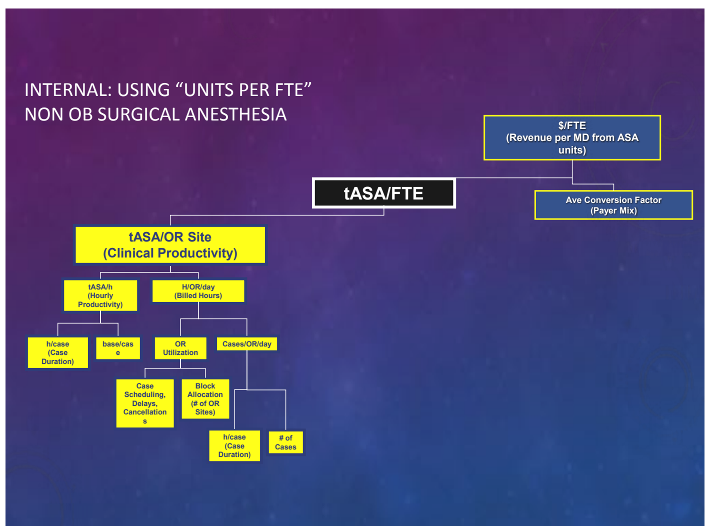


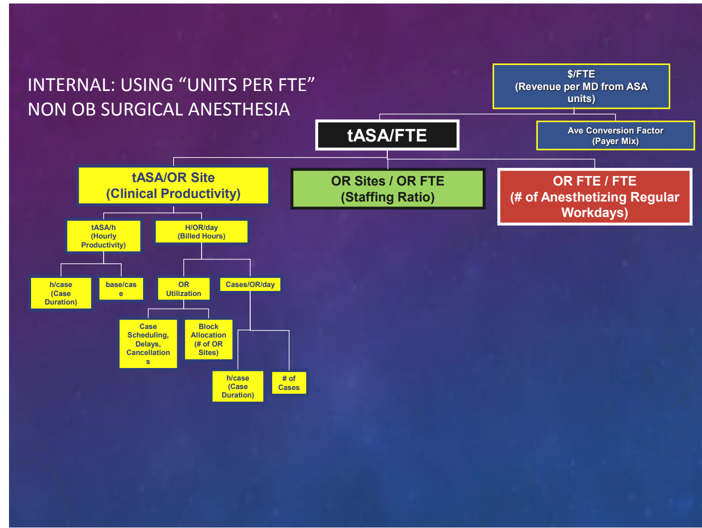


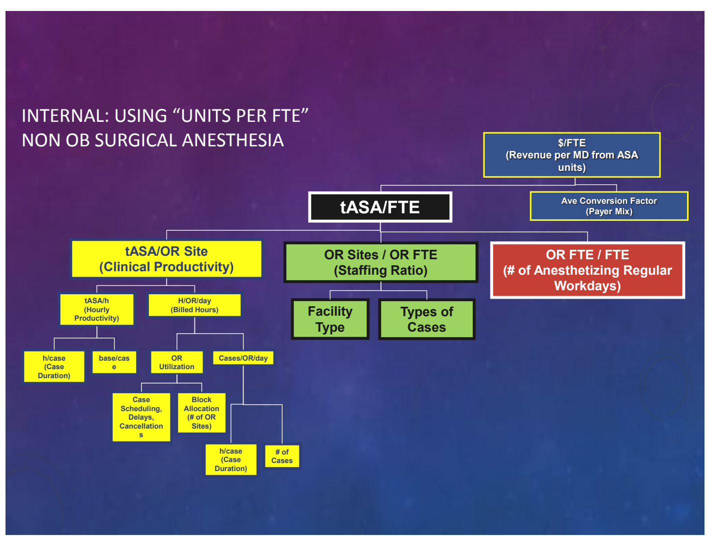


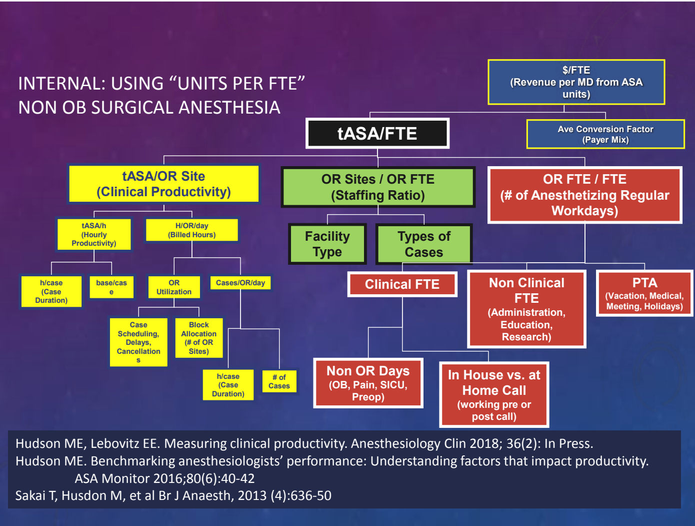


Back to Schedule







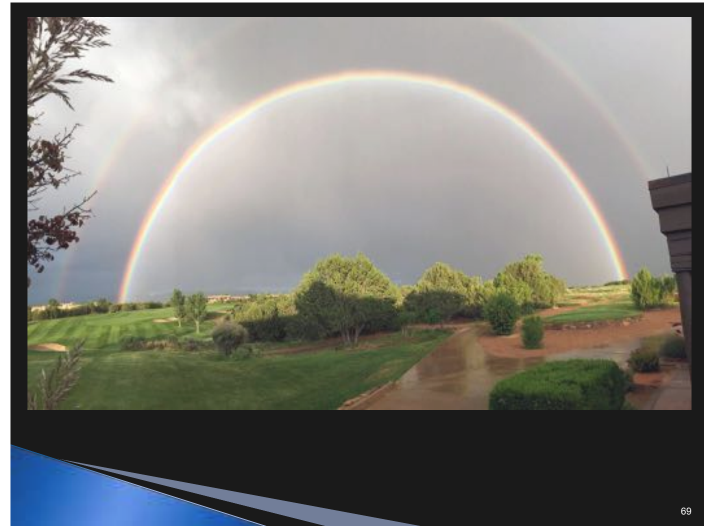


TAKE HOME MESSAGES

- Group/Facility productivity is often a surrogate to OR productivity
- Use algorithm to understand your dashboard
- Many factors can affect measurements
- Compare like-facilities to minimize these factors
- Internal comparisons allow for you to control and define the measurements to your specifications

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. Many of us are also seeing capitated fees for the MD portion of a case involving a CRNA.

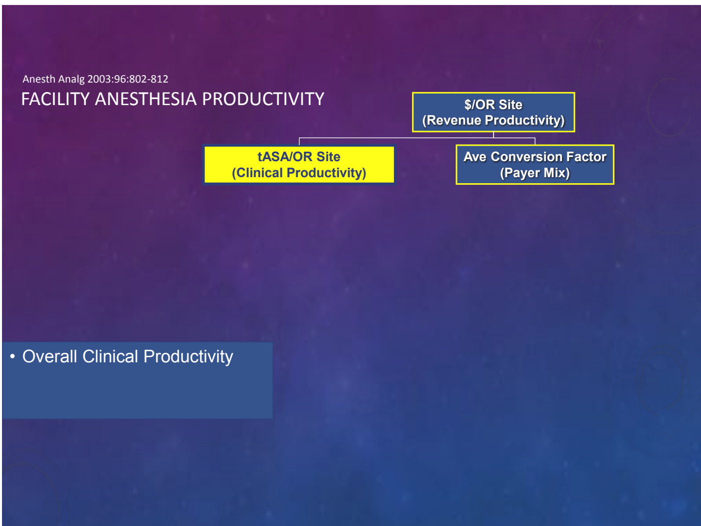
68

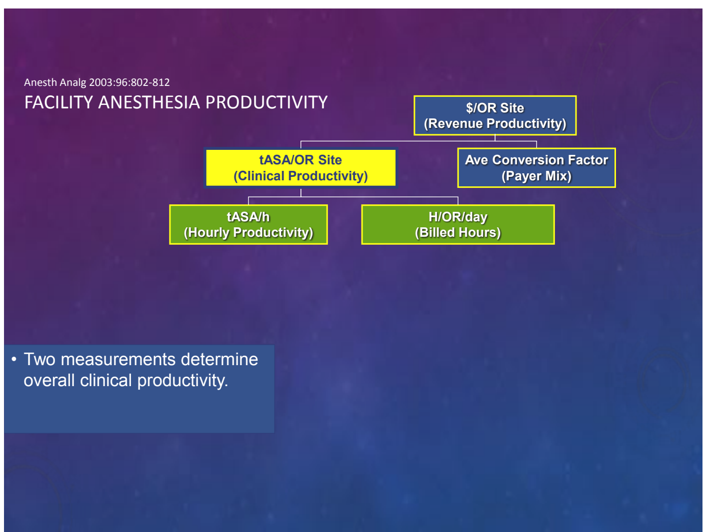


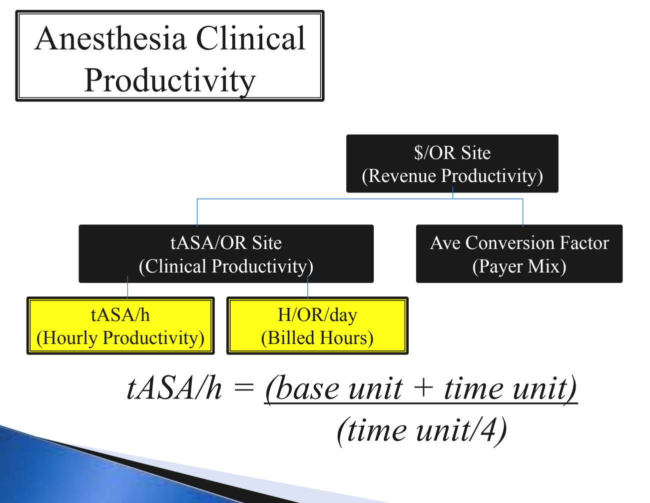
69

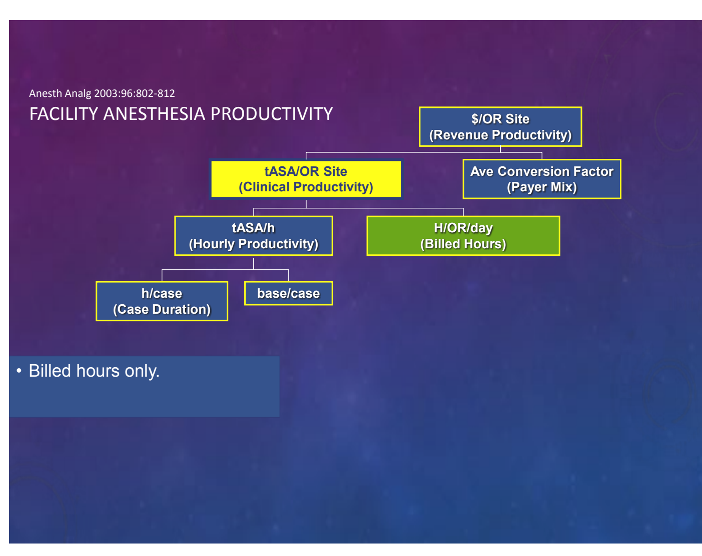
Other Findings

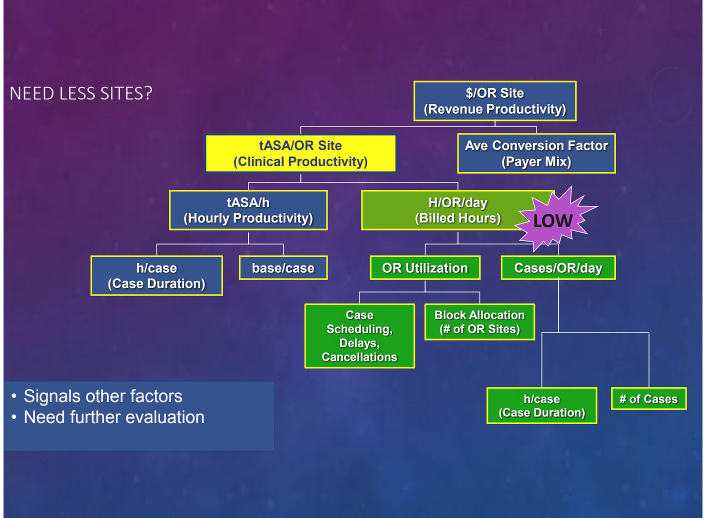
- Breakdown by number of sites, type of surgical staff (academic or mixed private/academic)
- Staffing ratio






Anesthesia Clinical Productivity
$/OR Site
(Revenue Productivity)
tASA/OR Site
(Clinical Productivity)
Ave Conversion Factor
(Payer Mix)
tASA/h
(Hourly Productivity)
H/OR/day
(Billed Hours)
tASA/h = (base unit + time unit)
(time unit/4)
74


Anesth Analg 2003:96:802-812
FACILITY ANESTHESIA PRODUCTIVITY
$/OR Site
(Revenue Productivity)
tASA/OR Site
(Clinical Productivity)
Ave Conversion Factor
(Payer Mix)
tASA/h
(Hourly Productivity)
H/OR/day
(Billed Hours)
h/case
(Case Duration)
base/case
• Billed hours only.


NEED LESS SITES?
$/OR Site
(Revenue Productivity)
tASA/OR Site
(Clinical Productivity)
Ave Conversion Factor
(Payer Mix)
tASA/h
(Hourly Productivity)
H/OR/day
(Billed Hours)
LOW
h/case
(Case Duration)
base/case
OR Utilization
Cases/OR/day
Case Scheduling, Delays, Cancellations
Block Allocation
(# of OR Sites)
h/case
(Case Duration)
# of Cases
• Signals other factors
• Need further evaluation

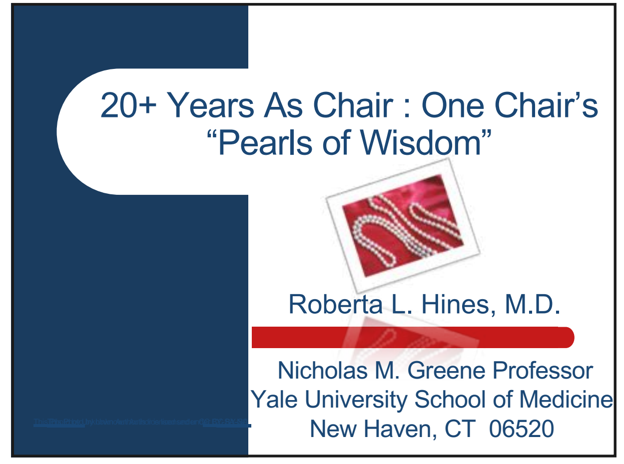
Back to Schedule

HANDOUT

The Need for Chairs to Take Care of Themselves First / How Have Long Serving Chairs Sustained Their Interest Passion and Engagement?

Roberta L. Hines, MD

11/02/2018
2:10pm – 2:30pm



Don't Be Afraid to Be Yourself and Celebrate It !

Surround Yourself with People Smarter Than You

Assemble a Group of Trusted Friends/Advisors and Allow them to Challenge Your Ideas (The Vegas Principle)

Celebrate the Success of Your Faculty / Department

Highlight Success and Acknowledge Defeats

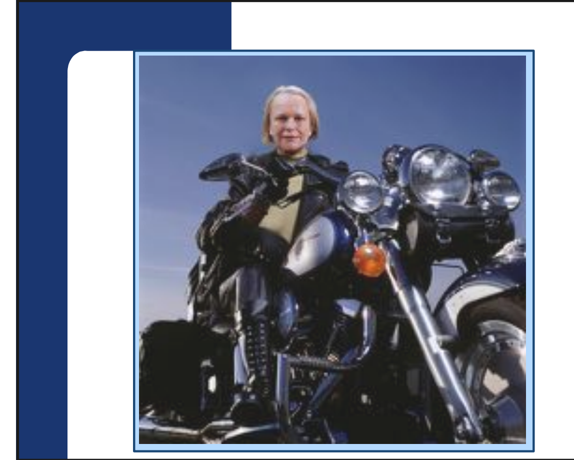
Don't Be So Concerned with Keeping the Job That You Can't Do

Be Open to Change and Embrace It

Think Nationally/ Internationally Act Locally

Cultivate Meaningful and Substantial Non-work Activities

Always Have An Exit Strategy



Back to Schedule

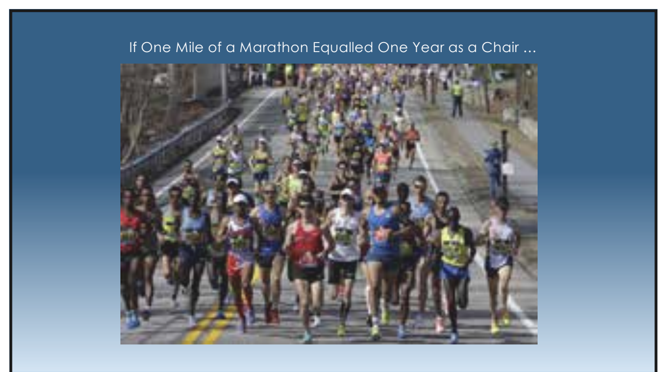
HANDOUT

The Need for Chairs to Take Care of Themselves First / How Have Long Serving Chairs Sustained Their Interest Passion and Engagement?

Donald S. Prough, MD

11/02/2018
2:30pm – 2:50pm

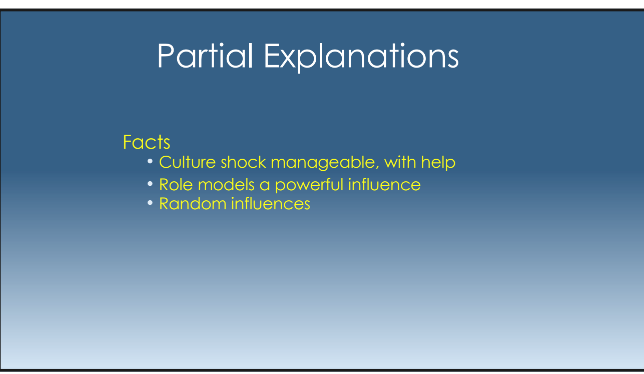
Back to Schedule

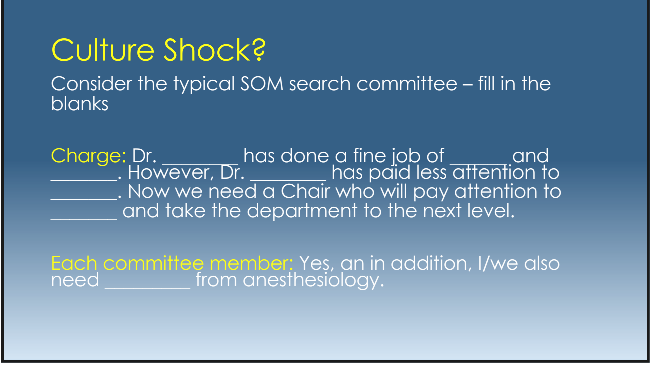


26.2+ Years, A Few Facts and a Few Inferences

Facts
- Survived the first few years of Culture Shock
- Did not move to a different administrative job
- Not asked to step down

Inferences
- Most of the everyday job must be satisfactory
- Alternatives are less attractive





Back to Schedule

Culture Shock, Four Stages of

1. Honeymoon Stage
2. Frustration Stage
3. Adjustment Stage
4. Acceptance Stage

Culture Shock, Four Stages of

~~1.~~ Honeymoon Stage
~~2.~~ Frustration Stage
~~3.~~ Adjustment Stage
~~4.~~ Acceptance Stage

1. Anxiety Stage
2. Honeymoon Stage
3. Frustration Stage
4. Adjustment Stage
5. Acceptance Stage

This process requires patient, insightful friends, coaches and mentors, most of whom are not in the department

Role Models

People doing the job

Role models ≠ clinical or research mentors
- Subconscious aspirational model
- Watch and infer
- Not see one, do one, teach one

First Chair: Captain Robert Van Houten, MD

First Civilian Chair: Thomas Irving, MD

Second Civilian Chair: Frank James, MD

Role Models

Key characteristics of anesthesiology role models
- They know how institutional processes work
- They understand key relationships
- They support their colleagues

External perspective may be less developed
- Role model for external perspective: Jerry Reves, MD

Random Influences – Enhance External Perspective

Associate Chief of Professional Services at Wake Forest
- Unofficial mentor: Ala Jo Koonts

Head of Practice Plan at UTMB, Chief Physician Executive

Lessons from random influences
- External includes administrators, nonphysicians
- External perspective on anesthesiology in a health system
- External perspective invaluable in supporting anesthesiology faculty and residents

Non-random influences: "business" courses

So How Does a New Culture Evolve?

Team
- Vice-Chairs
- Medical Director(s) of ORs
- Subspecialty Chiefs
- Key Committee Chairs

New faculty usually acclimate to new culture

Disgruntled faculty diminish over time (but can be disruptive)

Back to Schedule

Did Not Move to a Different Administrative Job

Hypothesis: I Would Not Enjoy Most Other Administrative Jobs as Much

Hypothesis Testing

One year sentence as Interim Dean of the UTMB School of Medicine

Hypothesis Testing

A few things were novel and enjoyable
Intensive exposure to non-anesthesia environments
Anesthesiologists are better company
Within anesthesiology, unanimity difficult, concensus possible
Within SOM concensus unachievable
It wasn't much fun

Response to Change

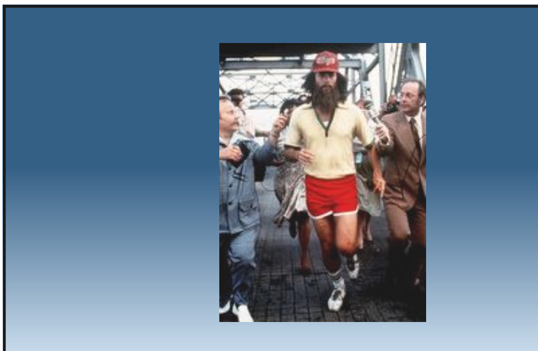
Change inevitable and constant – embrace it
- Since 1992, four UT Chancellors, three UTMB Presidents, five SOM Deans, four health system CEOs, four health system CMOs, three Chairs of Surgery, multiple Chairs of other surgical specialties

Some components are remarkably stable
Internally and externally, both little and big things change
- Clinical practice changes
- Big concepts change (example):
  - 1992 SICU: surgery tolerated anesthesiology in an open unit
  - 2018: many surgeons would prefer a closed unit managed by Anesthesiology

Administrative Oasis

Multidisciplinary research
- Within Anesthesiology
- Across clinical and basic science departments
- Necessary range of expertise increasingly broad

Role models/random associations important here too
- Attend basic science research presentations whenever possible
- Participate in PhD Advisory Committees



What Would I Do Differently?

- More business education, MBA?
- More attention to specific needs of subspecialties
- More specifically communicate departmental goals to new faculty members
- More specifically communicate changes in departmental and institutional goals to all faculty

Back to Schedule

HANDOUT

The Need for Chairs to Take Care of Themselves First / How Have Long Serving Chairs Sustained Their Interest Passion and Engagement?

Ellise Delphin, MD, MPH

11/02/2018
2:50pm – 3:10pm

Back to Schedule

The Need For Chairs to Take Care of Themselves

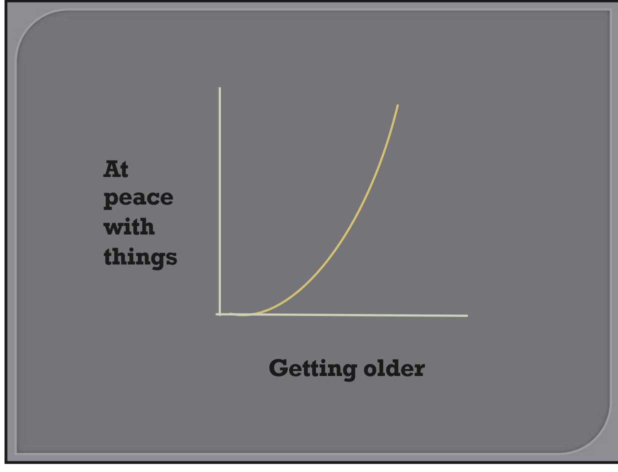
Ellise Delphin MD, MPH
Montefiore Medical Center
Albert Einstein College of Medicine

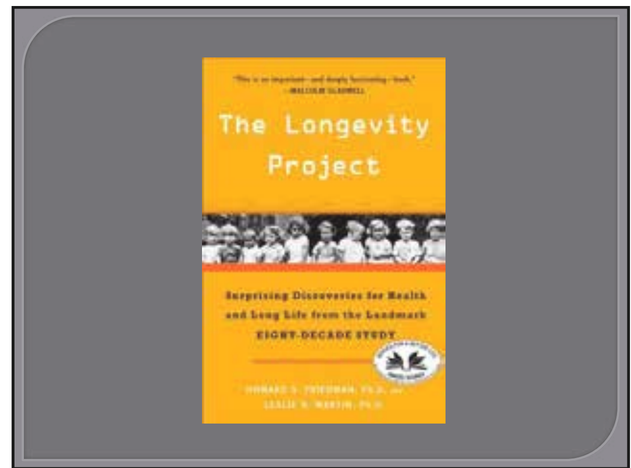
At the conclusion of this activity, the participants will be able to:

- Recognize how self awareness, vision and values translate into performance
- Identify the qualities and lifestyles cultivated by people with professional longevity in the Chair position

Self Care

- Noun
  - OED –The practice of taking action to "preserve or improve one's own health
  - NY Times – Self care is for anyone who wants it. It can be as easy and free as taking a walk or as complex as learning a trade. It can include but is not limited to: saying no, buying things, helping others, exercising organizing things, spending time alone, singing karaoke, intending to one day start meditating
    - NY Times, August 12, 2018





Back to Schedule

Twitter Summary

It was those whose pattern of persistence, prudence, hard work and involvement with friends and communities achieved longevity

The Terman Study

- September, 1921 – 1500 gifted children born around 1910
- Selected by teachers as brightest children in class
- Interested in sources of intellectual leadership
- Looking for early glimmers of high potential

Friedman and Martin

- Past 20 years following up on 1500 children focusing on longevity
- Long lived among them were individuals with certain constellations of habits and patterns of living
- Personality, career trajectories and social lives prove highly relevant to long term health

- Longitudinal 80 year study
- Determine which characteristics influence subsequent qualities behaviors and outcomes
- Designed & conducted studies using sophisticated statistical models

Predictors of Long-Life Paths

- Complex pattern of persistence, hard work, prudence, and close involvement with friends and communities
- Active pursuit of goals, deep satisfaction with life, strong sense of accomplishment
- Large social network, physical activities that draw you in, nurturing marriage or close friendships, thriving in your career

Myths Debunked

- Get married and you will live longer
- Take it easy, don't work so hard and you will be healthier
- Happy thoughts reduce stress leading to long life
- Religious people live longer
- Hobbies like gardening and cooking should be replaced by more vigorous exercise

Staying Healthy, Living Long

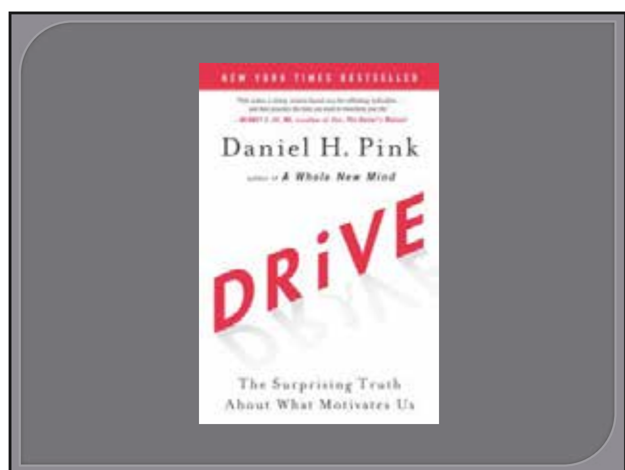
- Social settings and social ties emerge as crucial components of health across decades
- Individual health depends on social health

Strongest Predictors of Longevity

- Conscientious
- Thoughtful planning, sense of control and accomplishment
- Perseverance
- Hard work and ambition
- Love of learning
- Resilience was learned

A Life of Purpose

- Large social network
- Physical activities that draw you in
- Giving back to community
- Enjoying and thriving in your career
- Close friendships

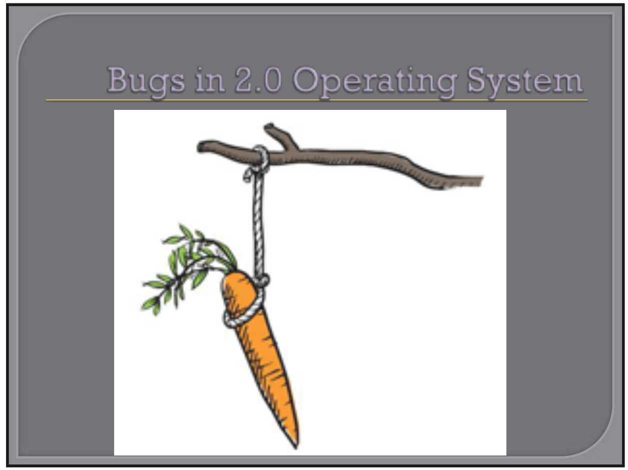


Twitter Summary

- Carrots and Sticks are so last century
- *Drive* says for 21st century work, we need to upgrade to autonomy, mastery and purpose

Motivation Operating Systems

- 1.0 = Survival
- 2.0 = External Reward and Punishment
- 3.0 = Internal Motivation
  - Autonomy
  - Mastery
  - Purpose



- Carrots and sticks effective for rule based routine tasks requiring no creativity
- Non-routine conceptual tasks non-contingent rewards work better and encourage creative right brain performance

Autonomy

- Over task – what they do
- Time – when they do it
- Team – who they do it with
- Technique – how they do it

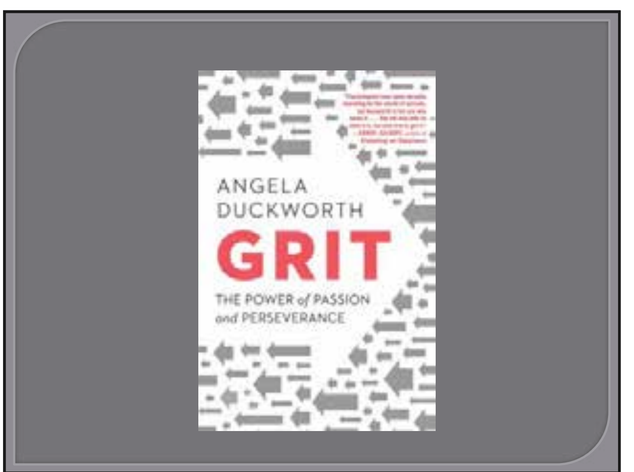
Rules of Mastery

- Mindset
  - Capacity to see abilities as infinite
- Pain
  - Effort, grit and deliberate practice
- Asymptote
  - Impossible to fully realize

Purpose

- Goals that use motives other than profit to reach purpose
- Words that emphasize more than self interest
- Policies that allow people to pursue purpose on their own terms

Back to Schedule



Grit Predicts Success

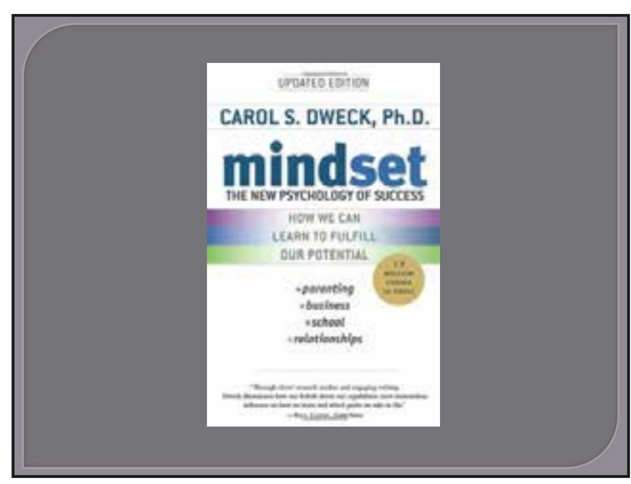
- Passion
  - Consistency of goals held over long periods of time, endurance
- Perseverance
  - Ability to overcome setbacks, put in hard work and finish things you've started

Effort Counts Twice

- Skill = Talent x Effort
- Achievement = Skill x Effort
- Achievement =Talent x $(\text{Effort})^2$

Components of Grit

- **Interest:** Enjoy what you're doing
- **Practice:** Conduct deliberate practice to improve on weaknesses
- **Purpose:** Believe that your work matters and improves the lives of others
- **Hope:** Believe in your capacity for achievement and ability to overcome difficulties



Twitter Summary

- Mindset is the view you have of your characteristics and whether they can change
- This belief profoundly affects the way you conduct your life

---

- Fixed Mindset
  - Qualities are immutable
  - Intelligence, personality, and creativity are fixed
- Growth Mindset
  - Qualities can be cultivated
  - Aptitude, talent, interest and temperament can change

What Kind of Mindset Do You Have?

Growth Mindset	Fixed Mindset
I can learn anything I want to.	I'm either good at it, or I'm not.
When I'm frustrated, I persevere.	When I'm frustrated, I give up.
I want to challenge myself.	I don't like to be challenged.
When I fail, I learn.	When I fail, I'm no good.
Tell me I try hard.	Tell me I'm smart.
If you succeed, I'm inspired.	If you succeed, I feel threatened.
My effort and attitude determine everything.	My abilities determine everything.

Growth Mindset

- Encourages learning and effort
- Criticism and feedback are embraced
- Passion for sticking with it especially when things are not going well

---

In summary

- Know what motivates you
- Learn what motivates others
- Take care not to catastrophize
- Understand the meaning of "It's always something. If it's not one thing, it's another"
  - SNL, Roseanne Rosanadana

Back to Schedule

HANDOUT

Culture Change

MIchael C. Lewis, MD, FASA

11/02/2018
3:50pm – 4:10pm

Culture Change - One Department's Experience: The view from Henry Ford Health System's Department of Anesthesiology, Pain Management & Perioperative Medicine.

Michael C. Lewis, MD, FASA
Joseph L. Ponka Chair, Department of Anesthesiology, Pain Management & Perioperative Medicine, Henry Ford Health System,
Professor of Anesthesiology, Wayne State University

Changing a department's leadership team is a uniformly disruptive process. Commonly, one of the foremost mandates given to a new leader is to facilitate "culture change." However, culture is not just a facet of an Anesthesiology department; it is, in fact, the very essence of the department and penetrates every aspect of its function.

A successful culture is built through shared learning and mutual experience. Yet shaping the ideal culture can be tough, especially ,when new "external" leadership is introduced. Such culture change includes a broad spectrum of individual, team, and organizational level interventions aimed at aligning the values and capabilities of the workforce to meet the department's goals for success. However, when basic components (e.g., clinical operations, educational processes, research, etc.) essential to a functional department are missing, there is an urgency for change that may not allow such a mindful approach.

This lecture will describe the reality of the Henry Ford Health System Department of Anesthesiology in October 2015, the strategies and the tactics that were deployed to create a new culture, more closely aligned with "best practices" and the organization's values.

Back to Schedule

HANDOUT

Culture Change

Cynthia A. Wong, MD

11/02/2018
4:10pm – 4:30pm

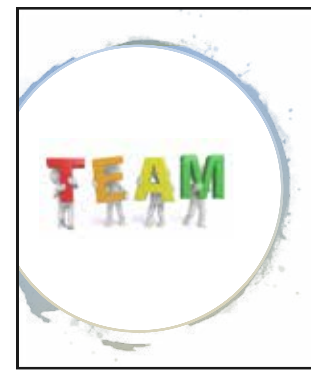
Back to Schedule

Culture Change: Why Can't We Just Work Together Peacefully?

Cynthia A. Wong, MD
Cynthia-wong@uiowa.edu
November 2018

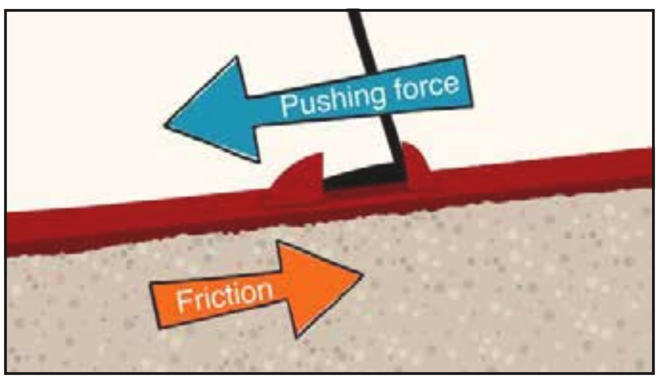
Background

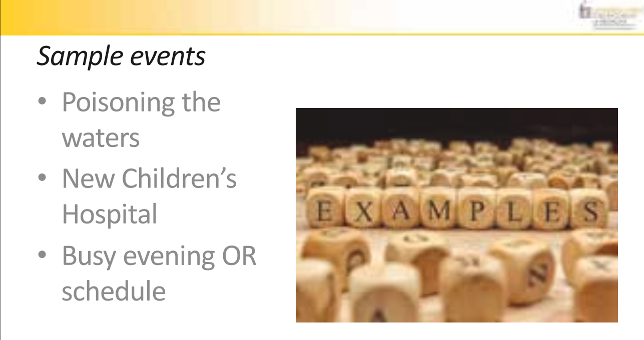
- ≈ 35,000 cases/year
- 3-OR suites / multiple satellites
  - ≈ 52 anesthetizing sites
- Residents: N = 60 (15/class)
- CRNAs: N ≈ 55
- SRNA: N = 10/class (x 3)



The Scenario

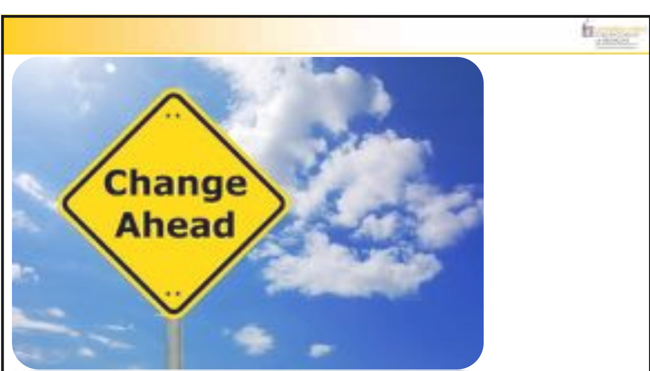
- Anesthesia care team model
  - Both residents and CRNAs provide care
  - Many experienced CRNAs
  - IA is an opt-out state





Actions

- Change environment
- Set / discuss expectations
  - Joint understanding of institution/department/individual goals
- Listen
- Talk
- Group planning



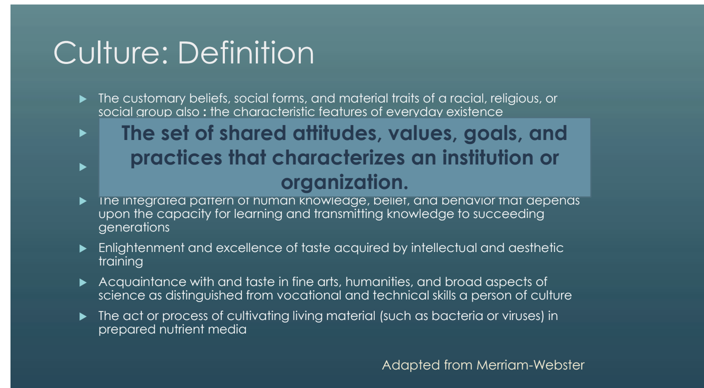
HANDOUT

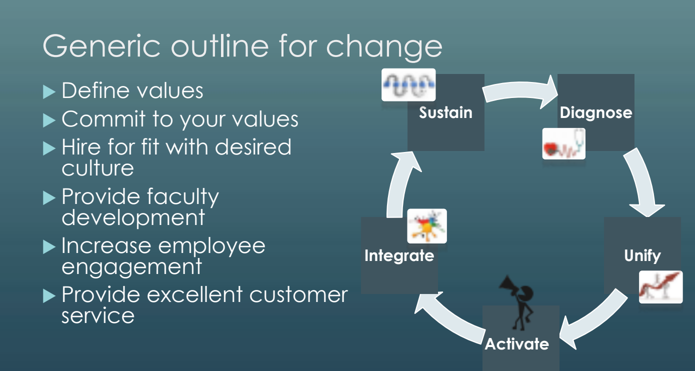
Culture Change

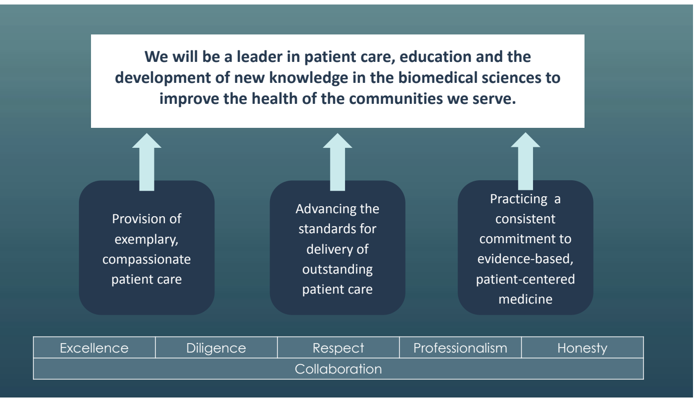
Cynthia A. Lien, MD

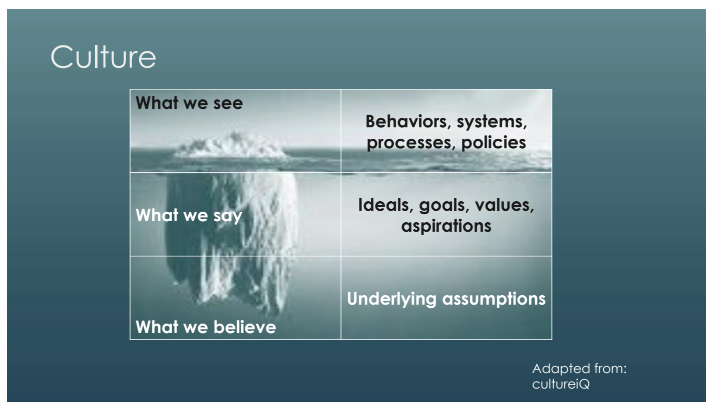
11/02/2018
4:30pm – 4:50pm

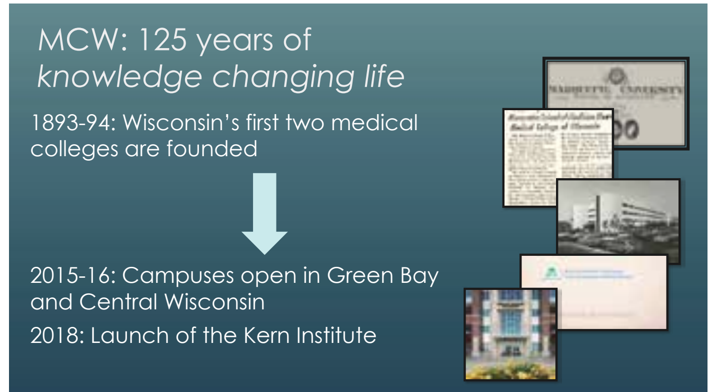
Changing Culture
CYNTHIA A. LIEN, MD
JOHN P KAMPINE PROFESSOR AND CHAIR
DEPARTMENT OF ANESTHESIOLOGY
MEDICAL COLLEGE OF WISCONSIN
knowledge changing life


Culture: Definition
The customary beliefs, social forms, and material traits of a racial, religious, or social group also : the characteristic features of everyday existence
The set of shared attitudes, values, goals, and practices that characterizes an institution or organization.
The integrated pattern of human knowledge, belief, and behavior that depends upon the capacity for learning and transmitting knowledge to succeeding generations
Enlightenment and excellence of taste acquired by intellectual and aesthetic training
Acquaintance with and taste in fine arts, humanities, and broad aspects of science as distinguished from vocational and technical skills a person of culture
The act or process of cultivating living material (such as bacteria or viruses) in prepared nutrient media
Adapted from Merriam-Webster


Generic outline for change
Define values
Commit to your values
Hire for fit with desired culture
Provide faculty development
Increase employee engagement
Provide excellent customer service
Sustain
Diagnose
Unify
Activate
Integrate


We will be a leader in patient care, education and the development of new knowledge in the biomedical sciences to improve the health of the communities we serve.
Provision of exemplary, compassionate patient care
Advancing the standards for delivery of outstanding patient care
Practicing a consistent commitment to evidence-based, patient-centered medicine
Excellence
Diligence
Respect
Professionalism
Honesty
Collaboration


Culture
What we see
Behaviors, systems, processes, policies
What we say
Ideals, goals, values, aspirations
Underlying assumptions
What we believe
Adapted from: cultureiQ


MCW: 125 years of knowledge changing life
1893-94: Wisconsin's first two medical colleges are founded
2015-16: Campuses open in Green Bay and Central Wisconsin
2018: Launch of the Kern Institute

MCW Department of Anesthesiology: History

- 1979-2005
  - Chair: John P. Kampine
  - Department grew from 25 faculty to more than 100
  - Research flourishes
- 1980: Froedtert Memorial Hospital, a private hospital staffed by MCW physicians, opens
- 1981: Pain Fellowship first offered
- 1982: The Critical Care Division was established; the fellowship was offered in 1987
- 1985: The Pediatric Anesthesia Division was established
- 2005-2016
  - Chair: David Warltier
  - Research remained a productive component of the department's portfolio
  - Volume of surgical cases grew substantially
  - Anesthesia services at Community Memorial became the responsibility of the Department of Anesthesiology
  - The MSA program was launched in 2015

Summary…

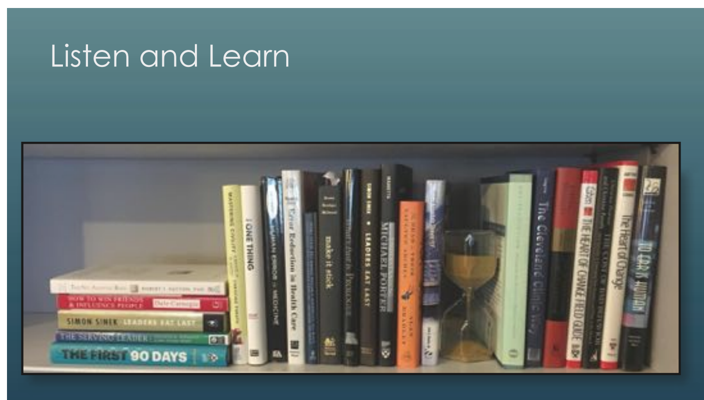
In the preceding years, much had changed including:

- The physical plant
- The clinical work load
- The size of the department
- Expectations of the Department from the Medical College, the Hospital and the Practice Plan

Where to go from there…

Medical College of Wisconsin
knowledge changing life

Listen and Learn

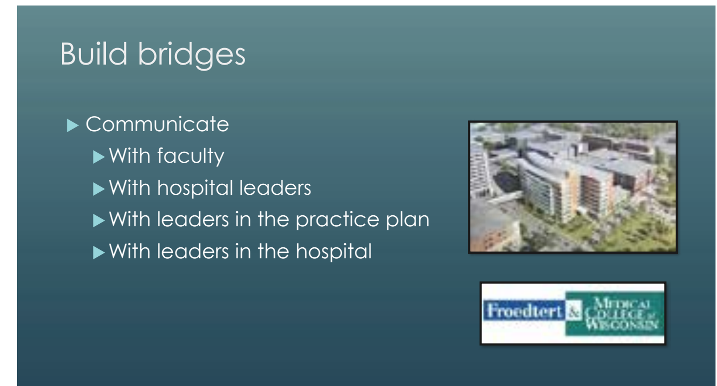


Approaches

- Improve communication & teamwork
- Recognize successes of faculty, residents, staff, APPs
- Increase transparency
- Provide feedback
- Increase faculty responsibility in departmental/college/hospital administration
- Support faculty development

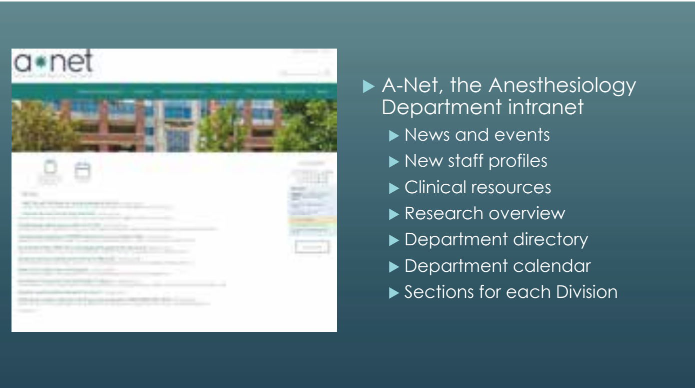
Back to Schedule

Improving communication, recognition & teamwork



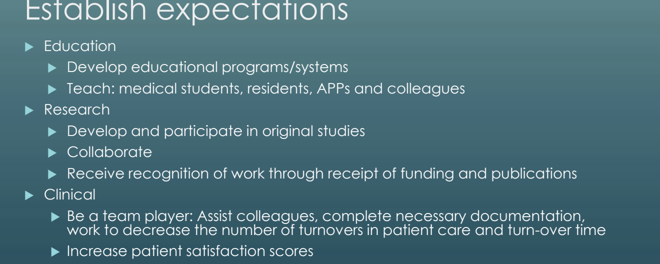
Improving communication & celebrating success

- Identify a communication specialist
- Communicate with faculty, staff, residents, APPs
  - Intranet
  - Newsletter
  - Midweek Message
  - Monthly faculty meetings
  - Weekly meetings with the residents
  - Frequent notes to celebrate individual successes



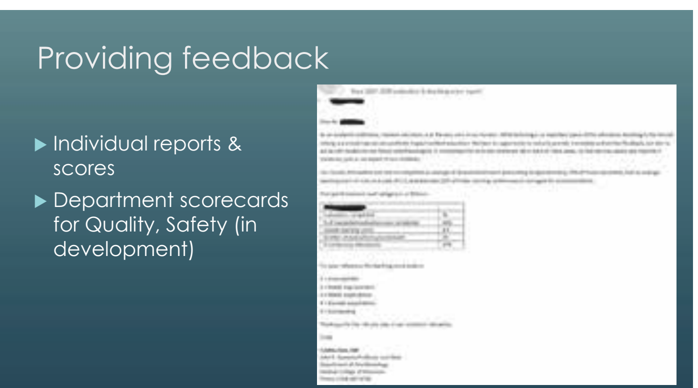
Increasing transparency & providing feedback

Establish expectations



Metrics

- Patient care
  - Productivity
  - Hours worked
- Academic
  - Research
    - Grants, publications
  - Education
    - Locally and nationally
- Administration
  - Hospital and Medical School committee involvement
  - Local, national and international society involvement
- Citizenship

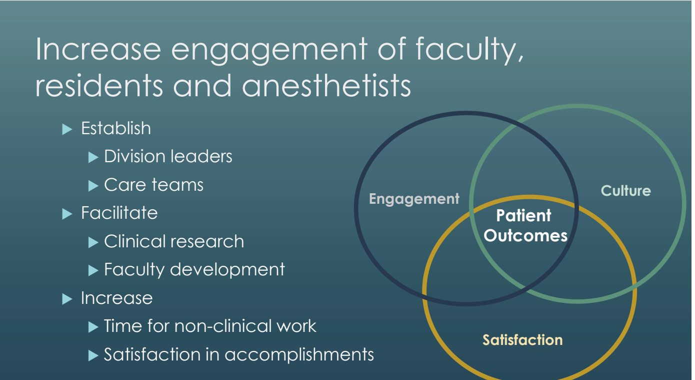


Back to Schedule

Increasing faculty responsibility & supporting faculty development

Increase engagement of faculty, residents and anesthetists

- Establish
  - Division leaders
  - Care teams
- Facilitate
  - Clinical research
  - Faculty development
- Increase
  - Time for non-clinical work
  - Satisfaction in accomplishments



Use the tools and resources provided by MCW and Froedtert

- Further expansion of the medical practice into the local market
- Changes in MCP: Integration of Academic and Community Practices
- Proposed changes in funds flow

Act with purpose. Change what's possible.

Appreciate and build upon small successes.

Thank you

HANDOUT

RRC Updates

Cynthia A. Wong, MD
Anne Gravel Sullivan, PHD

11/02/2018
8:00am – 8:15am

Anesthesiology RC Update

Cynthia Wong, MD

Chair, Anesthesiology Review Committee

Anne Gravel Sullivan, PhD

Executive Director, Anesthesiology Review Committee

Disclosures

Dr. Wong has no conflicts of interest

Dr. Gravel Sullivan works for the ACGME

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Objectives

- Introduce new RC members
- Summarize specialty 2018 Annual Program Review
- Common Program Requirement Revisions
  - Core Anesthesiology
  - Multidisciplinary Pain Medicine
- Review ACGME and RC Initiatives in 2018
- Answer questions

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RC Executive Committee

Chair
Cynthia Wong, MD
Professor and Chair, Department of Anesthesia
University of Iowa Carver College of Medicine

Vice Chair
Aditee Ambardekar, MD
Assistant Professor, Department of Anesthesiology
University of Texas Southwestern Medical Center

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New RC Member

Alex Macario, MD (July 1, 2019)
Professor, Department of Anesthesiology,
Perioperative and Pain Medicine
Department of Health Research and Policy
Stanford University

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Committee Members

Andrew Patterson, MD, PhD
Keith Baker, MD, PhD
Andrew Rosenberg, MD
Santhanam Suresh, MD
Mark Stafford-Smith, MD
Timothy Clapper, PhD
David Simons, DO, FAOCA
Manual Vallejo, Jr., MD, DMD
Anne Marie McKenzie-Brown, MD
Kaitlyn Brennan, DO (resident member)

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Executive Director Change

Cheryl Gross, MA, CAE
Executive Director for Anesthesiology,Transitional Year, Radiation Oncology

- Former ED for Pathology
- Previous Associate VP for Education with American Osteopathic Association
- Biography
- Effective October, 2018

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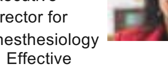
Associate Executive Director & Accreditation Administrator

Victoria Varela



Associate Executive Director for Anesthesiology
- Effective February, 2018
- Completing MHA in December 2018

Aimee Morales

Accreditation Administrator for Anesthesiology, Transitional Year & Radiation Oncology
- Effective November, 2018
- Bachelors in International Business and Management

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2017-18 Annual Program Review

127 Programs Reviewed

68 Continued Accreditation

1 Continued Pre-accreditation

8 CA with Warning

26 Initial Accreditation

1 IA with Warning

4 Withholds

Common Citations

Faculty and resident scholarly activity

Qualifications of faculty (subspecialty)

Responsibilities of program director (failure to provide accurate information)

Responsibilities of faculty

Curricular development

Evaluation of residents

Educational program—Patient care experience and didactic components

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Common Program Requirement Revisions

- Major change to ***all*** CPRs implemented July 1, 2019
- Certain CPRs will not be cited until July 1, 2020
  - Implementation Dates
- These changes will impact the Anesthesiology PRs: RC Subcommittee formed to review and make recommendations
- Eligibility and Scholarly Activity PRs

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CPR Impact on Anesthesiology Requirements (Core & Subs)

Review Committee begins work on Revisions…………………....…………..…April 5, 2019

Proposed Requirements posted for Review & Comment…………………..October 28, 2019

Review & Comment ends..………..……..December 12, 2019

Committee on Requirement review……June 12, 2020

Effective Date…………………………..……July 1, 2020

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Multidisciplinary Pain Medicine PR Revision

Proposed Requirements posted for Review & Comment…………………..September 10, 2018

Review & Comment ended……………..October 24, 2018

Committee on Requirement review……February 3, 2019

Effective Date……………………………July 1, 2019

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RC Activities

Revisions to FAQs and Applications

- FAQs waiting for Committee on Requirements approval prior to posting on website
- New Foundational Clinical Skills Year (CBY) application has been posted
- Changes to other applications will be forthcoming

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Milestones 2.0

ACGME Milestones Team seeking work group volunteers

- 2-3 Meetings in Chicago
- Information and application at:

https://www.acgme.org/What-We-Do/Accreditation/Milestones/Engagement

- Submit by November 30th

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RC Presentations & Outreach

Annual Education Conference - March 2019

American Osteopathic Colleges of Anesthesiology Meetings - September 2018 & March 2019

New Program Coordinator Workshop – October 2018

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Questions?

Cheryl Gross, MA, CAE
Executive Director
RC for Anesthesiology
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cgross@acgme.org

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Accreditation Administrator
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Victoria Varela
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varela@acgme.org

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Back to Schedule

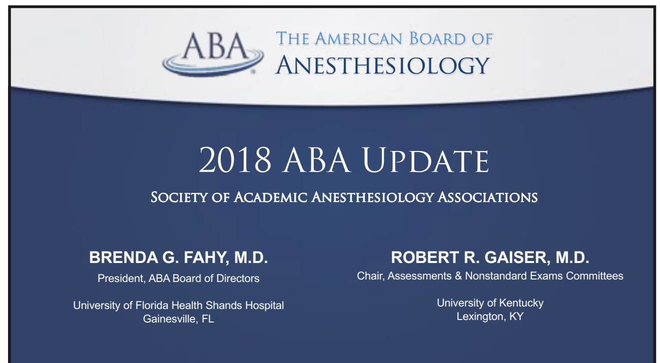
HANDOUT

ABA Updates

Brenda G. Fahy, MD, MCCM
Robert Gaiser, MD

11/02/2018
8:25am – 8:50am

Back to Schedule



What's changing?

Current Policy	Proposed Policy
• Up to 12 weeks (60 working days) of time away during CA1-3 years	• Up to 12 weeks (60 working days) of time away during CA1-3 years • Up to **8 additional weeks of leave** with ABA-approval (40 working days) during the CA1-3 years **without extending training** • Additional leave must be approved by the program director and chair prior to submission

Absences in excess of both the current and proposed policies will require lengthening total training time

Request for Feedback

- We sent surveys via email to trainees, chairs and program directors to ensure policy meets their needs before it's effective on July 1, 2019
  - We've received 650+ responses so far, of which 600 indicated that the new policy meets their needs very well or fairly well
- The survey closes Nov. 9, so please submit your responses soon from the email, our website or our social media sites
  - Once we receive the survey data we will finalize and announce the policy
  - It will go into effect July 1, 2019

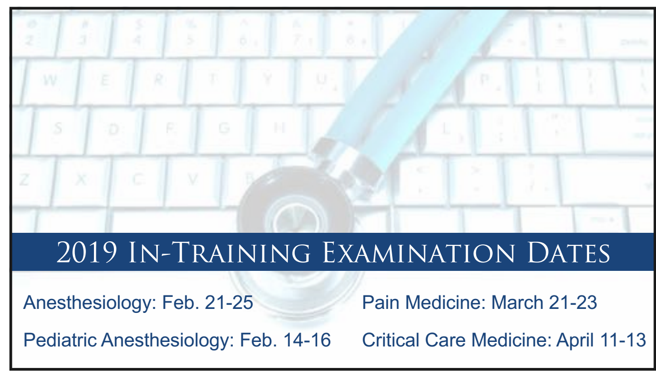
5

Feedback Themes

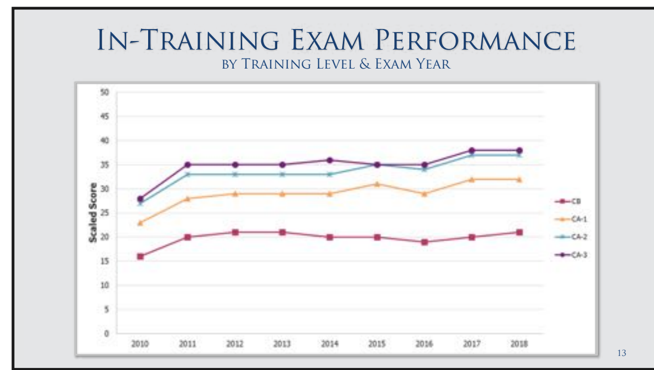
- Residents may experience significant personal concerns that require leave, but feel guilty about taking time off
- Residents need as much time as possible in training to meet the clinical competency standards
- This may cause division between residents
- *"This is an amazing and wonderful change to the policy! Especially as all specialties are moving towards a milestone based curriculum."*

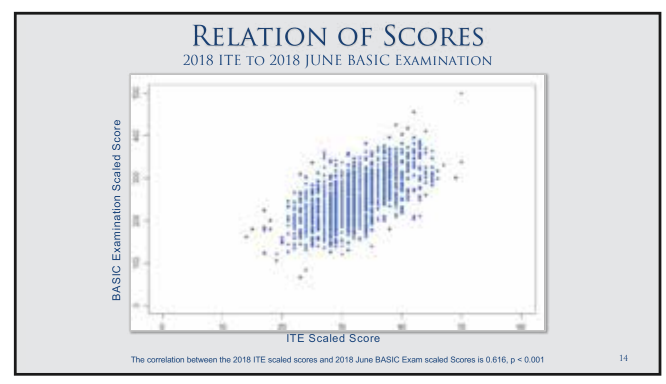
6

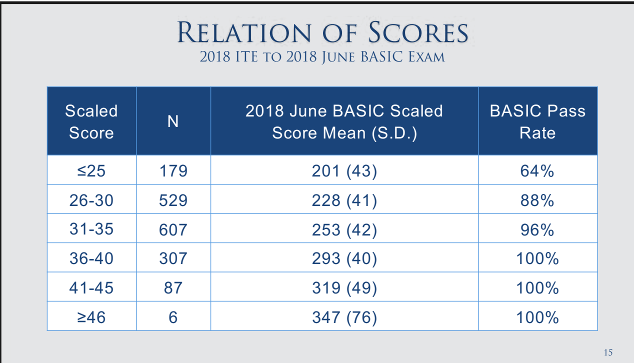
Back to Schedule



Back to Schedule





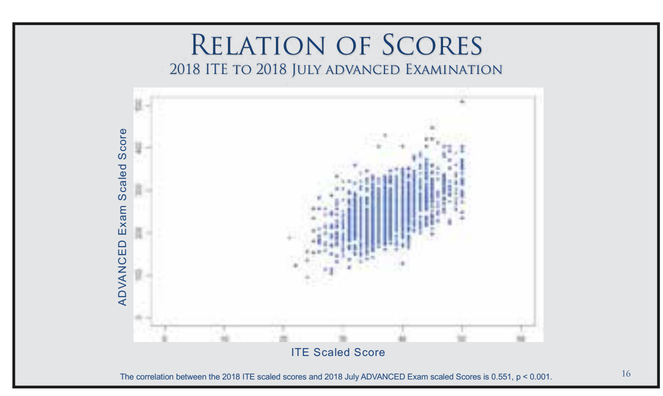


Relation of Scores

2018 ITE to 2018 June BASIC Exam

Scaled Score	N	2018 June BASIC Scaled Score Mean (S.D.)	BASIC Pass Rate
≤25	179	201 (43)	64%
26-30	529	228 (41)	88%
31-35	607	253 (42)	96%
36-40	307	293 (40)	100%
41-45	87	319 (49)	100%
≥46	6	347 (76)	100%

15



Relation of Scores

2018 ITE to 2018 July ADVANCED Exam

Scaled Score	N	2018 ADVANCED Scaled Score Mean (S.D.)	ADVANCED Pass Rate
≤25	10	172 (50)	50%
26-30	90	207 (44)	80%
31-35	414	229 (42)	93%
36-40	587	251 (41)	99%
41-45	359	281 (42)	100%
≥46	104	313 (49)	100%

17

2018 June BASIC Exam Results

- Candidates were assigned to examine on Friday or Saturday
- Key validation eliminated six items from two forms
- 90.9% of residents passed

N	Mean Scaled Score	Standard Deviation	Pass Rate	Reliability
1,733	250.9	52.4	90.9%	0.86

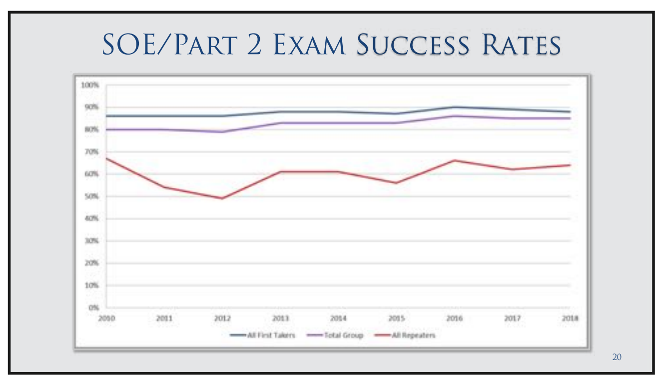
18

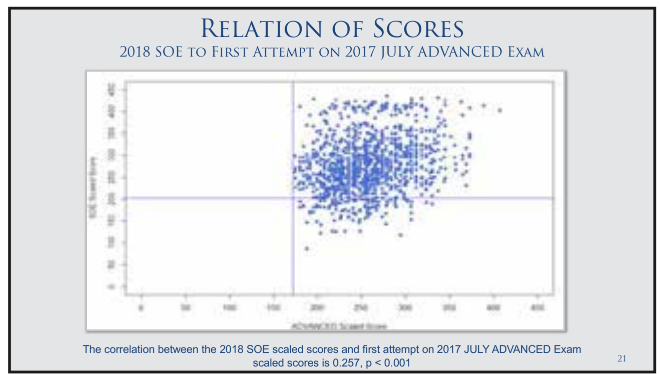
2018 July ADVANCED Exam Results

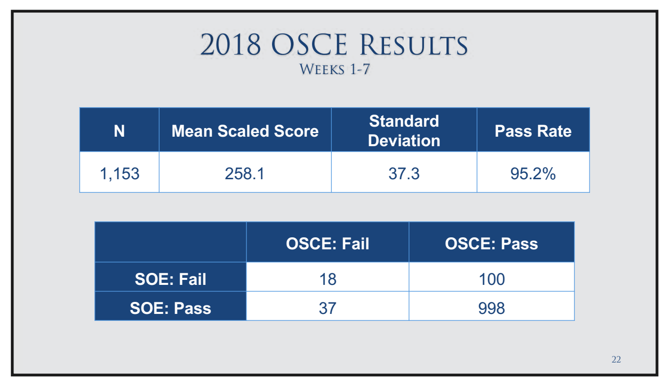
- Candidates were assigned to examine on Friday or Saturday
- Key validation eliminated ten items from two forms
- 94.7% of candidates passed

N	Mean Scaled Score	Standard Deviation	Pass Rate	Reliability
1,653	250.9	52.1	94.7%	0.77

19

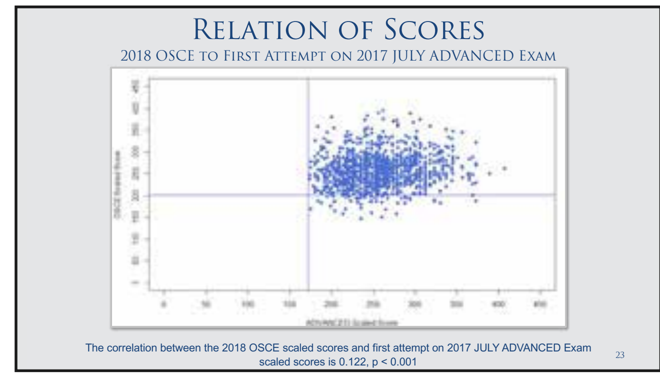


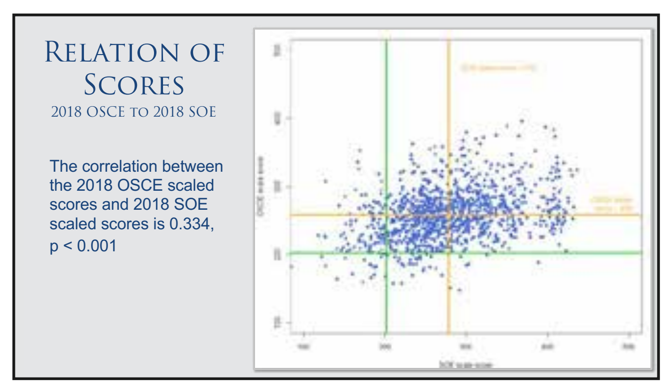




N	Mean Scaled Score	Standard Deviation	Pass Rate
1,153	258.1	37.3	95.2%

	OSCE: Fail	OSCE: Pass
SOE: Fail	18	100
SOE: Pass	37	998





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

Back to Schedule

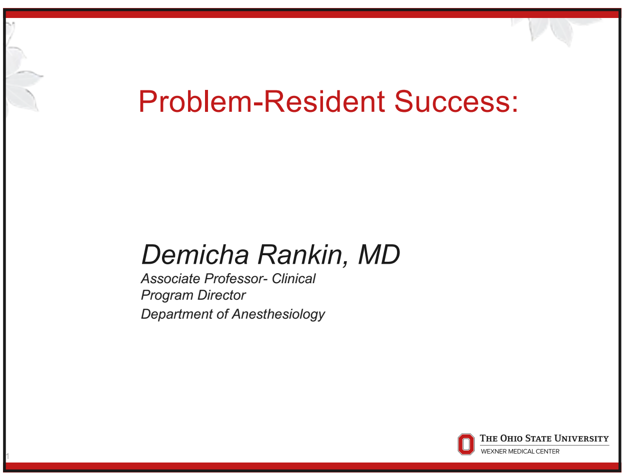
HANDOUT

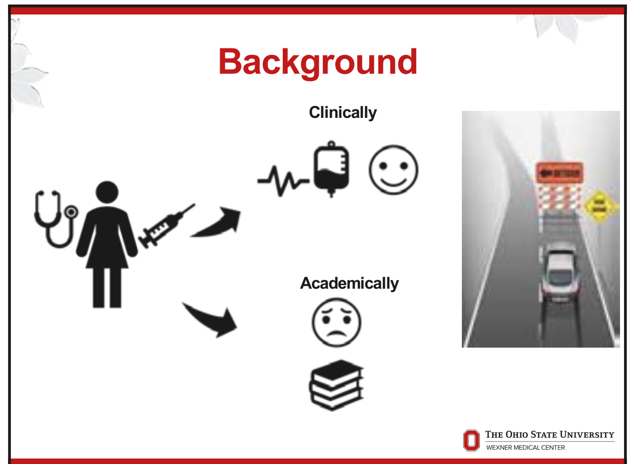
Problem Resident Success Stories

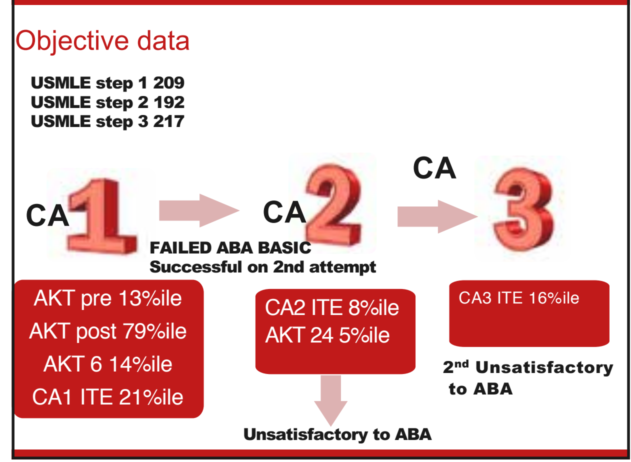
Demicha D. Rankin, MD

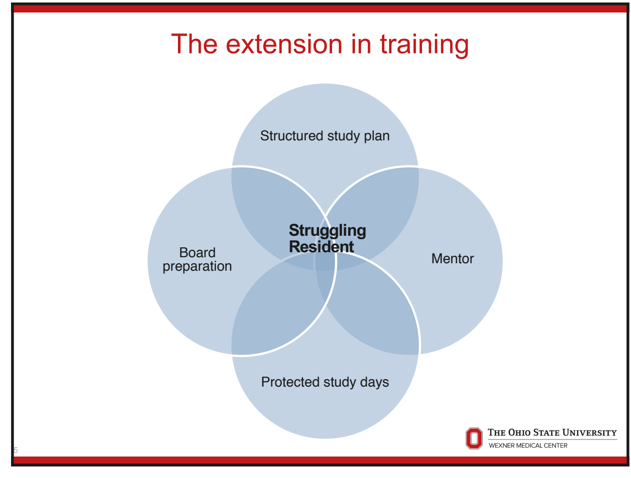
11/02/2018
9:00am – 9:12am

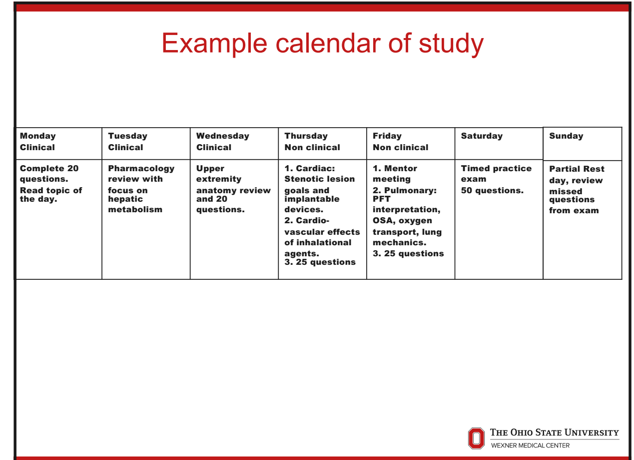
Back to Schedule



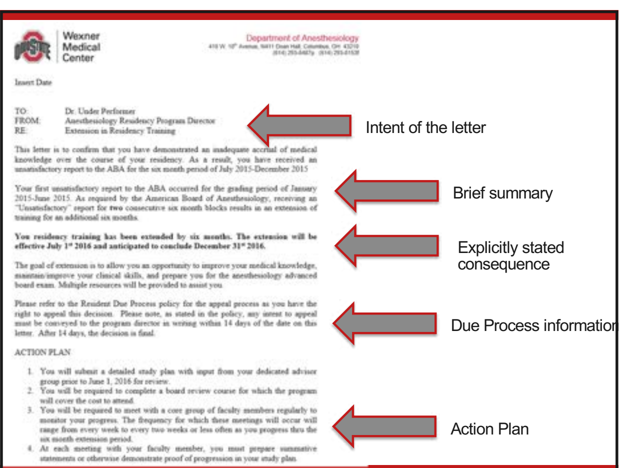








Monday Clinical	Tuesday Clinical	Wednesday Clinical	Thursday Non clinical	Friday Non clinical	Saturday	Sunday
Complete 20 questions. Read topic of the day.	Pharmacology review with focus on hepatic metabolism	Upper extremity anatomy review and 20 questions.	1. Cardiac: Stenotic lesion goals and implantable devices. 2. Cardio-vascular effects of inhalational agents. 3. 25 questions	1. Mentor meeting 2. Pulmonary: PFT interpretation, OSA, oxygen transport, lung mechanics. 3. 25 questions	Timed practice exam 50 questions.	Partial Rest day, review missed questions from exam



Wexner Medical Center

Department of Anesthesiology
410 W. 10th Avenue, N411 Doan Hall, Columbus, OH 43210
(614) 293-8487p (614) 293-8153f

Insert Date

TO: Dr. Under Performer
FROM: Anesthesiology Residency Program Director
RE: Extension in Residency Training

This letter is to confirm that you have demonstrated an inadequate accrual of medical knowledge over the course of your residency. As a result, you have received an unsatisfactory report to the ABA for the six month period of July 2015-December 2015

Your first unsatisfactory report to the ABA occurred for the grading period of January 2015-June 2015. As required by the American Board of Anesthesiology, receiving an "Unsatisfactory" report for **two** consecutive six month blocks results in an extension of training for an additional six months.

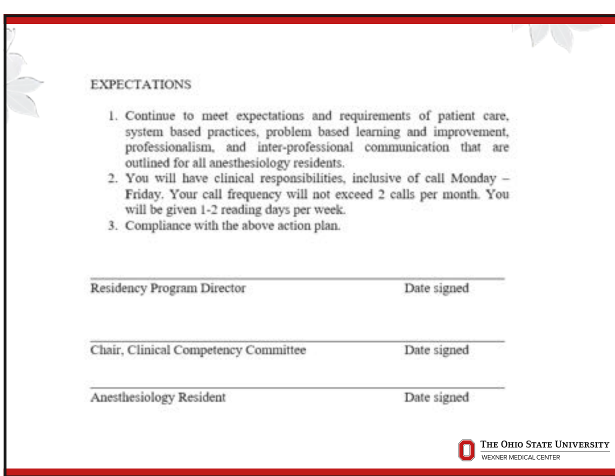
You residency training has been extended by six months. The extension will be effective July 1st 2016 and anticipated to conclude December 31st 2016.

The goal of extension is to allow you an opportunity to improve your medical knowledge, maintain/improve your clinical skills, and prepare you for the anesthesiology advanced board exam. Multiple resources will be provided to assist you.

Please refer to the Resident Due Process policy for the appeal process as you have the right to appeal this decision. Please note, as stated in the policy, any intent to appeal must be conveyed to the program director in writing within 14 days of the date on this letter. After 14 days, the decision is final.

ACTION PLAN

1. You will submit a detailed study plan with input from your dedicated advisor group prior to June 1, 2016 for review.
2. You will be required to complete a board review course for which the program will cover the cost to attend.
3. You will be required to meet with a core group of faculty members regularly to monitor your progress. The frequency for which these meetings will occur will range from every week to every two weeks or less often as you progress thru the six month extension period.
4. At each meeting with your faculty member, you must prepare summative statements or otherwise demonstrate proof of progression in your study plan.



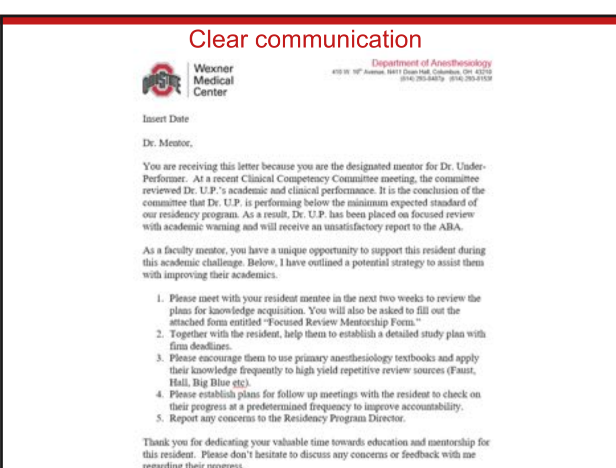
EXPECTATIONS

1. Continue to meet expectations and requirements of patient care, system based practices, problem based learning and improvement, professionalism, and inter-professional communication that are outlined for all anesthesiology residents.
2. You will have clinical responsibilities, inclusive of call Monday – Friday. Your call frequency will not exceed 2 calls per month. You will be given 1-2 reading days per week.
3. Compliance with the above action plan.

Residency Program Director   Date signed

Chair, Clinical Competency Committee   Date signed

Anesthesiology Resident   Date signed



Clear communication

Wexner Medical Center

Department of Anesthesiology
410 W. 10th Avenue, N411 Doan Hall, Columbus, OH 43210
(614) 293-8487p (614) 293-8153f

Insert Date

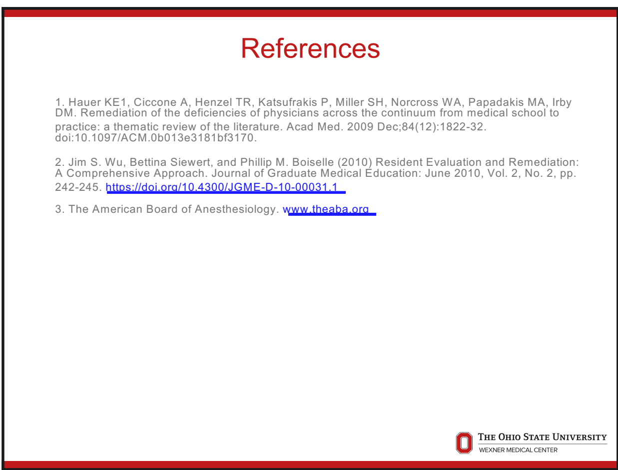
Dr. Mentor,

You are receiving this letter because you are the designated mentor for Dr. Under-Performer. At a recent Clinical Competency Committee meeting, the committee reviewed Dr. U.P.'s academic and clinical performance. It is the conclusion of the committee that Dr. U.P. is performing below the minimum expected standard of our residency program. As a result, Dr. U.P. has been placed on focused review with academic warning and will receive an unsatisfactory report to the ABA.

As a faculty mentor, you have a unique opportunity to support this resident during this academic challenge. Below, I have outlined a potential strategy to assist them with improving their academics.

1. Please meet with your resident mentee in the next two weeks to review the plans for knowledge acquisition. You will also be asked to fill out the attached form entitled "Focused Review Mentorship Form."
2. Together with the resident, help them to establish a detailed study plan with firm deadlines.
3. Please encourage them to use primary anesthesiology textbooks and apply their knowledge frequently to high yield repetitive review sources (Faust, Hall, Big Blue etc).
4. Please establish plans for follow up meetings with the resident to check on their progress at a predetermined frequency to improve accountability.
5. Report any concerns to the Residency Program Director.

Thank you for dedicating your valuable time towards education and mentorship for this resident. Please don't hesitate to discuss any concerns or feedback with me regarding their progress.



References

1. Hauer KE1, Ciccone A, Henzel TR, Katsufrakis P, Miller SH, Norcross WA, Papadakis MA, Irby DM. Remediation of the deficiencies of physicians across the continuum from medical school to practice: a thematic review of the literature. Acad Med. 2009 Dec;84(12):1822-32. doi:10.1097/ACM.0b013e3181bf3170.

2. Jim S. Wu, Bettina Siewert, and Phillip M. Boiselle (2010) Resident Evaluation and Remediation: A Comprehensive Approach. Journal of Graduate Medical Education: June 2010, Vol. 2, No. 2, pp. 242-245. https://doi.org/10.4300/JGME-D-10-00031.1

3. The American Board of Anesthesiology. www.theaba.org

HANDOUT

Problem Resident Success Stories

Harendra Arora, MD, MBA, FASA

11/02/2018
9:12am – 9:24am

Remediation, or "Improvement" plan options

1. <u>Interpersonal skills and communication deficiency</u>
    a. Assign a mentor to meet with monthly to review progress
    b. Meet with counselor/psychiatrist for intake visit and consideration for regular therapy – with permission, update PD
    c. Mandate sessions "in the role" of the person/position having conflicts with
    d. Disruptive physician course
    e. OSCE sessions with SPs (#): inter-professional with conflict
    f. Read a book on apology and write an apology letter approved by PD
    g. Write an essay on noted poor communication (include word limit) – how could this have been handled differently? Why are strong relationships key to successful practice? When a disagreement occurs, what some alternative strategies for resolution? Write a commitment statement.
    h. Last chance contact – sign something with limits on behaviors
    i. Determine specific goals for progress to remain in program?
        i. When will CCC revisit improvement?
        ii. What are the next steps for continued failure? Dismissal?
        iii. How will trainee know they are no longer being remediated?

2. <u>Professionalism deficiency</u>
    a. Assign a mentor to meet monthly to review progress
    b. Meet with counselor/psychiatrist for intake visit and consideration for regular therapy – with permission, update PD
    c. Drug testing – witnessed
    d. "Fitness to duty" evaluation by an independent entity
    e. Referral to State's Physician Health Program (PHP) or a Career Coach
    f. Read a book on professionalism and report with mentor
    g. Write an essay on noted poor behaviors (include word limit) – why they are wrong, whom they hurt, disruption to self, patient, team and system. How might this behavior affect your future employment status? Write a commitment statement for future behavior.
    h. Keep a log of time in/out, submit log to mentor/PD
    i. Determine specific goals for progress to remain in program?
        i. When will CCC revisit improvement?
        ii. What are the next steps for continued failure? Dismissal?
        iii. How will trainee know they are no longer being remediated?

3. <u>Medical knowledge deficiency</u>
    a. Assign a mentor to meet twice a month to review progress
    b. Create a plan for studying that incorporates
        i. Basic text
        ii. Question review

iii. Key word, or wrong item review
iv. Old examination practice tests
v. Consideration of environment (where?)
vi. Mix in group study regularly
vii. Technique: read, notes, outlining, re-read (how many times?)
viii. Time commitment (how long? Increase focus-time)
ix. Support (family, friends, peers)
x. Write down plan on calendar and share with mentor and PD

c. Meet with a specialist to understand learning style and perhaps obtain an assessment. Possibly require assessment prior to return to program? May require accommodation for test.
d. Assign a teaching role to strengthen knowledge-base
e. Is there a Policy that addresses academic performance?
    i. Program doesn't pay for exam fees with score below certain threshold
    ii. Can't become chief resident or participate in certain electives without meeting certain ITE threshold
    iii. Report poor performance to specialty ABMS Board
f. Determine specific goals for progress to remain in program
    i. When will CCC revisit improvement?
    ii. What scoring and/or clinical performance will signify improvement? Within 1 SD of mean scoring or evals?
    iii. What are next steps for continued failure? Dismissal?
    iv. How will trainee know they are no longer being remediated?

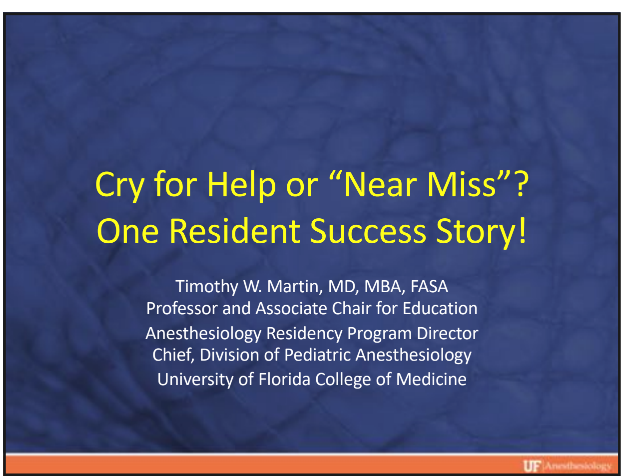
HANDOUT

Problem Resident Success Stories

Timothy W. Martin, MD, MBA, FAAP

11/02/2018
9:24am – 9:36am

Back to Schedule



Case Presentation

- 27 y/o female CA-1 resident who was graduate of medical school at another university
- Single, no roommate or close relationships
- Recently completed CB year with generally satisfactory performance, although undocumented "concerns" from various sources during internship (after-the-fact)
- "Paired period" in late July of CA-1 year (upper-level resident and basic competency checklist)

Case Presentation (2)

- CA-1 resident in OR with anesthetized patient under GETA, attending surgeon, and OR nursing team
- "Paired" upper level resident outside OR door in scrub area talking to colleague
- Surgical procedure concludes, patient ventilating spontaneously; surgery attending directs CA-1 to extubate patient!

Case Presentation (3)

- Immediate airway obstruction with hypoventilation and desaturation— "green button" emergency
- Help arrives, patient reintubated and stabilized

Case Presentation (4)

- Next day the CA-1 fails to show for OR set-up and work (but is still "paired", so OR starts on time)
- Resident colleague goes to CA-1 apartment, finds CA-1 with several nooses hanging in apt and burn marks on neck
- *Resident colleague notifies no one at that point*
- Another resident alerts GME office that he is aware a resident may be trying to "hurt" herself, but refuses to say who is involved

Case Presentation (5)

- Several days later CA-1 returns to work; attending anesthesiologist notices burn marks on neck and contacts PD
- CA-1 resident is confronted and "Baker-acted" (involuntary mental health admission and assessment)
- Begins extended inpatient and outpatient evaluation and treatment, including PRN referral

Post-Return Factors Contributing to Success

- Solid foundation of post-attempt inpatient treatment and rehabilitation, including thorough mental health evaluation
- Clearance from Professionals Resource Network (PRN) and state medical board for specific return to anesthesiology training
- Delay in reentry to residency training to coincide with next July peer group cohort
- Repeated "paired period" in second/repeat start of CA-1 year
- Careful match with "hand-picked" faculty advisor (gender, family background)
- Regular, discrete follow-up with PD
- Careful and diligent attention to assure scheduled mental health appointments and random drug tests were prioritized (clinical relief)

Physician Suicide in the United States

- Overall, suicide is 10th leading cause of death in United States
  - 12.4 per 100,000 (2014)
  - Men die by suicide 4X more often than women, although women have more attempts
- Interesting that in late 1800s, physicians overall had a *higher* mortality than age-matched controls for most causes of death, including suicide, BUT due to several factors, including dramatic reductions in tobacco use among physicians, physician mortality is now *lower* by all causes EXCEPT suicide
- Physician suicide is:
  - 40% higher in male physicians than general population
  - 130% higher in female physicians than general population
  - Predictors for physicians include known mental health disorder or job problem that contributed to suicide
  - More likely associated with antipsychotics, benzos, barbs in system (but not anti-depressants) than general population
  - Traditionally associated with poisoning/intentional drug overdose, but recent NVDRS report indicates firearms as most common mode for physicians and non-physicians

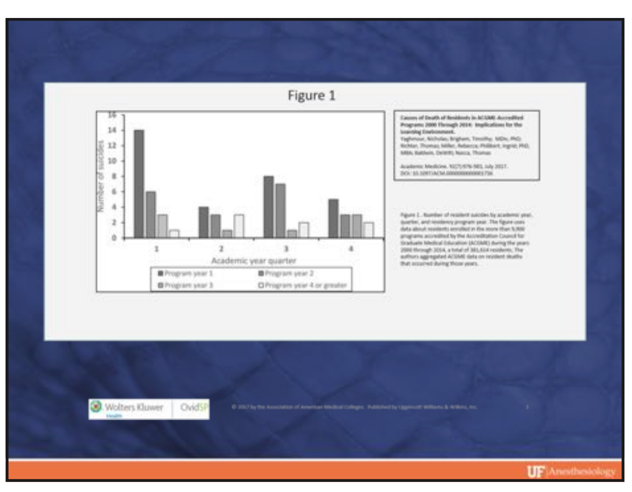
What Do We Know About **Resident** Physician Suicide?

- Extreme end of continuum that includes stress, burn out, depression, substance abuse, failing personal relationships
- Subset of the larger, more general problem of physician suicide
- Residents *less* likely to die by suicide than general population controls
- However, resident physicians (like physicians in general) far more likely to succeed in first attempt
- Most common cause of death in male residents, and second most common (following malignancy) in female residents

Profile of a Vulnerable Resident

- Sense of inadequacy
- Failure to "help" patients
- Failure, or *sense* of failure to live up to senior resident/attending expectations
- Making a mistake that causes a patient's death (personal guilt)
- Being single and having no children/dependents
- Being alone in a new high-stress environment with little support

(Hochberg MS, Berman RS, Kalet AL, et al: The stress of residency: recognizing signs of depression and suicide in you and your fellow residents. *Am J Surg* 2013. 205:141-146.)



Theories of Physician Predilection for Suicide

- Interpersonal Psychological Theory of Suicidal Behavior (IPTS—Joiner 2005) & "provocative work experiences"
  - Thwarted belongingness
  - Perceived burdensomeness
  - Acquired capability**
- "Three Factors" Approach
  - Mental state (unbalanced)
  - Social situation (unbearable)
  - Easy access to suicide methods

UF Anesthesiology

Strategies for Prevention of Physician Suicide

- Specific, on-going education on stress, "burn out," depression, and suicidal ideation/behavior recognition
- Reduction of stigmas surrounding mental health (including licensure and credentialing)

  ("I would never want to have a mental health diagnosis on my record")
- Reduction of barriers to seeking mental health care
- Reduction of workplace and work-home balance stressors
- Restriction of access to means of suicide for physicians recognized at elevated risk

UF Anesthesiology

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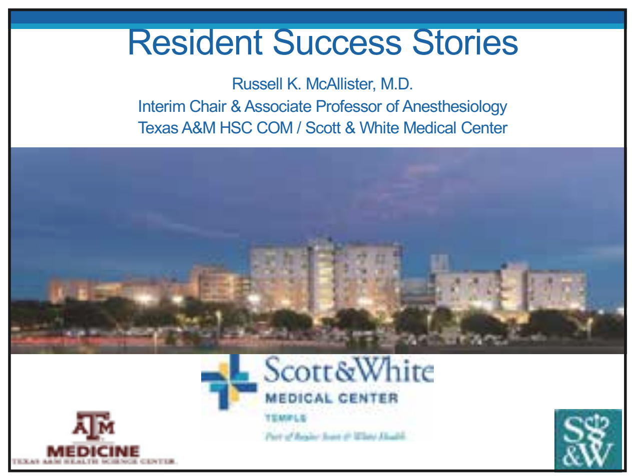
HANDOUT

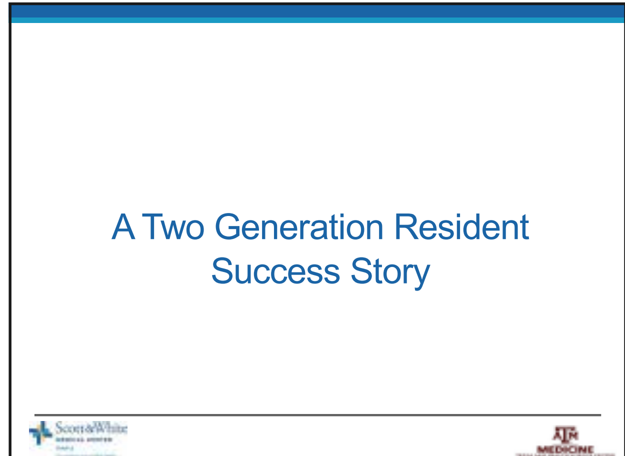
Problem Resident Success Stories

Russell K. McAllister, MD, FASA

11/02/2018
9:36am – 9:48am

Back to Schedule





Resident One

- This resident had a rough start during her intern year
- Their reputation was that they were not a team player
- Early in the PGY-II year, on the SICU rotation, the situation escalated with frequent episodes of being late, pushing work off on others, and being absent at key times
- Missing morning rounds to go get breakfast was the final straw for her fellow residents to voice their complaints to me

2

Resident One

- I had a sit down meeting with the resident and spelled out the complaints which had been well documented and verified by multiple colleagues/attendings
- I bluntly told them this behavior was unacceptable and that this would be their last warning prior to an unsatisfactory evaluation
- I put it in writing and made them co sign the letter for their file

3

Resident One

- They actually made drastic improvement over the next few months and years and they became a very good resident and our chairman hired them to be a faculty member
- I found out after they graduated, that they had kept a copy of my letter on their person every day, and whenever they thought about cutting a corner, they would take the letter out and be inspired to do the extra work needed to be a valued team member
- Currently, they are a very solid faculty member

4

Resident Two

- Two years behind Resident one
- Struggling academically
- Newly married with a child on the way
- Spouse with a failing small business
- Huge financial burden
- Child on the way
- Unrealistic expectations from spouse regarding time

5

Back to Schedule

Resident Two

- Spent extra time helping spouse with failing business
- No time left for studying led to single digit ITE percentile
- Wife had unrealistic expectations about his need to stay at home and take her to her appointments or stay home when she was having morning sickness
- Absenteeism became a huge issue
- I had a discussion with him about his commitment to the training program

6

Resident Two

- The CCC convened to discuss the next step
- Resident One, now board certified, had just been added to the CCC
- They saw glimpses of their early residency struggles in this resident
- They made this resident their pet project and gave support, empathy, guidance for them and their spouse and met with the resident every two weeks for progress reports

7

Outcome

- Resident One continued to encourage/support Resident Two
- Resident Two passed the Basic Exam, absenteeism resolved with a change in attitude from their spouse, the failing business was shut down so he could concentrate on residency
- He became one of our best residents and was hired as faculty
- Currently a favorite among the faculty/residents/nursing staff

8

Take home messages

- Sometimes, when their status in the residency is threatened, the light bulb turns on and they make life changes to respond
- Having a faculty who can relate to their situation can provide valuable support when all seems lost
- Our residents are valuable and I think we need to be open to supporting them as long as they are open to changing

9

Take home messages

- What I told both of these residents:

“I want you to be successful, but I can’t want it more than you.”

10

Resident Success Stories

Russell K. McAllister, M.D.
Interim Chair & Associate Professor of Anesthesiology
Texas A&M HSC COM / Scott & White Medical Center
Russell.McAllister@BSWHealth.org

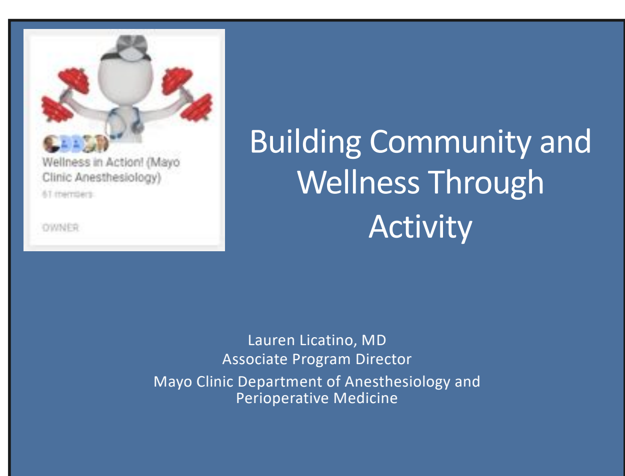
Back to Schedule

HANDOUT

Best Practices and New Approaches in Wellness

Lauren Katherine Licatino, MD

11/02/2018
10:30am – 11:00am



What We Did

- 8 week partner activity challenge
- Participants randomly paired by resident or attending status
- Rules
  - Each partner must exercise 20 minutes per day
  - If one participant could not do the workout, the partner could make up the time

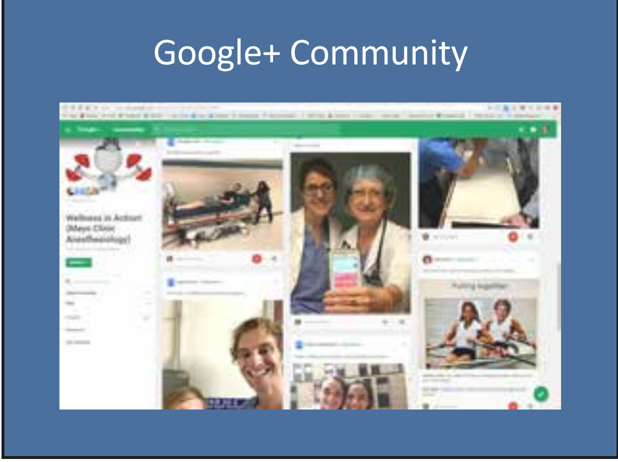
Why We Did It

- Fun
- Fitness
- Community
- Culture of Wellness

Community Building

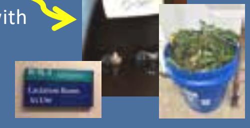
In order to create a culture of wellness, "It is essential to build a culture of appreciation, support, and compassion along with a deep sense of community."

-Bohman, B, et al. NEJM Catalyst. April, 2017



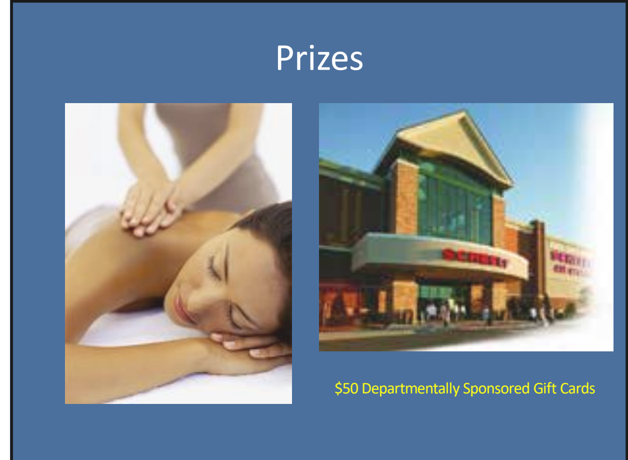
Bonuses

- Picture of healthy food
- Picture of something you do to support your wellness
- Name one thing that brought you joy or gratitude at work
- Name one thing you struggle with
- Picture of self with partner



Back to Schedule

Prizes



$50 Departmentally Sponsored Gift Cards

Reaction

- Survey sent to all 76 participants
- Response rate 38/76 (50%)
- Visual Analog Scale

None (0) -------------------------- Significant (100)

- Affect on overall wellness – 68.8
- Affect on activity level – 69.4
- Affect on sense of community – 82.5

What Were the Best Aspects of the Challenge?

- Google groups broke down any social barriers for me between residents and consultants, novice and veteran. I really enjoyed the format.
- Sense of community and camaraderie that was shared.
- The platform in which to share photos and comments with one another
- This challenge made me feel much more connected to the anesthesia consultants. It was nice to feel some camaraderie between residents and consultants.

What Were the Best Aspects of the Challenge?

- Felt like a part of a team; motivated to communicate with my partner everyday
- Seeing the consultants and residents talk together. Improving activity level of everyone.
- Felt connected to my colleagues and residents. Strong work!
- Interactions within group, sense of community

ALL RESPONDANTS SAID THEY WOULD DO IT AGAIN!

How Can I Do This?

- It's EASY!
- Find a tech savvy Champion
- Departmental Buy-in (for prizes)
- Sign up and pair randomly pair participants
- Have fun!
- Find the Anesthesiology in Action (SAAAPM) group on Google+ communities for resources!

Questions?

Email: Licatino.Lauren@mayo.edu

Twitter: @laurenlicatino

*All participants pictured in this presentation consented to the use of their images

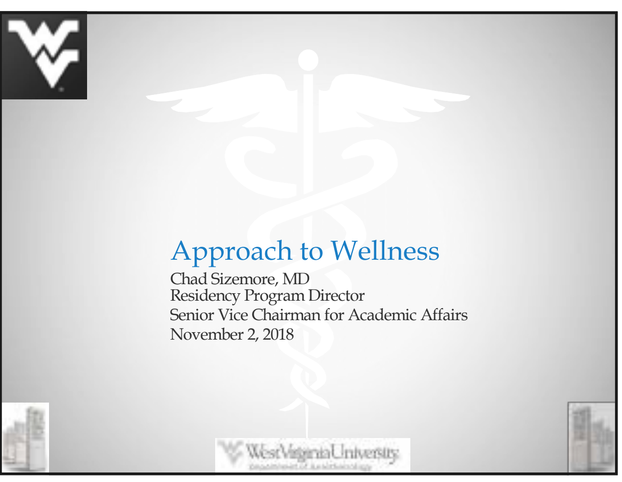
Back to Schedule

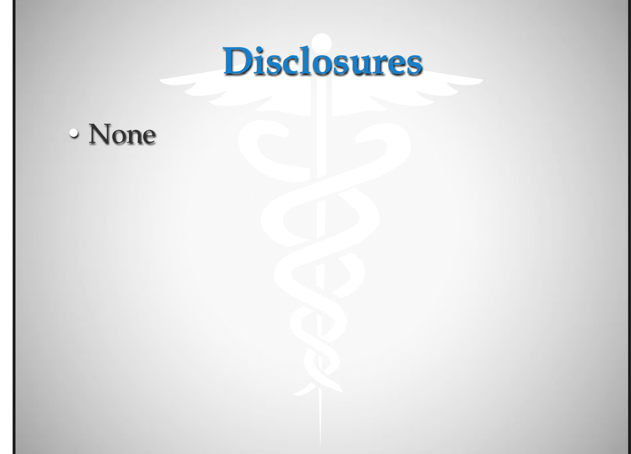
HANDOUT

Best Practices and New Approaches in Wellness

Daniel C. Sizemore, MD

11/02/2018
10:30am - 11:00am





History

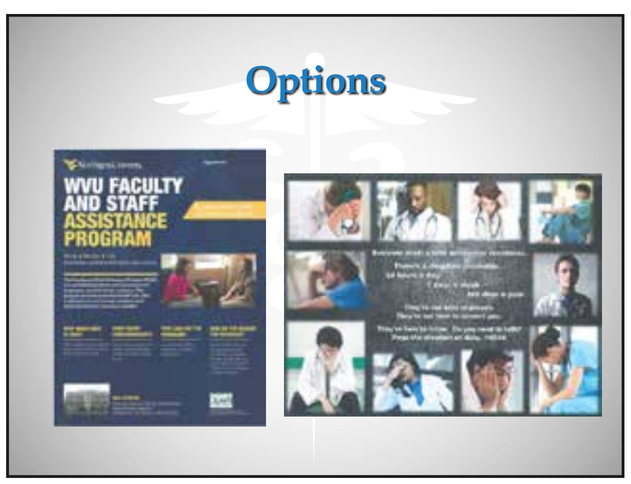
- 2012
  - Preexisting Substance Abuse Didactic Series and training
  - Sessions developed and included in lecture series and department grand rounds for:
    - Fatigue mitigation
    - Sleep maintenance

2017-2018

- Resident Wellness Survey results dictated a need for change
- Well-being policy initiated with WVU GME administered learning modules
- Universal Wellness Screening Program

Universal Wellness Screening

- Residents and Fellows were required to complete a wellness screening visit during the academic year
- Goals
  - Brief assessment for depression or burnout
  - Introduce options for counseling
  - Afford the opportunity for discussing current work/life stressors
  - Familiarize resident with confidential urgent availability of someone to discuss work events



Resources

- Residents in anesthesiology were scheduled for one "wellness" day
  - Intake wellness assessment
  - Survey completion
  - Assigned learning modules

Obstacles

- Chaplain/Spiritual Services
  - Stigma
- Availability
  - Resident
  - FSAP
- Financial support

Results

- Local resident survey
  - 1 negative response
  - 22 positive responses
- Global GME survey upcoming

- Thank you!

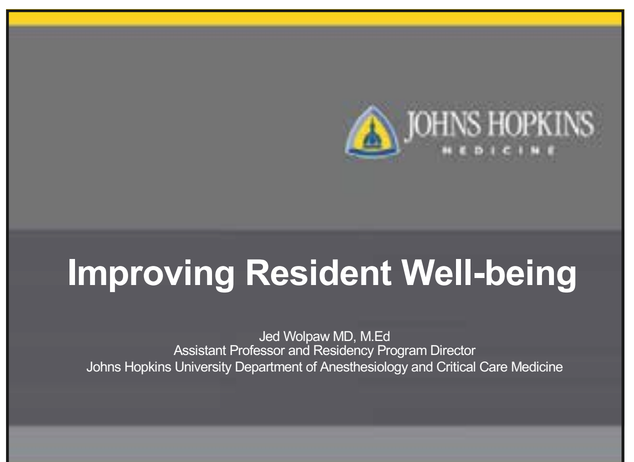
Back to Schedule

HANDOUT

Best Practices and New Approaches in Wellness

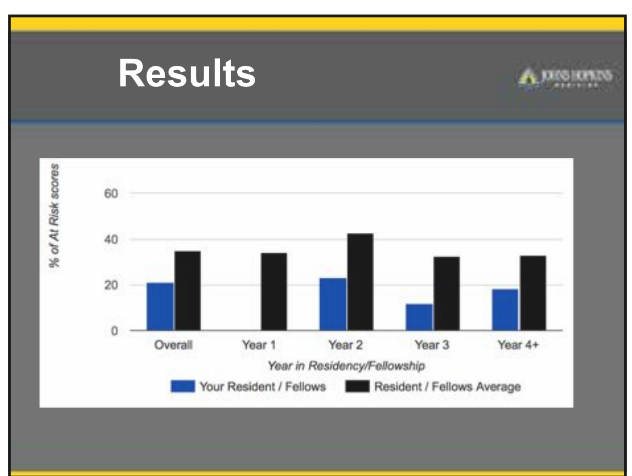
Jed Wolpaw, MD, MEd

11/02/2018
10:30am - 11:00am



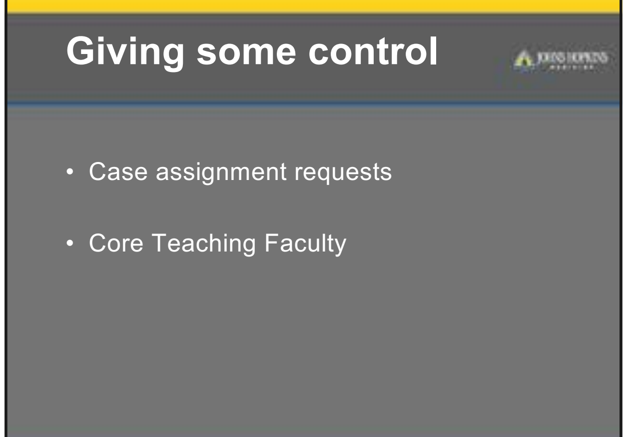
Disclosures

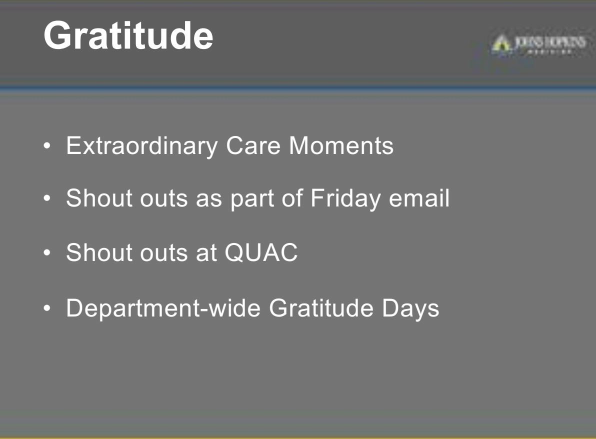
- I have no conflicts of interest and nothing to disclose

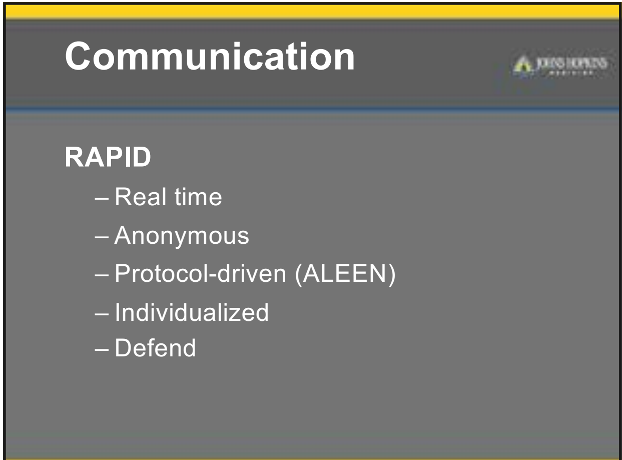


Well-being sessions

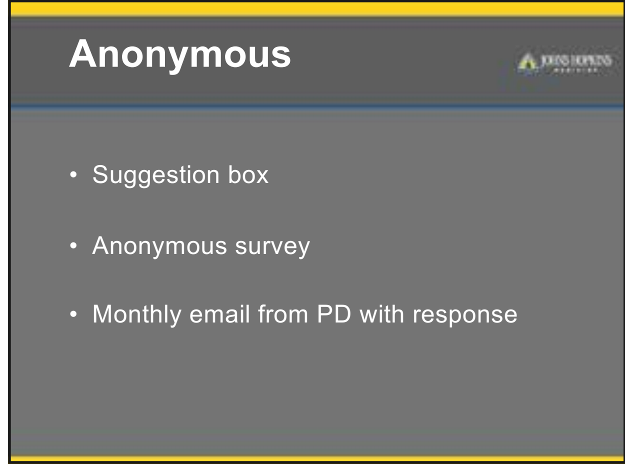
- Part of twice per month college days
- Yoga, meditation, quick gym, own time
- Mindfulness course
- Free early morning and evening yoga

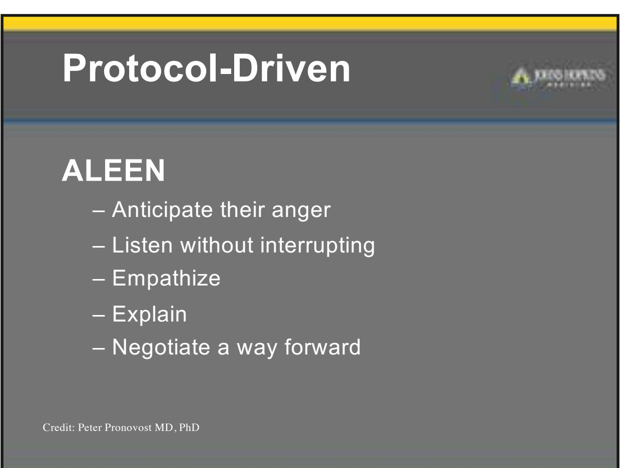

Giving some control
Case assignment requests
Core Teaching Faculty


Gratitude
Extraordinary Care Moments
Shout outs as part of Friday email
Shout outs at QUAC
Department-wide Gratitude Days

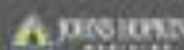

Communication
RAPID
– Real time
– Anonymous
– Protocol-driven (ALEEN)
– Individualized
– Defend

Real Time and Anonymous
Confessions Sessions
– In person with PD
– Anonymous
– Participants get support from hearing others
– Participants get real time feedback from PD
Karan SB et al, JGME 2015


Anonymous
Suggestion box
Anonymous survey
Monthly email from PD with response


Protocol-Driven
ALEEN
– Anticipate their anger
– Listen without interrupting
– Empathize
– Explain
– Negotiate a way forward
Credit: Peter Pronovost MD, PhD

Individualized

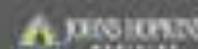


- At least monthly one-on-one check-ins
- When an issue arises: in-person meeting
- Individual unique circumstances

Defend (Advocate framing)

- Frame discussions around advocacy for resident
  - To improve reputation
  - To improve future job prospects
  - To be seen as they want to be seen
  - To achieve their goals

References



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HANDOUT

Mistakes Made; Lessons Learned as a Program Director

Manuel Pardo, Jr., MD

11/02/2018
11:00am – 11:10am

Mistakes Made, Lessons Learned as Program Director

Manuel Pardo, Jr. MD
UCSF Department of Anesthesia and Perioperative Care

AACPD Annual Meeting
November 2, 2018

I have no financial disclosures

My Mistake:
Failure to adapt to generational differences in attitude towards work

My medical training background

Training	Years	Comments
Medical School	1987-1991	Overnight call, immersive rotations
Residency	1992-1995	No duty hours, mindset on clinical work
Fellowship	1996	

1990's Training Paradigm:
"Come early, stay late, work hard, don't complain."

Residency Leadership

Position	Years	Comments
Associate PD	2006-2009	ACGME rules, Duty Hours
Program Director	2009-2019	Lots of ACGME changes

Back to Schedule

Prior PD's approach to preparing residents for program

Inspired by The Ten Commandments e.g.,

1. I am the Program Director, who makes the rules
2. You shall have no other residency rule maker of higher authority (except the chair)
3. You shall obey all the rules

Symptoms that old paradigm not working…

1. Resident complaints about having to take call
2. Resident complaints about fairness
3. Elaborate requests for special treatment
4. Faculty complaints of the type "how come the residents don't …"
5. Program director's longing for the past

How I became determined to make a change

1. Chief resident book recommendation: Millenials and Management: The Essential Guide to Making it Work at Work, by Lee Caraher

2. Several other books on Amazon.com

3. Realization that the past is behind us

What I Changed:
Created a framework for working with residents, including specific advice to them, and to the faculty

Advice from Making it Work at Work
1. Making work meaningful
2. Give clear direction
3. Be transparent
4. A full-life approach to work

1. Making work meaningful

Advice to PD/Faculty	What you as a resident can do
Share vision for you as an successful anesthesiologist	If you don't know, ask
I won't assume you know your roles at all times	Don't assume I know everything
Explain how what you do is tied to the residency mission	Volunteer for things

2. Give clear direction

Advice to Faculty	What you as a resident can do
Be explicit and reiterate expectations	Ask for clarification
Describe how work impacts rest of team	Ask for sample work
Don't accept unsatisfactory work; do tell when work is good	Try it instructor's way – then improve it

3. Be transparent

Advice to PD/Faculty	What you as a resident can do
Communicate good news and bad news	Don't assume you are entitled to every bit of info
Don't sweep bad news under the rug	Don't assume all you hear is true
Answer questions openly and honestly, if confidential, explain	Do ask open, positively framed questions

4. A full-life approach to work

Advice to PD/Faculty	What you as a resident can do
Articulate expectations for presence at work	Don't assume work policy is without reason
Don't assume people know about time away from work	Don't assume you can just take time off
Be consistent	Do think before you complain (venting is okay)

Lesson Learned:
Be proactive in seeking to understand how the current generation of trainees (students and residents) approach work, so that you can better help them achieve excellence.

Back to Schedule

HANDOUT

Mistakes Made; Lessons Learned as a Program Director

Jerome M. Klafta, MD

11/02/2018
11:10am – 11:20am

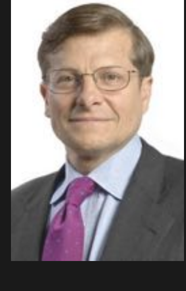
Back to Schedule

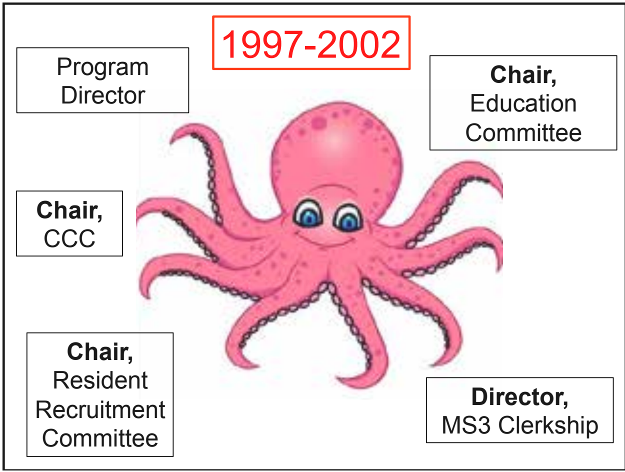
My mistake:
Not insisting on succession planning

Jerome M. Klafta, MD
Professor
Vice-Chair for Education
Department of Anesthesia and Critical Care
University of Chicago

November 2, 2018

"I want you to be the Education Czar"





Back to Schedule

We just got used to this model!

- Pros
  - Everyone knows who to contact
  - Efforts are well-coordinated
- Cons
  - Burnout
  - No succession planning

In 2006, I got tired….

Mohammed Minhaj:	5 years
Mike Hernandez:	4 years
Jennifer Hofer:	3 years
Junaid Nizmuddin:	2018-

+ 2 Associate PDs…finally!

What does the ACGME say?

Anesthesiology

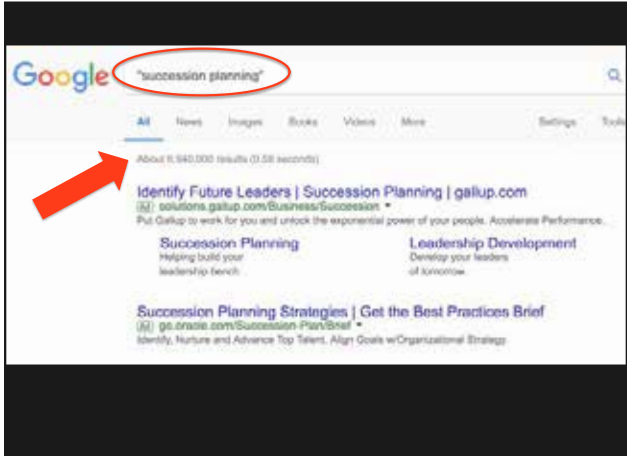
Programs with more than 20 residents must provide a minimum of 40 percent protected time for the program director.

Neurology

At a minimum the sponsoring institution must provide time and funding to support at least 20% FTE and should provide an additional 1% per trainee.

Pediatrics

For programs with 31-60 residents, there must be a minimum of 1.0 combined FTE program director and associate program director, 2.0 FTE liaisons, and 1.5 FTE residency coordinators.



Lessons Learned

- *Insist* on developing bench strength
- Being a Czar has its downsides

HANDOUT

Mistakes Made; Lessons Learned as a Program Director

Mark J. Harris, MD, MPH

11/02/2018
11:20am – 11:30am

Back to Schedule

Mistakes Made

MARK J. HARRIS, MD MPH

The speaker has no disclosures to make.

Learning objectives:

1. To describe how failing to proactively engage faculty colleagues with a planned change to the residency program adversely affected the process.
2. To suggest a mechanism for recovery from a faux pas as described in objective 1.

The story

Historically our residency programs' faculty evaluations of the residents have been anonymous. This originated from a belief that a couple of promotion attempts had been scuppered by some residents' antagonism toward particular faculty members. I had always felt that this was flawed logic, and so when I took over as Program Director last summer, it was on my "list of things to fix".

At around the same time as my transition to PD, our institution adopted a new GME management system. As you all know, these are complex systems, and in the move, the anonymity of the faculty evaluations was never turned on. We didn't realize this for 3 months. When we did notice, I informed the faculty of the fact by email, and went on to say that as I had intended to move towards a non-anonymous system anyway, I was going to leave the evaluations as they were. This was greeted by a huge outcry. I was accused of authoritarianism, of potentially ruining careers, and many faculty members threatened to stop evaluating the residents entirely.

Realizing my mistake, I apologized, and called for volunteers to form a committee to address the concerns and develop solutions. Out of a faculty of about 75, I got about 10 volunteers, and despite multiple attempts at maximizing our attendance, ended up with about 5 people attending the committee meetings.

We had a very constructive discussion. I learned that the rumor mill had been working overtime in the last few years, and those concerns about trainee sabotage of promising careers had grown into monstrous horror stories, the falsity of which I could confirm having sat on most of the committees involved. We worked through their concerns, examined fears, explored opportunities for mitigating some possibilities, and discussed the logic behind the change. By the end, this group of people, those originally most committed to fighting this 'enforced' change, were unanimous in their support of it.

How to avoid the problems

1. Consult early and often with your faculty.
    a. They can voice their concerns, some of which you might never have imagined.
    b. You get to explain your reasoning. "*Goals and strategies need to be explained downward, to the people you lead. If they understand what you want and why, they become teammates. If they do not, they see themselves as pawns*." [1]
    c. You can address misconceptions before they are blown out of all proportion.
2. Don't take it personally. It isn't about you it's about them.
3. Gossip / horror stories should not be a reason to derail logical plans, but they should be considered and addressed in step 1.

References.

1. Conflict Communication (ConCom): A New Paradigm in Conscious Communication. Rory Miller. Wolfeboro, NH, USA: YMAA Publication Center [2015]

Back to Schedule

HANDOUT

Mistakes Made; Lessons Learned as a Program Director

Sujatha Ramachandran, MD, MACM

11/02/2018
11:30am – 11:40am

Back to Schedule

Mistakes Made, Lessons Learned

Sujatha Ramachandran, MD, MACM.

The Problem

- Resident DT
- Well liked, Excellent ITE scores
- Unable to integrate his knowledge to clinical practice
- CCC felt that Anesthesiology was not a suitable field for DT and this was discussed with DT
- DT was determined to complete anesthesia training and specialize in pain management.

Remediation

- DT was placed on remediation in the second half of his CA-1 year.
- It was difficult to remediate the non-cognitive aspects of his performance.
- His focus seemed to have improved.
- DT was advanced to his second year largely based on ITE scores, professionalism and pleasant nature

Results of remediation

- DT could not adapt his performance to the needs of the different subspecialties
- Failed most of his rotations in his CA-2 year.
- Placed on remediation again
- His performance did not improve and DT was asked to reconsider his choice of specialty.
- DT insisted that he wanted to complete anesthesia residency and was asked to repeat his second year accordingly.

- His repeated CA-2 year was very rough and involved further remediation
- At the end of this year, he was told that his contract will not be renewed.
- We assisted DT in finding a position in a different specialty where he thrived.

Our Mistake

- DT had gone through his internship year and 3 years in Anesthesia residency when his contract was terminated.
- We had recognized within the first six months that DT was not suited for the rapid pace and the emergent nature of the field of anesthesiology, yet allowed DT to remain in our training program for two and half more years.
- This decision was not based on successful remediation. We believe that we were biased because he was well-liked and consistently demonstrated professionalism.

- It was a big mistake to allow him to continue training despite clear indications that he was not suited for the specialty.
- It was traumatic for DT because of the time he had invested and for us because he was well-liked.

Lesson Learned

- We must identify focused remediation parameters with clear expectations and outcome measures.
- In DT's case neither his medical knowledge nor his professionalism was in question.
- These competencies should not be considered in isolation while making the decision to advance or terminate a trainee.
- If there are clear indications that a resident is not going to be successful, help reevaluate the resident's career choice.

Back to Schedule

HANDOUT

Resident Recruitment, Administration and Interview Formats – The Program Administrator Perspective

Amy DiLorenzo, MA

11/02/2018
1:30pm – 1:55pm

Back to Schedule

Residency Recruitment

The Coordinator/Educator Perspective

Amy DiLorenzo

Assistant Dean for Educational Innovation and Scholarship – GME
Education Specialist
Department of Anesthesiology
University of Kentucky College of Medicine
Lexington, KY

• No disclosures or conflicts of interest.

Objectives

- Discuss the multi-faceted role of the program coordinator/educator in the recruitment process
- Describe the experiences of program coordinators/educators with recruitment
- Describe common and unique/innovative recruitment practices
- Suggest ideas of additional resources to support program coordinators and educators in this role

Association of Anesthesiology Program Administrators and Educators (AAPAE)

Who we are:

- Residency and Fellowship Program Coordinators
- Medical Education Specialists
- Current members: ~252

- Qualtrics survey of members

Experience as a Coordinator/Educator

YEARS OF EXPERIENCE

1-5 years | 6-10 years | More than 10 years

40%
47%
13%

College of
Medicine
Anesthesiology

Association of Anesthesiology Program Administrators and Educators (AAPAE)

Our role in recruitment (varies widely by institution/position):

- Screening applications
- Scheduling interviews
- Arranging travel, faculty interview schedules, dinners, lunches, transportation, hotels,.......
- Communication with applicants (phone, email, scheduling software)
- Managing additional staff involved in recruitment
- ERAS and scheduling software management
- Compiling interview scores
- Surveys to applicants
- Assistance with rank order meetings
- Developing interview questions, preparing residents for interview
- Interviewing applicants
- Research on interview practices and techniques

What do you **enjoy most** about your role in recruitment?

- Helping to continue and add to a legacy
- Being an active participant in the selection process
- Working hard to ensure that everything is organized for our candidates. I want them to be impressed!
- Promoting our city and our department
- **Meeting each of the candidates from all over the country and world. I love meeting new people and seeing them grow throughout residency.**

College of Medicine

What have been the **most difficult/challenging/frustrating** things about recruitment from your perspective?

- Issues with ERAS
- Having to say "no" to so many good applicants
- Our department website is not up to par
- Not having an adequate budget for recruitment activities
- Last minute cancellations and changes in the schedule
- **Difficulty getting faculty involved to participate in interviews**

College of Medicine

What **resources** are **most helpful** to you during the recruitment season?

- The residents – they are the greatest advocates for the program and greatest source of knowledge for the candidates
- A reliable caterer
- Fellow coordinators and other department staff
- Organizational tools (Thalamus, Interview Broker, Google Docs)
- My PD – wonderful and helpful during recruitment and the whole year

What resources do you wish you had for recruitment that would help the process to be smoother/more efficient/more successful?

What resources do you wish you had for recruitment that would help the process to be smoother/more efficient/more successful?

- A collection of interview day examples (what others are doing for scheduling, what the day looks like, how tours are conducted, who do applicants interact with)
- A checklist for everything that needs to happen before, during, and after interviews
- **An assistant/"extra hands" for interview days (student worker, another staff person assigned)**

What recruitment **techniques/practices** have you seen that have been **very successful** from your perspective?

Common practices:

- The use of interview scheduling software
- Release all interview dates at the same time
- A mix of interview and social time for the applicants
- Arrange the applicants to have as much time as possible with the residents
- Pre-work and attention to detail
- Teamwork between the PD/Coordinator/Chief Residents

College of Medicine

Back to Schedule

What recruitment **techniques/practices** have you seen that have been **very successful** from your perspective?

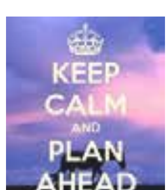
Unique ideas:

- The use of positive social networking
- Provide flash drive with info rather than printed materials
- Saturday morning interviews
- Bus tours of various sites where residents rotate and then to a scenic location for a photo opportunity

What recruitment **techniques/practices** have you seen that have **not been successful** from your perspective?

- Afternoon/evening interviews (mixed reviews)
- Having a large recruitment committee
- Last minute scheduling changes
- Interview days with a large number of applicants (impersonal)
- Trying to be a one woman/man show

What **advice** about recruitment would you give to a new program coordinator/educator?



What **advice** about recruitment would you give to a new program coordinator/educator?

Unique ideas:

- Talk to other coordinators in your department and institution – share ideas
- Take care of your OWN health during recruitment! Have hand sanitizer everywhere…

If you could share **one piece of advice** with Program Directors about recruitment, what would it be?

- Try to stay to the planned schedule – it helps everyone have a smooth day
- Advocate for additional administrative help for interview days
- Gut buy-in from the faculty for our interview process
- Reconsider the utility of “courtesy interviews”
- **Listen to your coordinator’s impressions about candidates**

College of Medicine

Parting thoughts…..

Program Coordinators/Educators:

- Provide first impressions of the program
- Essential partners in the recruitment process
- **Invested, dedicated, and interested**

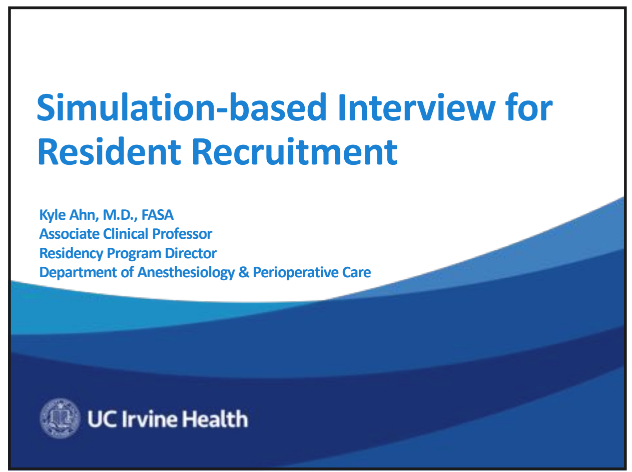
Back to Schedule

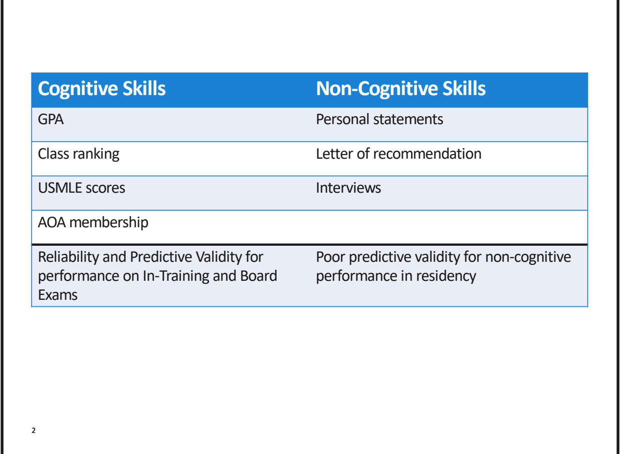
HANDOUT

Resident Recruitment, Administration and Interview Formats – Simulation

Kyle S. Ahn, MD, FASA

11/02/2018
1:55pm – 2:10pm





Cognitive Skills	Non-Cognitive Skills
GPA	Personal statements
Class ranking	Letter of recommendation
USMLE scores	Interviews
AOA membership	
Reliability and Predictive Validity for performance on In-Training and Board Exams	Poor predictive validity for non-cognitive performance in residency

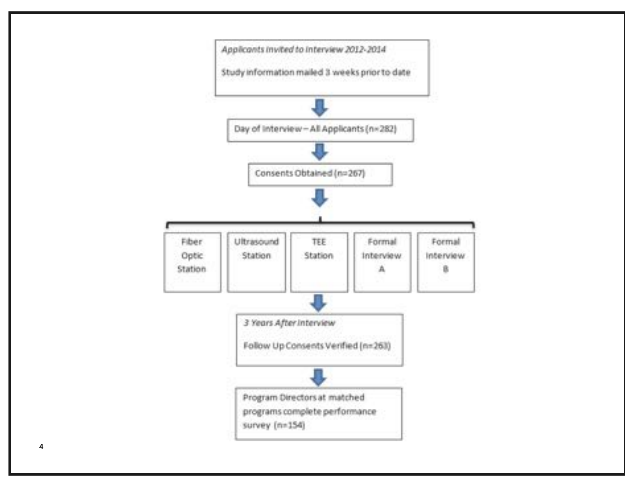
2

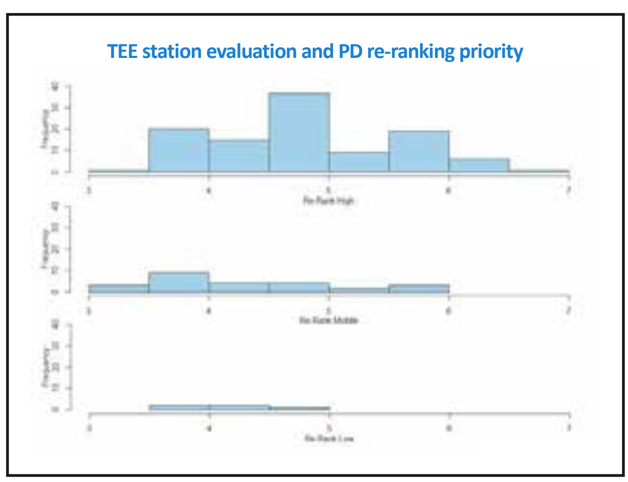
Purpose of Simulation

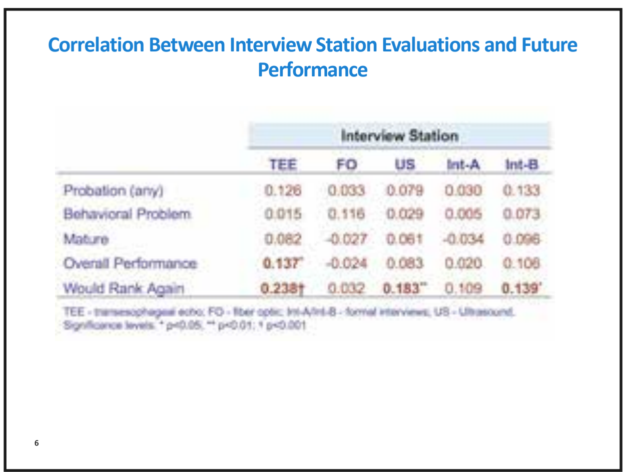
- Assess non-cognitive attributes
- Stratify candidates to a greater degree than standard interview format alone

Performance in simulation a predictor of performance in residency?

3





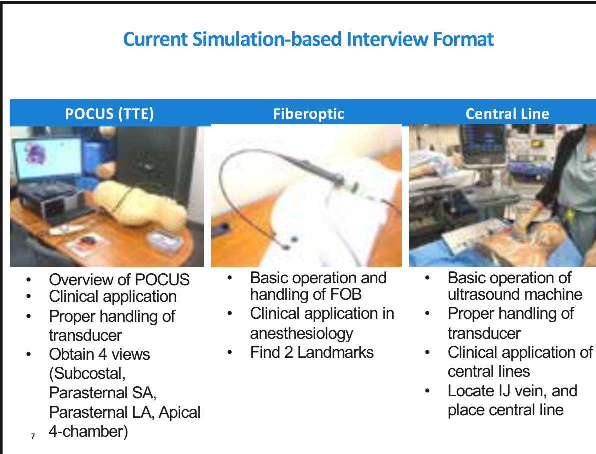


Correlation Between Interview Station Evaluations and Future Performance

	Interview Station				
	TEE	FO	US	Int-A	Int-B
Probation (any)	0.126	0.033	0.079	0.030	0.133
Behavioral Problem	0.015	0.116	0.029	0.005	0.073
Mature	0.082	-0.027	0.061	-0.034	0.096
Overall Performance	**0.137***	-0.024	0.083	0.020	0.106
Would Rank Again	**0.238†**	0.032	**0.183****	0.109	**0.139***

TEE - transesophageal echo; FO - fiber optic; Int-A/Int-B - formal interviews; US - Ultrasound.
Significance levels: * $p<0.05$; ** $p<0.01$; † $p<0.001$

6



Evaluation of Two ACGME Core Competencies

- Interpersonal and Communication Skills
- Professionalism

*Not evaluating medical knowledge or the ability to do the procedure.

8

Simulation Evaluation Form – Residency Recruitment

During simulation, we are primarily focused on interpersonal and communication skills (ICS), and professionalism. Keep in mind that we are not evaluating candidates on their medical knowledge or their ability to do procedures. When filling out the evaluation forms, think about the candidate's ability to be taught, follow instructions, take redirections, and learn from mistakes. Are they adaptable? Does the candidate demonstrate effective exchange of information? Does the candidate demonstrate respect for others and professional conduct?

Please fill out this form and return it to City Tower at the end of each day. It is best to complete the forms immediately after every morning and afternoon simulation sessions.

Grading Scale of demonstration of ICS and Professionalism:	1	2	3	4	5
	Poor	Below Average	Average	Above Average	Outstanding

Profile	Name & Medical School	Comments	Overall Grade

9

Why Continue with Simulation?

- Provide candidates with quality interactions
- Highlight education resources in the program
- Demonstrate resident education and research
- Interact with simulation and administrative staff
- Opportunity for residents to teach
- Opportunity for residents to demonstrate knowledge, teaching and technical skills to candidates
- Engage our residents in the recruitment process

10

Back to Schedule

HANDOUT

Resident Recruitment, Administration and Interview Formats – Video Interviews

Jason W. Gatling, MD

11/02/2018
2:10pm – 2:25pm

Back to Schedule

Where did the idea come from?

- Chance
- Deep thinking from the education committee
- The **Department Chairman** came up with it!

Consumer-goods giant Unilever has been hiring employees using brain games and artificial intelligence — and it's a huge success

- Used **artificial intelligence to screen all entry-level employees** for the past year.
- Candidates play **neuroscience-based games** to measure inherent traits, then have **recorded interviews analyzed by AI.**
- The company considers the experiment a BIG success and will **continue it indefinitely.**

Unilever wants to be a global leader when it comes to using artificial intelligence for hiring. HireVue

Expounding on the Concept

- Brought the idea to education committee and had a "rousing" discussion
- Came up with a "one year" pilot study
- Wanted to trial a new innovative thought process that was completely different from the traditional resident interview system

Back to Schedule

Research Study

- Would applicants choose to do a web-based interview vs. traditional in-person interview
- Follow-up Questionnaire:
  1. Why did you choose to do a web-based interview?
  2. What were the barriers to the interview process?
  3. Where would the interviewees be ranked on the internal departmental rank list?
  4. Would anyone rank our program based solely on the web-based interview?
  5. Would anyone match to our program from the web-based interview pool?
  6. Would anyone match to our program without ever having physically been to our hospital / program / area?

Why Applicants Choose A Web-Based Interview

1. Conflict of interview dates between programs
   - Unable to get a program interview day when available
2. Travel concerns
3. Financial limitations
4. Time management efficiency
5. "See" or "review" a program that would not have traditionally been on the applicants' radar
6. Program perceived as market place progressive / innovative

Barriers

- Have to be "reasonably" comfortable with technology (FaceTime or Skype)
- Connectivity issues
- Interviewers comfort and ability to improvise
- Disruption of social graces in conversation
- Disconnection of non-verbal cues
  - How do you get a real feel for the applicant without them right in front of you

Residency Program Gains

- Applicant pool increased
- Geographic range of applicants increased
- Decreased interview day cost
  - No dinner the night before
  - No lunch on the day of
  - Larger number of applicants to be interviewed per day (16 vs. 12)
- Time resource efficiency
  - Off-line viewing of residency program information
  - Pre-recorded Chairperson's introduction and program director's presentation

Day of Interview Process

- Interview schedule is prepared ahead of time with the applicants knowing what hour they will be interviewed
- 0830 – Contact the first 4 applicants via phone and have them call in to the web-based application (FaceTime vs. Skype)
- 0900 – Four applicants are on separate computers in faculty offices.
  - Four faculty member interviewers spend 12-15 minutes per applicant and then they are prompted to move to the next office
  - Process continues until 0850 when first applicant session of interviews is complete (10 minute break between sessions)

Day of Interview Process

- 0950 – Support staff contacts the next 4 applicants to prepare them for the interview
- At the end of each session, the applicants are highly encouraged to go to our resident "Google Hangout".
  - Allows the applicant to interact "directly" with our residents and ask questions that they would not ask the faculty
  - Honestly, this is one of the best parts of the process
- ~1300 – Web-based interview day is complete and the faculty interviewers and chief residents sit down to discuss each of the applicants and tentatively place them on the master spreadsheet of applicants

Secondary Impression

- Applicants are always invited to come visit the campus / program as a "second look" when time and cost is more convenient
- Have been able to recruit applicants based on the personal interaction on the "second look"
- Had to get full "buy-in" from the department

What we learned to do differently

- Be "ok" with applicants presenting themselves in different environments
- Make sure that computer connectivity is strong
- Able to pick up different non-verbal cues
  - Location
  - Surroundings
  - Interruptions
  - Multi-tasking
  - Adaptability
  - Meet applicants on their terms
  - Potential interaction with other members of the applicants family (spouse, significant-other, children, parents)

Results

- 2014-2015 interview season was the first year
- 30% of our total interviews are now web-based
  - first year was 25%
- Statistically equal distribution of web-based applicants into the 4 quartiles of our rank list
- 1-4 individuals have matched to LLU Anesthesiology each year
- One of our current chief residents was recruited via the web-based interview
- Composed a publication from the idea / project

International Journal of Medical Education. 2016;7:102-108
ISSN: 2042-6372
DOI: 10.5116/ijme.56e5.491a

Comparison of web-based and face-to-face interviews for application to an anesthesiology training program: a pilot study

Marissa G. Vadi, Mathew R. Malkin, John Lenart, Gary R. Stier, Jason W. Gatling, Richard L. Applegate II
Department of Anesthesiology, Loma Linda University School of Medicine, Loma Linda, California, 92354, USA

Lessons that we learned?

- Take a chance on an idea!
- Who knows where the idea will lead!

Special Thanks to…

- Dr. Robert Martin
- Dr. Matthew Malkin
- Dr. Richard Applegate
- Dr. Gary Stier
- Dr. John Lenart
- Dr. Marissa Vadi

HANDOUT

Resident Recruitment, Administration and Interview Formats – Resident Perspective

Rohit Choudhary, MD
Danisa Daubenspeck, DO
Derek Rizzo, MD, MHSA
Lara R.I. Rosewicz, MD

11/02/2018
2:25pm – 2:50pm

Back to Schedule

HANDOUT

Everything You Always Wanted to Know About Other Programs...

Timothy R. Long, MD
Michael Wiisanen, MD

11/02/2018
3:30pm – 5:00pm

Programs, please sit together (i.e. one clicker per program)

Everything You Always Wanted to Know About Other Programs…

Timothy R. Long, M.D.
Associate Professor of Anesthesiology
Residency Program Director

Michael Wiisanen, MD
Associate Professor of Anesthesiology
Residency Program Director

Outline

- ABA
- Program structure
- The working environment
- Recruitment
- ACGME
- Bonus questions

My favorite Chicago restaurant is:

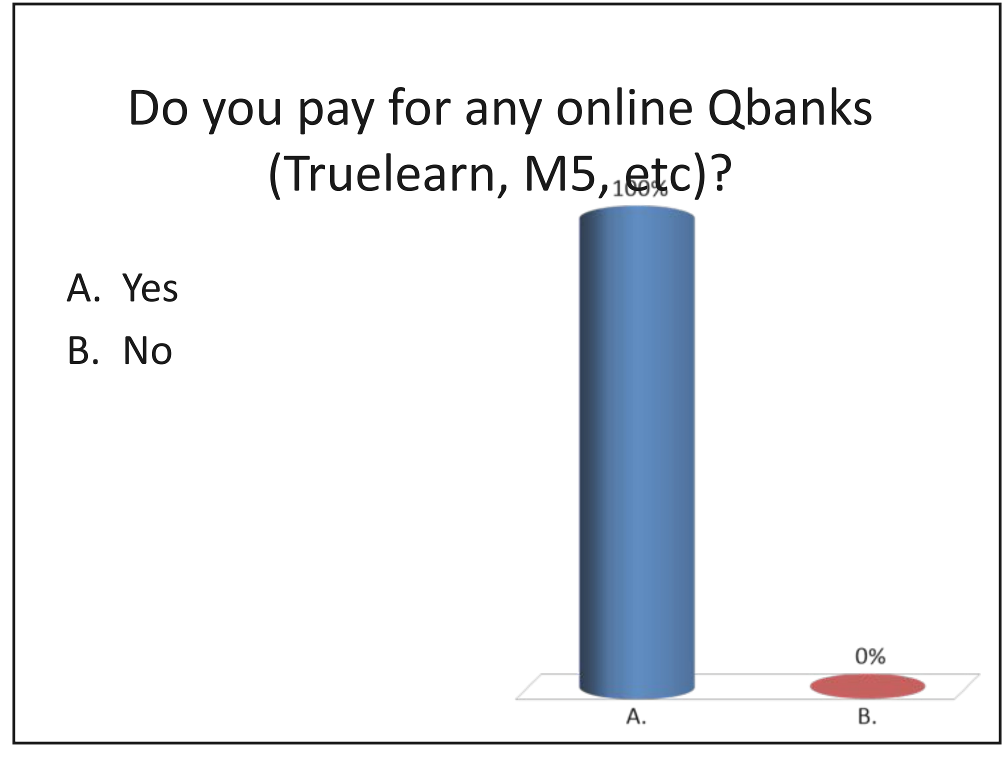
A. Portillo's
B. Girl and the Goat
C. Alinea
D. Chicago Cut Steakhouse
E. Giordano's
F. I haven't tried any of these!

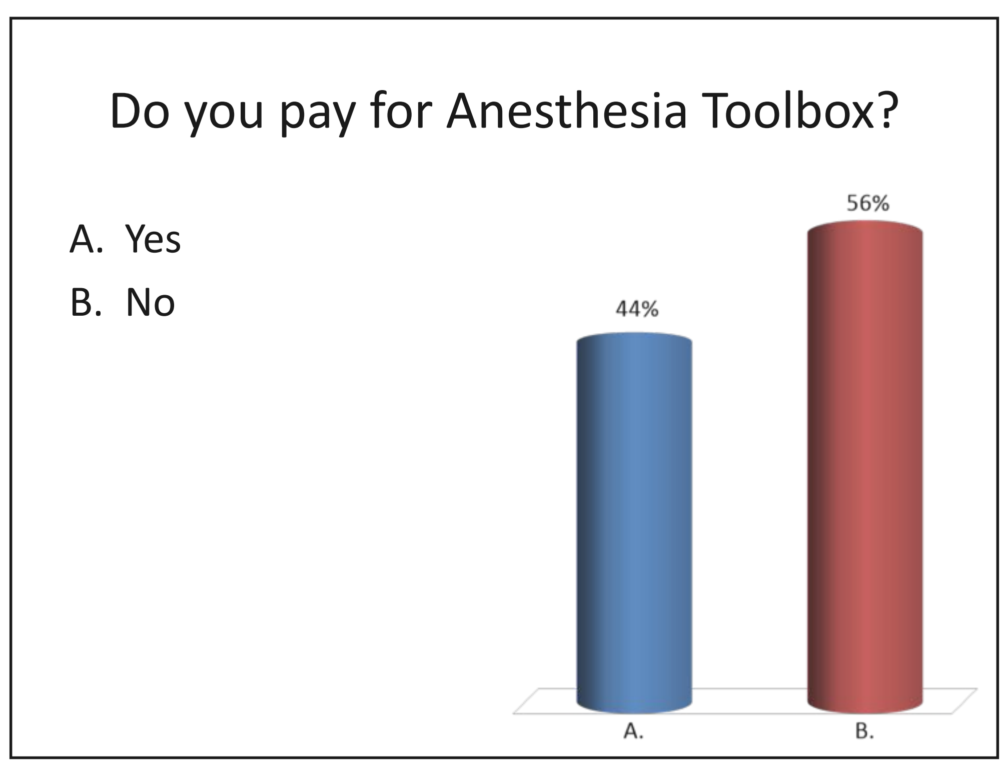
ABA

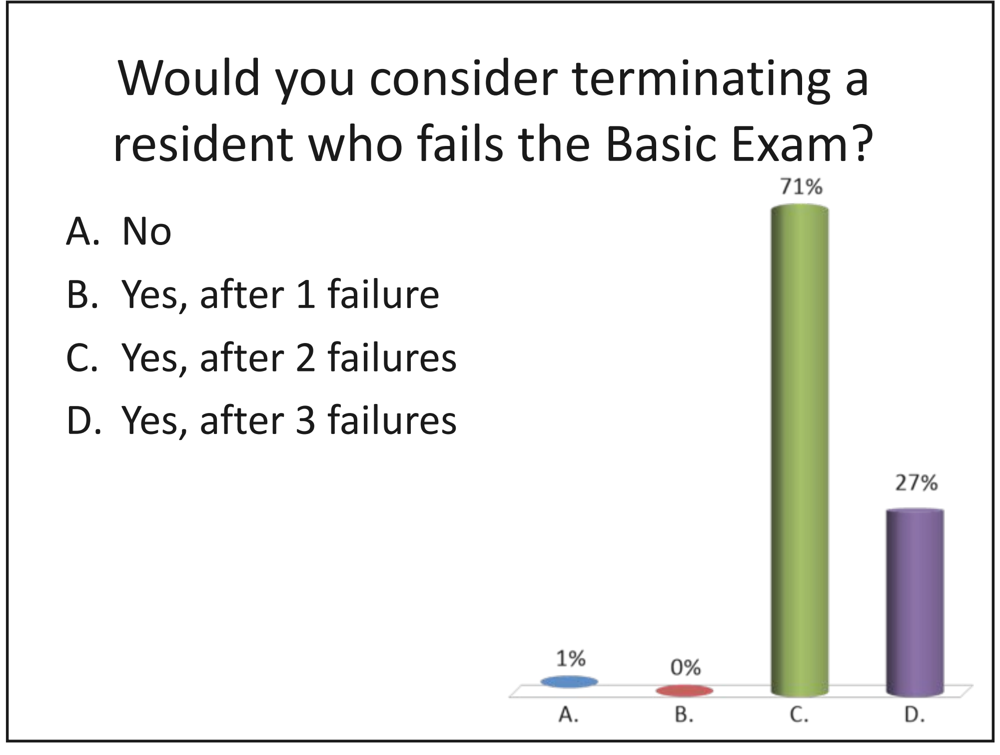
Do you pay for the ABA Basic Exam?

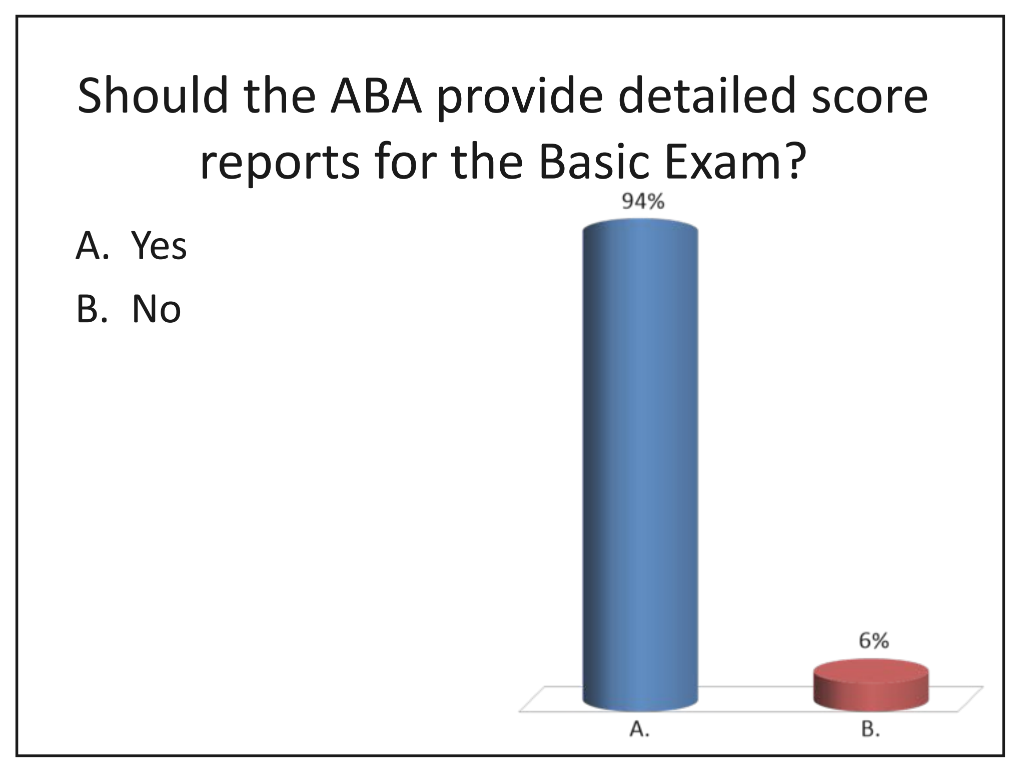
A. Yes
B. No
C. Only if resident exceeds a specific score on the ITE

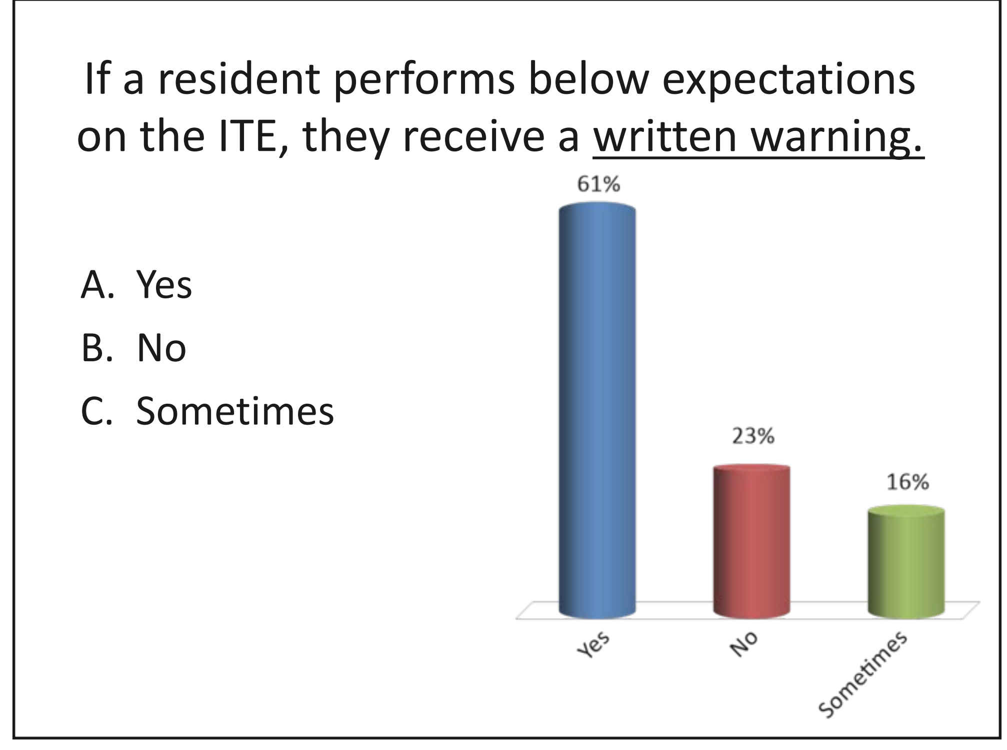
	A.	B.	C.
	58%	23%	20%

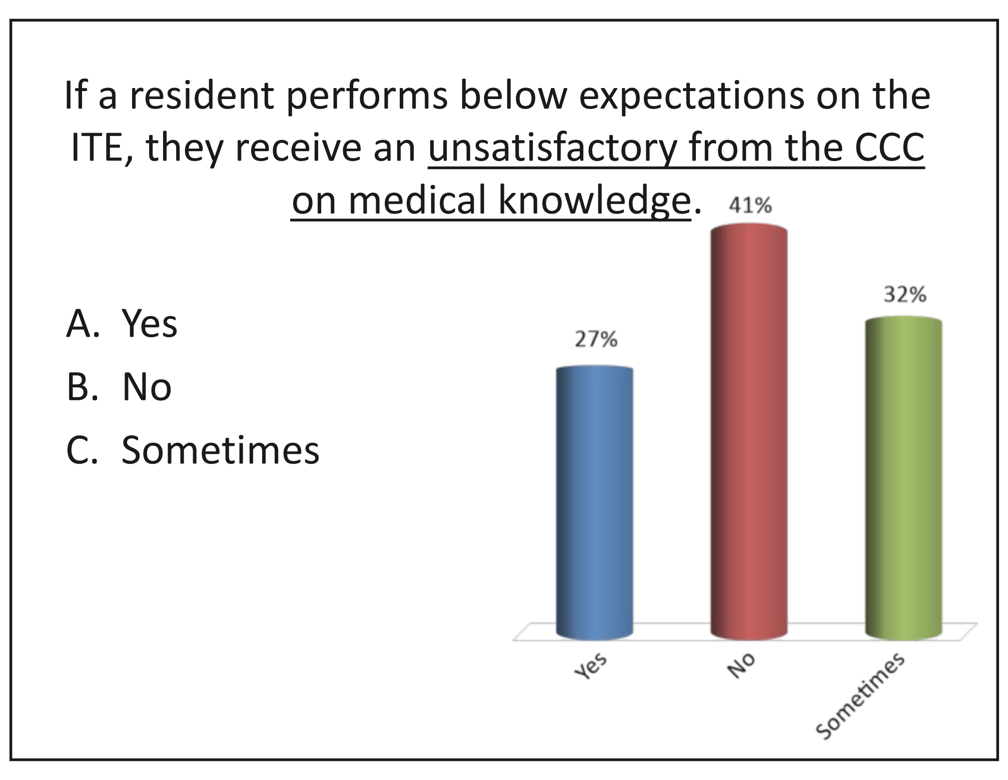

Do you pay for any online Qbanks (Truelearn, M5, etc)?
A. Yes
B. No
100%
0%
A.
B.

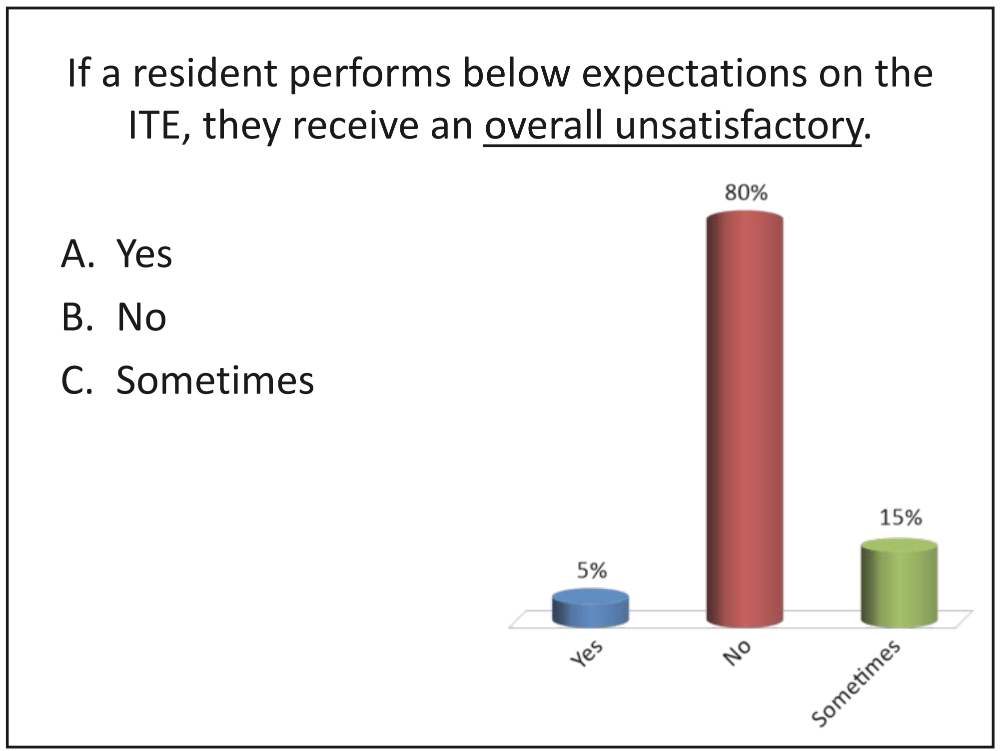

Do you pay for Anesthesia Toolbox?
A. Yes
B. No
44%
56%
A.
B.

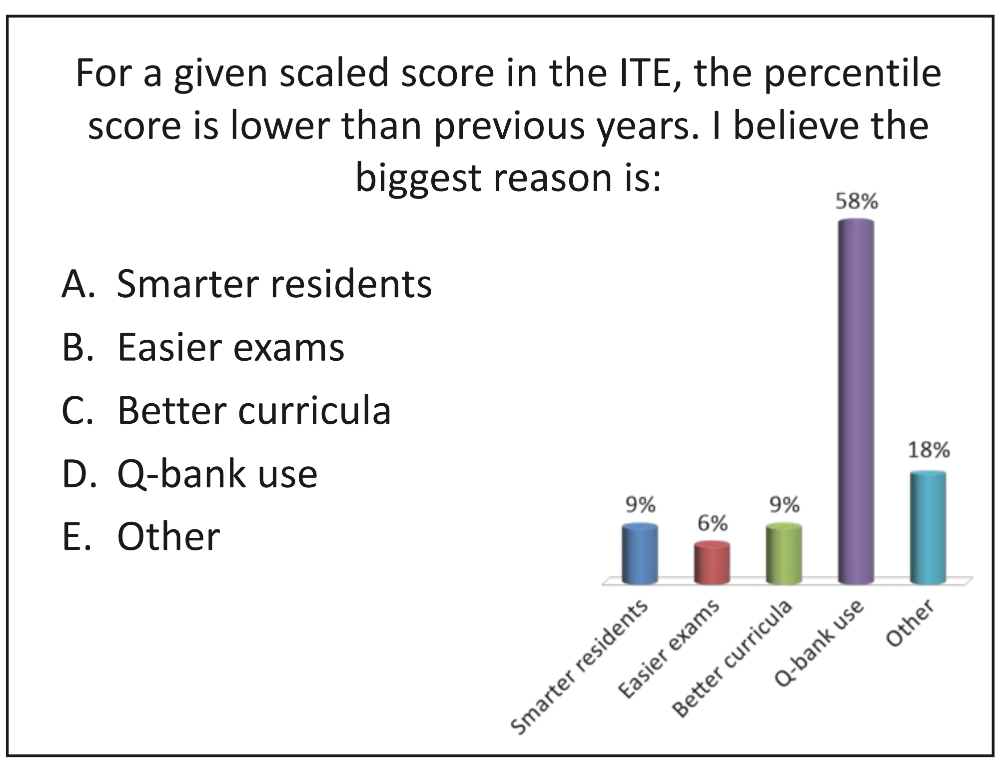

Would you consider terminating a resident who fails the Basic Exam?
A. No
B. Yes, after 1 failure
C. Yes, after 2 failures
D. Yes, after 3 failures
71%
27%
1%
0%
A.
B.
C.
D.


Should the ABA provide detailed score reports for the Basic Exam?
A. Yes
B. No
94%
6%
A.
B.


If a resident performs below expectations on the ITE, they receive a written warning.
A. Yes
B. No
C. Sometimes
61%
23%
16%
Yes
No
Sometimes

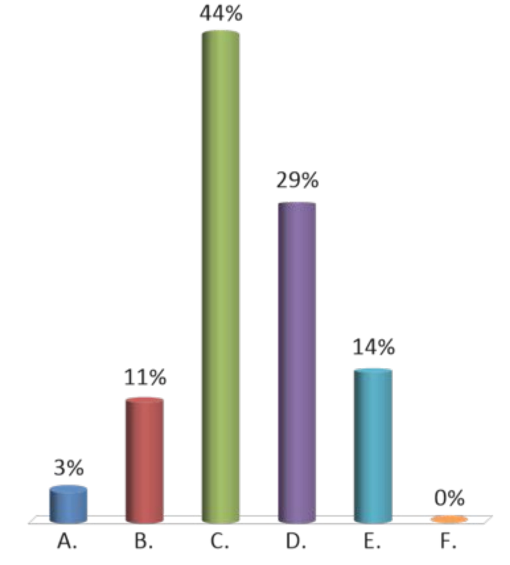

If a resident performs below expectations on the ITE, they receive an unsatisfactory from the CCC on medical knowledge.
A. Yes
B. No
C. Sometimes
27%
41%
32%
Yes
No
Sometimes


If a resident performs below expectations on the ITE, they receive an overall unsatisfactory.
A. Yes
B. No
C. Sometimes
80%
15%
5%
Yes
No
Sometimes


For a given scaled score in the ITE, the percentile score is lower than previous years. I believe the biggest reason is:
A. Smarter residents
B. Easier exams
C. Better curricula
D. Q-bank use
E. Other
58%
18%
9%
6%
9%
Smarter residents
Easier exams
Better curricula
Q-bank use
Other

What is threshold for remediation from low ITE?

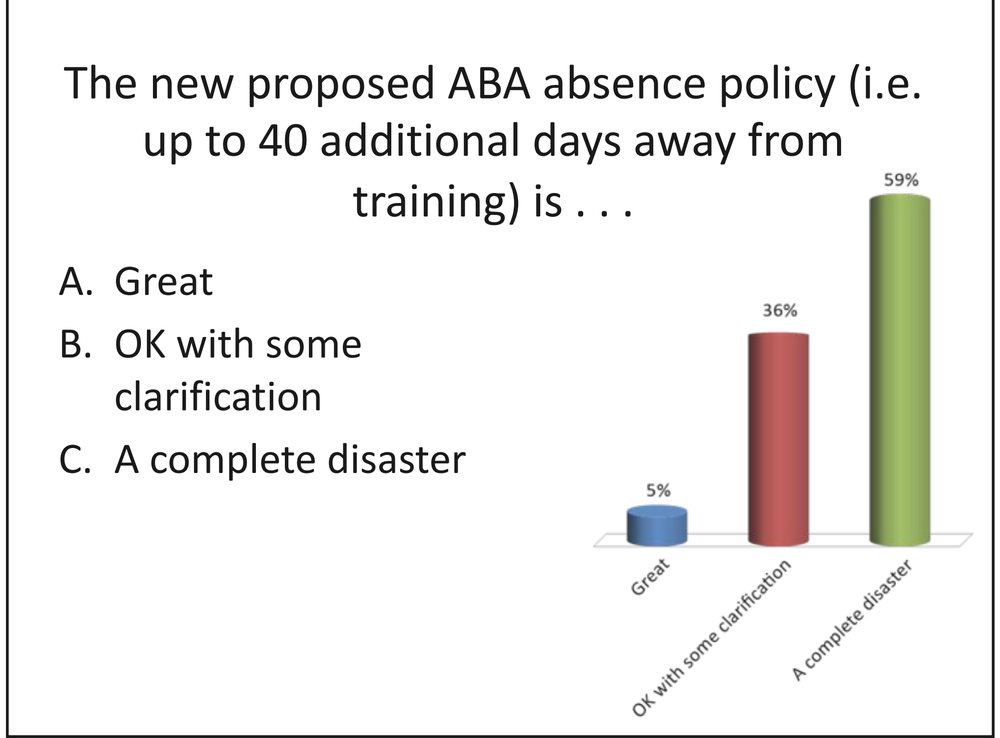
A. <40-50th %ile
B. <30-40th %ile
C. <20-30th %ile
D. <10-20th %ile
E. <10th %ile
F. No penalty for poor performance



I have changed my threshold for remediation/warning for low ITE scores based on overall program performance:

A. No, I have not made any recent changes
B. Yes, we have raised the minimum
C. Yes, we have lowered the minimum

78%
13%
9%
No, I have not made any re...
Yes, we have raised the mi...
Yes, we have lowered the...

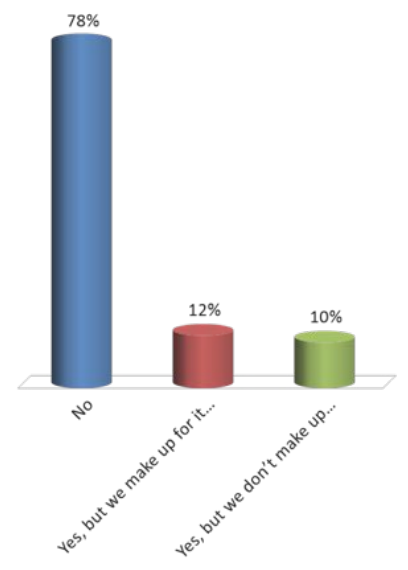


Program Structure

Back to Schedule

Do you offer more than 1 month of anesthesia during intern year?

A. No
B. Yes, but we make up for it during CA1-3 years
C. Yes, but we don't make up for it (shhhh, don't tell anyone!)



For rotations that are not required subspecialty rotations, do you structure them based on case type (e.g. ENT, ortho, uro/gyn, etc.)?

A. Yes
B. No, and I don't plan to
C. No, but that's a great idea!

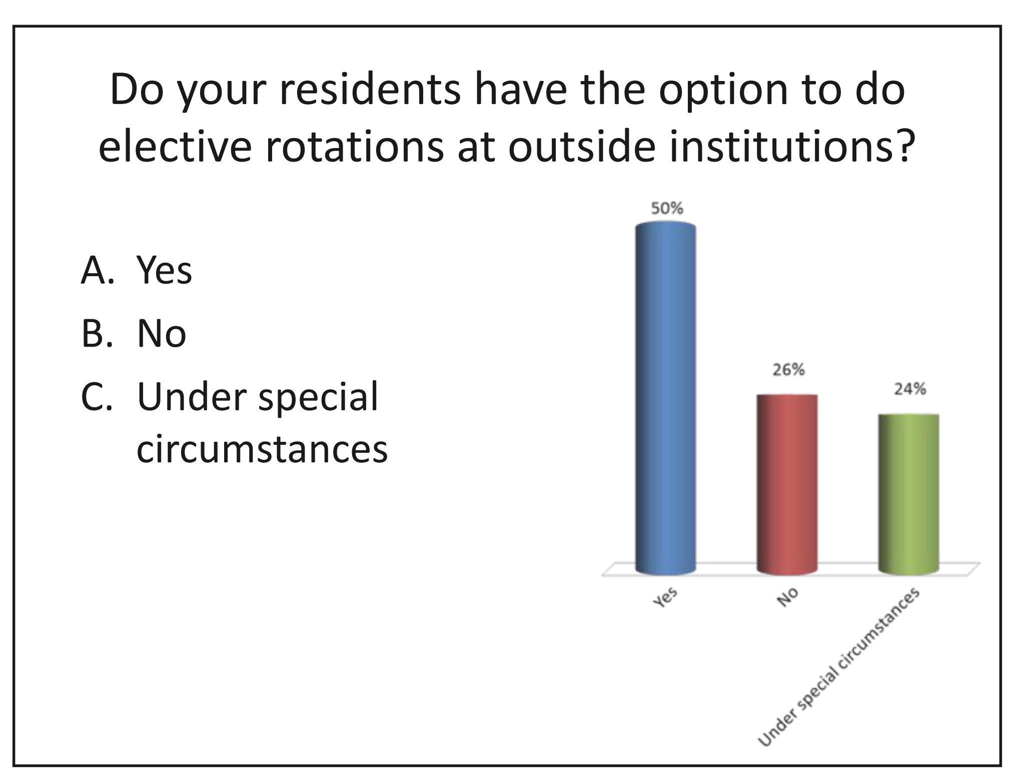
38%
55%
7%
Yes
No, and I don't plan to
No, but that's a great idea!

How much elective time do your residents get during the CA1-3 years?

A. None
B. < 1 month
C. 1 month
D. 1-2 months
E. > 2 months

3% 3% 17% 26% 51%

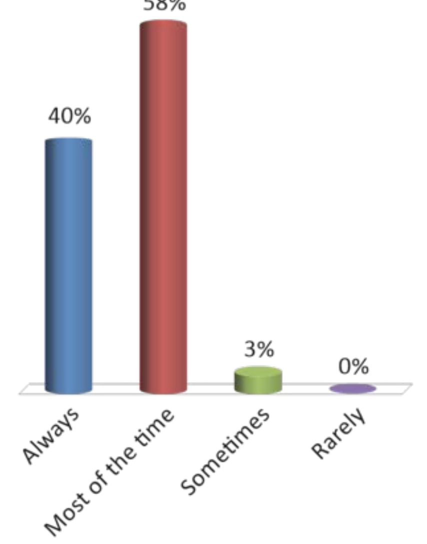
A. B. C. D. E.



Back to Schedule

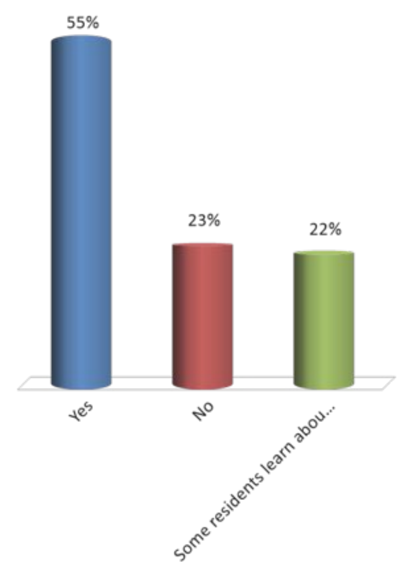
We are able to get our residents relieved for required didactic time:

A. Always
B. Most of the time
C. Sometimes
D. Rarely



Does your program have a formal point-of-care ultrasound curriculum?

A. Yes
B. No
C. Some residents learn about it, but informally

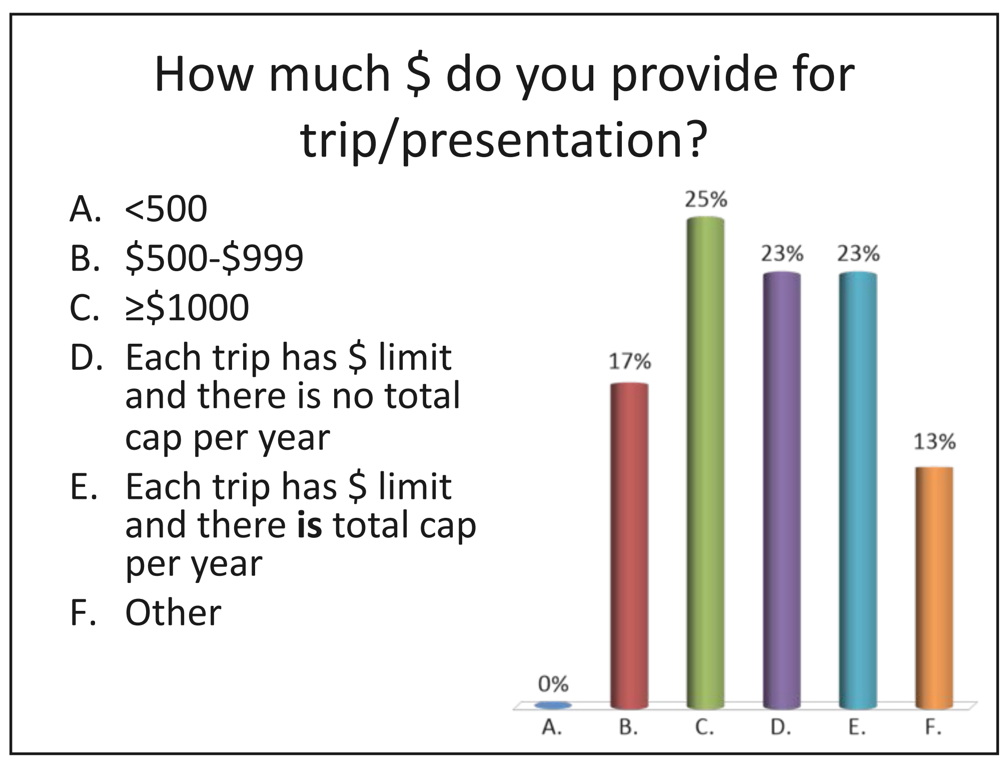


Back to Schedule

In what rotation do your residents practice POCUS skills most?

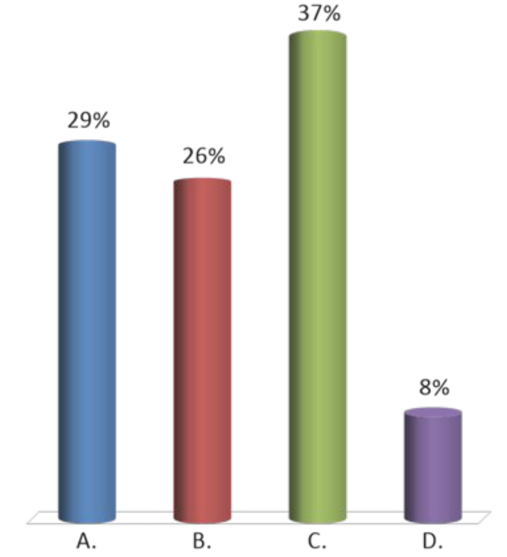
A. CCS/ICU
B. PACU
C. Other
D. Not applicable

41%
20%
27%
13%
CCS/ICU
PACU
Other
Not applicable



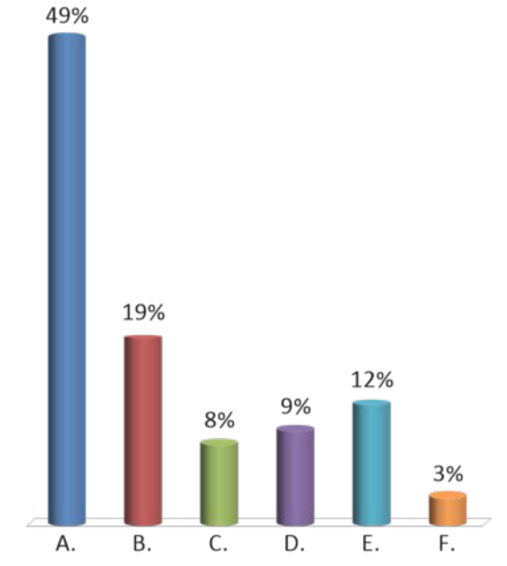
Do you have dedicated quality and safety project time?

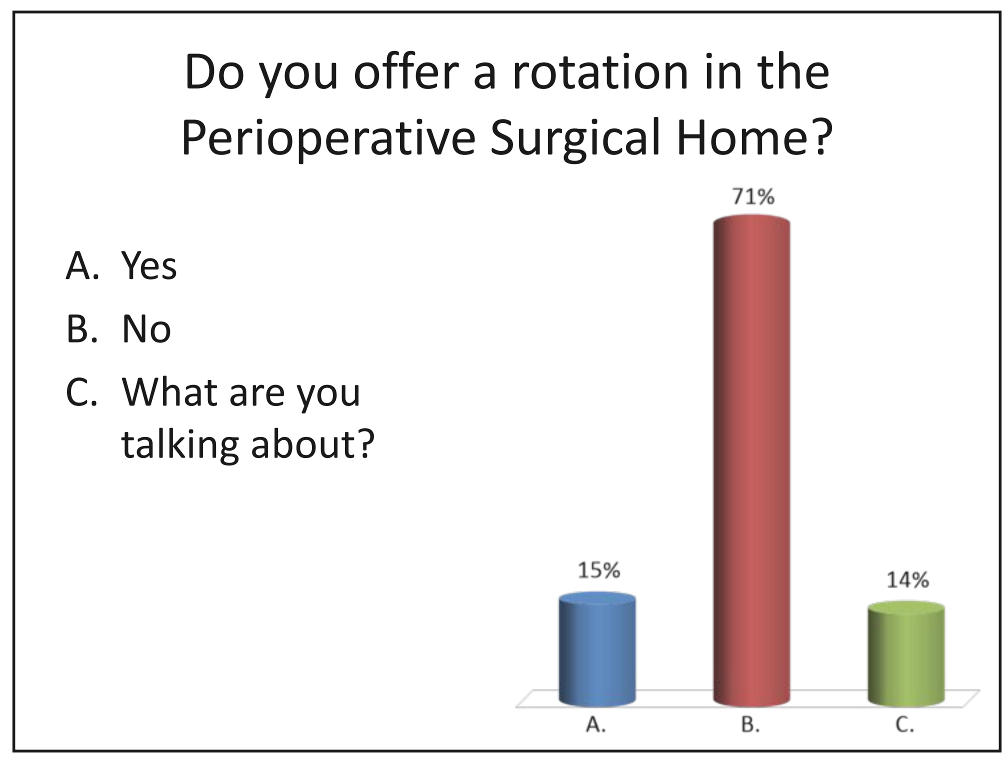
A. Yes, it is a required rotation
B. Yes, it is scheduled randomly
C. No but it's a good idea
D. No, it's a waste of time

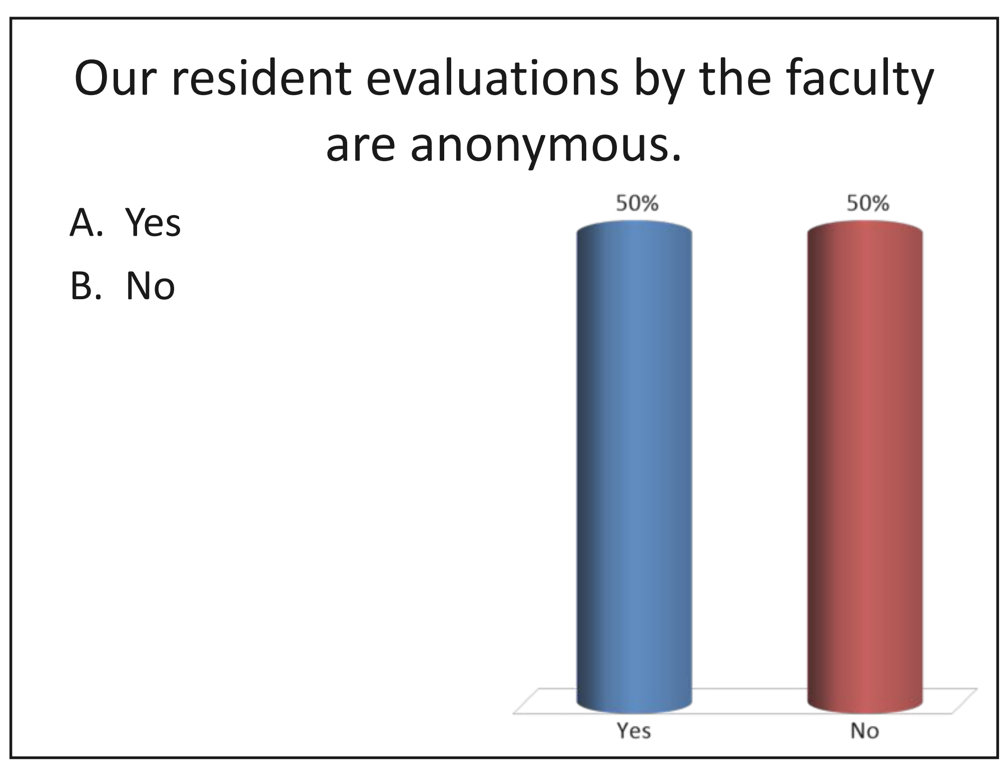


What percentage of your residents complete a QI project?

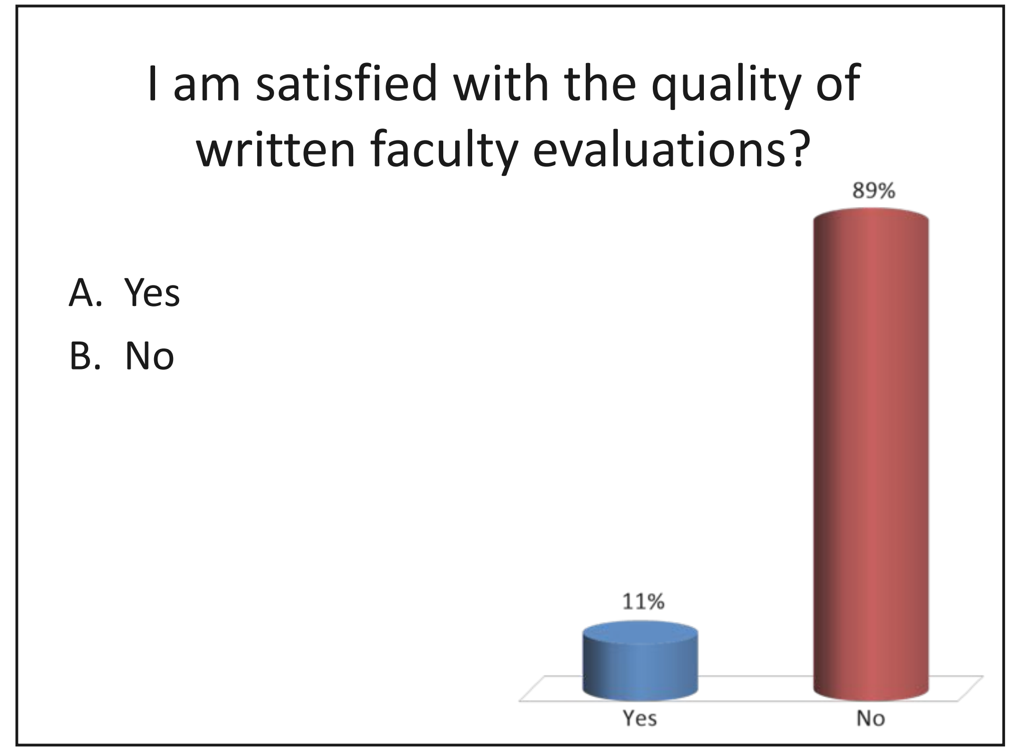
A. 100%
B. 75-99%
C. 50-75%
D. 25-50%
E. <25%
F. None

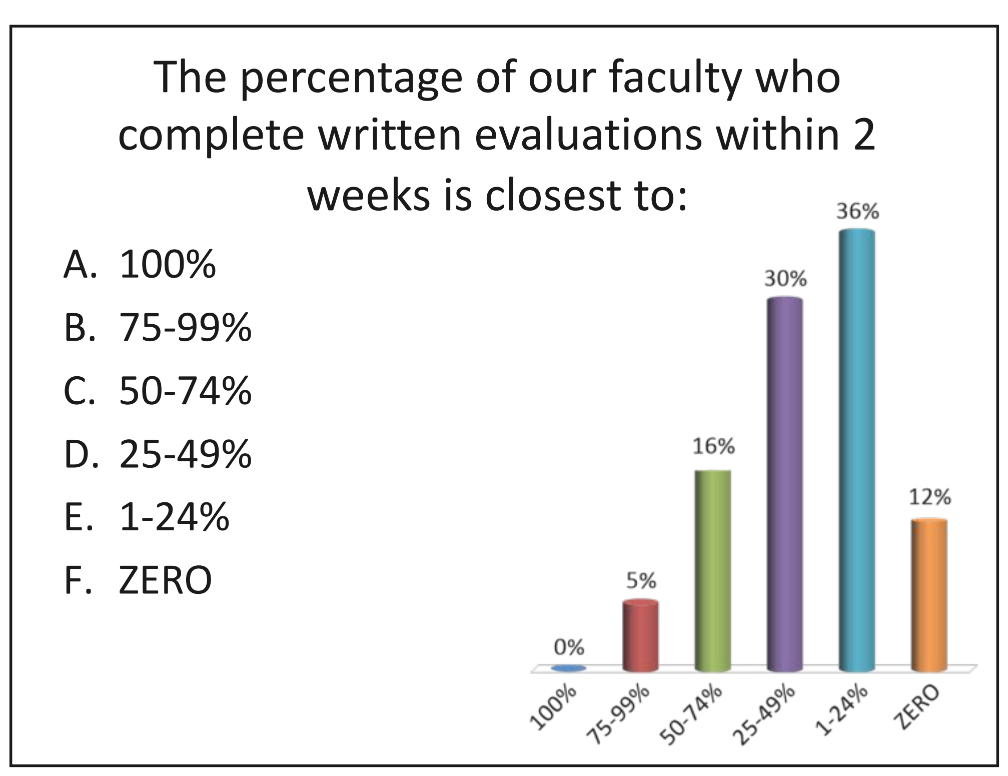



Do you offer a rotation in the Perioperative Surgical Home?
A. Yes
B. No
C. What are you talking about?
71%
15%
14%
A.
B.
C.


Our resident evaluations by the faculty are anonymous.
A. Yes
B. No
50%
50%
Yes
No

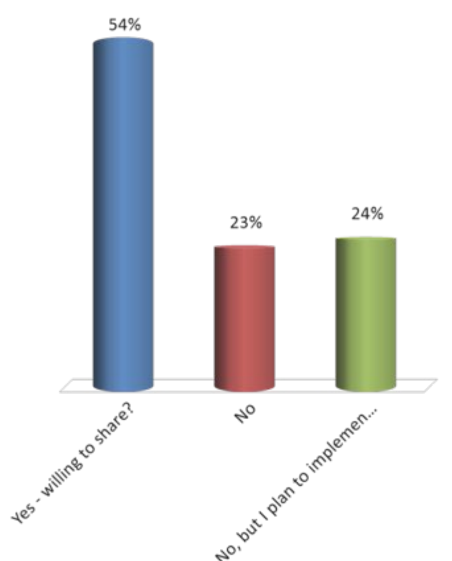
Back to Schedule



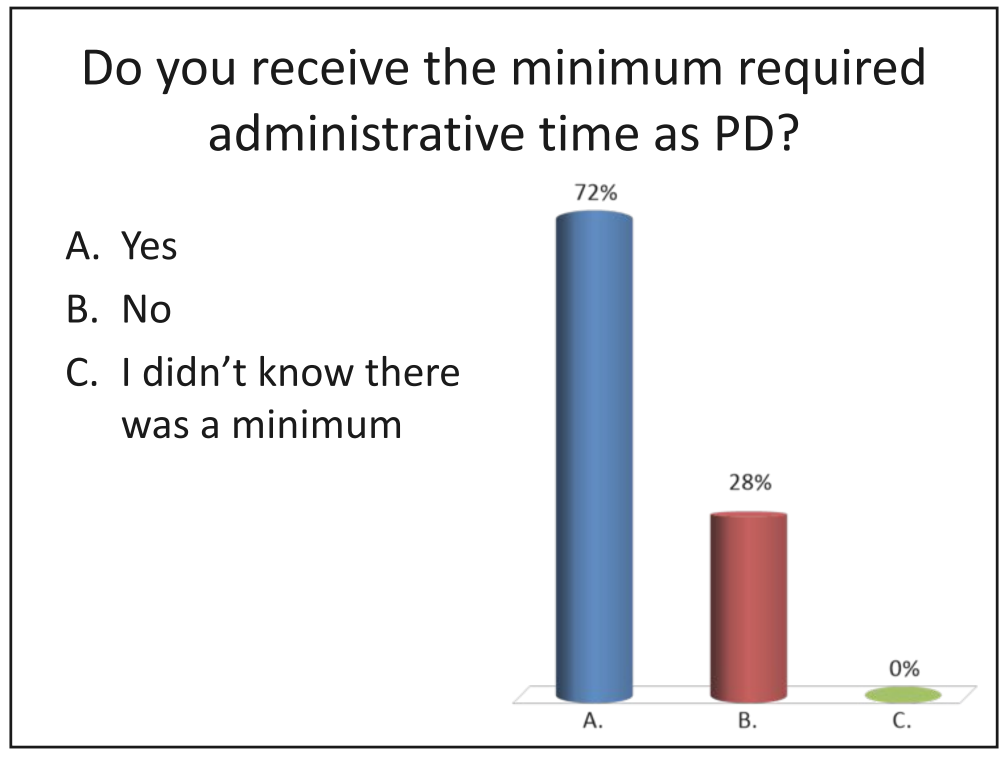


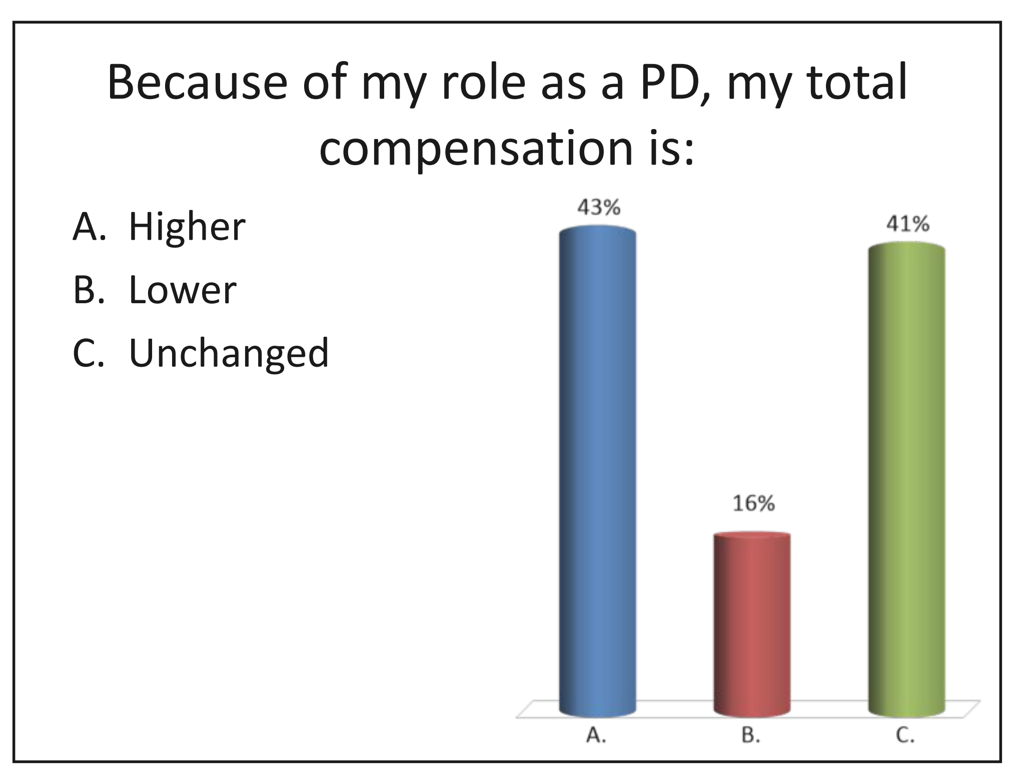
I have made interventions that have improved our written evaluations?

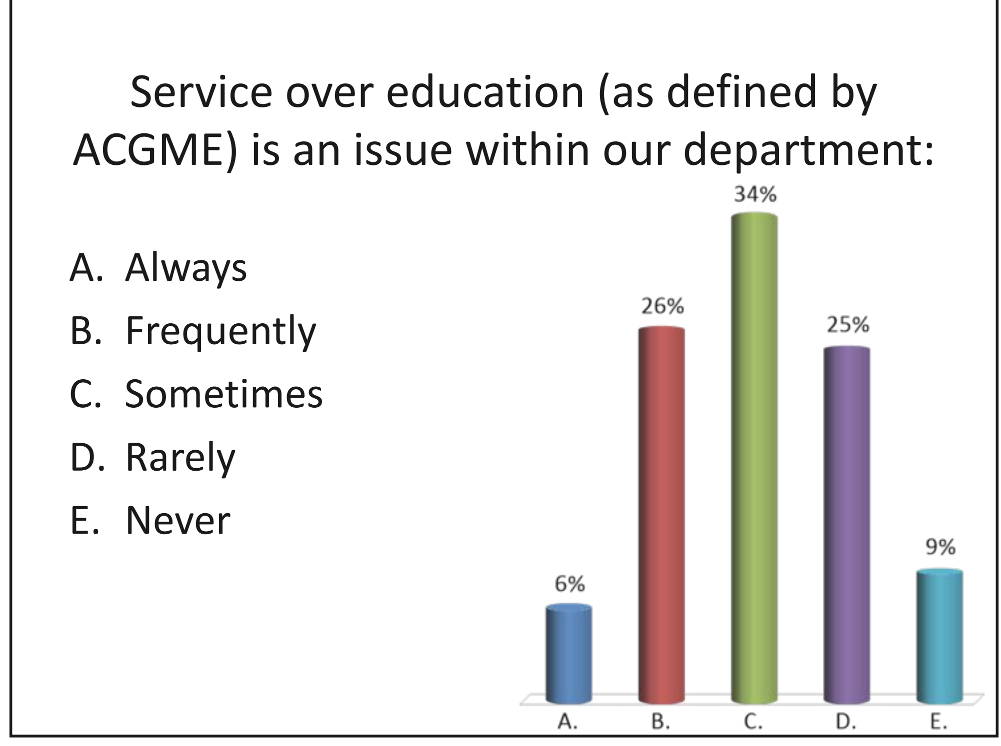
A. Yes - willing to share?
B. No
C. No, but I plan to implement a change – willing to share?

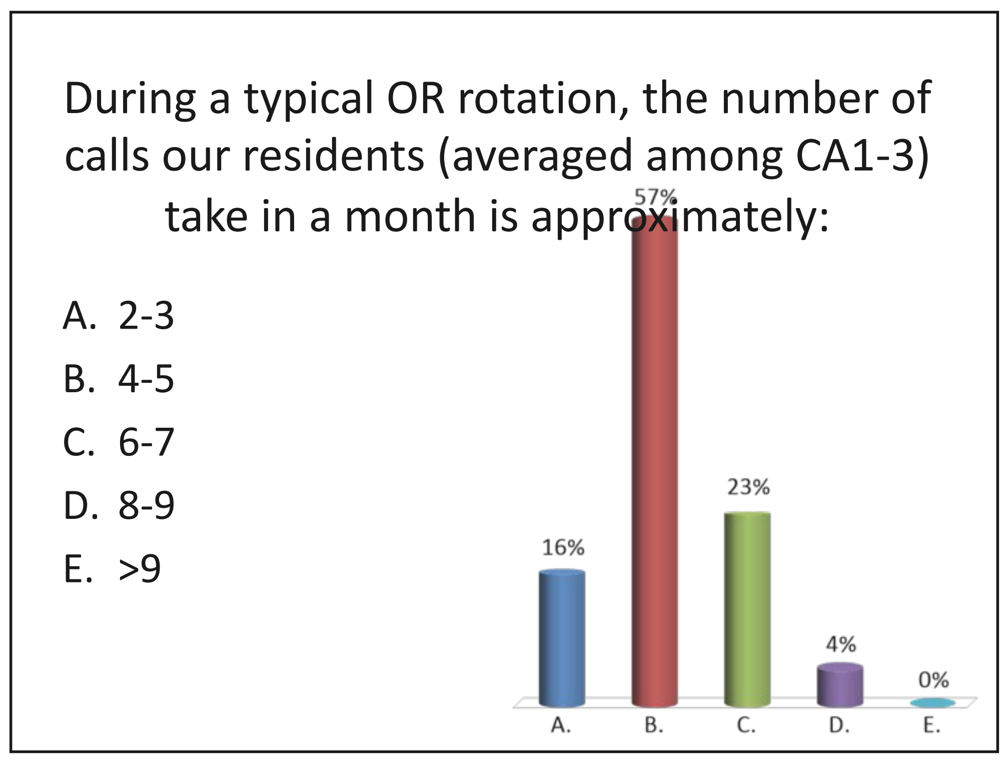


The Working Environment


Do you receive the minimum required administrative time as PD?
A. Yes
B. No
C. I didn't know there was a minimum
72%
28%
0%
A.
B.
C.

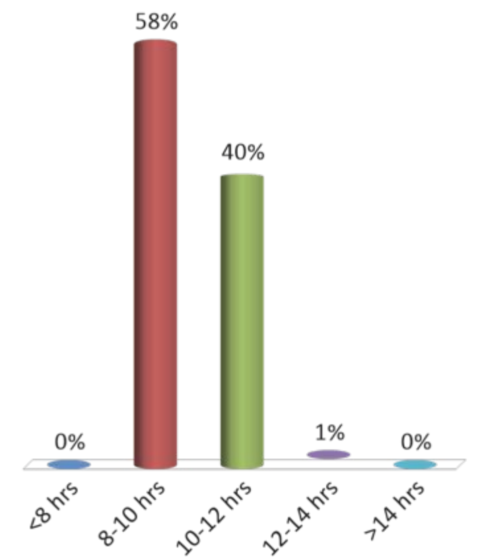

Because of my role as a PD, my total compensation is:
A. Higher
B. Lower
C. Unchanged
43%
16%
41%
A.
B.
C.


Service over education (as defined by ACGME) is an issue within our department:
A. Always
B. Frequently
C. Sometimes
D. Rarely
E. Never
34%
26%
25%
9%
6%
A.
B.
C.
D.
E.


During a typical OR rotation, the number of calls our residents (averaged among CA1-3) take in a month is approximately:
A. 2-3
B. 4-5
C. 6-7
D. 8-9
E. >9
57%
23%
16%
4%
0%
A.
B.
C.
D.
E.

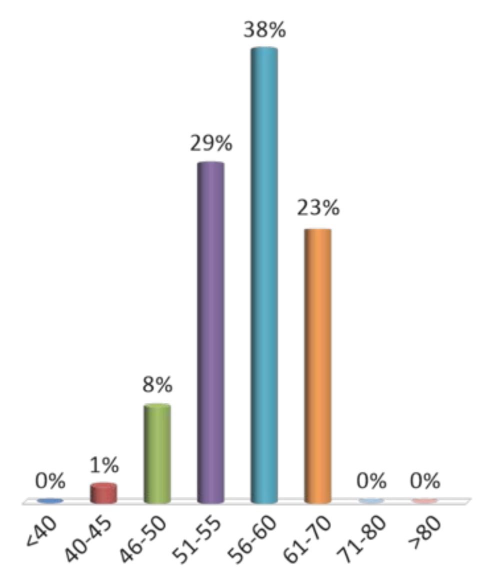
The average day for our residents on a typical OR rotation is closest to:

A. <8 hrs
B. 8-10 hrs
C. 10-12 hrs
D. 12-14 hrs
E. >14 hrs



How many hours per week do your residents typically work?

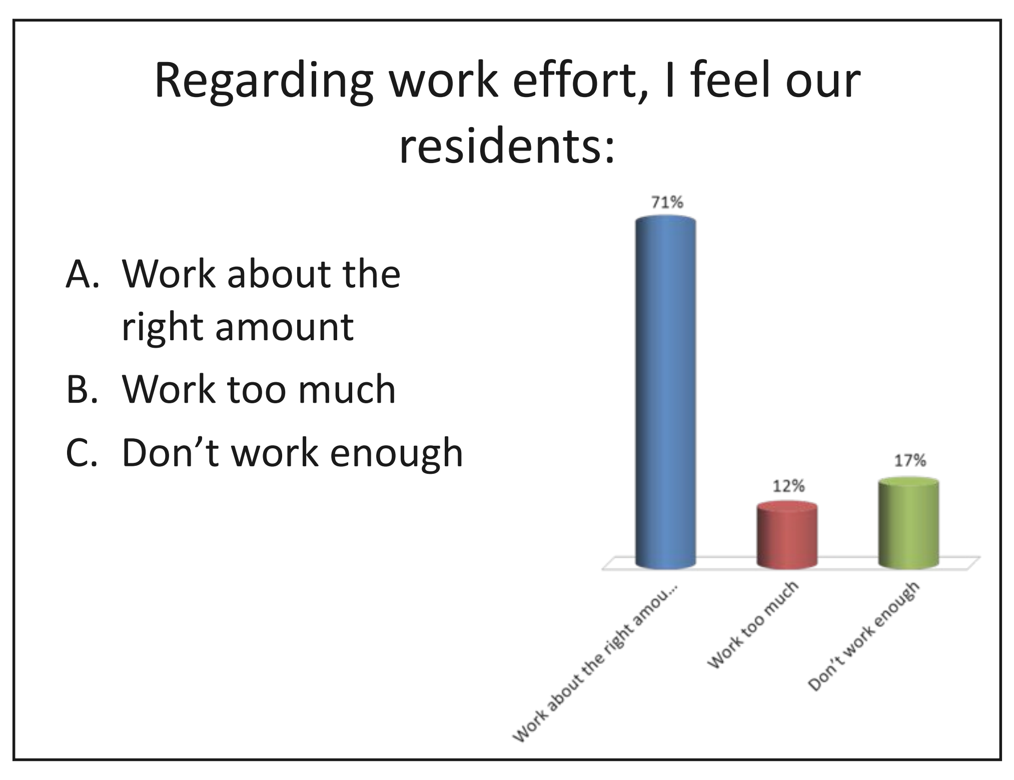
A. <40
B. 40-45
C. 46-50
D. 51-55
E. 56-60
F. 61-70
G. 71-80
H. >80

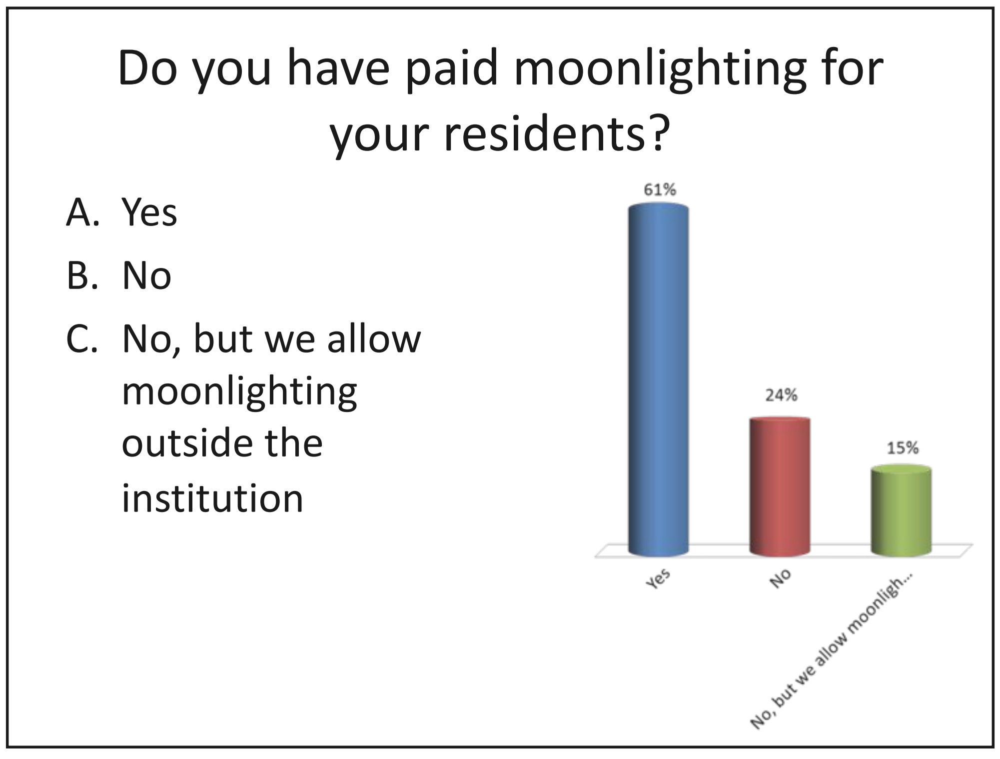


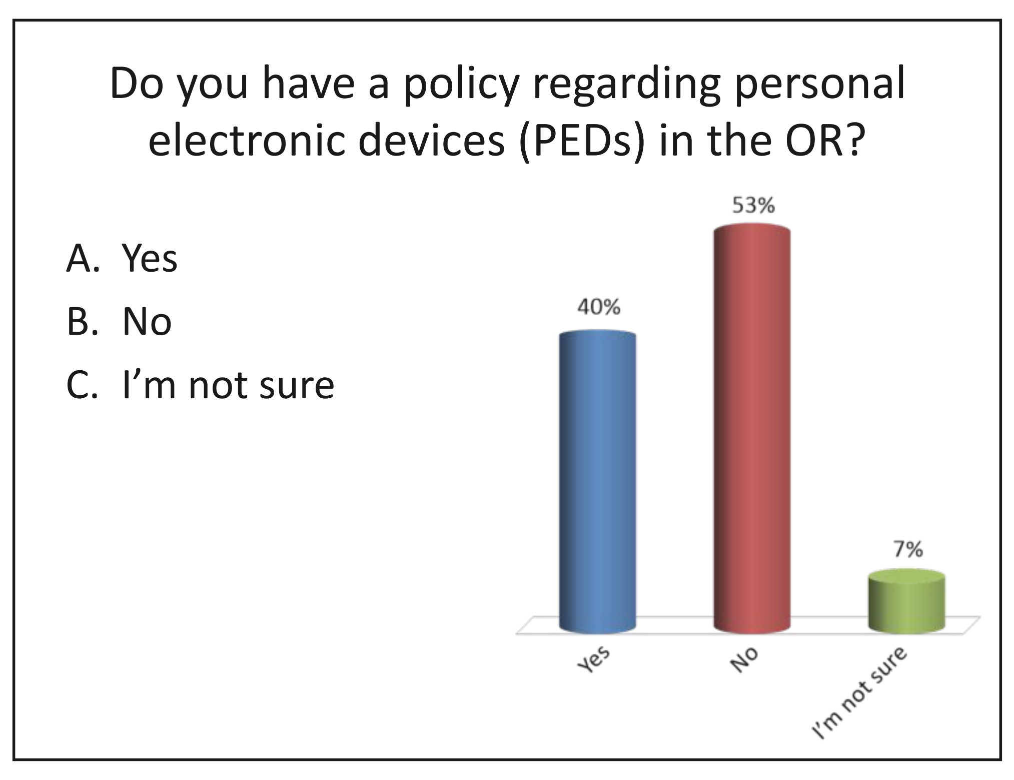
Regarding work effort, our residents:

A. Are content
B. Think they work too hard
C. Think they don't work enough

87%
13%
0%
Are content
Think they work too hard
Think they don't work eno...

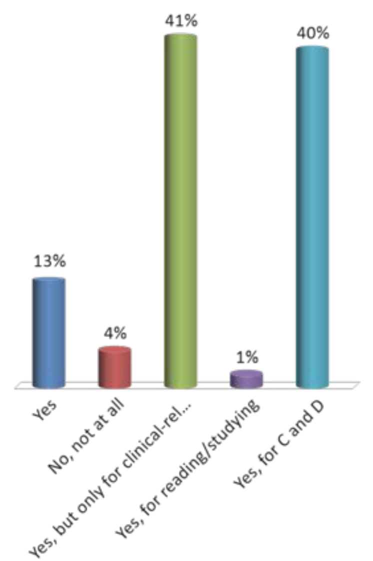



Do you have paid moonlighting for your residents?
A. Yes
B. No
C. No, but we allow moonlighting outside the institution
61%
24%
15%
Yes
No
No, but we allow moonligh...


Do you have a policy regarding personal electronic devices (PEDs) in the OR?
A. Yes
B. No
C. I'm not sure
40%
53%
7%
Yes
No
I'm not sure

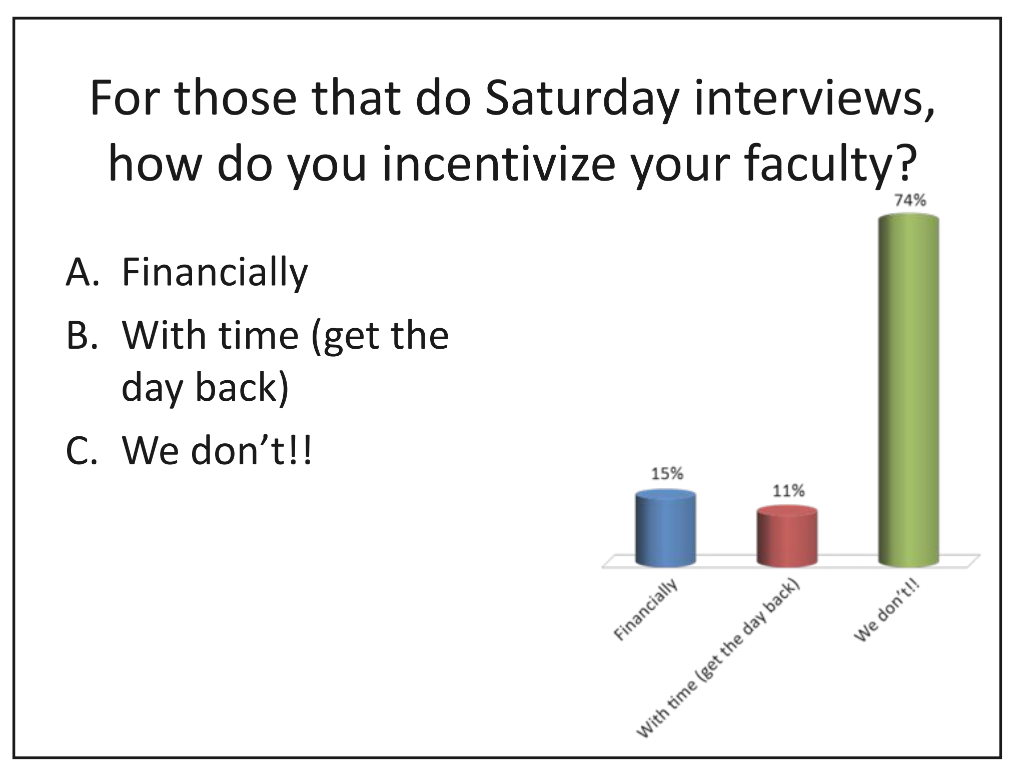
Do you feel that PEDs should be allowed in the OR?

A. Yes
B. No, not at all
C. Yes, but only for clinical-related tasks
D. Yes, for reading/studying
E. Yes, for C and D



Recruitment

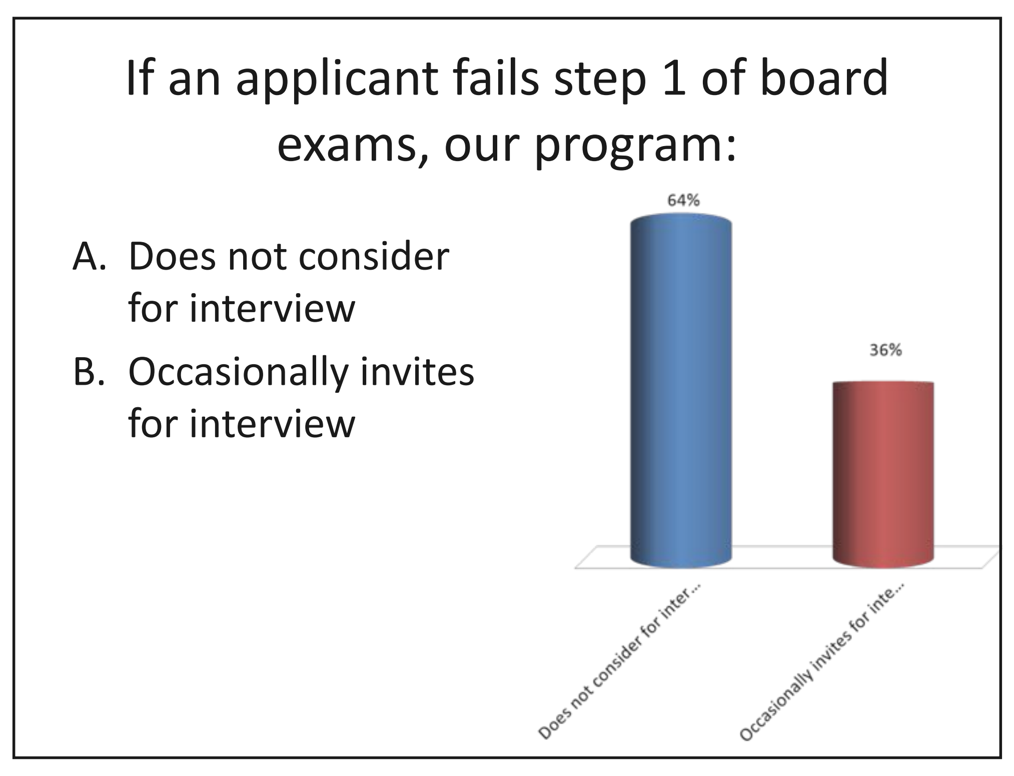
Back to Schedule



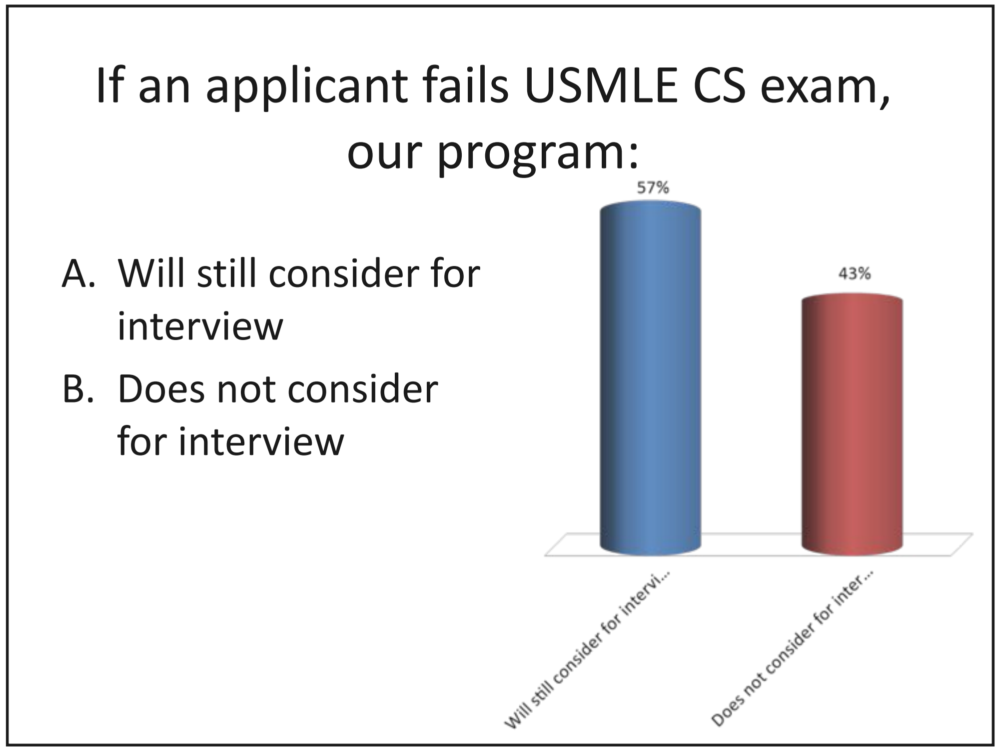
Do you involve residents (e.g. chiefs) in the final candidate selection/rank meeting?

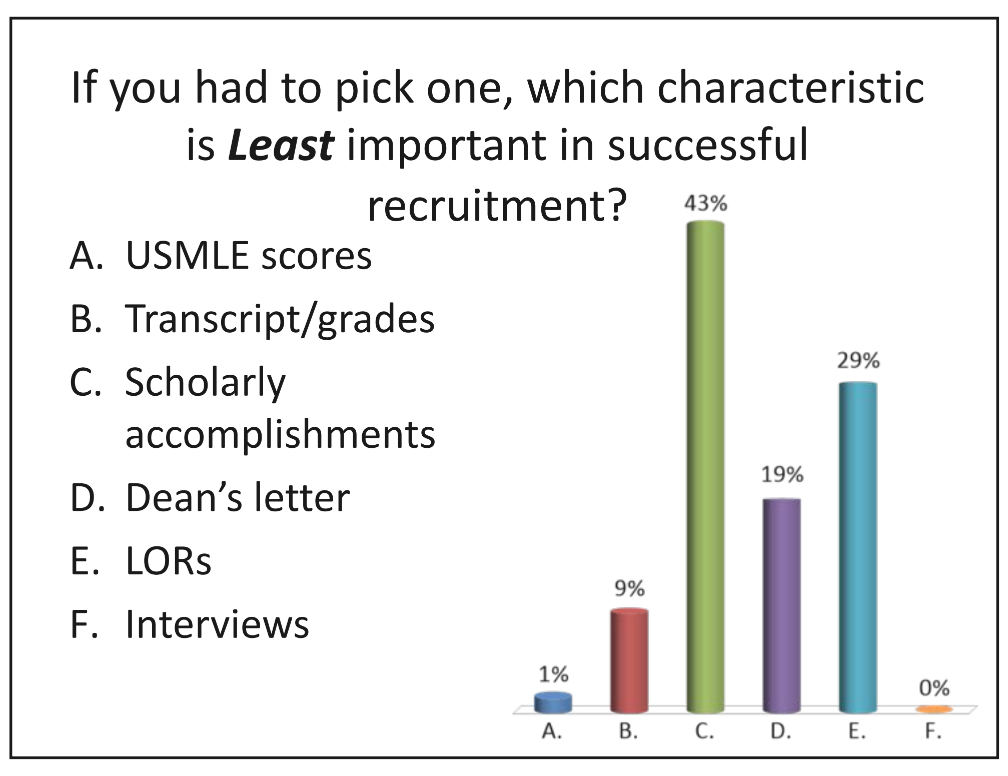
A. Yes
B. No
C. No, but we do have residents involved with interviewing

57%
19%
24%
Yes
No
No, but we do have residen...



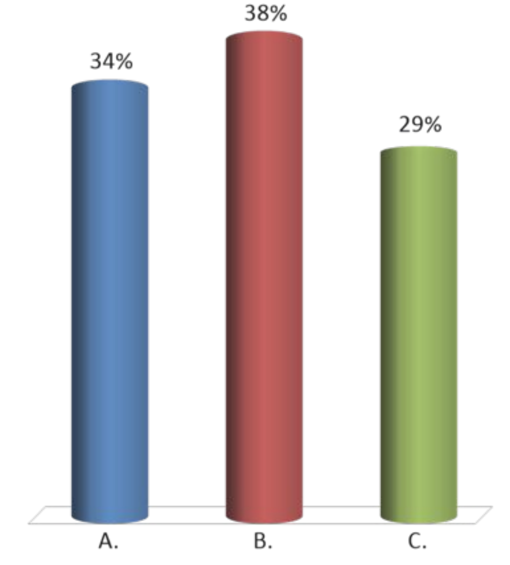
Back to Schedule





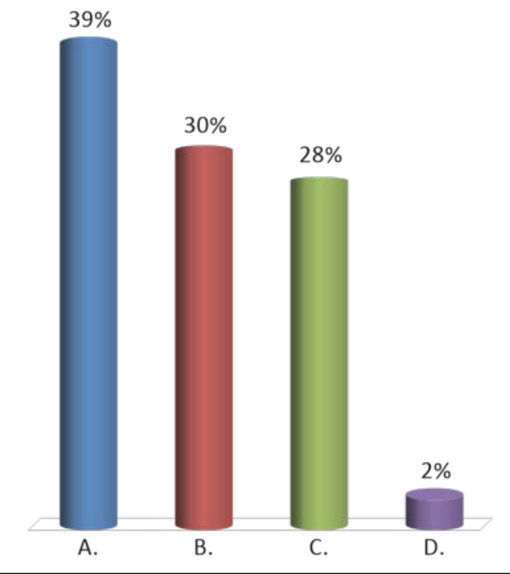
Do you provide alcohol at recruitment events?

A. Yes and we learn a lot about our applicants this way
B. Yes, but we don't pay much attention to it
C. No



Do you pay for recruits' hotel?

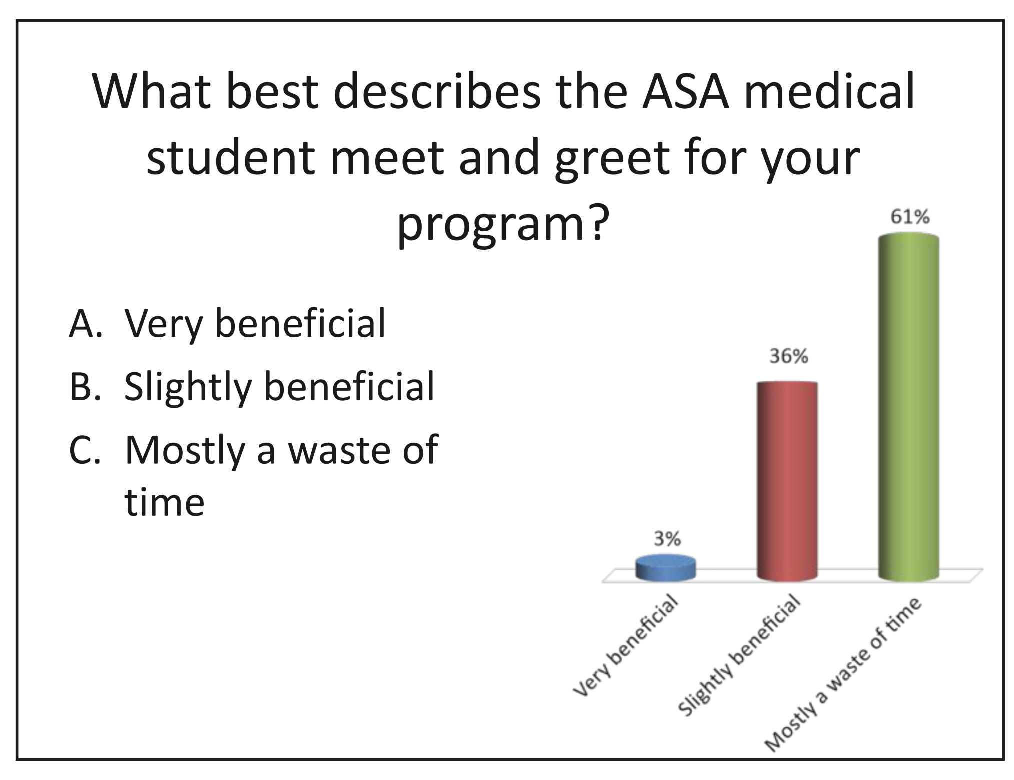
A. No
B. No, but they get a discounted rate
C. Yes, 1 night
D. Yes, 2 or more nights

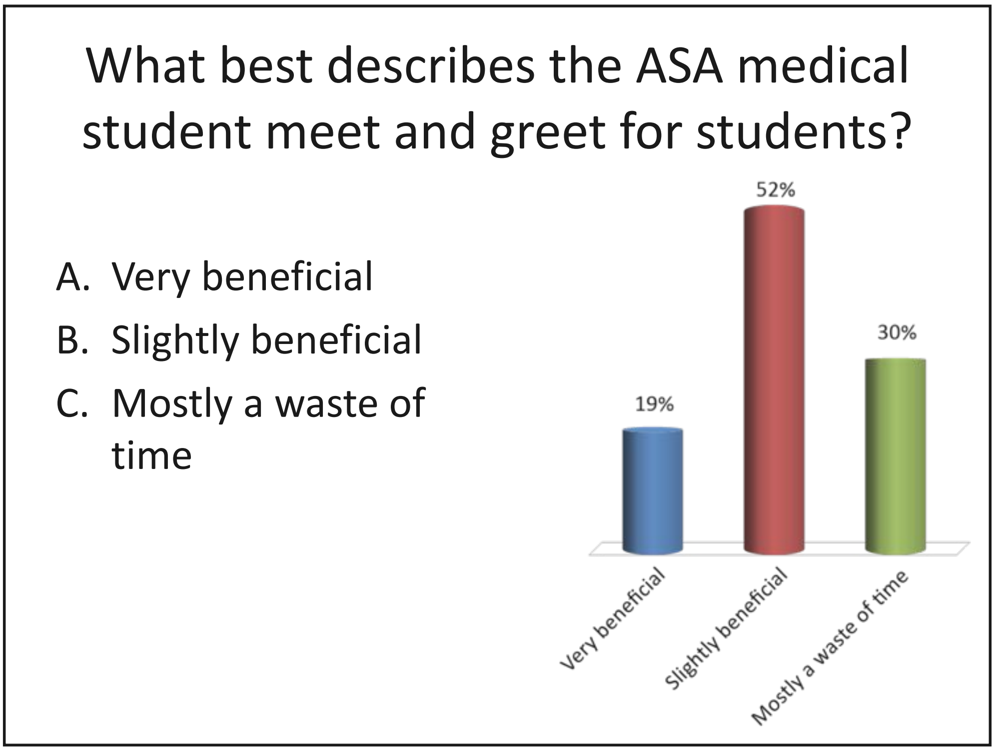


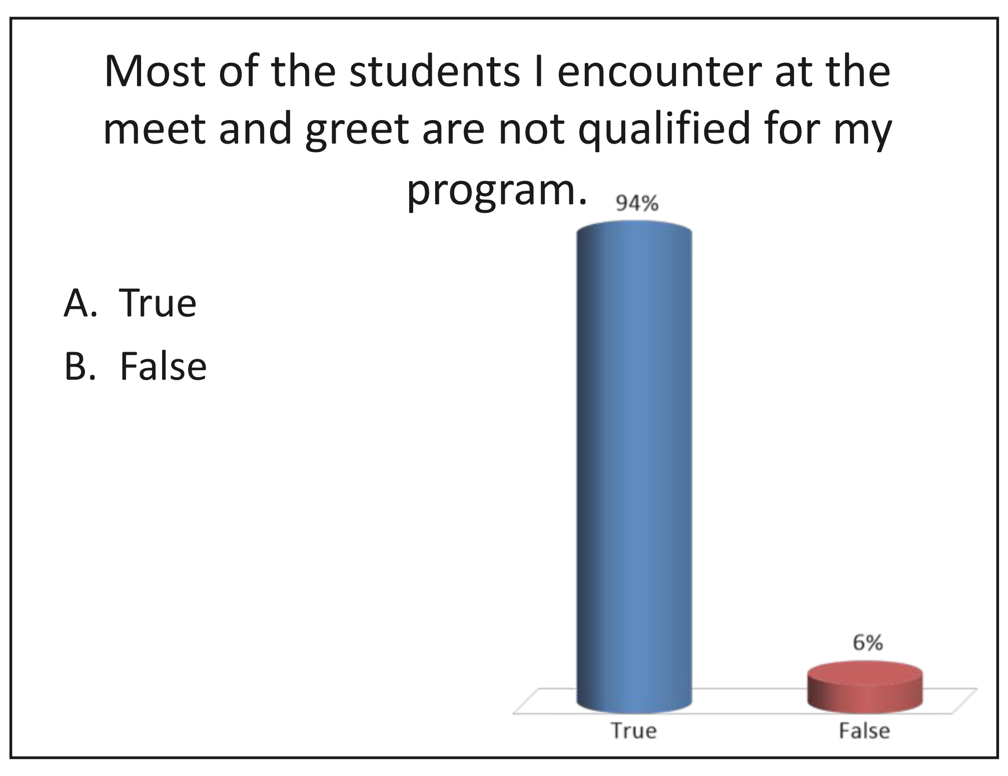
Our program conducts behavioral interviews.

A. Yes – the entire interview
B. Yes – a component of at least one interview
C. No

4%
45%
51%
Yes – the entire interview
Yes – a component of at le...
No



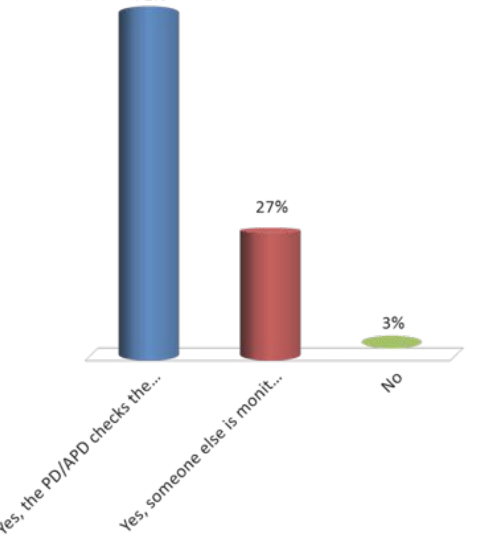

What best describes the ASA medical student meet and greet for students?
A. Very beneficial
B. Slightly beneficial
C. Mostly a waste of time
52%
30%
19%
Very beneficial
Slightly beneficial
Mostly a waste of time


Most of the students I encounter at the meet and greet are not qualified for my program.
A. True
B. False
94%
6%
True
False

ACGME

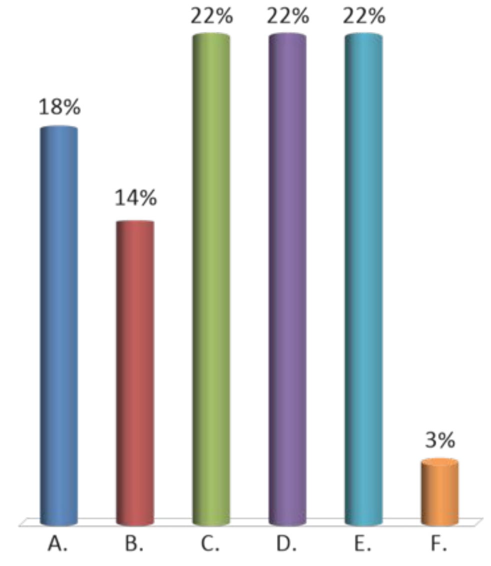
Are you monitoring resident case logs?

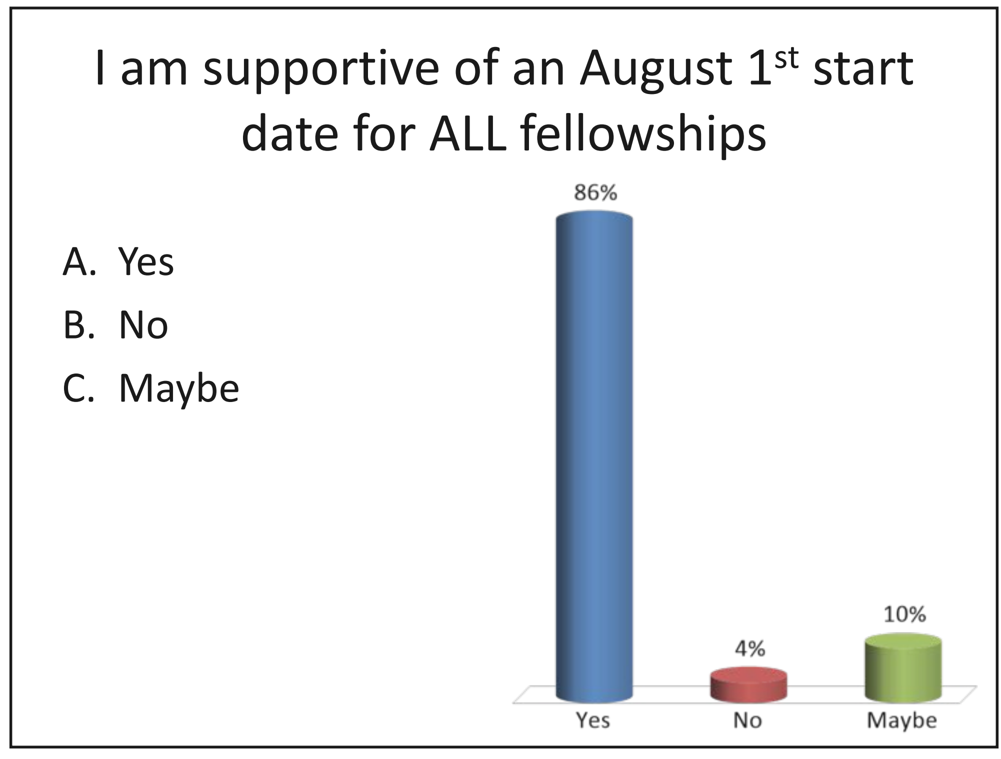
A. Yes, the PD/APD checks them regularly
B. Yes, someone else is monitoring them (e.g. coordinator)
C. No

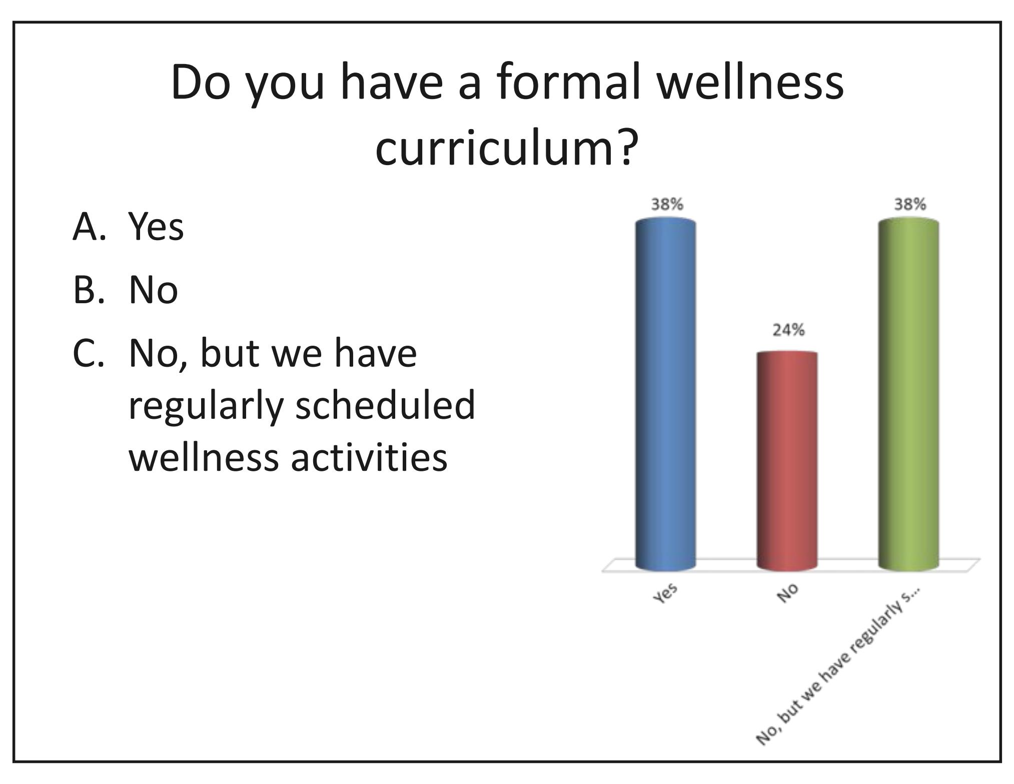


How do you handle "practice habits" that are queried on the ACGME survey?

A. Automated clinical data collection fed back to trainee
B. Information provided at semiannual review
C. We sort of do this but not the way I would like (general performance metrics)
D. We educate our residents on this every year prior to the survey
E. We cross our fingers every year with this question
F. Other



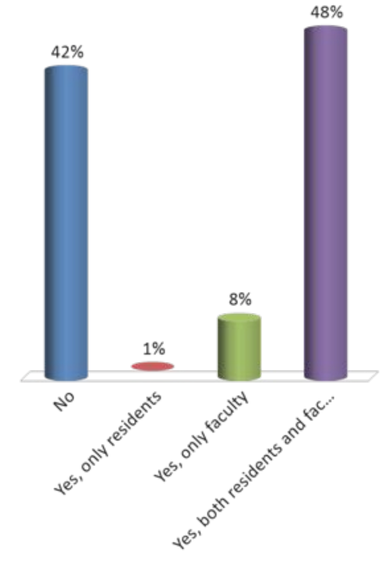

I am supportive of an August 1st start date for ALL fellowships
A. Yes
B. No
C. Maybe
86%
4%
10%
Yes
No
Maybe


Do you have a formal wellness curriculum?
A. Yes
B. No
C. No, but we have regularly scheduled wellness activities
38%
24%
38%
Yes
No
No, but we have regularly s...

Back to Schedule

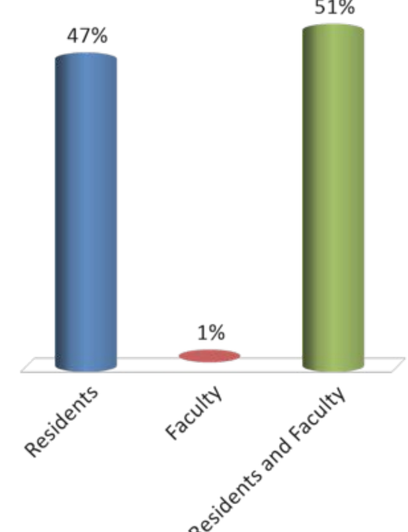
Do you have a wellness committee?

A. No
B. Yes, only residents
C. Yes, only faculty
D. Yes, both residents and faculty



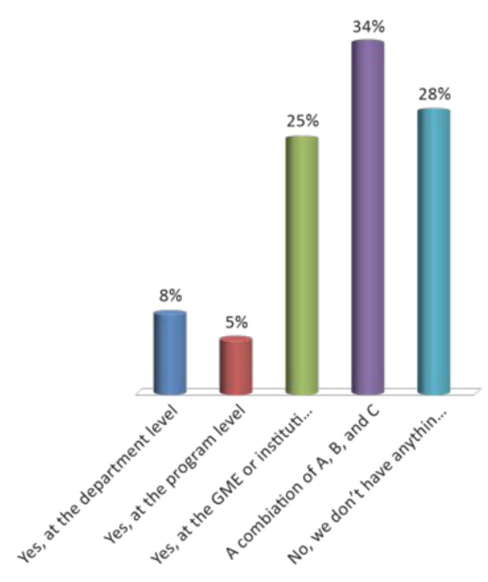
Who is the target of your wellness committee efforts?

A. Residents
B. Faculty
C. Residents and Faculty



Do you have a system in place to help residents cope with patient deaths/adverse outcomes?

A. Yes, at the department level
B. Yes, at the program level
C. Yes, at the GME or institutional level
D. A combiation of A, B, and C
E. No, we don't have anything formal



Per ACGME, faculty cannot supervise more than 2 residents. How often does your program violate this rule?

A. Never
B. Rarely, only in emergency situations
C. Occasionally
D. Frequently
E. All the time

37%
47%
9%
5%
1%
Never
Rarely, only in emergency s...
Occasionally
Frequently
All the time

Bonus questions!!

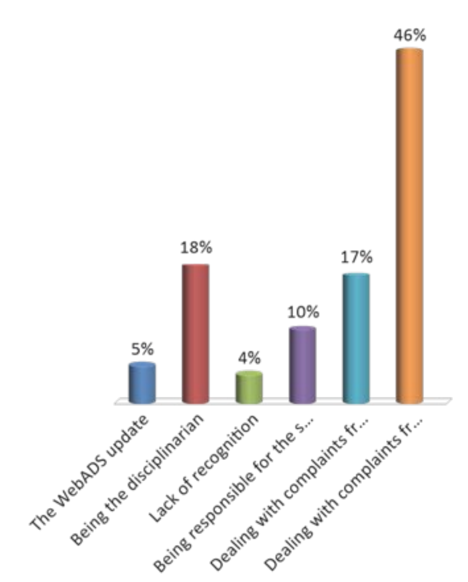
The MOST rewarding part of my job as PD is . . .

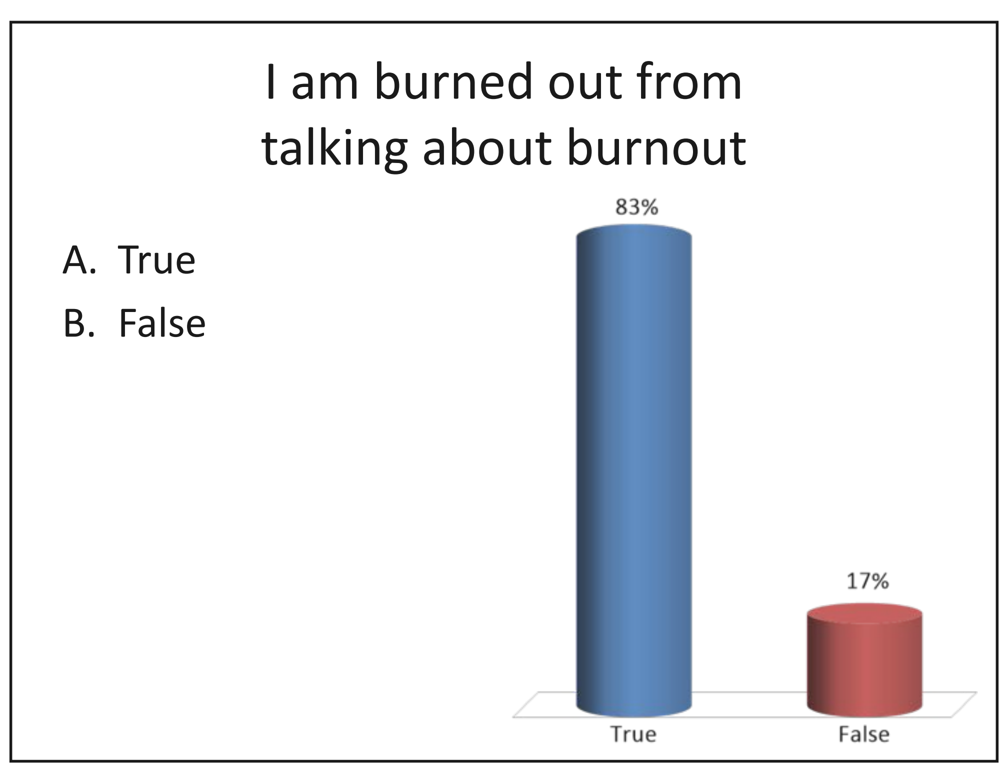
A. Mentorship
B. Recruitment
C. Being the boss
D. Completing the WebADS update
E. Glamour/Recognition

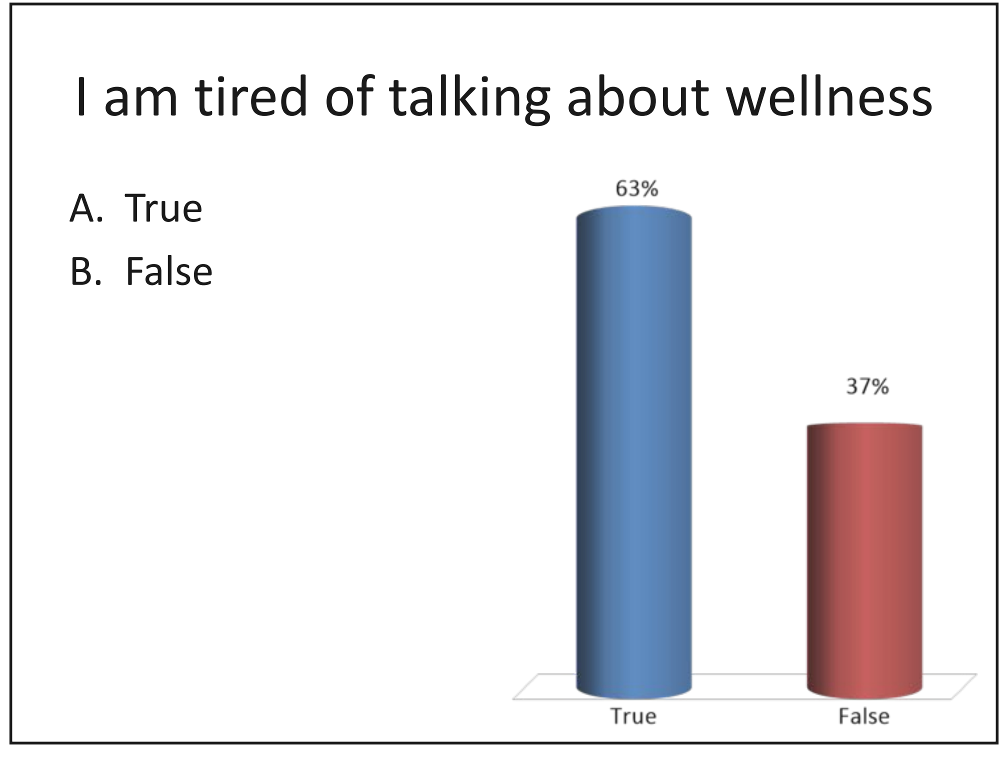
Back to Schedule

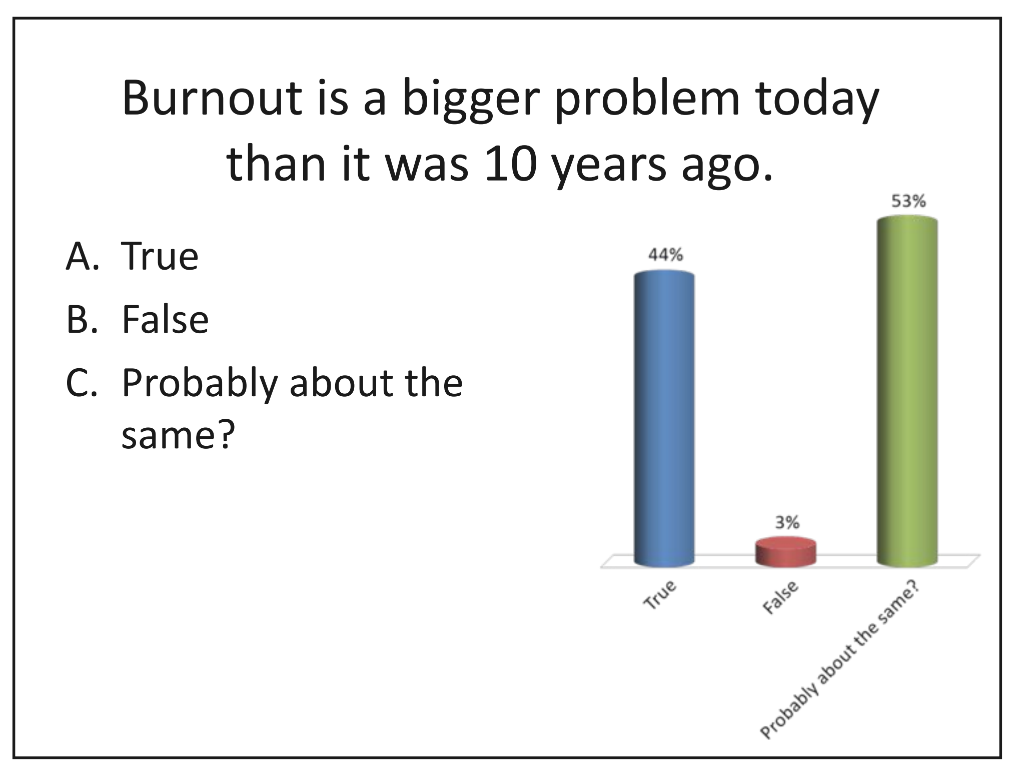
The LEAST rewarding part of my job as PD is . . .

A. The WebADS update
B. Being the disciplinarian
C. Lack of recognition
D. Being responsible for the success of a program
E. Dealing with complaints from residents
F. Dealing with complaints from faculty



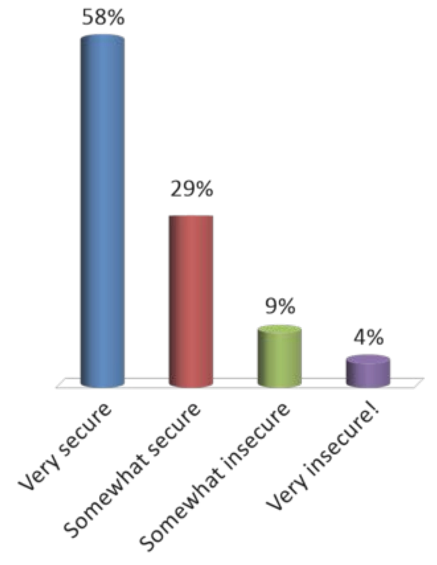



I am tired of talking about wellness
A. True
B. False
63%
37%
True
False


Burnout is a bigger problem today than it was 10 years ago.
A. True
B. False
C. Probably about the same?
44%
3%
53%
True
False
Probably about the same?

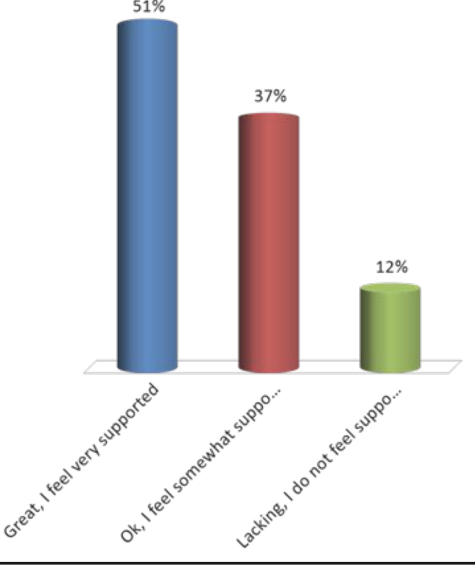
In terms of my job security as PD I feel

A. Very secure
B. Somewhat secure
C. Somewhat insecure
D. Very insecure!



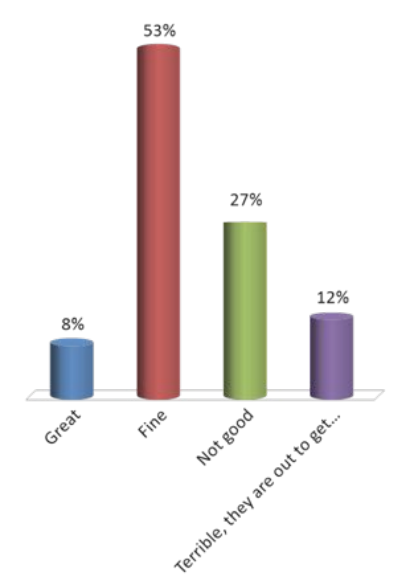
Support from my chair is . . .

A. Great, I feel very supported
B. Ok, I feel somewhat supported
C. Lacking, I do not feel supported at all



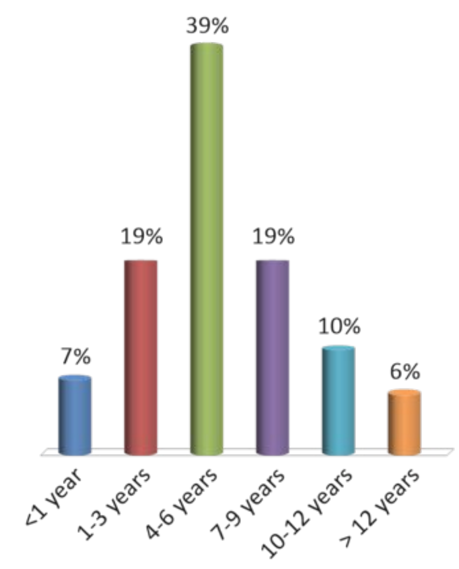
Support from the faculty as PD is . . .

A. Great
B. Fine
C. Not good
D. Terrible, they are out to get me!



How long do you anticipate being PD?

A. <1 year
B. 1-3 years
C. 4-6 years
D. 7-9 years
E. 10-12 years
F. > 12 years



Thank you!!!!!

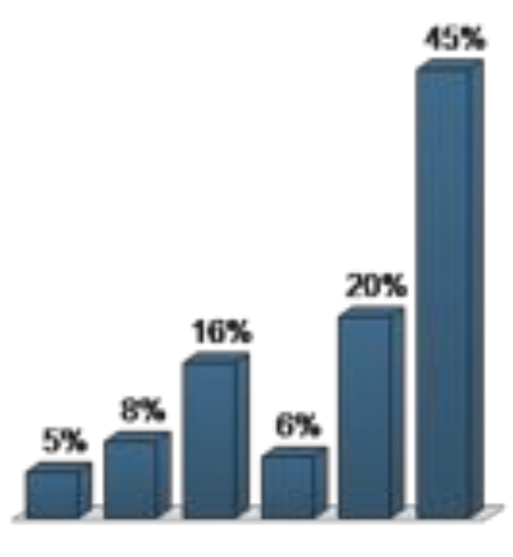
Session Name: Current Session

Date Created:	11/2/2018 3:12:09 PM	**Active Participants:**	105 of 105
Average Score:	0.00%	**Questions:**	69

Results by Question

1. My favorite Chicago restaurant is: (Multiple Choice)

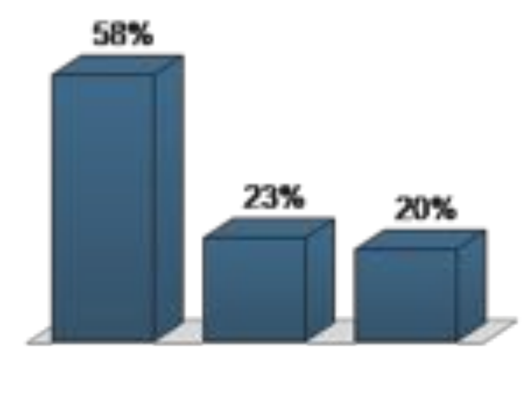
	Responses	
	Percent	**Count**
Portillo's	4.69%	3
Girl and the Goat	7.81%	5
Alinea	15.62%	10
Chicago Cut Steakhouse	6.25%	4
Giordano's	20.31%	13
I haven't tried any of these!	45.31%	29
Totals	**100%**	**64**



Back to Schedule

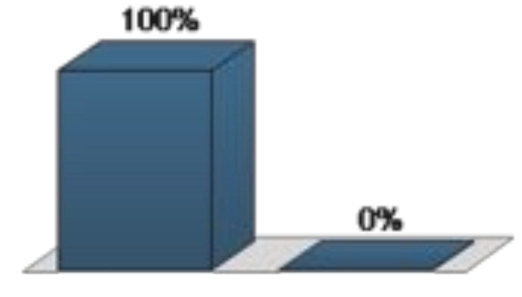
2. Do you pay for the ABA Basic Exam? (Multiple Choice)

	Responses	
	Percent	Count
Yes	57.75%	41
No	22.54%	16
Only if resident exceeds a specific score on the ITE	19.72%	14
Totals	**100%**	**71**



3. Do you pay for any online Qbanks (Truelearn, M5, etc)? (Multiple Choice)

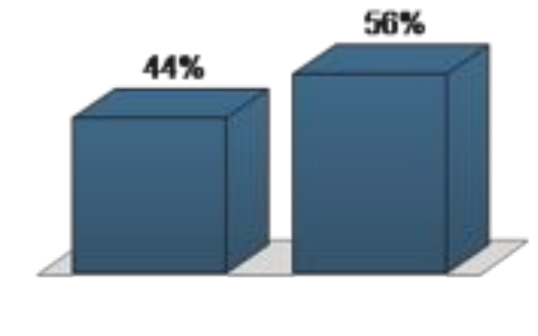
	Responses	
	Percent	Count
Yes	100%	9
No	0%	0
Totals	**100%**	**9**



Back to Schedule

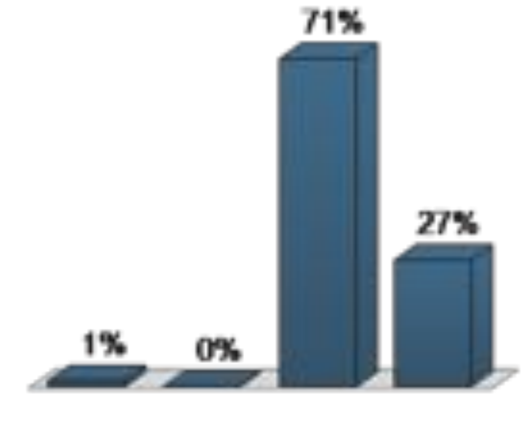
4. Do you pay for Anesthesia Toolbox? (Multiple Choice)

	Responses	
	Percent	Count
Yes	43.66%	31
No	56.34%	40
Totals	**100%**	**71**



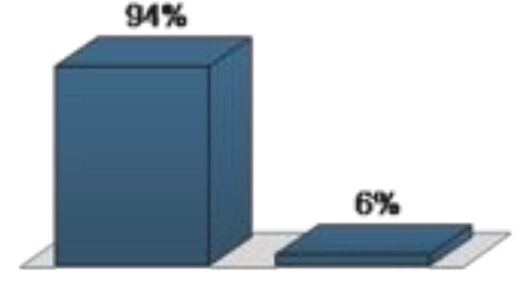
5. Would you consider terminating a resident who fails the Basic Exam? (Multiple Choice)

	Responses	
	Percent	Count
No	1.37%	1
Yes, after 1 failure	0%	0
Yes, after 2 failures	71.23%	52
Yes, after 3 failures	27.4%	20
Totals	**100%**	**73**



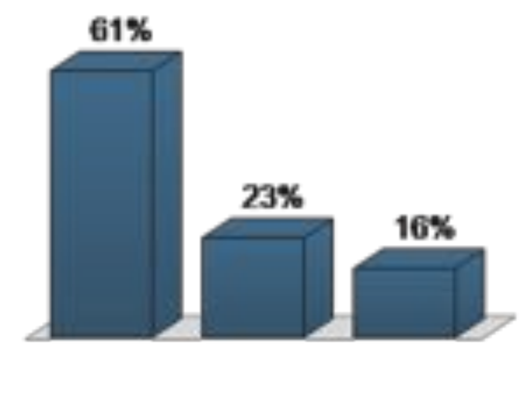
6. Should the ABA provide detailed score reports for the Basic Exam? (Multiple Choice)

	Responses	
	Percent	Count
Yes	94.29%	66
No	5.71%	4
Totals	**100%**	**70**



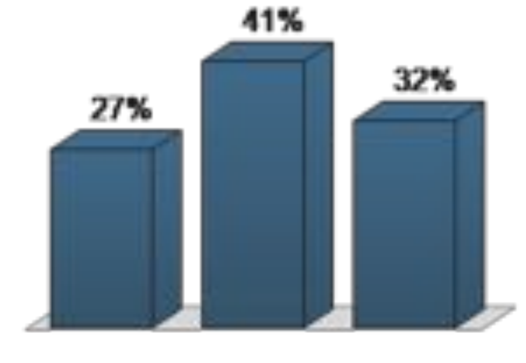
7. If a resident performs below expectations on the ITE, they receive a written warning. (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	61.43%	43
No	22.86%	16
Sometimes	15.71%	11
Totals	**100%**	**70**



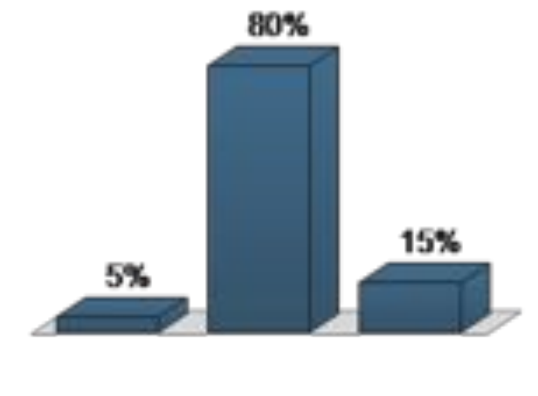
8. If a resident performs below expectations on the ITE, they receive an unsatisfactory from the CCC on medical knowledge. (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	27.27%	18
No	40.91%	27
Sometimes	31.82%	21
Totals	**100%**	**66**



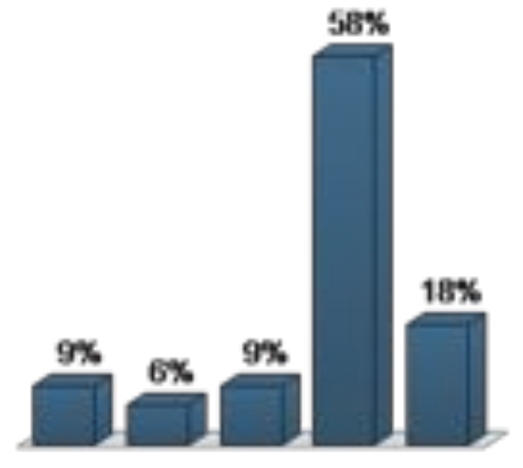
9. If a resident performs below expectations on the ITE, they receive an overall unsatisfactory. (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	4.55%	3
No	80.3%	53
Sometimes	15.15%	10
Totals	**100%**	**66**



10. For a given scaled score in the ITE, the percentile score is lower than previous years. I believe the biggest reason is: (Multiple Choice)

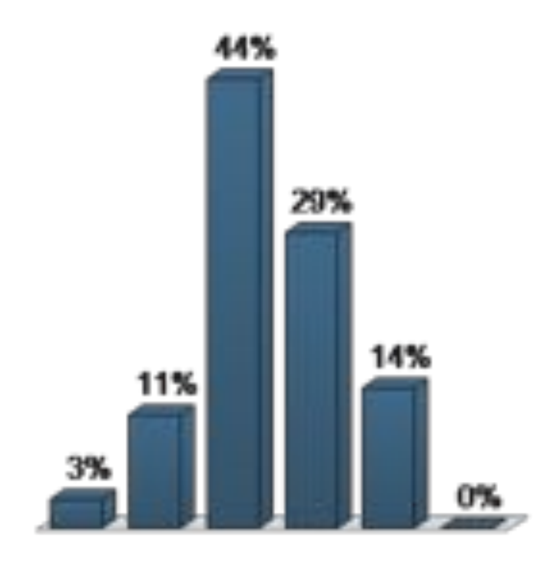
	Responses	
	Percent	**Count**
Smarter residents	8.96%	6
Easier exams	5.97%	4
Better curricula	8.96%	6
Q-bank use	58.21%	39
Other	17.91%	12
Totals	**100%**	**67**



Back to Schedule

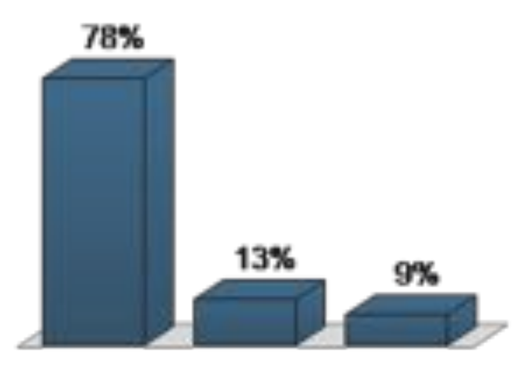
11. What is threshold for remediation from low ITE? (Multiple Choice)

	Responses	
	Percent	**Count**
<40-50th %ile	2.74%	2
<30-40th %ile	10.96%	8
<20-30th %ile	43.84%	32
<10-20th %ile	28.77%	21
<10th %ile	13.7%	10
No penalty for poor performance	0%	0
Totals	**100%**	**73**



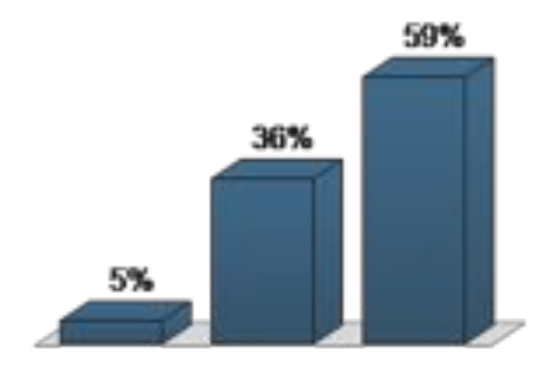
12. I have changed my threshold for remediation/warning for low ITE scores based on overall program performance: (Multiple Choice)

	Responses	
	Percent	**Count**
No, I have not made any recent changes	77.94%	53
Yes, we have raised the minimum	13.24%	9
Yes, we have lowered the minimum	8.82%	6
Totals	**100%**	**68**



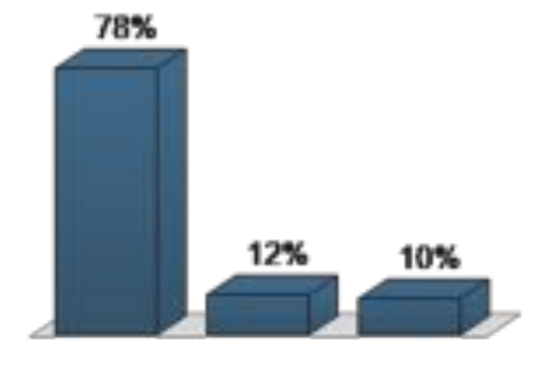
13. The new proposed ABA absence policy (i.e. up to 40 additional days away from training) is . . . (Multiple Choice)

	Responses	
	Percent	Count
Great	5%	4
OK with some clarification	36.25%	29
A complete disaster	58.75%	47
Totals	**100%**	**80**



14. Do you offer more than 1 month of anesthesia during intern year? (Multiple Choice)

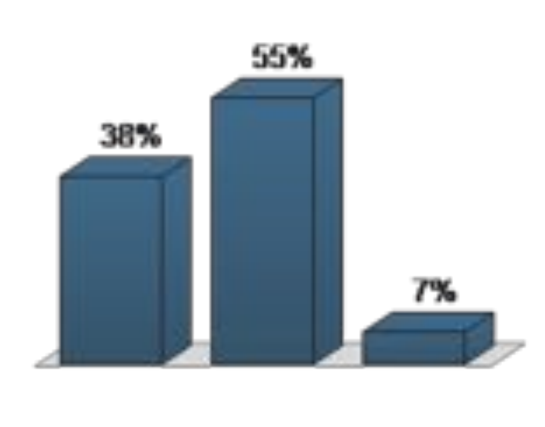
	Responses	
	Percent	Count
No	77.61%	52
Yes, but we make up for it during CA1-3 years	11.94%	8
Yes, but we don't make up for it (shhhh, don't tell anyone!)	10.45%	7
Totals	**100%**	**67**



Back to Schedule

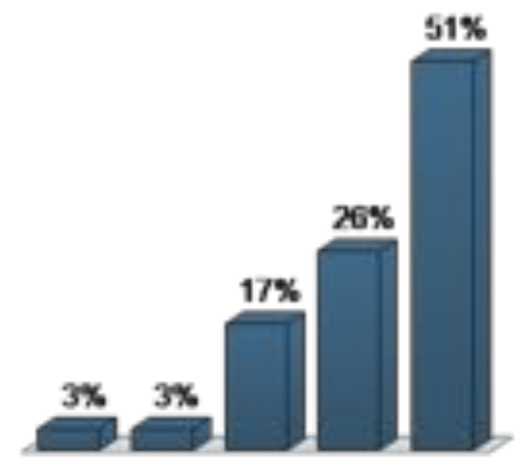
15. For rotations that are not required subspecialty rotations, do you structure them based on case type (e.g. ENT, ortho, uro/gyn, etc.)? (Multiple Choice)

	Responses	
	Percent	Count
Yes	38.36%	28
No, and I don't plan to	54.79%	40
No, but that's a great idea!	6.85%	5
Totals	**100%**	**73**



16. How much elective time do your residents get during the CA1-3 years? (Multiple Choice)

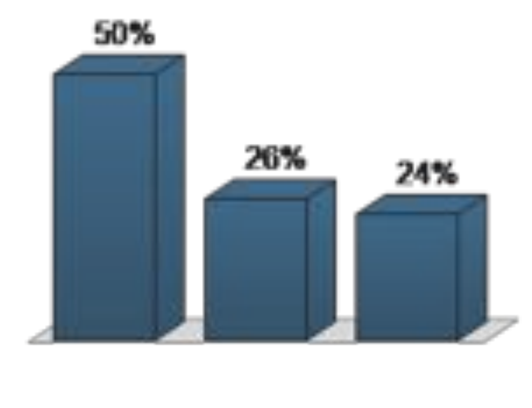
	Responses	
	Percent	Count
None	2.78%	2
< 1 month	2.78%	2
1 month	16.67%	12
1-2 months	26.39%	19
> 2 months	51.39%	37
Totals	**100%**	**72**



Back to Schedule

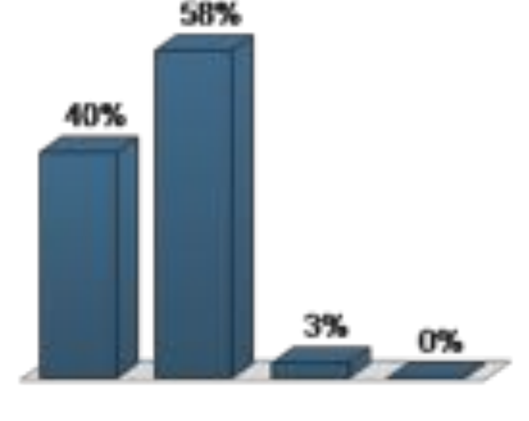
17. Do your residents have the option to do elective rotations at outside institutions? (Multiple Choice)

	Responses	
	Percent	Count
Yes	50%	36
No	26.39%	19
Under special circumstances	23.61%	17
Totals	**100%**	**72**



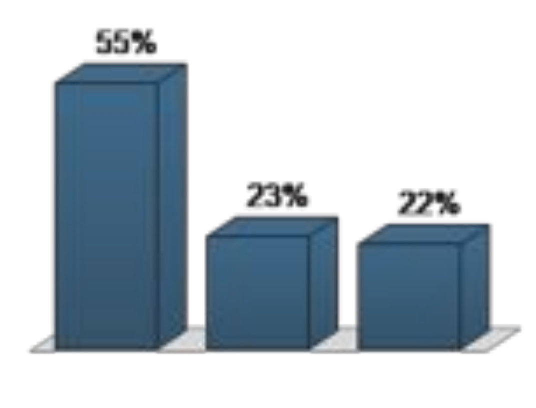
18. We are able to get our residents relieved for required didactic time: (Multiple Choice)

	Responses	
	Percent	Count
Always	39.73%	29
Most of the time	57.53%	42
Sometimes	2.74%	2
Rarely	0%	0
Totals	**100%**	**73**



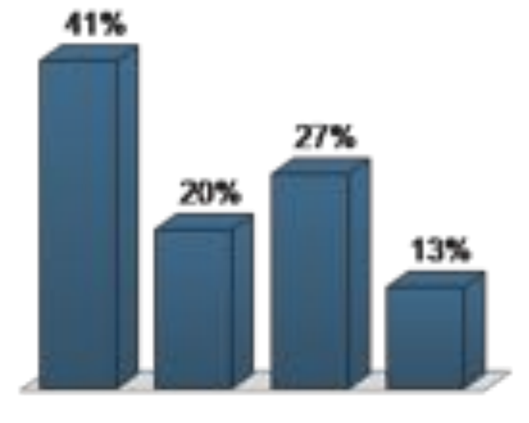
19. Does your program have a formal point-of-care ultrasound curriculum? (Multiple Choice)

	Responses	
	Percent	Count
Yes	55.07%	38
No	23.19%	16
Some residents learn about it, but informally	21.74%	15
Totals	**100%**	**69**



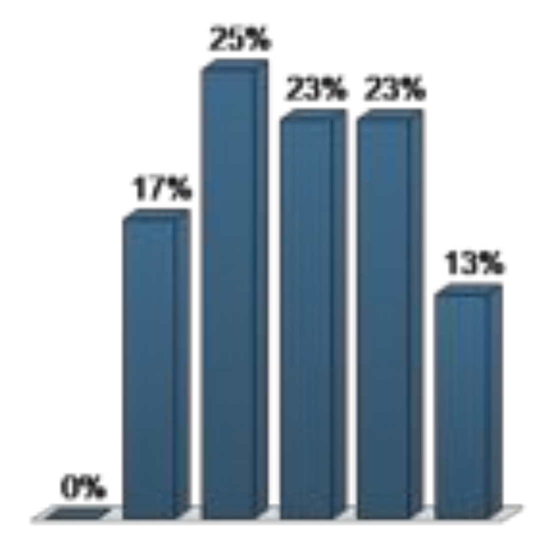
20. In what rotation do your residents practice POCUS skills most? (Multiple Choice)

	Responses	
	Percent	Count
CCS/ICU	40.85%	29
PACU	19.72%	14
Other	26.76%	19
Not applicable	12.68%	9
Totals	**100%**	**71**



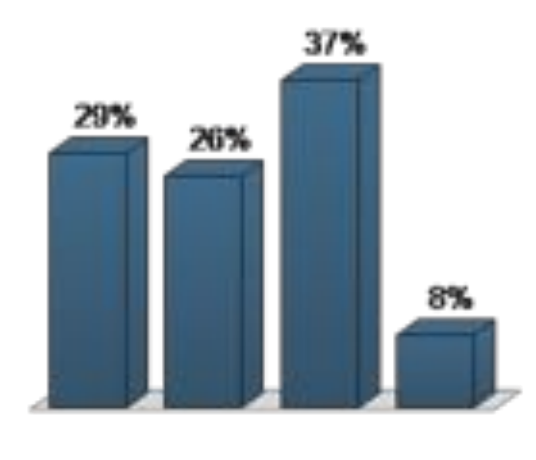
21. How much $ do you provide for trip/presentation? (Multiple Choice)

	Responses	
	Percent	**Count**
<500	0%	0
$500-$999	16.9%	12
≥$1000	25.35%	18
Each trip has $ limit and there is no total cap per year	22.54%	16
Each trip has $ limit and there is total cap per year	22.54%	16
Other	12.68%	9
Totals	**100%**	**71**



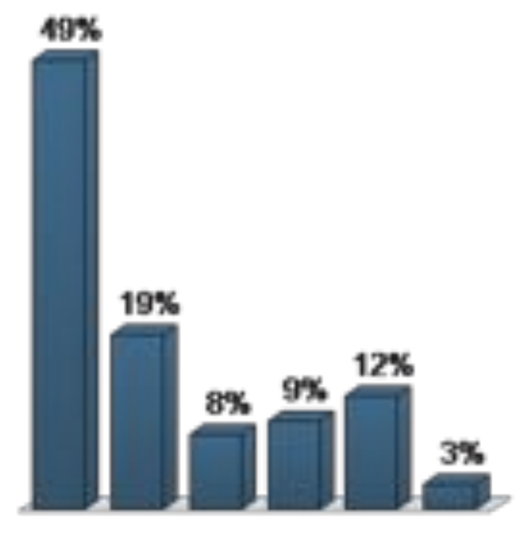
22. Do you have dedicated quality and safety project time? (Multiple Choice)

	Responses	
	Percent	Count
Yes, it is a required rotation	28.77%	21
Yes, it is scheduled randomly	26.03%	19
No but it's a good idea	36.99%	27
No, it's a waste of time	8.22%	6
Totals	**100%**	**73**



23. What percentage of your residents complete a QI project? (Multiple Choice)

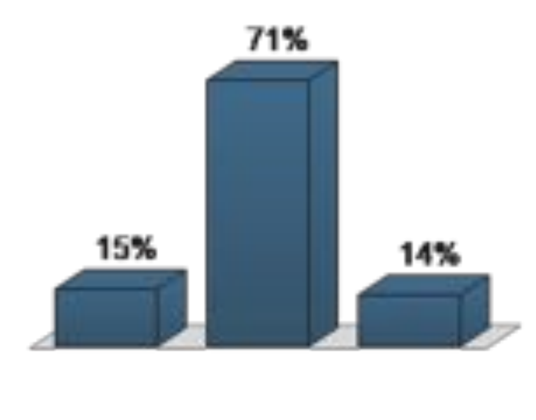
	Responses	
	Percent	Count
100%	48.65%	36
75-99%	18.92%	14
50-75%	8.11%	6
25-50%	9.46%	7
<25%	12.16%	9
None	2.7%	2
Totals	**100%**	**74**



Back to Schedule

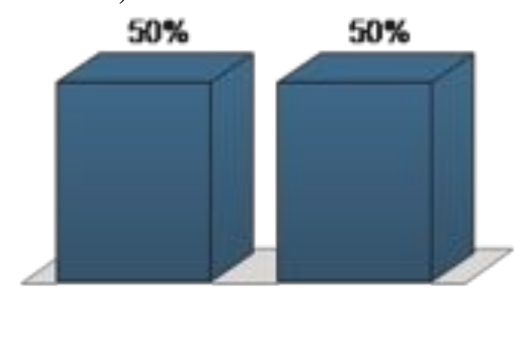
24. Do you offer a rotation in the Perioperative Surgical Home? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	15.28%	11
No	70.83%	51
What are you talking about?	13.89%	10
Totals	**100%**	**72**



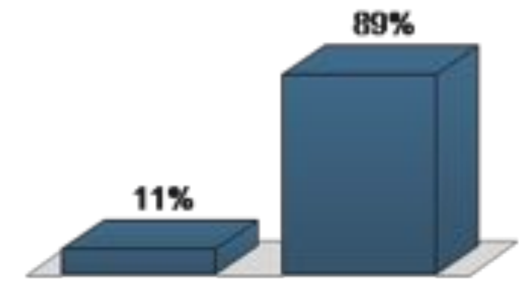
25. Our resident evaluations by the faculty are anonymous. (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	50%	38
No	50%	38
Totals	**100%**	**76**



26. I am satisfied with the quality of written faculty evaluations? (Multiple Choice)

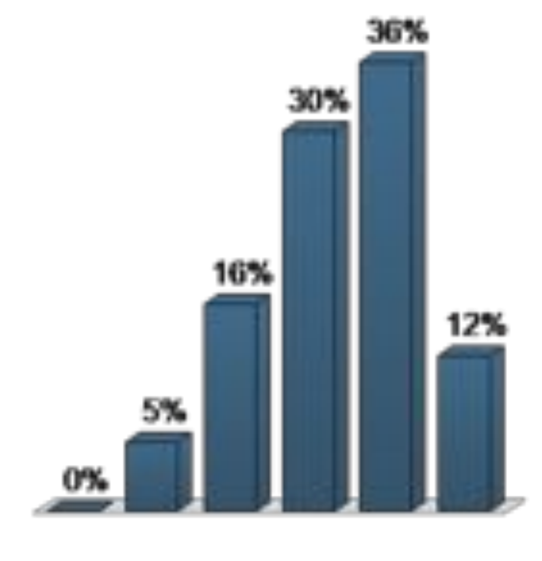
	Responses	
	Percent	**Count**
Yes	10.96%	8
No	89.04%	65
Totals	**100%**	**73**



Back to Schedule

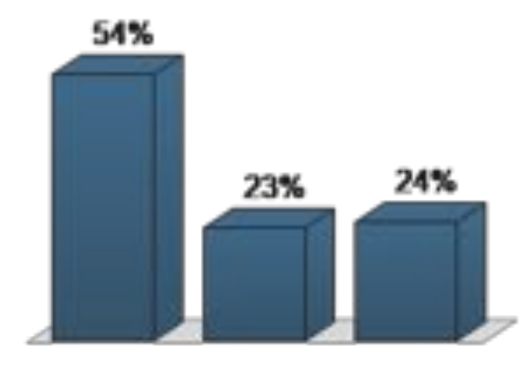
27. The percentage of our faculty who complete written evaluations within 2 weeks is closest to: (Multiple Choice)

	Responses	
	Percent	**Count**
100%	0%	0
75-99%	5.48%	4
50-74%	16.44%	12
25-49%	30.14%	22
1-24%	35.62%	26
ZERO	12.33%	9
Totals	**100%**	**73**



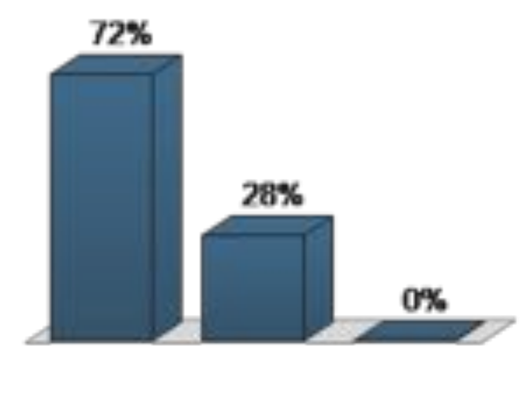
28. I have made interventions that have improved our written evaluations? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes - willing to share?	53.52%	38
No	22.54%	16
No, but I plan to implement a change – willing to share?	23.94%	17
Totals	**100%**	**71**



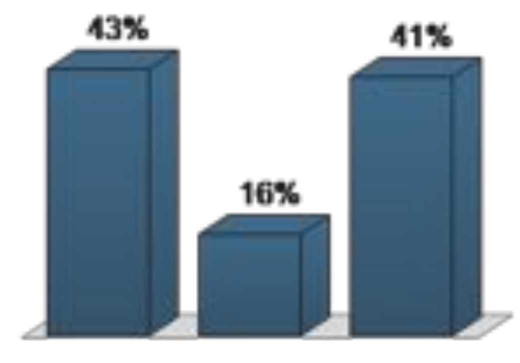
29. Do you receive the minimum required administrative time as PD? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	71.83%	51
No	28.17%	20
I didn't know there was a minimum	0%	0
Totals	**100%**	**71**



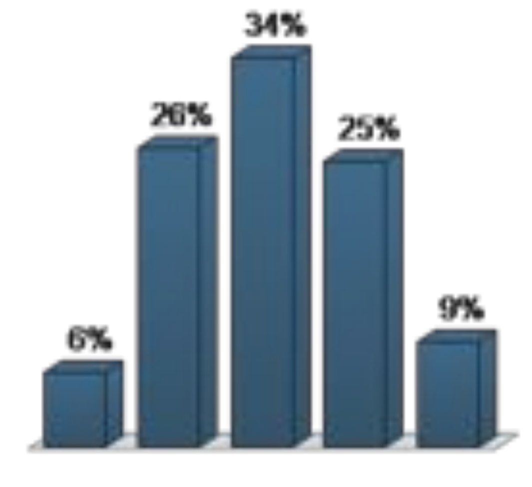
30. Because of my role as a PD, my total compensation is: (Multiple Choice)

	Responses	
	Percent	**Count**
Higher	42.65%	29
Lower	16.18%	11
Unchanged	41.18%	28
Totals	**100%**	**68**



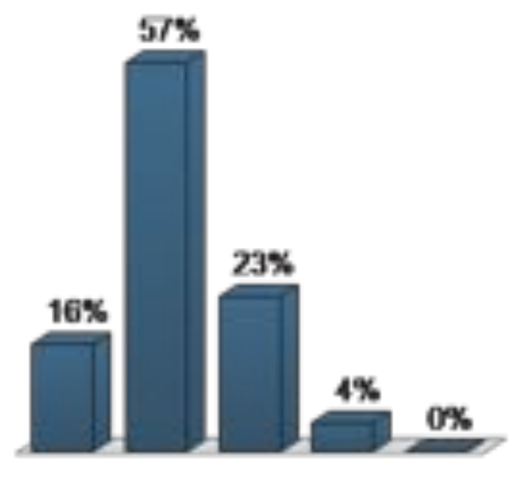
31. Service over education (as defined by ACGME) is an issue within our department: (Multiple Choice)

	Responses	
	Percent	Count
Always	6.49%	5
Frequently	25.97%	20
Sometimes	33.77%	26
Rarely	24.68%	19
Never	9.09%	7
Totals	**100%**	**77**



32. During a typical OR rotation, the number of calls our residents (averaged among CA1-3) take in a month is approximately: (Multiple Choice)

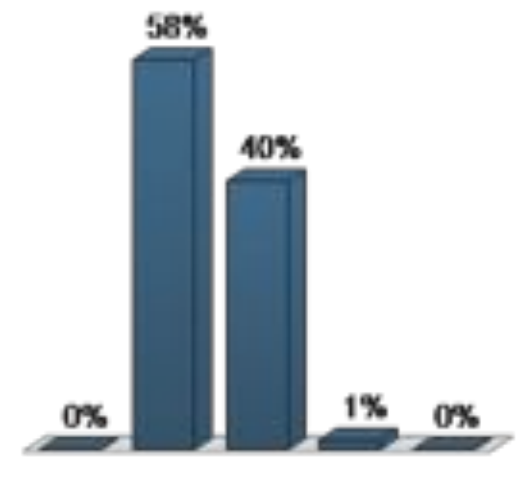
	Responses	
	Percent	Count
2-3	15.71%	11
4-5	57.14%	40
6-7	22.86%	16
8-9	4.29%	3
>9	0%	0
Totals	**100%**	**70**



Back to Schedule

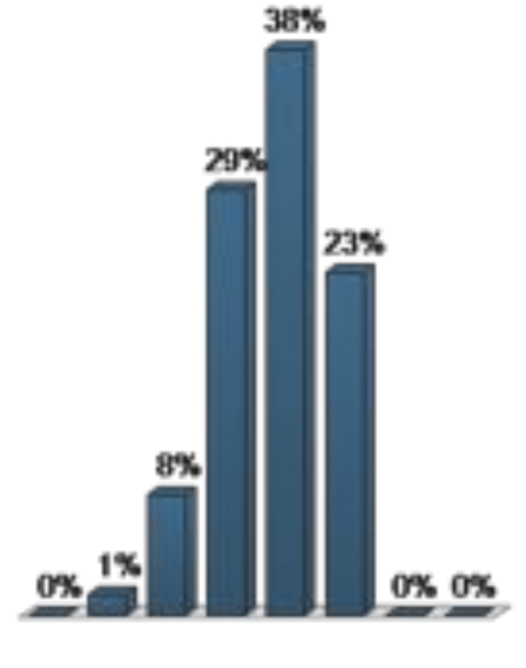
33. The average day for our residents on a typical OR rotation is closest to: (Multiple Choice)

	Responses	
	Percent	Count
<8 hrs	0%	0
8-10 hrs	58.33%	42
10-12 hrs	40.28%	29
12-14 hrs	1.39%	1
>14 hrs	0%	0
Totals	**100%**	**72**



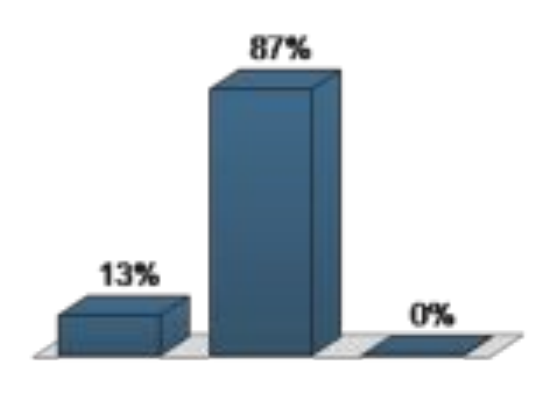
34. How many hours per week do your residents typically work? (Multiple Choice)

	Responses	
	Percent	Count
<40	0%	0
40-45	1.37%	1
46-50	8.22%	6
51-55	28.77%	21
56-60	38.36%	28
61-70	23.29%	17
71-80	0%	0
>80	0%	0
Totals	**100%**	**73**



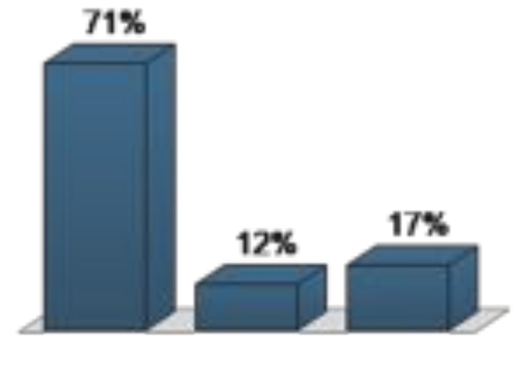
35. Regarding work effort, our residents: (Multiple Choice)

	Responses	
	Percent	**Count**
Are content	13.16%	10
Think they work too hard	86.84%	66
Think they don't work enough	0%	0
Totals	**100%**	**76**



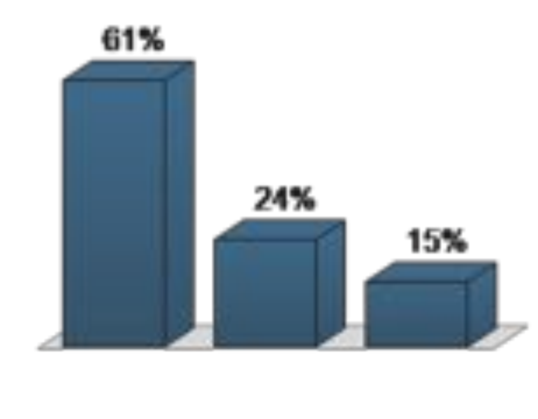
36. Regarding work effort, I feel our residents: (Multiple Choice)

	Responses	
	Percent	**Count**
Work about the right amount	70.67%	53
Work too much	12%	9
Don't work enough	17.33%	13
Totals	**100%**	**75**



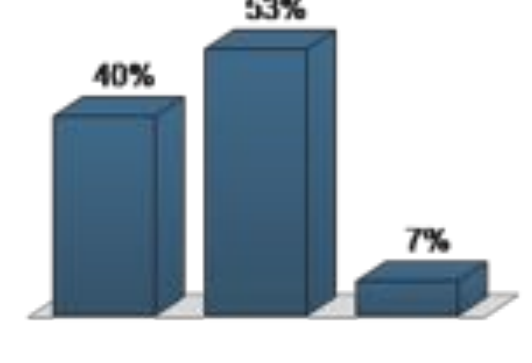
37. Do you have paid moonlighting for your residents? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	60.81%	45
No	24.32%	18
No, but we allow moonlighting outside the institution	14.86%	11
Totals	**100%**	**74**



38. Do you have a policy regarding personal electronic devices (PEDs) in the OR? (Multiple Choice)

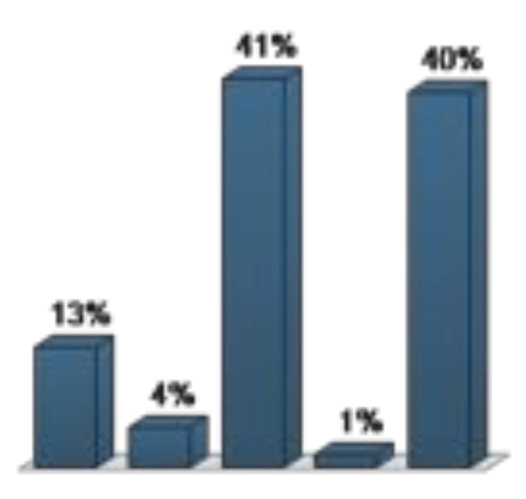
	Responses	
	Percent	**Count**
Yes	39.73%	29
No	53.42%	39
I'm not sure	6.85%	5
Totals	**100%**	**73**



Back to Schedule

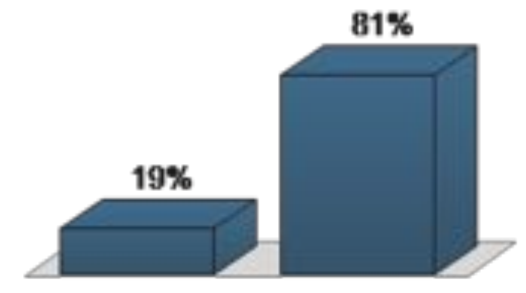
39. Do you feel that PEDs should be allowed in the OR? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	12.86%	9
No, not at all	4.29%	3
Yes, but only for clinical-related tasks	41.43%	29
Yes, for reading/studying	1.43%	1
Yes, for C and D	40%	28
Totals	**100%**	**70**



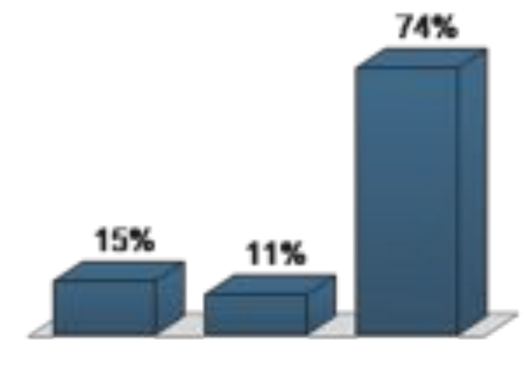
40. Do you do any Saturday interviews? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	18.75%	15
No	81.25%	65
Totals	**100%**	**80**



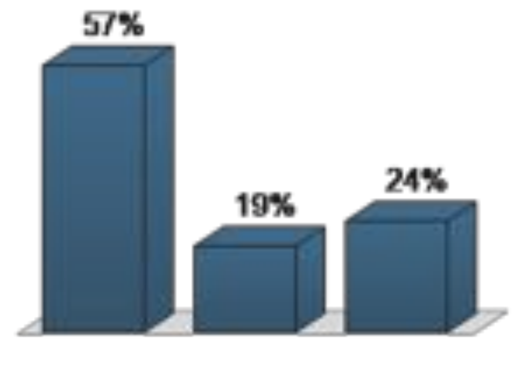
41. For those that do Saturday interviews, how do you incentivize your faculty? (Multiple Choice)

	Responses	
	Percent	**Count**
Financially	14.81%	4
With time (get the day back)	11.11%	3
We don't!!	74.07%	20
Totals	**100%**	**27**



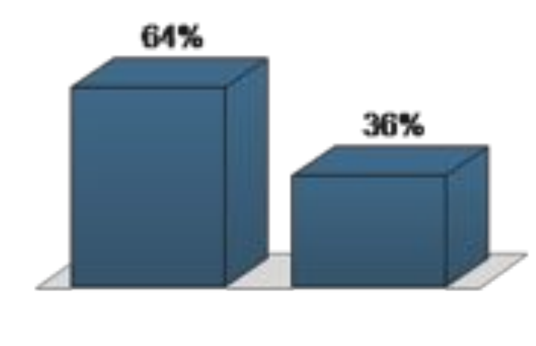
42. Do you involve residents (e.g. chiefs) in the final candidate selection/rank meeting? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	57.33%	43
No	18.67%	14
No, but we do have residents involved with interviewing	24%	18
Totals	**100%**	**75**



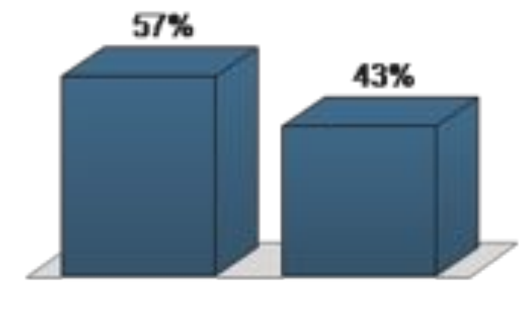
43. If an applicant fails step 1 of board exams, our program: (Multiple Choice)

	Responses	
	Percent	**Count**
Does not consider for interview	64.47%	49
Occasionally invites for interview	35.53%	27
Totals	**100%**	**76**



44. If an applicant fails USMLE CS exam, our program: (Multiple Choice)

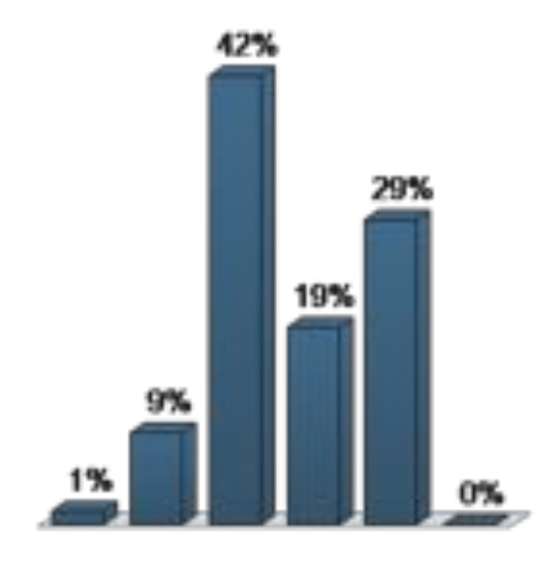
	Responses	
	Percent	**Count**
Will still consider for interview	57.33%	43
Does not consider for interview	42.67%	32
Totals	**100%**	**75**



Back to Schedule

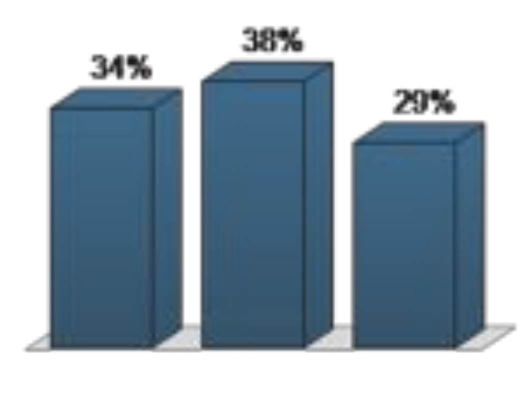
45. If you had to pick one, which characteristic is Least important in successful recruitment? (Multiple Choice)

	Responses	
	Percent	Count
USMLE scores	1.25%	1
Transcript/grades	8.75%	7
Scholarly accomplishments	42.5%	34
Dean's letter	18.75%	15
LORs	28.75%	23
Interviews	0%	0
Totals	**100%**	**80**



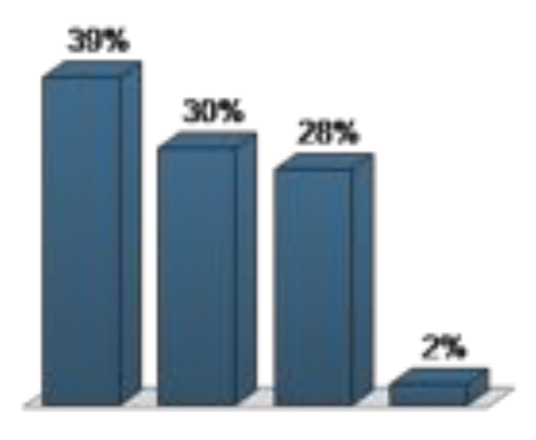
46. Do you provide alcohol at recruitment events? (Multiple Choice)

	Responses	
	Percent	Count
Yes and we learn a lot about our applicants this way	33.75%	27
Yes, but we don't pay much attention to it	37.5%	30
No	28.75%	23
Totals	**100%**	**80**



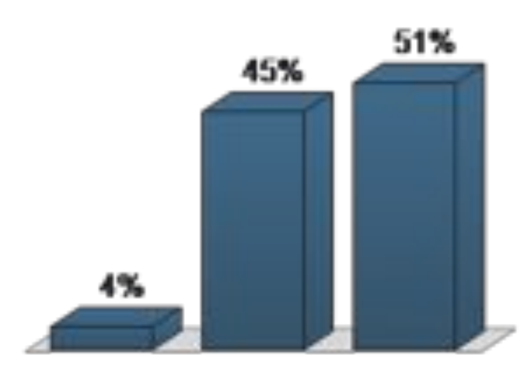
47. Do you pay for recruits' hotel? (Multiple Choice)

	Responses	
	Percent	Count
No	39.02%	32
No, but they get a discounted rate	30.49%	25
Yes, 1 night	28.05%	23
Yes, 2 or more nights	2.44%	2
Totals	**100%**	**82**



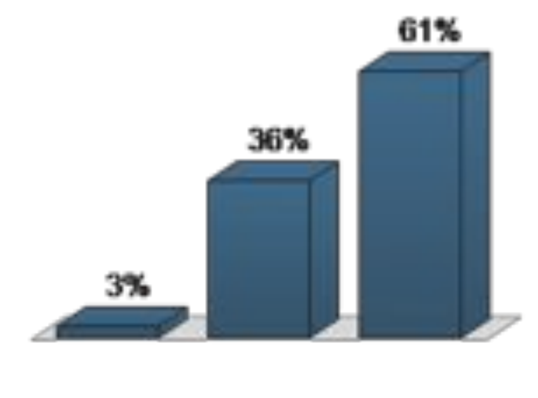
48. Our program conducts behavioral interviews. (Multiple Choice)

	Responses	
	Percent	Count
Yes – the entire interview	4.23%	3
Yes – a component of at least one interview	45.07%	32
No	50.7%	36
Totals	**100%**	**71**



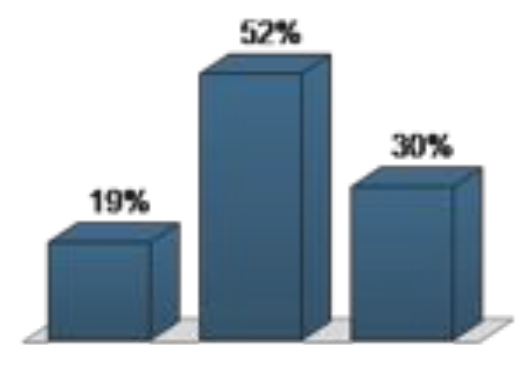
49. What best describes the ASA medical student meet and greet for your program? (Multiple Choice)

	Responses	
	Percent	**Count**
Very beneficial	2.67%	2
Slightly beneficial	36%	27
Mostly a waste of time	61.33%	46
Totals	**100%**	**75**



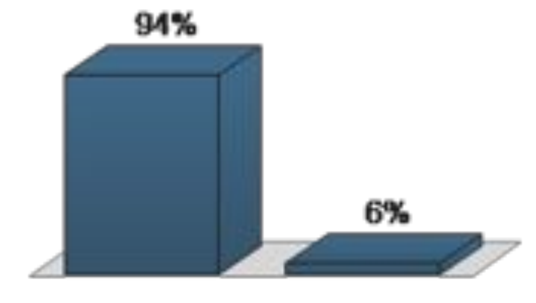
50. What best describes the ASA medical student meet and greet for students? (Multiple Choice)

	Responses	
	Percent	**Count**
Very beneficial	18.75%	12
Slightly beneficial	51.56%	33
Mostly a waste of time	29.69%	19
Totals	**100%**	**64**



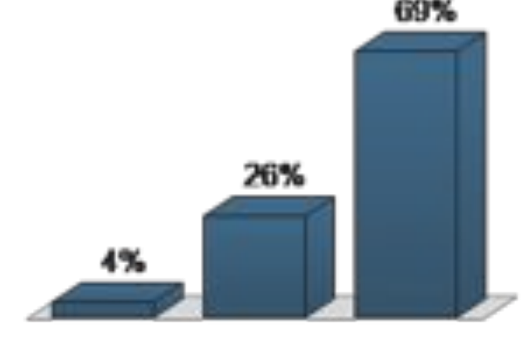
51. Most of the students I encounter at the meet and greet are not qualified for my program. (Multiple Choice)

	Responses	
	Percent	**Count**
True	94.29%	66
False	5.71%	4
Totals	**100%**	**70**



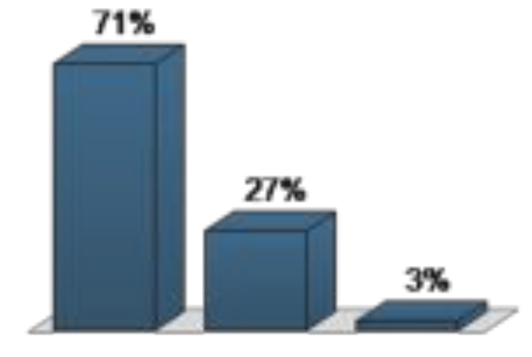
52. I'm looking forward to the meet and greet next year. (Multiple Choice)

	Responses	
	Percent	**Count**
Yes – can't wait!	4.17%	3
Eh – it's OK	26.39%	19
Nope	69.44%	50
Totals	**100%**	**72**



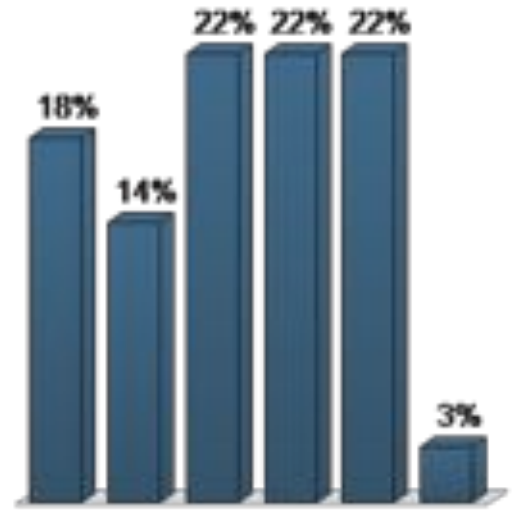
53. Are you monitoring resident case logs? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, the PD/APD checks them regularly	70.89%	56
Yes, someone else is monitoring them (e.g. coordinator)	26.58%	21
No	2.53%	2
Totals	**100%**	**79**



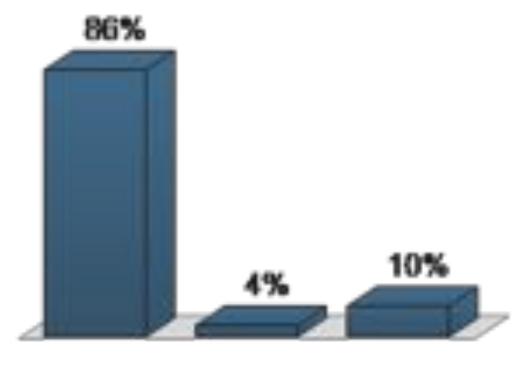
54. How do you handle "practice habits" that are queried on the ACGME survey? (Multiple Choice)

	Responses	
	Percent	**Count**
Automated clinical data collection fed back to trainee	17.81%	13
Information provided at semiannual review	13.7%	10
We sort of do this but not the way I would like (general performance metrics)	21.92%	16
We educate our residents on this every year prior to the survey	21.92%	16
We cross our fingers every year with this question	21.92%	16
Other	2.74%	2
Totals	**100%**	**73**



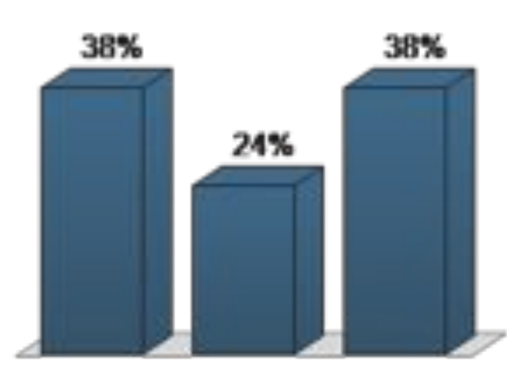
55. I am supportive of an August 1st start date for ALL fellowships (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	86.42%	70
No	3.7%	3
Maybe	9.88%	8
Totals	**100%**	**81**



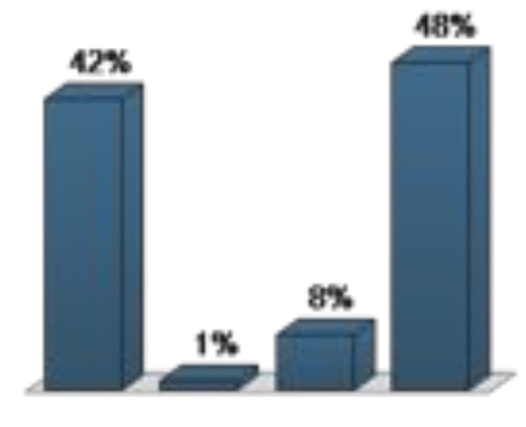
56. Do you have a formal wellness curriculum? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	37.97%	30
No	24.05%	19
No, but we have regularly scheduled wellness activities	37.97%	30
Totals	**100%**	**79**



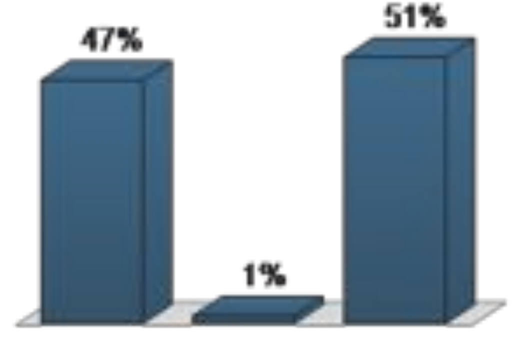
57. Do you have a wellness committee? (Multiple Choice)

	Responses	
	Percent	Count
No	42.47%	31
Yes, only residents	1.37%	1
Yes, only faculty	8.22%	6
Yes, both residents and faculty	47.95%	35
Totals	**100%**	**73**



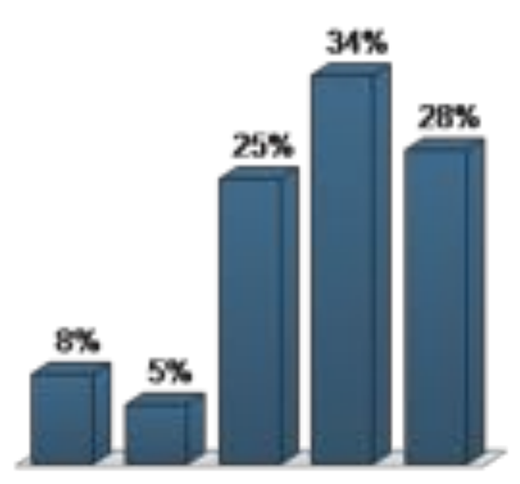
58. Who is the target of your wellness committee efforts? (Multiple Choice)

	Responses	
	Percent	Count
Residents	47.06%	32
Faculty	1.47%	1
Residents and Faculty	51.47%	35
Totals	**100%**	**68**



59. Do you have a system in place to help residents cope with patient deaths/adverse outcomes? (Multiple Choice)

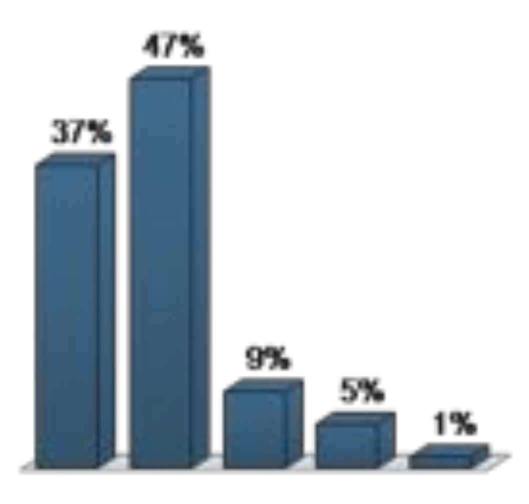
	Responses	
	Percent	**Count**
Yes, at the department level	7.89%	6
Yes, at the program level	5.26%	4
Yes, at the GME or institutional level	25%	19
A combiation of A, B, and C	34.21%	26
No, we don't have anything formal	27.63%	21
Totals	**100%**	**76**



Back to Schedule

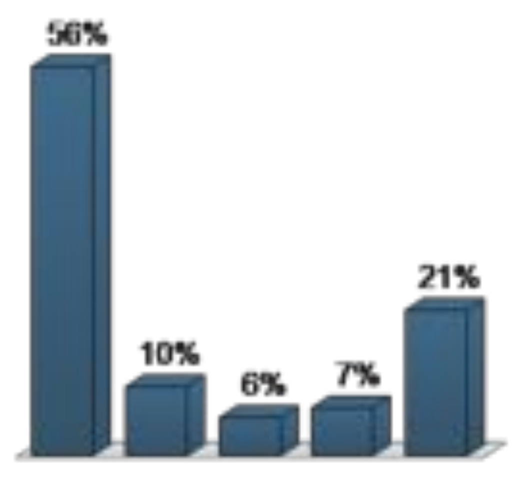
60. Per ACGME, faculty cannot supervise more than 2 residents. How often does your program violate this rule? (Multiple Choice)

	Responses	
	Percent	Count
Never	36.84%	28
Rarely, only in emergency situations	47.37%	36
Occasionally	9.21%	7
Frequently	5.26%	4
All the time	1.32%	1
Totals	**100%**	**76**



61. The MOST rewarding part of my job as PD is . . . (Multiple Choice)

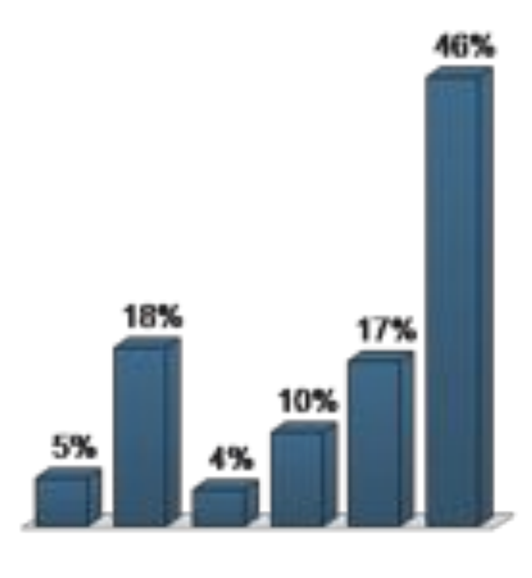
	Responses	
	Percent	Count
Mentorship	56.34%	40
Recruitment	9.86%	7
Being the boss	5.63%	4
Completing the WebADS update	7.04%	5
Glamour/Recognition	21.13%	15
Totals	**100%**	**71**



Back to Schedule

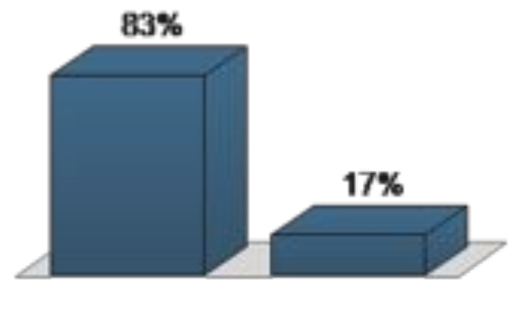
62. The LEAST rewarding part of my job as PD is . . . (Multiple Choice)

	Responses	
	Percent	Count
The WebADS update	4.88%	4
Being the disciplinarian	18.29%	15
Lack of recognition	3.66%	3
Being responsible for the success of a program	9.76%	8
Dealing with complaints from residents	17.07%	14
Dealing with complaints from faculty	46.34%	38
Totals	**100%**	**82**



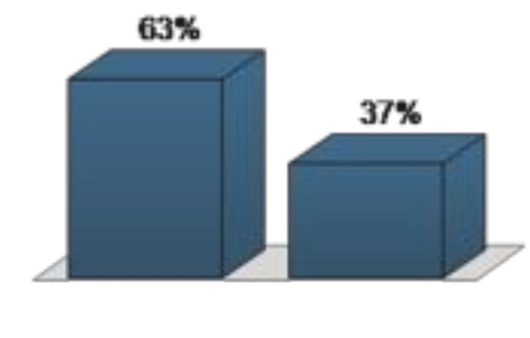
63. I am burned out from talking about burnout (Multiple Choice)

	Responses	
	Percent	Count
True	83.33%	60
False	16.67%	12
Totals	**100%**	**72**



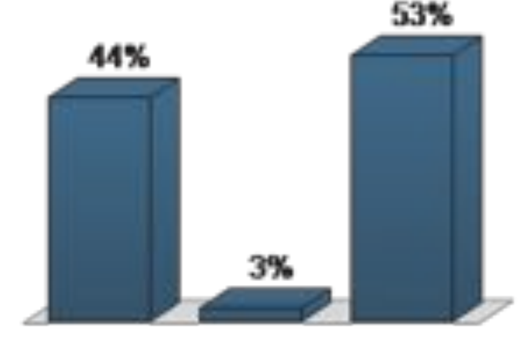
64. I am tired of talking about wellness (Multiple Choice)

	Responses	
	Percent	**Count**
True	63.38%	45
False	36.62%	26
Totals	**100%**	**71**



65. Burnout is a bigger problem today than it was 10 years ago. (Multiple Choice)

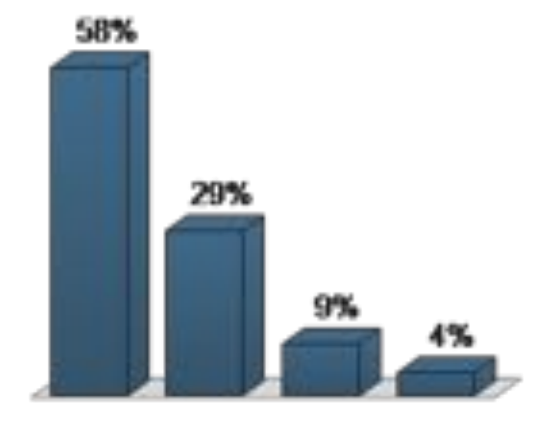
	Responses	
	Percent	**Count**
True	44.44%	32
False	2.78%	2
Probably about the same?	52.78%	38
Totals	**100%**	**72**



Back to Schedule

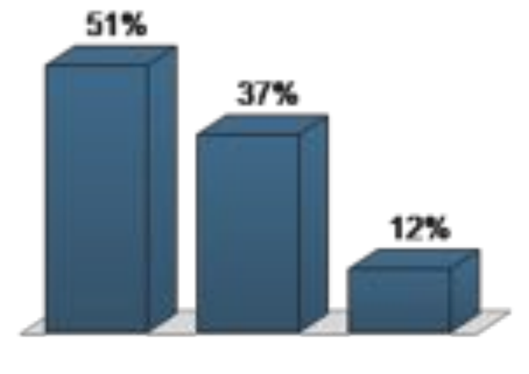
66. In terms of my job security as PD I feel (Multiple Choice)

	Responses	
	Percent	**Count**
Very secure	57.89%	44
Somewhat secure	28.95%	22
Somewhat insecure	9.21%	7
Very insecure!	3.95%	3
Totals	**100%**	**76**



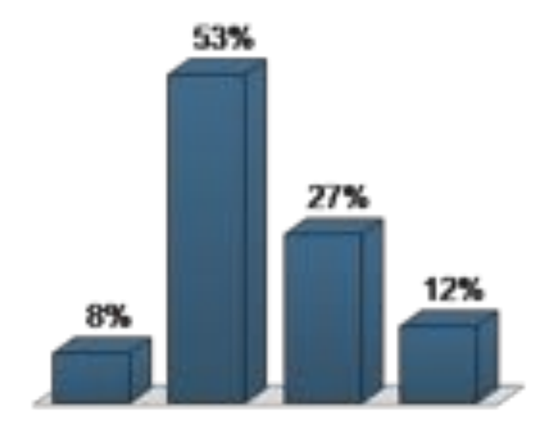
67. Support from my chair is . . . (Multiple Choice)

	Responses	
	Percent	**Count**
Great, I feel very supported	50.67%	38
Ok, I feel somewhat supported	37.33%	28
Lacking, I do not feel supported at all	12%	9
Totals	**100%**	**75**



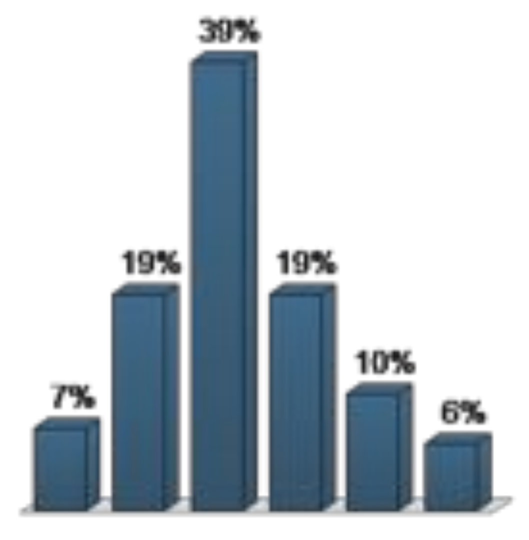
68. Support from the faculty as PD is . . . (Multiple Choice)

	Responses	
	Percent	**Count**
Great	8.11%	6
Fine	52.7%	39
Not good	27.03%	20
Terrible, they are out to get me!	12.16%	9
Totals	**100%**	**74**



69. How long do you anticipate being PD? (Multiple Choice)

	Responses	
	Percent	**Count**
<1 year	7.25%	5
1-3 years	18.84%	13
4-6 years	39.13%	27
7-9 years	18.84%	13
10-12 years	10.14%	7
> 12 years	5.8%	4
Totals	**100%**	**69**



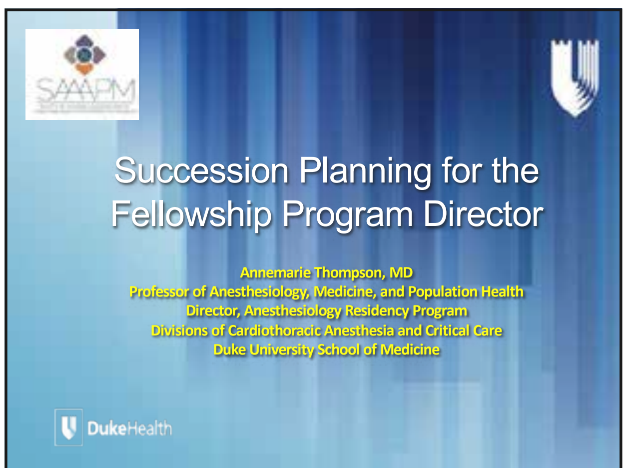
Back to Schedule

HANDOUT

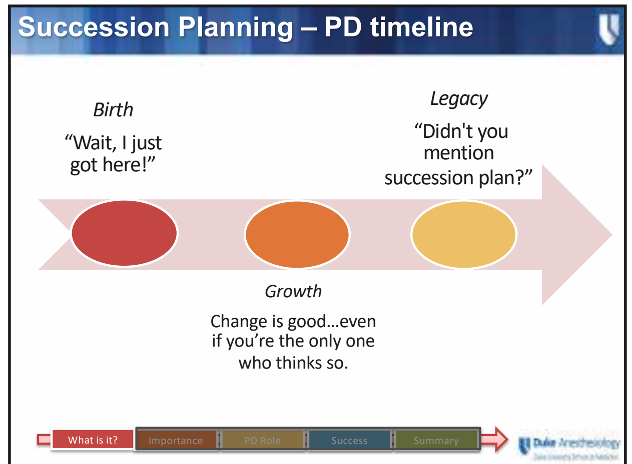
Succession Planning for the Program Director

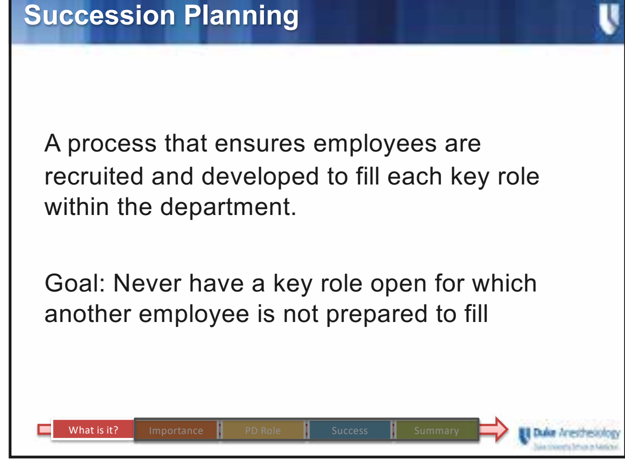
Annemarie Thompson, MD

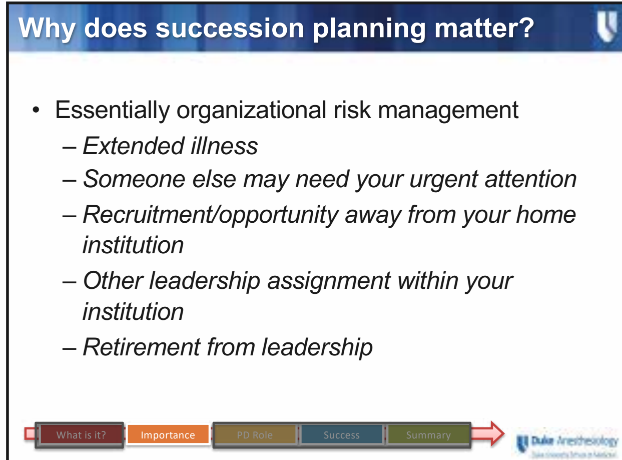
11/02/2018
8:05am – 8:25am

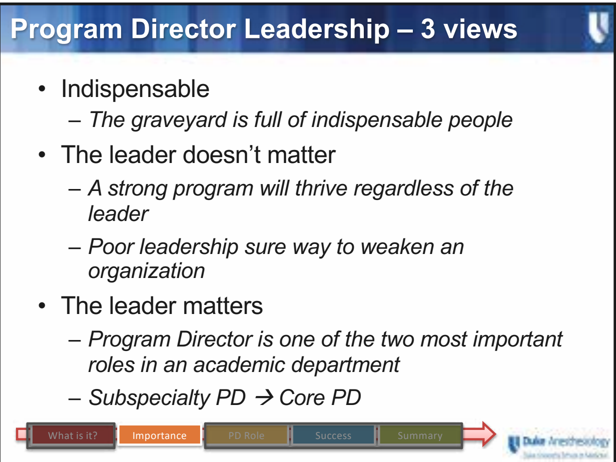

SAAAPM
Succession Planning for the Fellowship Program Director
Annemarie Thompson, MD
Professor of Anesthesiology, Medicine, and Population Health
Director, Anesthesiology Residency Program
Divisions of Cardiothoracic Anesthesia and Critical Care
Duke University School of Medicine
DukeHealth

Outline
What is succession planning?
Importance of succession planning
Defining The Program Director Role
Successful succession
Summary

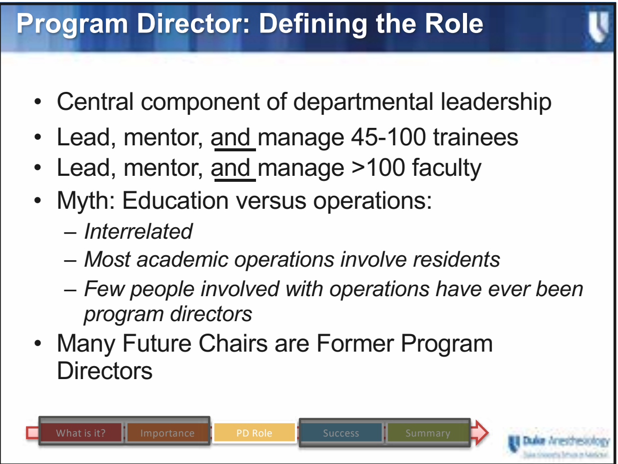

Succession Planning – PD timeline
Birth
"Wait, I just got here!"
Legacy
"Didn't you mention succession plan?"
Growth
Change is good…even if you're the only one who thinks so.
What is it?
Importance
PD Role
Success
Summary

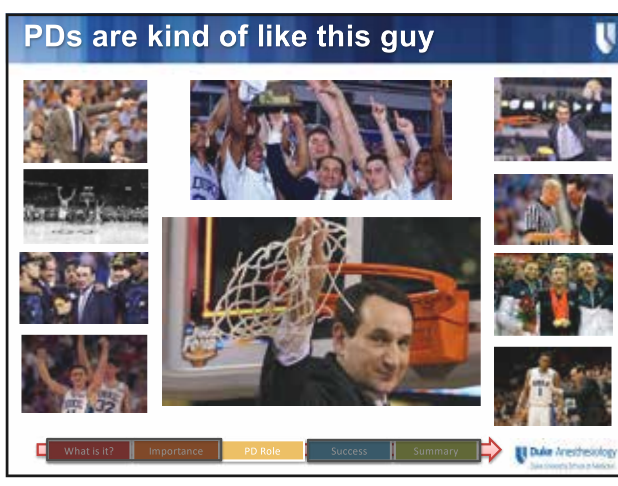

Succession Planning
A process that ensures employees are recruited and developed to fill each key role within the department.
Goal: Never have a key role open for which another employee is not prepared to fill
What is it?
Importance
PD Role
Success
Summary

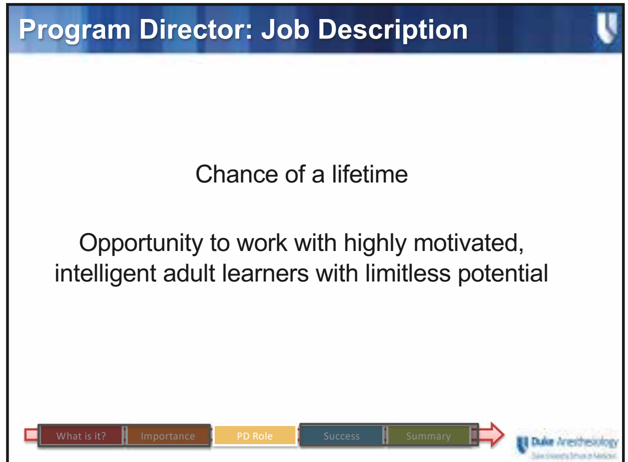

Why does succession planning matter?
Essentially organizational risk management
– Extended illness
– Someone else may need your urgent attention
– Recruitment/opportunity away from your home institution
– Other leadership assignment within your institution
– Retirement from leadership
What is it?
Importance
PD Role
Success
Summary

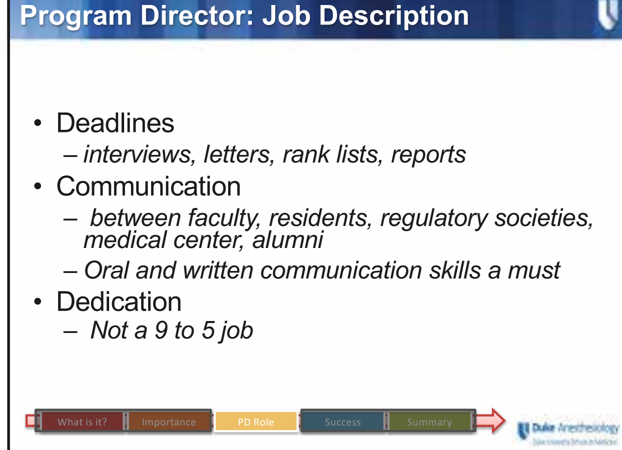

Program Director Leadership – 3 views
Indispensable
– The graveyard is full of indispensable people
The leader doesn't matter
– A strong program will thrive regardless of the leader
– Poor leadership sure way to weaken an organization
The leader matters
– Program Director is one of the two most important roles in an academic department
– Subspecialty PD → Core PD
What is it?
Importance
PD Role
Success
Summary

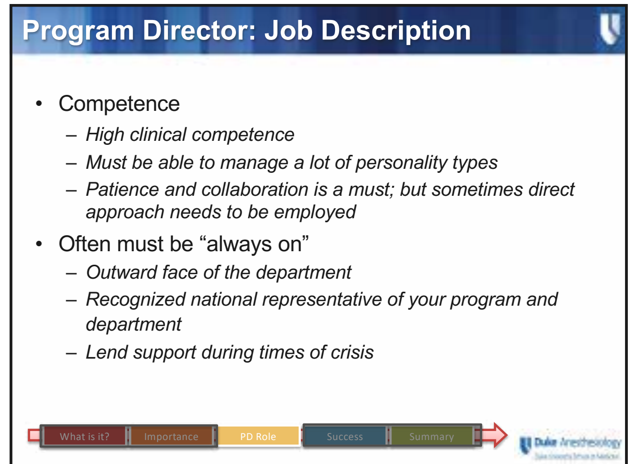
Back to Schedule

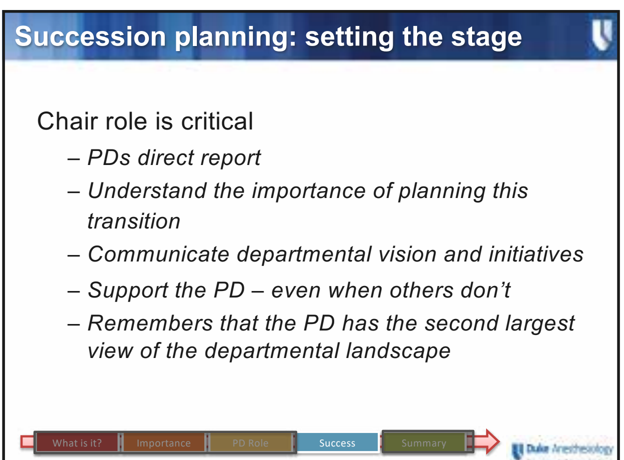


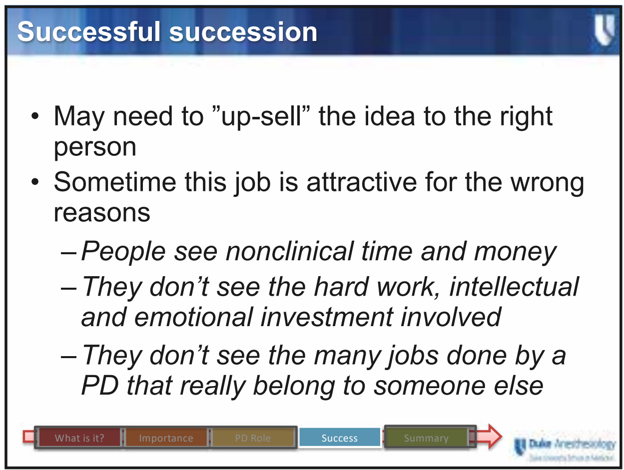




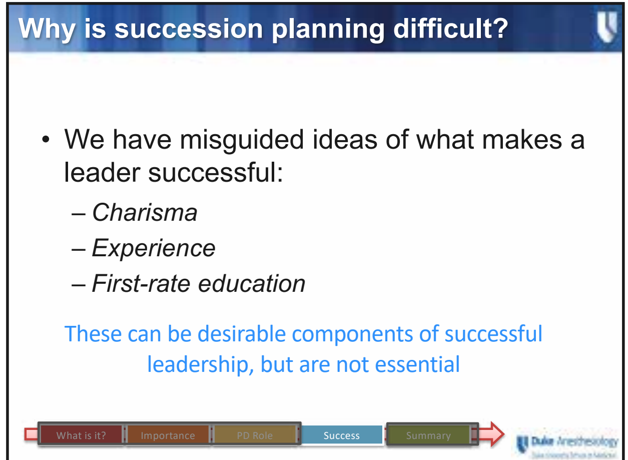


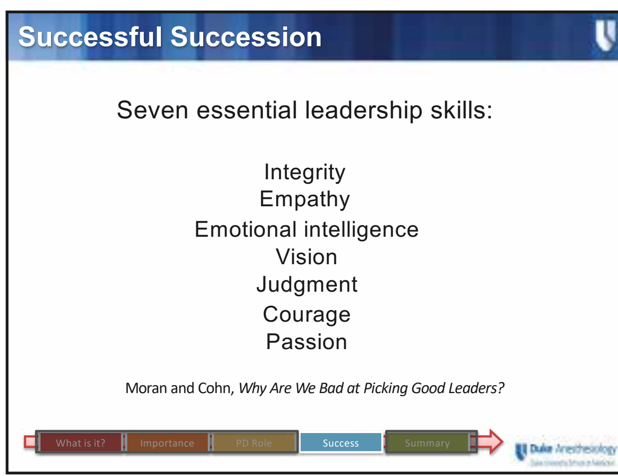


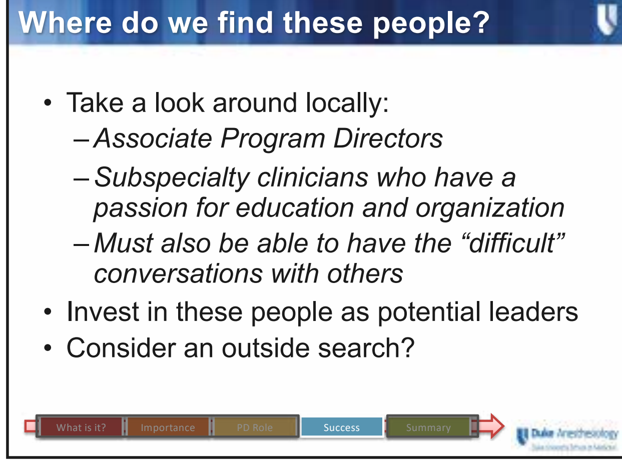


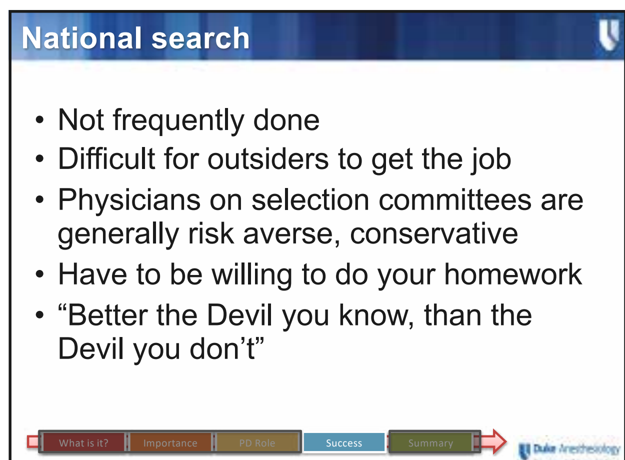

Successful succession
• May need to "up-sell" the idea to the right person
• Sometime this job is attractive for the wrong reasons
– People see nonclinical time and money
– They don't see the hard work, intellectual and emotional investment involved
– They don't see the many jobs done by a PD that really belong to someone else
What is it? Importance PD Role Success Summary

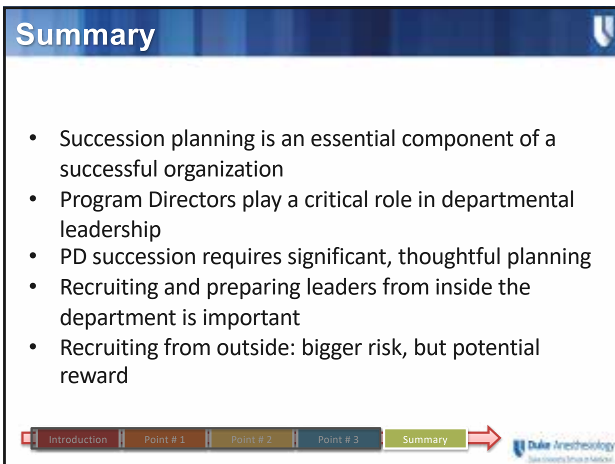
Successful Succession
What is it? Importance PD Role Success Summary


Why is succession planning difficult?
• We have misguided ideas of what makes a leader successful:
– Charisma
– Experience
– First-rate education
These can be desirable components of successful leadership, but are not essential
What is it? Importance PD Role Success Summary


Successful Succession
Seven essential leadership skills:
Integrity
Empathy
Emotional intelligence
Vision
Judgment
Courage
Passion
Moran and Cohn, Why Are We Bad at Picking Good Leaders?
What is it? Importance PD Role Success Summary


Where do we find these people?
• Take a look around locally:
– Associate Program Directors
– Subspecialty clinicians who have a passion for education and organization
– Must also be able to have the "difficult" conversations with others
• Invest in these people as potential leaders
• Consider an outside search?
What is it? Importance PD Role Success Summary


National search
• Not frequently done
• Difficult for outsiders to get the job
• Physicians on selection committees are generally risk averse, conservative
• Have to be willing to do your homework
• "Better the Devil you know, than the Devil you don't"
What is it? Importance PD Role Success Summary


Summary
Succession planning is an essential component of a successful organization
Program Directors play a critical role in departmental leadership
PD succession requires significant, thoughtful planning
Recruiting and preparing leaders from inside the department is important
Recruiting from outside: bigger risk, but potential reward
Introduction
Point # 1
Point # 2
Point # 3
Summary
Duke Anesthesiology

Thank you
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@amtmd
www.linkedin.com/in/annemarie-thompson-9823914a
Duke Anesthesiology

Back to Schedule

HANDOUT

Mentoring Junior Faculty

Gary J. Brenner, MD, PhD

11/02/2018
8:25am – 8:45am

Mentoring Junior Faculty 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

Objectives:

- Briefly review something about mentoring & academic medicine
- Consider advice that may be helpful to junior faculty in academic practice

Junior faculty: generally means instructors and assistant professors

Why do (should) departments & institutions care about mentoring of junior faculty?

- Faculty Satisfaction & Retention -

Mentoring in Academic Medicine
A Systematic Review

Mentoring Programs for Physicians in Academic Medicine: A Systematic Review

Positive Value of a Women's Junior Faculty Mentoring Program: A Mentor-Mentee Analysis

Data on Mentoring?

Literature on Mentoring in Academic Medicine

- Essentially no high quality data on mentoring in medicine and any sort of outcome.
  - Virtually all opinion pieces
  - What research exists is qualitative
- Mentoring cited as important in: career selection, productivity and advancement
- Mentees most interested in help with: career development, research, promotion.
- Interest in staying in academic medicine generally wanes during training, thus it is critical to provide & encourage mentorship of junior faculty who have an interest in academics.

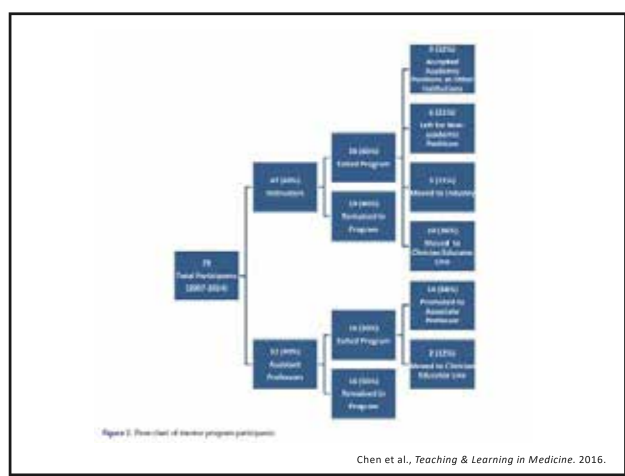
- Two other issues:
  - Management research has demonstrated that personality characteristics can influence a person's likelihood of receiving mentoring
  - There is a perception in the literature (not supported by data) that women are less likely to receive mentoring

Back to Schedule

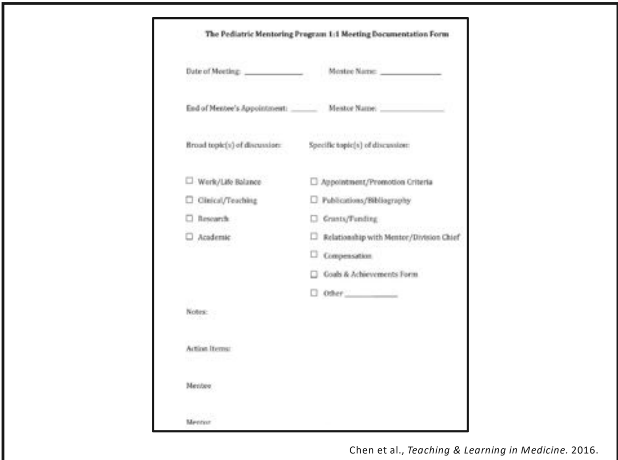
Literature on mentoring of junior faculty?

Chen et al., *Teaching & Learning in Medicine.* 2016.

- Involved 79 mentor/junior faculty mentee pairs from 2007 to 2014
- Progran
  - on x/yr)
  - did
  - gra
  - fac
- Progran
  - an
  - str
  - ret
- Results:
  - me
  - program was viewed positively regardless of promotion
  - workshops with tangible skills (grant writing) most valued
  - retention improved



Chen et al., *Teaching & Learning in Medicine.* 2016.



The Pediatric Mentoring Program 1:1 Meeting Documentation Form

Date of Meeting: ____________ Mentee Name: ____________

End of Mentee's Appointment: ______ Mentor Name: ____________

Broad topic(s) of discussion: Specific topic(s) of discussion:

- ☐ Work/Life Balance
- ☐ Clinical/Teaching
- ☐ Research
- ☐ Academic

- ☐ Appointment/Promotion Criteria
- ☐ Publications/Bibliography
- ☐ Grants/Funding
- ☐ Relationship with Mentor/Division Chief
- ☐ Compensation
- ☐ Goals & Achievements Form
- ☐ Other ____________

Notes:

Action Items:

Mentee

Mentor

Chen et al., *Teaching & Learning in Medicine.* 2016.

Obstacles (Badaway et al)

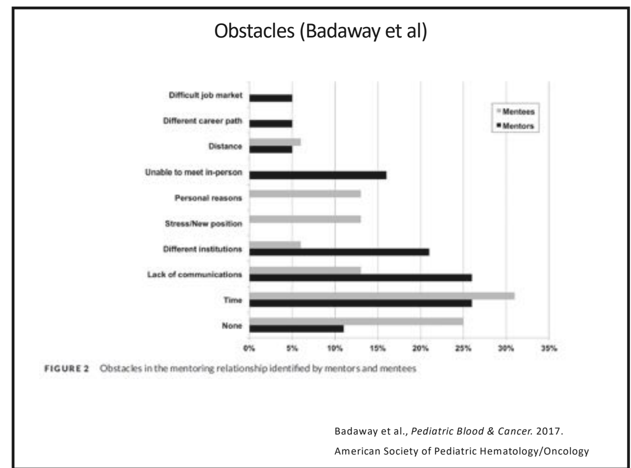


FIGURE 2 Obstacles in the mentoring relationship identified by mentors and mentees

Badaway et al., *Pediatric Blood & Cancer.* 2017.

American Society of Pediatric Hematology/Oncology

Positive Value of a Women's Junior Faculty Mentoring Program: A Mentor-Mentee Analysis

- Women represent about 38% of academic faculty (2014)
- Women are over-represented at junior faculty level and under-represented as senior faculty
- Voytko et al., - survey study 2010 to 2015
  - 83 mentees and 61 mentors
  - 470 responses
  - Mentees felt that the relationships were very valuable
  - Belief that mentoring assisted with:

    promotion, grant applications/awards, articles, presentations, and professional memberships

Providing Mentorship

Elements of good mentorship include:

- 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

Enemies of good mentorship include:

- Being unavailable/inaccessible typically due to over-commitment (The Avoider)
- Criticizing freely but rarely making positive comments (The Criticizer)
- Complimenting freely but rarely providing constructive criticism (The Pushover)

Back to Schedule

Junior Faculty Must Define a Primary Area of Interest

What do they want their contribution to the department's academic mission to be?

- Clinical care and education
  - There is no shame in contributing in this manner
- Research
  - Basic science
  - Clinical science/outcomes
  - Education
- Leadership?
- Talks and/or publishing is generally necessary for promotion

Defining the Junior Faculty's Personal Requirements for Success

- 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 (institutional, gov't, foundation, industry)
- Time frame of departmental commitment
- Understand departmental expectations
- Have focused set of goals – if oversubscribed:
  - Invariably will cut corners with responsibilities
  - High risk of burnout and toxicity

Responsibilities of Junior Faculty

- Define professional goals and career path
- 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.

In closing, you should encourage junior faculty to:

- Identify mentor(s) & develop networks of support.
- In negotiating with department first articulate what they will contribute, then define their needs for success.
- Balance 'good citizenship' and 'selfish' career development.
- Consider moving, if support is not present.

Back to Schedule

HANDOUT

Scholarly Productivity with a Fellowship

Edward R. Mariano, MD, MAS

11/02/2018
9:00am – 9:20am

Scholarly Productivity with a (1-Year) Fellowship: *Lessons Learned*

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

@EMARIANOMD

@EMARIANOMD

Disclosures

- None
- *For the purposes of this brief presentation, I will focus on clinical fellowship programs in anesthesiology only and not 2-year programs integrating research with or without a T32.*

@EMARIANOMD

The 4 Seasons

@EMARIANOMD

RAAPM Fellows 2016-17

- Fellow 1: Abstract Presented at ASRA Spring 2017
  - *Adherence to a Multimodal Analgesic Clinical Pathway: A Within-Group Comparison of Staged Bilateral Knee Arthroplasty Patients. PMID: 28267070.*
- Fellow 2: Abstract Presented at ASRA Spring 2017
  - *Virtual reality distraction decreases routine intravenous sedation and procedure-related pain during preoperative adductor canal catheter insertion: a retrospective study. PMID: 28794840.*
- Fellow 3: Abstract Presented at ASRA Spring 2017
  - *A comparison of strength for two continuous peripheral nerve block catheter dressings. PMID: 27703632.*
  - *Preliminary Experience Using Eye-Tracking Technology to Differentiate Novice and Expert Image Interpretation for Ultrasound-Guided Regional Anesthesia. PMID: 28777464.*
  - *Six Month Follow-Up of a Patient With a Retained Fascia Iliaca Catheter: A Case Report. PMID: 28990961.*
- Fellow 4: Abstract Presented at ASRA Spring 2017

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RAAPM Fellows 2017-18

- Fellow 1: Abstract Presented at ASRA Spring 2018
  - *Manuscript in preparation.*
- Fellow 2: Abstracts (2) Presented at ASRA Spring 2018
- Fellow 3: Abstracts (3) Presented at ASRA Spring 2018
  - *Patient education and engagement in postoperative pain management decreases opioid use following knee replacement surgery. PMID: 30219634.*
  - *Peripheral Nerve Blocks Are Not Associated with Increased Risk of Perioperative Peripheral Nerve Injury in a Veterans Affairs Inpatient Surgical Population. Accepted, in press.*
- Fellow 4: Abstracts (2) Presented at ASRA Spring 2018

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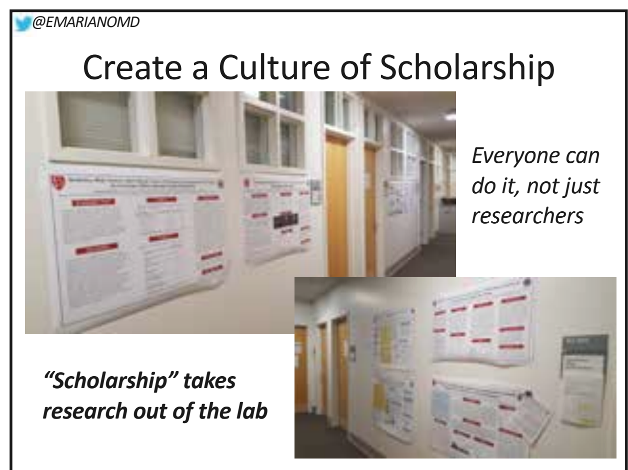
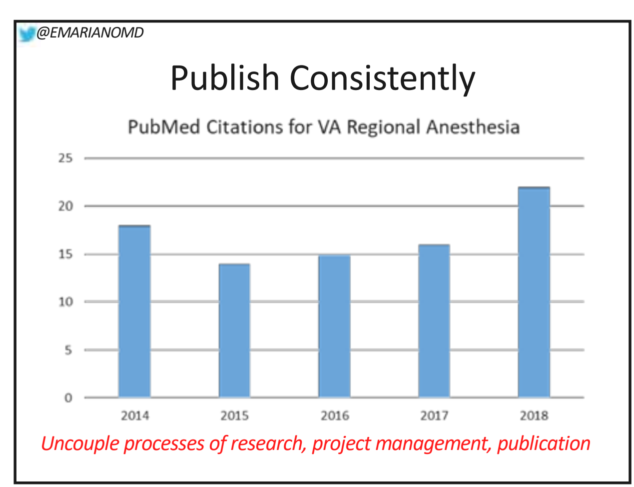
Create a Culture of Scholarship


@EMARIANOMD
Create a Culture of Scholarship
Everyone can do it, not just researchers
"Scholarship" takes research out of the lab


@EMARIANOMD
Publish Consistently
PubMed Citations for VA Regional Anesthesia
25
20
15
10
5
0
2014
2015
2016
2017
2018
Uncouple processes of research, project management, publication

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Offer Scholarship Diversity
1
2
3

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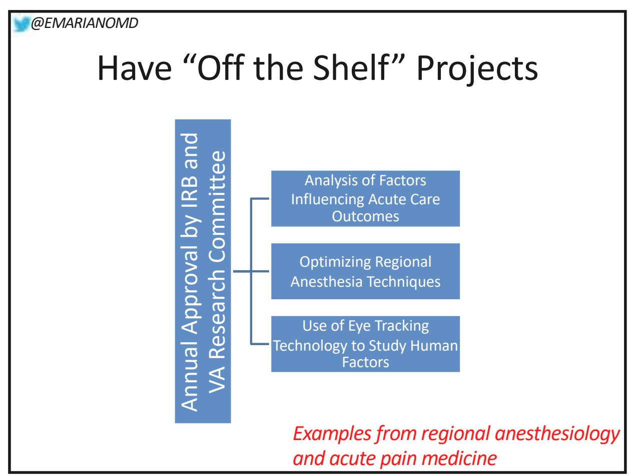
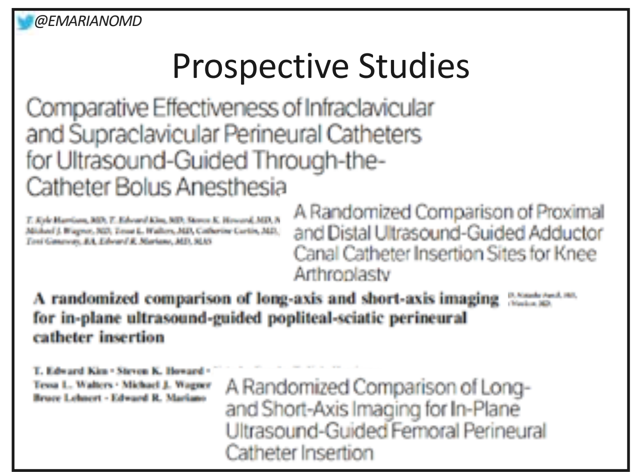
Offer Scholarship Diversity
Prospective studies
Retrospective studies
Improvement projects
In vitro studies
Case reports


@EMARIANOMD
Have "Off the Shelf" Projects
Annual Approval by IRB and VA Research Committee
Analysis of Factors Influencing Acute Care Outcomes
Optimizing Regional Anesthesia Techniques
Use of Eye Tracking Technology to Study Human Factors
Examples from regional anesthesiology and acute pain medicine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Prospective Studies
Comparative Effectiveness of Infraclavicular and Supraclavicular Perineural Catheters for Ultrasound-Guided Through-the-Catheter Bolus Anesthesia
A Randomized Comparison of Proximal and Distal Ultrasound-Guided Adductor Canal Catheter Insertion Sites for Knee Arthroplasty
A randomized comparison of long-axis and short-axis imaging for in-plane ultrasound-guided popliteal-sciatic perineural catheter insertion
A Randomized Comparison of Long- and Short-Axis Imaging for In-Plane Ultrasound-Guided Femoral Perineural Catheter Insertion

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Retrospective Studies

Vascular Surgery Patients Prescribed Preoperative β-Blockers Experienced a Decrease in the Maximal Heart Rate Observed During Induction of General Anesthesia

Continuous Adductor Canal Blocks Are Superior to Continuous Femoral Nerve Blocks in Promoting Early Ambulation After TKA

Association of age and packed red blood cell transfusion to 1-year survival – an observational study of ICU patients

Time-to-Cessation of Postoperative Opioids: A Population-Level Analysis of the Veterans Affairs Health Care System

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Quality Improvement Projects

Developing a Multidisciplinary Fall Reduction Program for Lower-Extremity Joint Arthroplasty Patients

Use of a home positive airway pressure device during intraoperative monitored anesthesia care for outpatient surgery

A matched case-control comparison of hospital costs and outcomes for knee replacement patients admitted postoperatively to acute care versus rehabilitation

Adherence to a Multimodal Analgesic Clinical Pathway
A Within-Group Comparison of Staged Bilateral Knee Arthroplasty Patients

The Perioperative Surgical Home model facilitates change implementation in anesthetic technique within a clinical pathway for total knee arthroplasty

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In Vitro (Simulation) Projects

Comparative Echogenicity of an Epidural Catheter and 2 New Catheters Designed for Ultrasound-Guided Continuous Peripheral Nerve Blocks

A Pilot In Vitro Evaluation of the "Air Test" for Perineural Catheter Tip Localization by a Novice Regional Anesthesiologist

Randomized comparison of popliteal-sciatic perineural catheter tip migration and dislocation in a cadaver model using two catheter designs

Feasibility of eye-tracking technology to quantify expertise in ultrasound-guided regional anesthesia

Preliminary Ex[...] Eye-Tracking [...] to Differentiate Novice and Expert Image Interpretation for Ultrasound-Guided Regional Anesthesia

Education as scholarship

@EMARIANOMD

A Cool Acronym Doesn't Hurt

Anesthesiology-
Directed
Advanced
Procedural
Training

HANDOUT

Quality Assurance Performance Improvement

Thomas Caruso, MD, MEd

11/02/2018
9:20am – 9:40am

Back to Schedule

QAPIs AND EMPOWERING FELLOWS TO BE CHANGE LEADERS

Lucile Packard Children's Hospital Stanford

Thomas Caruso, MD, MEd
Associate Clinical Professor
Director, Perioperative Improvement
Lucile Packard Children's Hospital Stanford
Stanford University School of Medicine

CARUSO 1

AGENDA

- Integration of Fellows into QAPIs
- Empowering and Teaching
  - Fellows Change Leadership
- Examples of Fellows in QAPIs

CARUSO 2

AGENDA

- Integration of Fellows into QAPIs
- Empowering and Teaching
  - Fellows Change Leadership
- Examples of Fellows in QAPIs

CARUSO 3

WHY ALL THE TALK ABOUT QAPIs?

…Finally, it is expected that ***anesthesia services*** *policies and procedures will undergo periodic re-evaluation that includes* ***analysis of adverse events, medication errors and other quality or safety indicators*** *related not only to anesthesia, but also to the administration of medications in clinical applications that the hospital has determined involve analgesia rather than anesthesia.*

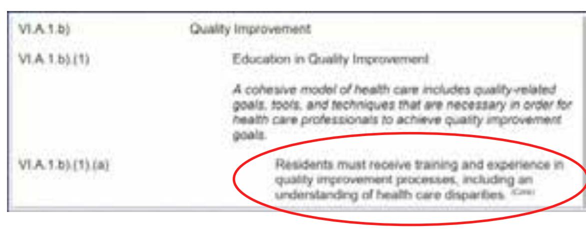
This expectation is also supported by the ***provisions of the Quality Assessment and Performance Improvement (QAPI) CoP at §482.21****, which requires the hospital to ensure its QAPI program…*

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R74SOMA.pdf

CARUSO 4

ACGME AND QUALITY IMPROVEMENT

2017 Common Program Requirements



VI.A.1.b)	Quality Improvement
VI.A.1.b).(1)	Education in Quality Improvement *A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.*
VI.A.1.b).(1).(a)	Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_2017-07-01.pdf

CARUSO 5

WHAT IS A QAPI?

QAPIs are quality directives aimed to ensure adequate oversite of the quality program within an area of coverage, such as Perioperative or Anesthesia Services.

Two Main Foci:

- ✓ Quality Assurance (QA): Assessment of factors that impact patient factors.
- ✓ Performance Improvement (PI): Project based improvements that bridge gaps identified by QA measures.

- Givens T. Quality Assessment and Performance Improvement: Oversight for Patient Safety. Nephrol Nurs J. 2018 Jan-Feb;45(1):75-76.

CARUSO 6

Back to Schedule

COMPONENTS OF QAPIs

- Goals and Scope
- Governance and Leadership
- Feedback, Data Systems, and Monitoring
- Performance Improvement Projects
- System Analysis and System Action

- https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiplan.pdf

CARUSO 7

GOALS AND SCOPE

Goals: Define the overall goals of the QAPI.

Consider redefining goals annually to align with institution's core goals.

Include ***incorporation and training of anesthesia residents/fellows as a core goal.***

Scope: Define how the QAPI is integrated into the patient's value stream.

Address:

i. Clinical care
ii. Quality of life
iii. Individual goals of care

- https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiplan.pdf

CARUSO 8

GOVERNANCE AND LEADERSHIP

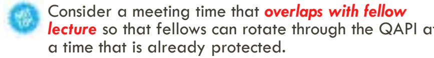
Define the QAPI's relationship with top level management, Board of Directors, and workforce.

Integrate fellows into key QAPI membership roles.

Establish formal coordination of conditions:

- Format and frequency of meetings.
- Method for communication between meetings.
- Designated way to document and track plans.
- Method for reporting to governing body.

Consider a meeting time that ***overlaps with fellow lecture*** so that fellows can rotate through the QAPI at a time that is already protected.



- https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiplan.pdf

CARUSO 9

FEEDBACK, DATA SYSTEMS, MONITORING

Identify sources of data to monitor:

i. Adverse Events
ii. Performance Indicators
iii. Survey Findings
iv. Complaints

For each measure, determine:

- Process to reliably collect the information
- Benchmark/targets for each measure
- Cadence for reviewing the measures

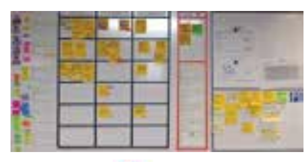
An anesthesia QAPI with fellow representation could include measures of ***fellow performance***, such as TAT or 'anesthesia ready,' within a predetermined percentage of normal.

- https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiplan.pdf

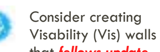
CARUSO 10

PERFORMANCE IMPROVEMENT PROJECTS

- Determine criteria for selecting projects to tackle.
- Describe how to designate project team members and required characteristics (ie, nurse, resident, physician, admin, etc).
- Method for describing project progress.
- Project management from 'below': ***Encourage fellows to lead improvement projects*** as frontline workers who are closest to the issues.



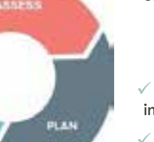
Consider creating Visability (Vis) walls that ***fellows update***.



- https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiplan.pdf

CARUSO 11

SYSTEM ANALYSIS AND SYSTEMIC ACTION



- Recognition the possibility of unintended consequences.
  - Create *balancing measures* for each project.
- Describe process for continuous monitoring of interventions to reduce risk of quality drift/decay.
- ***Fellows provide report-outs*** on the projects they are leading.
- Use electronic dashboards to track metrics if possible.

- https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiplan.pdf

CARUSO 12

AGENDA

- Integration of Fellows into QAPIs
- Empowering and Teaching Fellows Change Leadership
- Examples of Fellows in QAPIs

CARUSO 13

CREATING A CULTURE OF HIGH QUALITY CARE

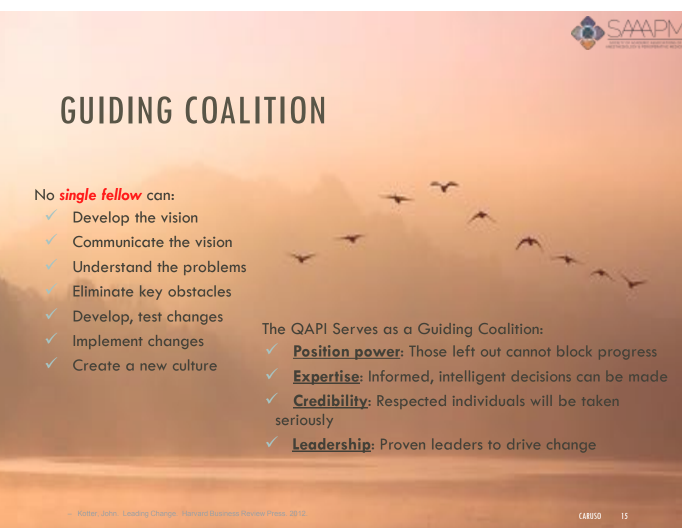
Leading Change
– John Kotter

Why do change efforts fail:

- No urgency
- No guiding coalition
- No vision
- Poor communication
- Obstacles
- No sense of progress
- Declaring victory too soon
- No culture change

– Kotter, John. Leading Change. Harvard Business Review Press. 2012.

CARUSO 14



GUIDING COALITION

No ***single fellow*** can:

- Develop the vision
- Communicate the vision
- Understand the problems
- Eliminate key obstacles
- Develop, test changes
- Implement changes
- Create a new culture

The QAPI Serves as a Guiding Coalition:

- **Position power**: Those left out cannot block progress
- **Expertise**: Informed, intelligent decisions can be made
- **Credibility**: Respected individuals will be taken seriously
- **Leadership**: Proven leaders to drive change

– Kotter, John. Leading Change. Harvard Business Review Press. 2012.

CARUSO 15

COMMUNICATE THE VISION

- Simple: No jargon
- Vivid: Paint a verbal picture
- Repeatable: Can spread to anyone
- Invitation: Two-way communication

– Kotter, John. Leading Change. Harvard Business Review Press. 2012.

CARUSO 16

EMPOWER ACTION

Structural ***barriers for fellows***:

- Formal structures make it difficult – embed roles into the QAPI.
- Lack of needed change management skills.
- Personnel and information systems – ensure representation from EMR in QAPI.
- Managers who undermine their vision.

Consider using the ***IHI modules to teach fellows*** change management science:

http://www.ihi.org/education/WebTraining/Pages/default.aspx

– Kotter, John. Leading Change. Harvard Business Review Press. 2012.

CARUSO 17

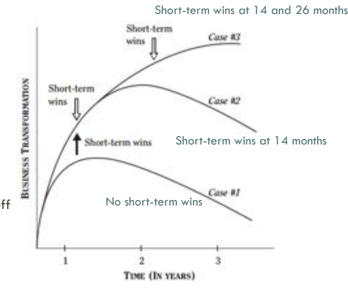
CELEBRATE SHORT-TERM WINS

It is ***easy for fellows to become discouraged***, especially ***during one year fellowships*** given a perceived time pressure to complete a project prior to graduation.

Plan to recognize short-term wins.

Short-term wins:

- Provide evidence that sacrifices are paying off
- Increase sense of urgency and optimism
- Reward change agents
- Undermine credibility of self-serving resistors
- Make it difficult for people to block change



– Kotter, John. Leading Change. Figure 8.1. 2012.

CARUSO 18

DON'T LET UP

"Resistance is always waiting in the wings to re-assert itself. Even if you are successful in the early stages, you may just drive resistors underground where they wait for an opportunity to emerge when you least expect it. They may celebrate with you and then suggest taking a break to savor the victory." – John Kotter

After early wins:
- ✓ More change, not less
- ✓ More help
- ✓ Leadership from senior management

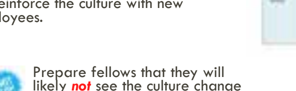
Project management from 'below'

– Kotter, John. Leading Change. Harvard Business Review Press. 2012.

CARUSO 19

ANCHORED IN CULTURE

Culture change comes **last**:
- ✓ Must prove the new way is better.
- ✓ Success must be visible.
- ✓ You will lose some people in the process.
- ✓ Must reinforce new norms and values.
- ✓ Reinforce the culture with new employees.

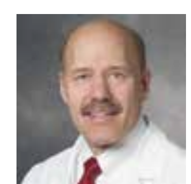


Prepare fellows that they will likely ***not*** see the culture change prior to graduation.

– Entrepreneurial Insights. Accessed 11/1/15 at: http://www.entrepreneurial-insights.com/understanding-kubler-ross-change-curve/

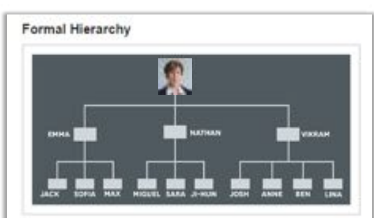
CARUSO 20

WHO IS SUITED TO BE A CHANGE/CULTURE LEADER?



CARUSO 21

WHO IS SUITED TO BE A CHANGE/CULTURE LEADER?



Trainees are often in the middle of the informal network

– Battilana, Julie; Casciaro, Tiziana. The Network Secrets of Great Change Agents. Harvard Business Review. July-August 2013.

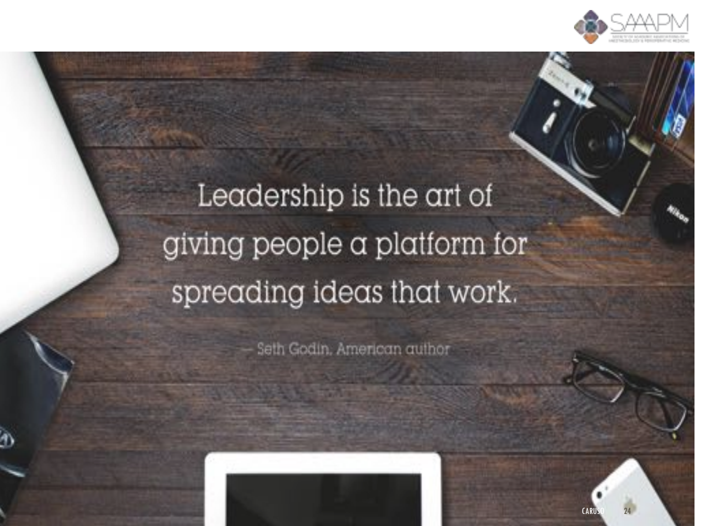
CARUSO 22

THERE IS NO ONE BETTER THAN YOU

If you a trainee has the vision and drive, they have the power to make the change.

Those in authority may be best suited to empower, but ***a trainee may be the only one who can pull it off.***

CARUSO 23



CARUSO 24

Back to Schedule

AGENDA

- Integration of Trainees into QAPIs
- Empowering and Teaching Trainees Change Leadership
- Examples of Trainees in QAPIs

CARUSO 25

FROM PAPER TO PRACTICAL

CASE 1: Fellowship

You are the PD for an anesthesia fellowship and are interested in creating a quality improvement experience for the fellows. You have created a month elective and have heard complaints that it is not enough time to accomplish something substantial.

'Bring the QAPI to the Trainee'

- ✓ Convert 1 lecture/month into the fellow QI/PI series.
- ✓ Split the fellowship into small working groups of 2-3 fellows.
- ✓ Integrate lectures on the science behind QI with time for fellows to work on longitudinal projects that overlap with core QAPI goals.
- ✓ This series is run by key anesthesia/periop QAPI leadership.

CARUSO 26

FROM PAPER TO PRACTICAL

CASE 2: GME

You are the PD for an anesthesia fellowship and are interested in creating a quality improvement experience that transcends your division. You have reached out to the a few PD buddies in surgery but have failed to find a self-sustaining solution.

'Leverage the Power of the GME/DIO'

- ✓ Work with the DIO to develop a Safety Council that has broad representation from different programs.
- ✓ Utilize the GME program management resources to drive the council/cadence/output.
- ✓ This series should have overlap with the institution's QI efforts, and close alignment with the office of the CQO

CARUSO 27

CARUSO 28

FROM PAPER TO PRACTICAL

CASE 3: QAPI

You are the PD for an anesthesia fellowship and are interested in creating a quality improvement experience that is fully integrated with the anesthesia or perioperative QAPI. You have invited QAPI leaders to present lectures to the fellows, but have failed to fully integrate the fellows into any meaningful improvement projects.

'Bring the Trainee to the QAPI'

- ✓ Method 1: Create a 'QI track' and have a single fellow go to the QAPI meetings routinely, with a formalized role within the QAPI.
- ✓ Method 2: Have a rotating seat at the QAPI for fellows. Designate which fellow to attend based on their rotation schedule. For example, the fellow on elective is the fellow who attends the QAPI.
- ✓ Fellows work on improvement projects between QAPI meetings during pre-existing time, such as substituting a journal club, case conference, or lecture with QI project improvement session.

CARUSO 29

SUMMARY

5 steps to creating a QAPI – integrate fellows at each step:

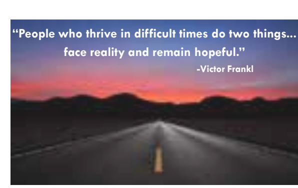
- ✓ Goals and Scope: ***Include fellow education as a goal***
- ✓ Governance and Leadership: ***Include formal fellow role***
- ✓ Feedback, Data Systems, and Monitoring: ***Fellow performance metrics***
- ✓ Performance Improvement Projects: ***Project management from 'below'***
- ✓ System Analysis and System Action: ***Vis wall that fellows update; access to dashboards***

Empower/teach fellows effective change leadership:

- ✓ Create a sense of urgency
- ✓ Develop a guiding coalition to support fellows
- ✓ Clear vision
- ✓ ***Empower fellows*** and other frontline workers
- ✓ Anchor change culture

From paper to practical:

- ✓ Bring the QAPI to the fellows
- ✓ Institutional support from GME
- ✓ ***Embed fellows into the QAPI***



CARUSO 30

HANDOUT

Session Breakout 1 – Methods to Promote Diversity in Fellows

Moderators:
Mark Stafford-Smith, MD, CM, FRCP(C)
John Eck, MD

11/02/2018
10:30am – 11:30am

AASPD Breakout Group 1
Methods to Promote Diversity in Fellows

Observations:

1. Some departments have well-organized systems in place to promote diversity (including diversity and inclusion committees, designated faculty/trainee leaders and/or ongoing training), whereas others have no organized approach.
2. Lack of available pertinent objective data in applications often leads to programs using less pertinent information (e.g. USMLE scores) for screening applications. Programs with large numbers of applications may simply screen out applicants based on scores without the opportunity to allow consideration of diversity and inclusion.
3. Increased diversity could include promoting NIH-defined categories (underrepresented minorities, disabled, or those from disadvantaged backgrounds), but could be also be broadened to include additional categories.

Barriers:

1. Pool of applicants to fellowship is limited to specialty-specific residents so diversity of the applicant group is largely predetermined (unlike medical schools or residency programs which draw from a larger, and potentially more diverse pool).
2. Applications (whether paper or electronic (e.g. ERAS)) discourage using indicators of diversity (race, gender etc.) in order to prevent bias in selection, but by excluding this information, they tend to minimize opportunities to promote diversity.
3. Application screening and interviews may unintentionally allow for implicit bias to impact decisions.
4. Lack of diversity of faculty may impact recruitment of a diverse and inclusive group of fellows. However, the makeup of the faculty is generally determined outside the scope of the fellowship.

Conclusions/Potential Solutions:

1. Departments/programs could formalize processes of promoting diversity and inclusion through committees, designated leaders, and/or training/education.
2. Programs could consider education/training on implicit bias for all screeners and interviewers in fellowships
3. Programs could consider “blinded” interviews (e.g. only letters of recommendation and personal statement available) to limit the influence of scores on final choices for fellowships.
4. Subspecialty fellowship groups or individual programs could provide an “optional demographic” section to fellowship application forms to allow the opportunity to volunteer information about gender, gender identity, race/ethnicity etc. for applicants who wished to provide this information. It was suggested that human resources in individual institutions should be consulted in these circumstances.

HANDOUT

Session Breakout 2 – Mentoring New Fellowship Directors in Your Department: Are the Critical Elements in Place and Occurring?

Moderators:
Charles Brock, MD
Magdalena Anitescu, MD, PhD

11/02/2018
10:30am – 11:30am

AASPD Breakout Group 2
Mentoring New Fellowship Directors in Your Department: Are the Critical Elements in Place and Occurring?

Mentoring Highlights:

1. Having an **Associate PD**-routinely PD with more than 3 positions but there is no requirement
    a. What this person would be? **Junior** going up or **senior** where the PD will discuss and have experience
    b. Divide and conquer: specific responsibilities for the APD (Journal club, lectures, QA, research
2. Collaborate through the PD network if you do not find one at your institution
3. **Joint chair PD meeting** with next meeting-chair need to recognize needs of PD
4. New PD nuts and Bolts
    a. Resource list
    b. Webinars, web based after recording sections, recorded session
    c. ACGME meetings for PD to attend (need time
    d. Involve faculty at each institution for noon lectures/webinars in addition to chairs
    e. Devoted sessions to the SAAAPM meeting on mentoring new and APD
    f. Speed dating with experienced PD for the APD

Pitfalls

1. Time, Money, PD need protected time
2. Administrative help needed as experienced, savvy person, one for each fellowship vs one for all; perhaps better for one for all but needs succession plans for that person
3. Commitment from the chairs to PD, perhaps common sessions with the chair next meeting

Diversity and inclusion in new PD mentoring

Highlights

1. Ways to encourage/ promote
2. Approach GME for their process, they have office or diversity
3. Role models, department faculty to become more divers-long process
4. approach med students, especially at MS 1, 2 as 3, 4 have the curriculum set
5. Get speakers on cultural bias, sociologists at grand rounds

Pitfalls
Variance by subspecialty
Geographic/gender race
Institutional bias

Back to Schedule

HANDOUT

Session Breakout 3 – Scholarly Productivity and Fostering Research Opportunities of Subspecialty Program Directors – How to Enhance the Careers of Busy PDs and Fellows

Moderators:
Erin Hennessey, MD
Rebecca D. Minehart, MD, MSHPEd

11/02/2018
10:30am – 11:30am

AASPD Breakout Group 3
Scholarly Productivity and Fostering Research Opportunities of Subspecialty Program Directors – How to Enhance the Careers of Busy PDs and Fellows?

This breakout group convened to brainstorm about the following two issues:

1) "What are the problems the PDs are facing in promoting their careers and the careers of their fellows through participation in scholarly activities and research?"
2) "What are strategies or solutions do you see with addressing the common challenges to PDs with helping them enhance or increase your and your fellows' scholarly activity?"

Through our discussion of almost 90 PDs and their representatives, we distilled suggestions into the following responses:

1) The problems facing PDs in promoting their careers and their fellows' careers were identified as:
   a. Clinically very busy
   b. No mentorship available
   c. Involvement at a national level is difficult because of a lack of publications
   d. Overall busy with running an educational program
   e. Medical educational work usually has a very small "n" and is challenging to publish
   f. Lack of funding for smaller projects
   g. IRB process is time-consuming and challenging to complete in a 1-year fellowship
   h. Fellows are often not entirely able to participate in research due to timing of boards
2) Strategies or solutions identified were narrowed to the top 7 through voting and categorized into Individual-Level Solutions and SAAAPM-Level Solutions. They were:
   a. Individual-Level Solutions:
      i. Create a rotating project schedule where each project was estimated to take a 2-year timespan, and have fellows hand-off projects so each fellow would be involved in at least 2 projects over their 1-year fellowship
      ii. Partner with surgeons to co-create research projects based on databases available locally and nationally
      iii. Keep a running list of interesting cases for case report material for anyone available
      iv. Conduct systematic reviews with fellows as a straightforward approach to creating research publications
   b. SAAAPM-Level Solutions:
      i. Facilitate a list of PDs through AASPD which includes contact information and focus of research to allow for more invited lectureships nationally among institutions looking for medical education (or other) talks
      ii. Facilitate a cohort of people interested in particular research topics which can then undergo rotating co-authorship with publications
      iii. Facilitate networking for medical education-based research projects at the Annual Meeting to increase the "n" of otherwise smaller research projects

HANDOUT

Session Breakout 4 – Ways to Maximize Preparing Fellows for the Boards – Subspecialty and OSCE

Moderators:
Edward R. Mariano, MD, MAS
Kevin Thornton, MD

11/02/2018
10:30am – 11:30am

AASPD Breakout Group 4
Ways to Maximize Preparing Fellows for the Boards – Subspecialty and OSCE

We broke this down into ABA oral boards and specialty exams.

For preparing fellows for the ABA standardized oral exam, these were the suggestions:

- "Piggyback" on the core residency program's oral board preparation
    - Scheduled mock oral exam sessions
    - One-on-one scheduling with ABA examiners and other faculty members who can provide practice exams
    - Group demonstration sessions with debriefing to identify ways to improve articulation and efficiency
    - Encourage fellows to practice exams with junior faculty who recently passes oral exams for relevant pointers
- Offer phone and/or videoconference options for mock oral exam practice for fellows with busy schedules
- Integrate oral exam preparation into fellows' lecture schedule using fellowship case examples as potential stems
- For fellows with subspecialty exams, one suggestion was to encourage fellows to delay ABA oral boards until fall to avoid distraction during fellowship (not mandatory of course)

For the Objective Structured Clinical Examination (OSCE), suggestions included:

- Having fellows participate in resident preparation activities typically hosted in a simulation center with standardized patients
- Using opportunities in the clinical setting to run through potential OSCE topics (eg, vascular access, regional anesthesia)
- Review list of OSCE content with fellows: http://www.theaba.org/PDFs/APPLIED-Exam/APPLIED-OSCE-ContentOutline

For the specialty exams, suggestions included:

- Many emphasized the importance of robust didactic programs
    - Keyword-based series are common
    - Some are trying out flipped classroom sessions
    - Collaboration across institutions via web-based videoconferencing can allow programs to leverage the expertise of a larger network of faculty
    - Some programs are experimenting with monthly education sessions that span several hours to overcome scheduling challenges
- In-training exams/national knowledge assessments can be used to help fellows get a feel for the exams and serve as a benchmark for exam preparation
- Modular self-study curricula with periodic exams/questions can be a mechanism to encourage outside reading/study
- Checklists of 'quick topics' can be utilized to bolster intra-operative and bedside teaching by faculty and ensure a spectrum of topics is covered

Back to Schedule

HANDOUT

Updates from the Subspecialties: Regional Anesthesiology and Acute Pain Medicine

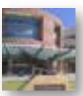
Edward R. Mariano, MD, MAS

11/02/2018
1:30pm – 2:15pm

Back to Schedule

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



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Disclosures

- None

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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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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
- 2017-18: Milestones development

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Today (2018)

- 75 RAAPM fellowships in US and Canada (+2 from 2017)
- 182 positions available in the US and Canada (+49 from 2017)

Fellowship directory

Physicians applying for a fellowship program in regional anesthesiology/acute pain medicine must be currently enrolled in, or have completed, an accredited anesthesiology residency program. Each individual program may have additional requirements such as medical licensing. The information published here has been supplied by the individual institutions. Please check back frequently for updates.

https://www.asra.com/fellowship-directory?showType=1

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ACGME-Approved Programs (22)

- Stanford
- Cedars-Sinai
- UCSF
- UCLA-Harbor
- Mayo Clinic (FL)
- Northwestern
- Univ of Iowa
- Johns Hopkins
- Mass General
- Brigham and Womens
- Mayo Clinic (MN)
- Dartmouth
- Montefiore
- St. Luke's-Roosevelt
- Columbia
- Cornell
- Mt. Sinai
- Duke
- Univ of Cincinnati
- Univ of Pittsburgh
- Vanderbilt
- Virginia Mason

https://apps.acgme.org/ads/Public/Programs/Search?stateId=&specialtyId=434&specialtyCategoryTypeId=&numCode=&city=

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Fellowship Directors Group

- Formed organically ~2002 and informal
- 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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1st Site Visits Next Spring 2019

- 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
- Montefiore Medical Center/Albert Einstein College of Medicine Program
- Icahn School of Medicine at Mount Sinai/St Luke's-Roosevelt Hospital Center Program
- Duke University Hospital Program
- Vanderbilt University Medical Center Program

http://www.edmariano.com/archives/1252

Back to Schedule

HANDOUT

Updates from the Subspecialties: Critical Care Medicine

Nicholas Sadovnikoff, MD, FCCM

11/02/2018
1:30pm – 2:15pm

Back to Schedule

AASPD SUBSPECIALTY UPDATE: CRITICAL CARE

Nicholas Sadovnikoff, MD, FCCM
Brigham and Women's Hospital
Boston, MA

November 2, 2018
Chicago

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)

Match Process

- SF Match
- Common Application Service: new as of 2017 cycle
- Standardized LOR: not using
- Exceptions to the Match: unchanged

Numbers

	2014	2015	2016	2017	2018
APPLICANT DATA					
Applicant registrations	196	189	194	203	187
# Applicant Rank Lists Submitted	147	148	153	157	156
Matched Total	127	137	149	150	151
Unmatched Total	20	11	4	7	5
Applicant Matching % (Overall)	86%	93%	97%	96%	97%
Total # of Withdrawals	20	19	16	11	18
PROGRAM DATA					
# Of Participating Programs	47	49	52	53	57
Positions Offered	150	167	186	202	209
Positions Filled	127	137	149	150	151
Unfilled Positions	23	30	37	52	58

Exceptions to the Match

- Requires agreement from applicant and program
- Exceptions 2018 (57), 2017 (41)
  - Commitment > 1 yr (36), 2017 (23)
  - Internal candidates (30), 2017 (19)
  - Both internal and commitment > 1 yr (10), 2017 (2)
  - 'Couples match' (1)
  - Active military service (0)
  - Outside US at time of application (0)
  - Not eligible for ABA certification (0)
- Applicants remaining in match pool 99, down from 115

Issues with the ACCM Match

- Exception Process

	2014	2015	2016	2017	2018
Positions Offered	150	167	187	202	209
Positions matched	127	137	149	150	151
Exceptions (%)	31(24)	36(26)	56(38)	41(27)	57(38)

  - Process
  - Fairness
  - Transparency
- Programs holding positions out of match/"irregularities"
- Timing

Back to Schedule

Match Timeline

	Date
Applicant Registration Begins	November 13, 2018
Rank List Submission Deadline	May 21, 2019
Results Released to Programs	May 28, 2019
Results Released to Applicants	May 28, 2019
Post-match vacancies posted	May 29, 2018
Fellowship Training Begins	July/August 2019

Program Director Meetings

- SOCCA/IARS
  - Formally sponsored starting 2013
- PDs meet 3 times a year
  - now
  - SCCM: San Diego, Monday February 18, 2019
  - SOCCA/IARS: Montreal, Saturday May 18, 2019
  - SAAAPM/AASPD: Chicago, Friday November 8, 2019

Other Updates

- Improved Fellowship Section in Website
  - Enhanced listings/photos
  - Links to Program Websites
  - Links to SF Match
- Recruitment to SOCCA
  - Automatic free resident membership with application to SF Match
- Critical Care Ultrasound Certification
  - NBE product sponsor
  - first exam Jan 2019
- ? Move towards universal August starting dates
  - Done by all Surgery fellowship programs 2 years ago

Back to Schedule

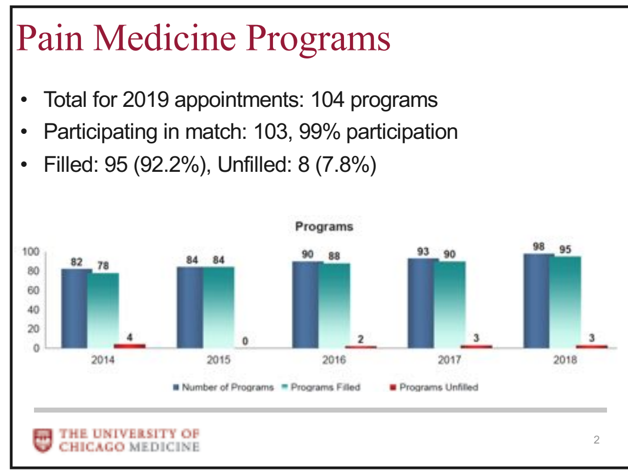
HANDOUT

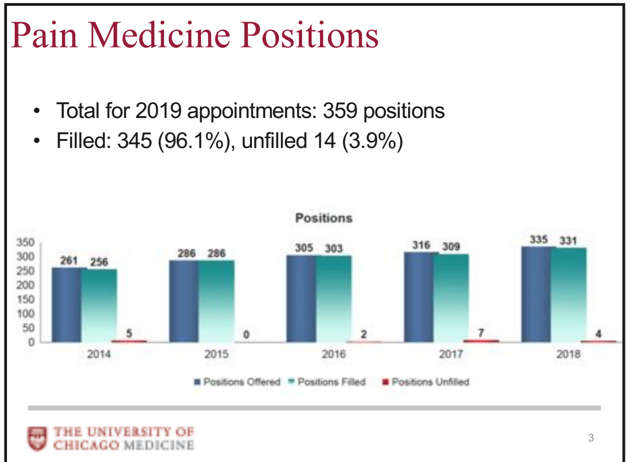
Updates from the Subspecialties: Pain Medicine

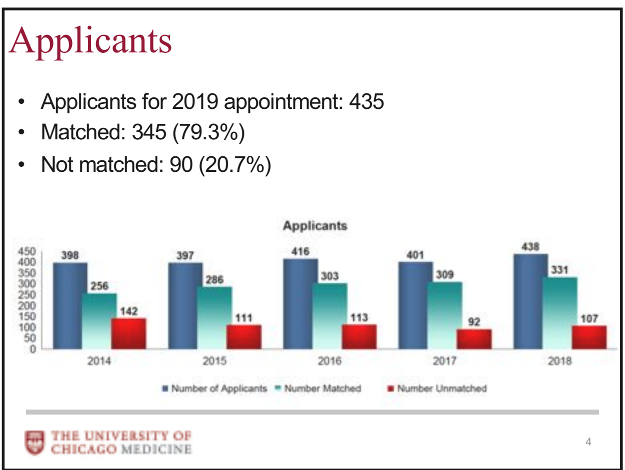
Magdalena Anitescu, MD, PhD

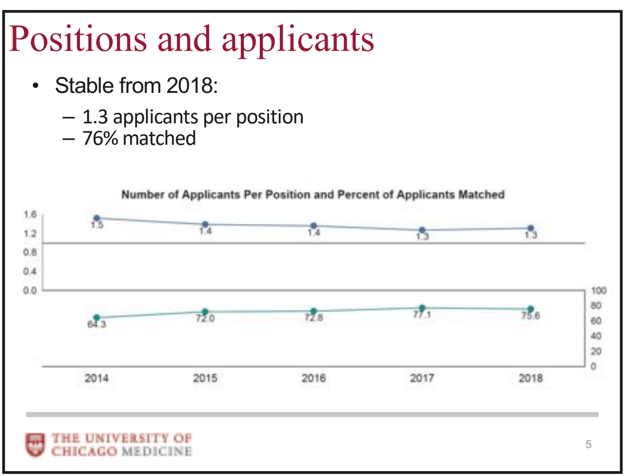
11/02/2018
1:30pm – 2:15pm

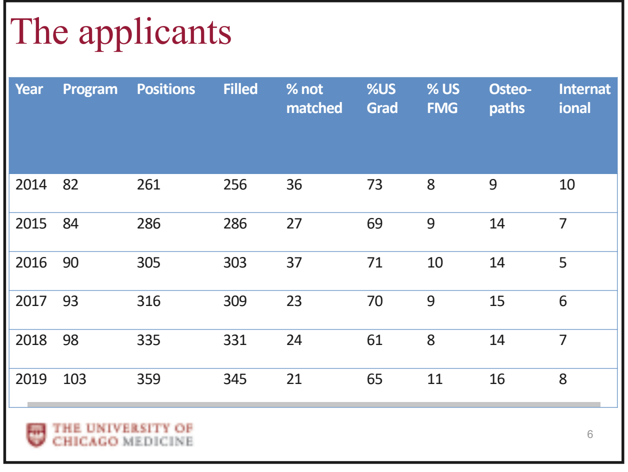
Back to Schedule











The applicants

Year	Program	Positions	Filled	% not matched	%US Grad	% US FMG	Osteo-paths	Internat ional
2014	82	261	256	36	73	8	9	10
2015	84	286	286	27	69	9	14	7
2016	90	305	303	37	71	10	14	5
2017	93	316	309	23	70	9	15	6
2018	98	335	331	24	61	8	14	7
2019	103	359	345	21	65	11	16	8

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6

What's new in the Pain World

Future of our fellows

THE UNIVERSITY OF CHICAGO MEDICINE

Presentation Title Here | 7

Pain Medicine Fellowship-2007 Program Requirements

- Multidisciplinary fellowship
- Base specialties
  - Anesthesiology
  - Physical Medicine and Rehabilitation
  - Neurology
  - Psychiatry
- Other specialties can apply: ED, pediatrics, radiology, etc
- ONLY 1 Fellowship Program per institution

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Presentation Title Here | 8

Pain Medicine Fellowship-2018 Program Requirements

- Updates
- Several minor issues (qualitative vs quantitative)
- One major issue: Eliminate the one fellowship per institution requirement.
- Letters from ASA, ASRA, AAPM, AAASPD emphasizing
  - The multidisciplinary aspects of the pain medicine fellowship
  - Collaboration between specialties
  - Use all institutional resources based on common planning and not competition

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9

CONCLUSIONS

- Consistent, high competitive fellowship 20% applicants not matching
- Steady state of the match, now the 6th year.
- Advantages/Disadvantages
  - Applicants:
    - Apply/interview widely
    - Costly
    - Time away from work
    - Extracurricular activities to serve the application best possible
  - Program directors
    - High number of applications,
    - Time consuming
    - No objective data majority of the applications
    - Time of the interview: sufficient?
    - What are we missing?

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

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10

THANK YOU FOR LISTENING!

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11

HANDOUT

Updates from the Subspecialties: Pediatric Anesthesiology

Franklyn P. Cladis, MD

11/02/2018
1:30pm – 2:15pm

Pediatric Anesthesiology

Franklyn Cladis, M.D., FAAP
President PAPDA

SAAAPM Subspecialty Updates
November 2, 2018
Chicago, Il

Agenda

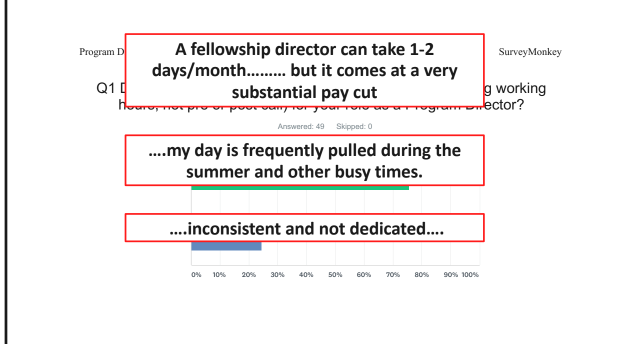
1. Review Program Director Protected Time Survey
2. Present Pediatric Anesthesiology Fellowship ACGME, ERAS, NRMP Data
3. Invite participation to the Society for Education in Anesthesia 2019 Fall Meeting

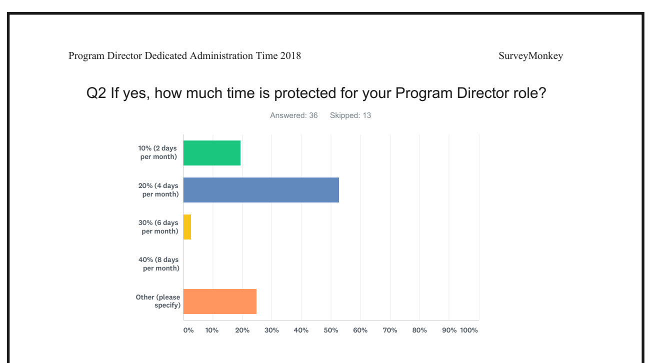
PAPDA Board

- Immediate Past President: Susan Staudt MD, Milwaukee
- President: Franklyn Cladis MD, Pittsburgh
- President-elect: Justin Lockman MD, Philadelphia
- Secretary: Chetta Lupa MD, North Carolina
- Members-at-large:
  - Dabnath Chatterjee MD, Denver
  - Michael Hernandez MD, Boston
  - Doyle Lim MD, Delaware

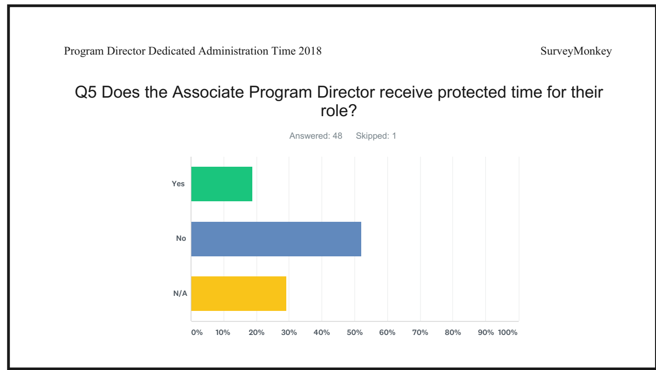
ACGME
Common Fellowship Program Requirements
2019

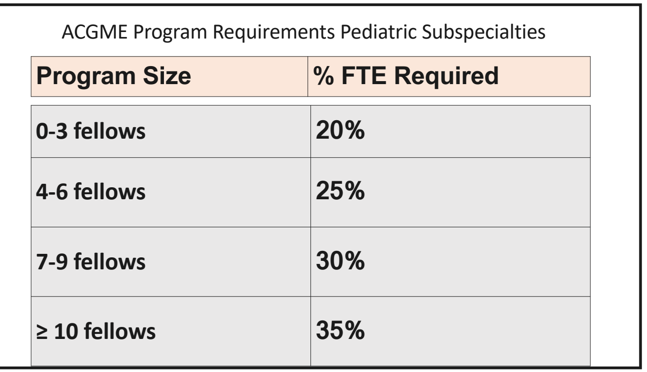
"This individual will have **dedicated time** for the leadership of the fellowship….."





Back to Schedule



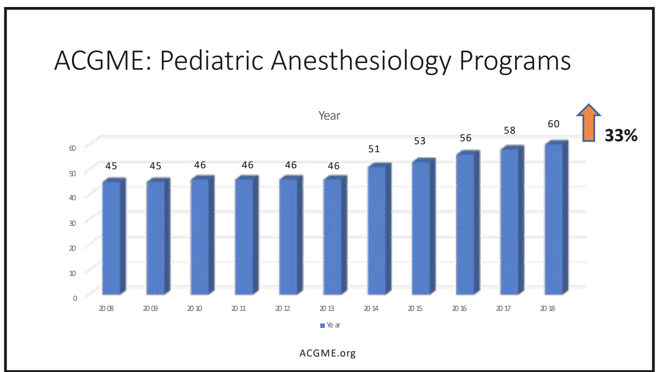


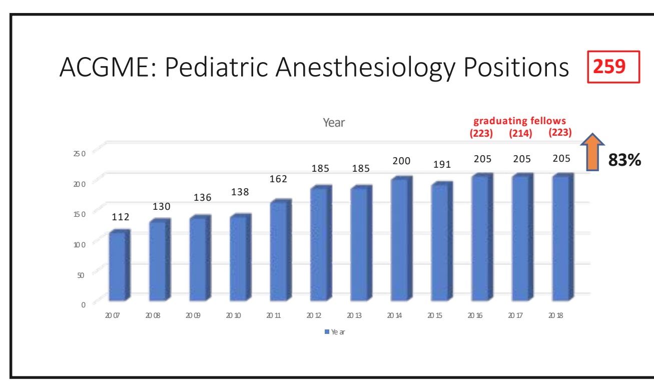
ACGME Program Requirements Pediatric Subspecialties

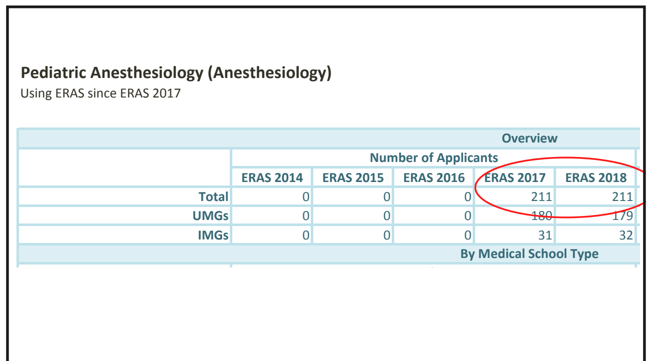
Program Size	% FTE Required
0-3 fellows	20%
4-6 fellows	25%
7-9 fellows	30%
≥ 10 fellows	35%

"PD (and APD) must be provided with a minimum combined total of 20-35 percent full time equivalent (FTE) protected time for the administration of the program **(not including scholarly activity),** depending on the size of the program……"

Pediatric Anesthesiology Fellowship: ACGME, ERAS, & NRMP Data 2019



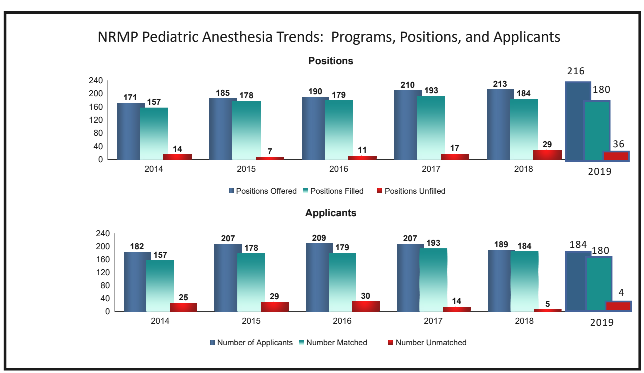


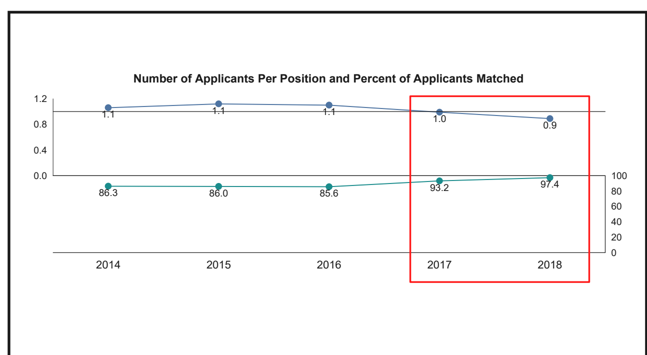


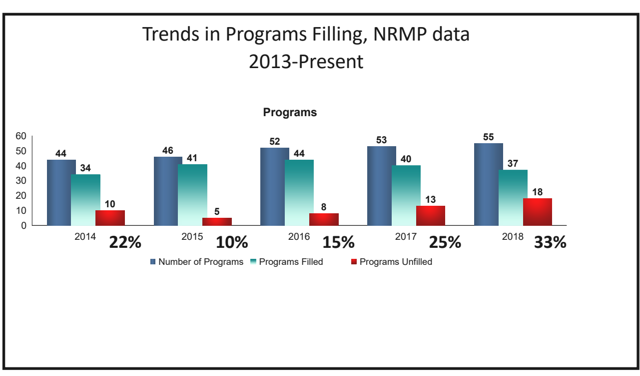
Pediatric Anesthesiology (Anesthesiology)

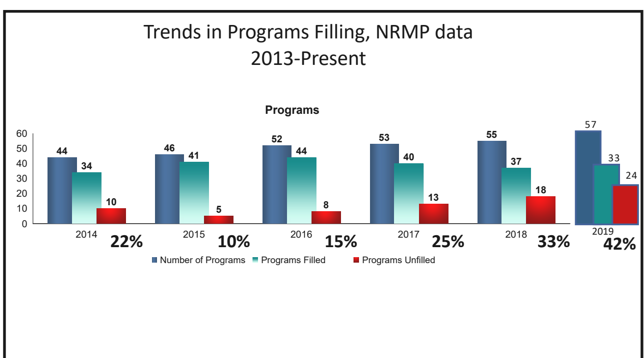
Using ERAS since ERAS 2017

	Overview				
	Number of Applicants				
	ERAS 2014	ERAS 2015	ERAS 2016	ERAS 2017	ERAS 2018
Total	0	0	0	211	211
UMGs	0	0	0	180	179
IMGs	0	0	0	31	32
	By Medical School Type				









Questions to Consider

1. Do we need to regulate the number of programs and/or the number of positions?
2. If yes, how? What mechanism determines the number of fellows per program?
3. What organization oversees this process? How is that enforced?

Fall Meeting November 7th 2019
One day prior to SAAAPM

www.seahq.org

Back to Schedule

HANDOUT

Updates from the Subspecialties: ACTA

Douglas C. Shook, MD

11/02/2018
1:30pm – 2:15pm

HANDOUT

Updates from the Subspecialties: OB Anesthesia

Rebecca D. Minehart, MD, MSHPEd

11/02/2018
1:30pm – 2:15pm

Back to Schedule

AASPD 2018: OB Anesthesia Fellowship Update Session

Rebecca D. Minehart, MD, MSHPEd
Program Director, Massachusetts General Hospital Obstetric Anesthesia Fellowship
Former Chair, SOAP OB Fellowship Committee
Former Chair, SOAP Strategic Task Force Initiative for OB Anesthesia Fellowships

I have no relevant financial disclosures.

HISTORY OF THE FELLOWSHIP:
OB Anesthesia was approved for ACGME accreditation in 2011.

MATCH STATUS FOR OB ANESTHESIA:
OB Anesthesia withdrew from the NRMP in 2018 for AY 2019-20. We are currently evaluating whether we will reenter a match process in the near future, but it is not likely to occur for recruitment of AY 2020-21. Multiple reasons have been cited; a recent survey tallied 48% of PDs as in favor of the SF match, 30% opposed, and 22% unsure (many reasons cited were related to new programs unfamiliar with options).

ACOG LEVELS OF MATERNAL CARE:
Need is growing for OB Anesthesia Fellowship-Trained BC/BE Anesthesiologists. Levels of Maternal Care (LMOC) were introduced by ACOG in 2015, and currently, Texas is requiring all hospitals providing maternity care services to be surveyed and designated as a LMOC hospital *in order to receive Medicaid reimbursement for maternity services.* Other states are likely to follow suit, given unacceptably high levels of maternal mortality in the US.

As a reminder, the designations are:

Birth Center: no anesthesia services available; term, singleton vertex presentation

Level 1: Basic Care; e.g., uncomplicated preeclampsia at term without severe features, uncomplicated term twin delivery

Level 2: Specialty Care; e.g., preeclampsia with severe features, placenta previa with no prior uterine surgery

Level 3: Subspecialty Care; e.g., suspected placenta accreta or previa with prior uterine surgery, suspected placenta percreta, ARDS, expectant management of early-onset preeclampsia with severe features

Level 4: Regional Perinatal Health Care Center; e.g., severe maternal cardiac conditions, severe pulmonary hypertension or liver failure, pregnant women requiring neurosurgery or cardiac surgery

PROGRAMS: There are currently 54 total programs in OB Anesthesia in North America, including 37 ACGME-accredited programs in the US, 12 non-ACGME accredited US-based programs, 5 Canadian programs, and 1 program based in Israel, for 55 total programs worldwide advertised on SOAP's website.

A recruitment survey was conducted to assess recruitment efforts; the majority of PDs stated that their recruitment was not as robust as when we participated in the NRMP Match, but many were still considering themselves actively recruiting (even in September 2018 for July 2019 positions).

POSITIONS: There are a total of 78 positions possible per year, both accredited and non-accredited.

Only 4 programs exist which admit more than 2 fellows/year; the majority of fellowships have 1 fellow/year.

FUTURE DIRECTIONS:

1) Recruitment and Networking: Evaluating Match process potential for future years, increase advertising for subspecialty training, creating alumni database, posting job opportunities
2) Education: Considering hosting educational content on SOAP website, offering access to experts for Q&A, sharing rotational goals & objectives
3) ACGME Program Requirements: Modernizing program requirements to allow programs to differentiate based on their strengths to better serve our trainees and our communities (e.g., private or community practices), developing focused requirements for increasingly morbid parturients (e.g., ICU training, POCUS/TTE training)

Back to Schedule

HANDOUT

Subspecialty Breakout Session: Adult Cardithoracic

Douglas C. Shook, MD

11/02/2018
2:45pm – 5:30pm

Back to Schedule

HANDOUT

Subspecialty Breakout Session: Critical Care Medicine

Nicholas Sadovnikoff, MD, FCCM

11/02/2018
2:45pm – 5:30pm

HANDOUT

Subspecialty Breakout Session: Obstetric

Rebecca D. Minehart, MD, MSHPEd

11/02/2018
2:45pm – 5:30pm

Back to Schedule

AASPD 2018: OB Anesthesia Fellowship Breakout Session

Rebecca D. Minehart, MD, MSHPEd
Program Director, Massachusetts General Hospital Obstetric Anesthesia Fellowship
Former Chair, SOAP OB Fellowship Committee
Former Chair, SOAP Strategic Task Force Initiative for OB Anesthesia Fellowships

I have no relevant financial disclosures.

DISCUSSION TOPICS

1) Review minutes from ASA SOAP Fellowship Committee Meeting
2) Strategies for Recruitment/Networking
3) Update on Educational Offerings, including Webinars
4) Discussion for Modernizing ACGME Program Requirements
5) Other business as required

HANDOUT

Subspecialty Breakout Session: Pain Medicine

Scott Brancolini, MD, MPH
Renee Przkora, MD, PhD

11/02/2018
2:45pm – 5:30pm

Back to Schedule

Pain Medicine Breakout Session

Moderators:
Scott Brancolini, MD, MPH
Associate Professor
University of Pittsburgh Medical Center

Rene Przorka, MD, PhD
Associate Professor
University of Florida

1. Updates in Pain Medicine Fellowship Requirements per Institution – Comments to ACGME
2. Pain Medicine Match Data
3. Review APPD Website
4. Dr. Susan Moeschler/Women in Pain Medicine Initiative
5. Dr. Rene Przorka – Pain Medicine Business Curriculum
6. Discussion
    a. Wellness Initiative
    b. Promotion materials

SAAPM – Pain Medicine Breakout Session

Rene Przkora

MD PhD

Title:

Practice and Business Development Curriculum

Content:

Background

Needs Analysis

Survey Results

Curriculum Design

Implementation

HANDOUT

Subspecialty Breakout Session: Pediatric

Franklyn P. Cladis, MD

11/02/2018
2:45pm – 5:30pm

Back to Schedule

HANDOUT

Subspecialty Breakout Session: Regional Anesthesia

Christina L. Jeng, MD, FASA
Jeff Gadsden, MD, FRCPC, FANZCA

11/02/2018
2:45pm – 5:30pm

Regional Anesthesia and Acute Pain Medicine Breakout Session

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

Jeff Gadsden, MD, FRCPC, FANZCA
Associate Professor
Duke University School of Medicine

1. Review Common Application – Dr. Brian Allen, MD
2. Updates in RAAPM Fellowship Requirements per Institution
3. Preparing for site visits in 2019
4. Discussion

HANDOUT

Welcome

Leslie Coker Fowler, MEd

11/02/2018
9:15am – 10:00am

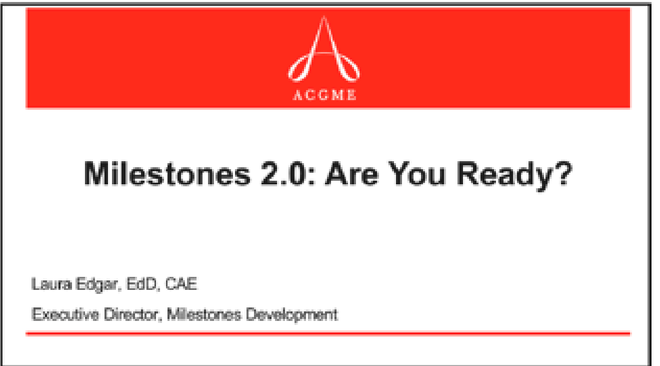
HANDOUT

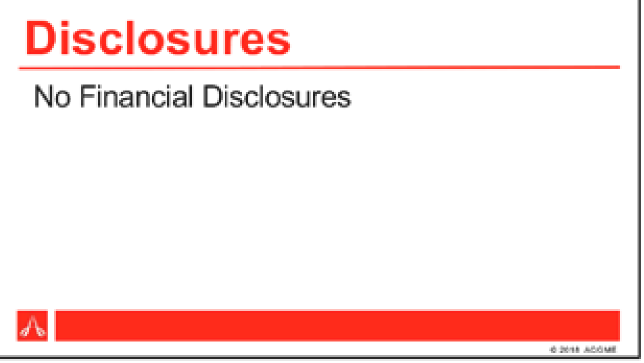
Milestones

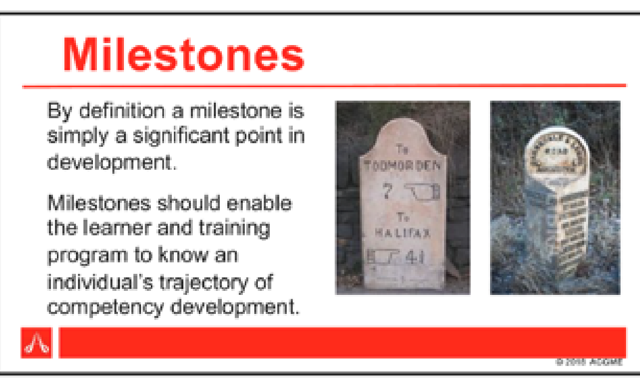
Laura Edgar, EdD, CAE

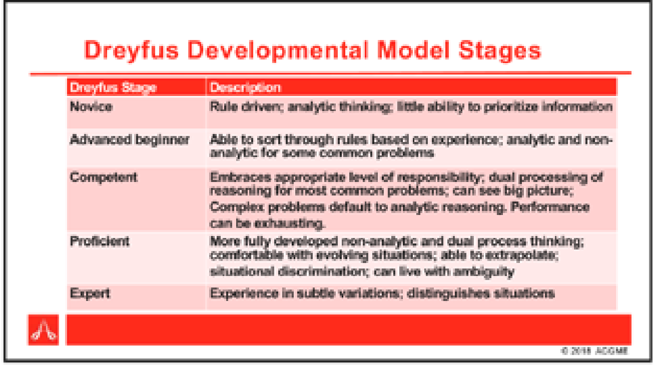
11/02/2018
10:30am – 11:30am

Back to Schedule








Dreyfus Developmental Model Stages

Dreyfus Stage	Description
Novice	Rule driven; analytic thinking; little ability to prioritize information
Advanced beginner	Able to sort through rules based on experience; analytic and non-analytic for some common problems
Competent	Embraces appropriate level of responsibility; dual processing of reasoning for most common problems; can see big picture; Complex problems default to analytic reasoning. Performance can be exhausting.
Proficient	More fully developed non-analytic and dual process thinking; comfortable with evolving situations; able to extrapolate; situational discrimination; can live with ambiguity
Expert	Experience in subtle variations; distinguishes situations

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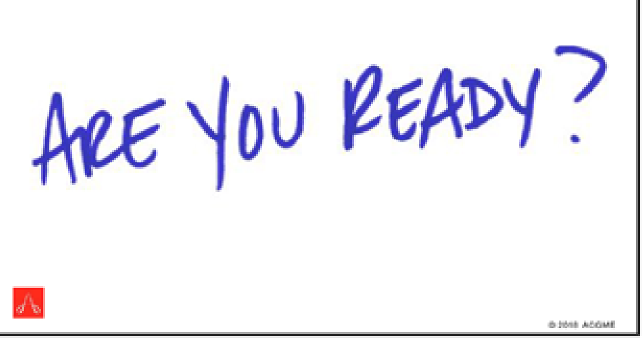

How are you using your Milestone data?

Take 2 minutes - tell your neighbor

Please share your thoughts with us!

© 2018 ACGME

Using Milestone Data

- How many annually review your Milestones as part of the PEC?
- How many annually review your Milestones with the faculty?
- How many provide on-going faculty development for use and evaluation of Milestones?

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Using Milestone Data

Reviewing program data annually allows the PEC to determine areas of strength and areas that need improvement

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Using Milestone Data

If residents are not achieving at the level expected what should be considered?

- Do residents have the same exposure as in the past?
- Did requirements change for residents during the clinical year?
- Have the faculty changed?
- Have the assessments changed?
- Has Faculty Development been offered?

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ARE YOU READY?

Milestones 2.0 is on its way!

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Why Now?

Because we said we would…

Much has been learned and we know we can improve the process

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What is the hardest part about the Milestones

Take a minute and tell your neighbor then switch it up

Please share your thoughts with us!

© 2018 ACGME

What is the best part about the Milestones

Take a minute and tell your neighbor then switch it up

Please share your thoughts with us!

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What have we learned?

Too many subcompetencies

Language too complex

Too much in each Milestone set

More people want to participate

Validity evidence is available

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What have we learned?

Performed a crosswalk of the Milestones within ICS, PBLI, PROF, and SBP for TY and 26 core specialties

What did we find:

- Self-directed learning was included 88 times; Communication with patients 73 times
- We had 144 different ways to describe ICS! More than **200** ways to describe Professionalism!!

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Timeline

Process started late 2016 with the creation of harmonized Milestones for ICS, PBLI, PROF, and SBP

2017 had the first specialty pilot the process – Neurological Surgery

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Timeline

25 additional specialties have started the process and 4 more are in the approval stage

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Timeline

Core specialties will begin 2018-2019

Subspecialties will follow

Anticipate all subspecialties to have started the process by 2020

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Differences For 2.0

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Differences

Stays the Same	What is different
Membership for each specialty will come from the community	We will put out a call for volunteers – anyone involved in medical education can be nominated
Review Committees, Boards, PD groups and residents/fellows will be represented	We will invite public members to participate

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Differences

Stays the Same	What is different
Specialties will control their content (within a framework)	We will have data to lead decisions made by the specialty

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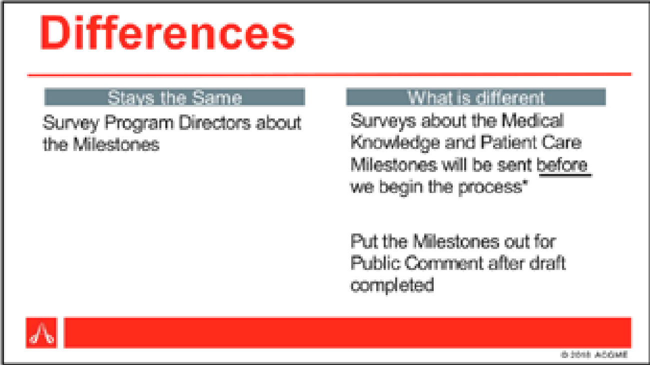
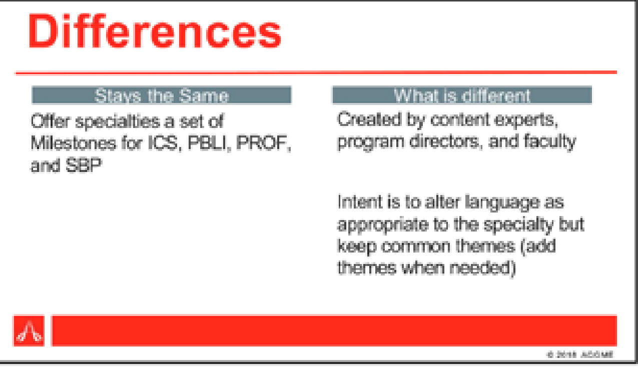
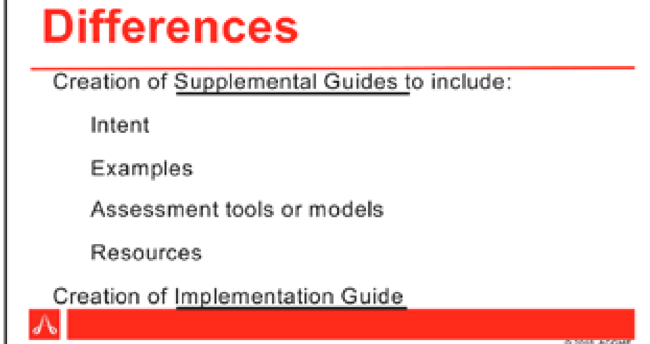
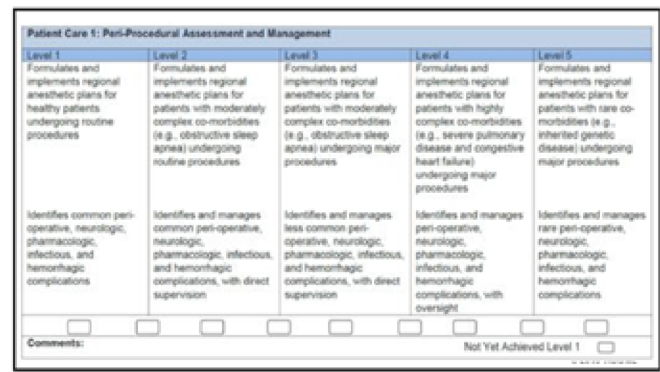




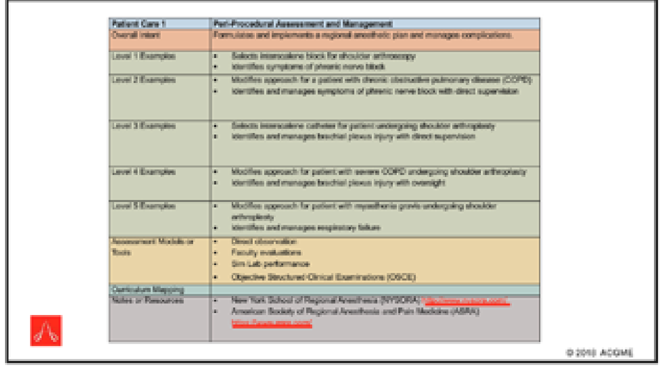




Patient Care 1: Peri-Procedural Assessment and Management				
Level 1	Level 2	Level 3	Level 4	Level 5
Formulates and implements regional anesthetic plans for healthy patients undergoing routine procedures	Formulates and implements regional anesthetic plans for patients with moderately complex co-morbidities (e.g., obstructive sleep apnea) undergoing routine procedures	Formulates and implements regional anesthetic plans for patients with moderately complex co-morbidities (e.g., obstructive sleep apnea) undergoing major procedures	Formulates and implements regional anesthetic plans for patients with highly complex co-morbidities (e.g., severe pulmonary disease and congestive heart failure) undergoing major procedures	Formulates and implements regional anesthetic plans for patients with rare co-morbidities (e.g., inherited genetic disease) undergoing major procedures
Identifies common peri-operative, neurologic, pharmacologic, infectious, and hemorrhagic complications	Identifies and manages common peri-operative, neurologic, pharmacologic, infectious, and hemorrhagic complications, with direct supervision	Identifies and manages less common peri-operative, neurologic, pharmacologic, infectious, and hemorrhagic complications, with direct supervision	Identifies and manages peri-operative, neurologic, pharmacologic, infectious, and hemorrhagic complications, with oversight	Identifies and manages rare peri-operative, neurologic, pharmacologic, infectious, and hemorrhagic complications

Comments:

Not Yet Achieved Level 1



Patient Care 1	Peri-Procedural Assessment and Management
Overall Intent	Formulates and implements a regional anesthetic plan and manages complications
Level 1 Examples	• Selects interscalene block for shoulder arthroscopy • Identifies symptoms of phrenic nerve block
Level 2 Examples	• Modifies approach for a patient with chronic obstructive pulmonary disease (COPD) • Identifies and manages symptoms of phrenic nerve block with direct supervision
Level 3 Examples	• Selects interscalene catheter for patient undergoing shoulder arthroplasty • Identifies and manages brachial plexus injury with direct supervision
Level 4 Examples	• Modifies approach for patient with severe COPD undergoing shoulder arthroplasty • Identifies and manages brachial plexus injury with oversight
Level 5 Examples	• Modifies approach for patient with myasthenia gravis undergoing shoulder arthroplasty • Identifies and manages respiratory failure
Assessment Models or Tools	• Direct observation • Faculty evaluations • Sim Lab performance • Objective Structured Clinical Examinations (OSCE)
Curriculum Mapping	
Notes or Resources	• New York School of Regional Anesthesia (NYSORA) [illegible] • American Society of Regional Anesthesia and Pain Medicine (ASRA) [illegible]

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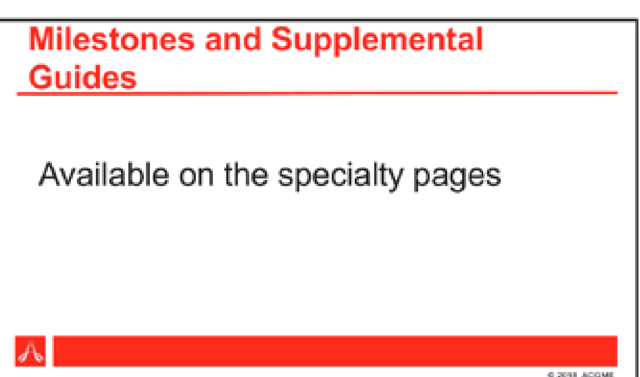

Back to Schedule

Milestones Implementation Guide

Recommendations for pre-implementation activities

Change management techniques for implementation

Methods for continuous program improvement

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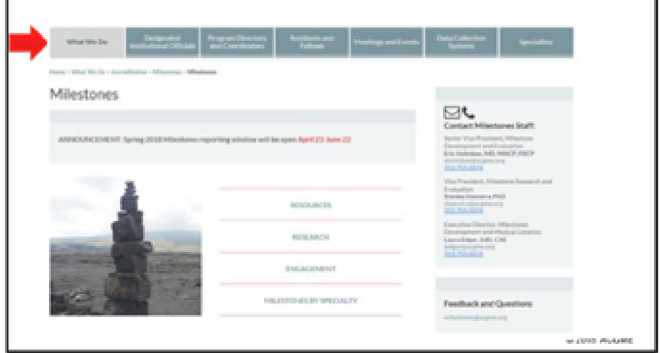

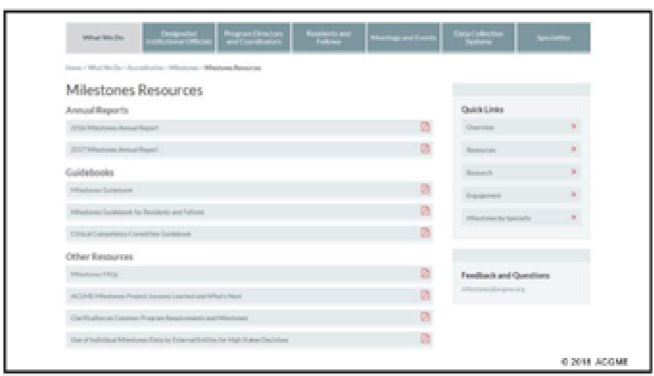

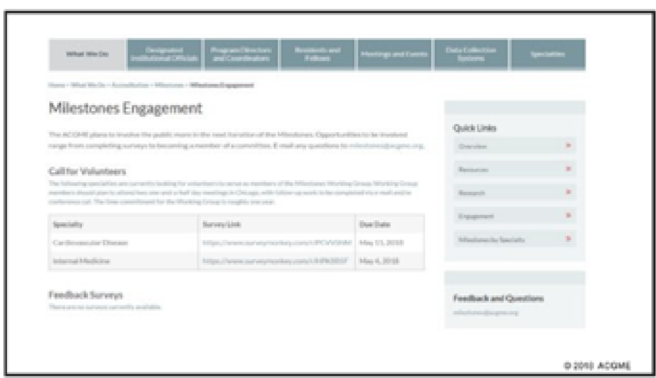

Courses Available
Developing Faculty Competencies in Assessment
6-day workshop in Chicago 3 times per year
3-day workshop at regional hubs
Vanderbilt, UCLA, Philadelphia Consortium, Cleveland Clinic, and more are being developed
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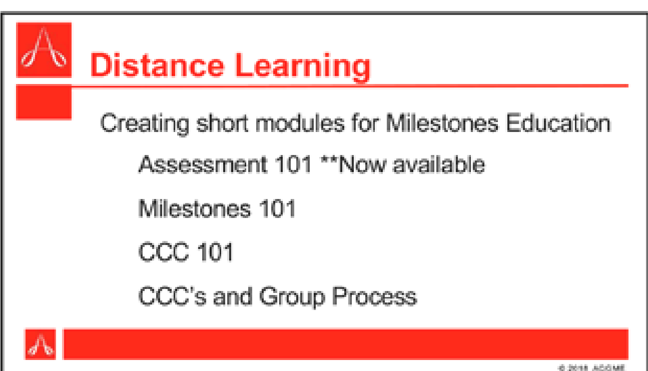
Distance Learning
Creating short modules for Milestones Education
Assessment 101 **Now available
Milestones 101
CCC 101
CCC's and Group Process
© 2018 ACGME

Other Resources
STFM
ALLIANCE
Clinical Competency Committee Meeting
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Other Resources
MindTools
UW Medicine
Avoiding Groupt
ADAPT Feedback
Practice
Prepare to ADAPT
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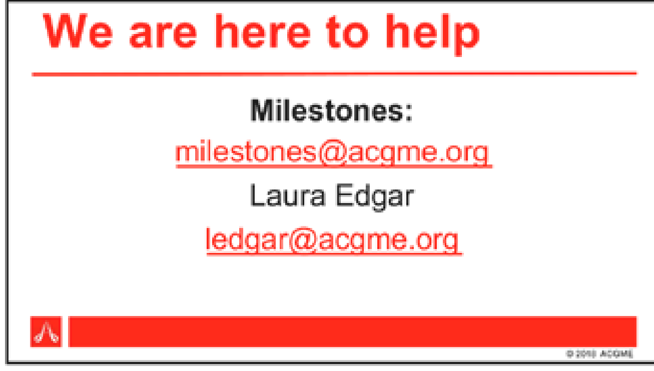
We are here to help
Milestones:
milestones@acgme.org
Laura Edgar
ledgar@acgme.org
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PERSPECTIVE
OH NO!
THERE'S A HUMAN TRAPPED IN THIS CAGE!
DON'T WORRY, FRIEND! WE WILL GET YOU OUT!
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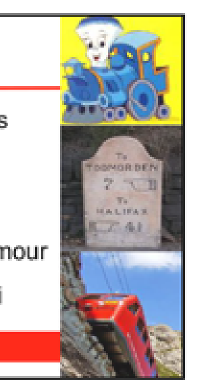
Back to Schedule

Milestones Team

Lisa Conforti	Sydney Roberts
Laura Edgar	Chandra Ross
Stanley Hamstra	Sonia Sangha
Eric Holmboe	Nicholas Yaghmour
Landyn Jordan	Kenji Yamazaki



Back to Schedule

HANDOUT

Practical Strategies for Engaging Faculty in Evaluation and Assessment Completion

Lara Zisblatt, EdD, MA, PMME

11/02/2018
11:30am – 12:00pm

Back to Schedule

Practical Strategies for Engaging Faculty in Evaluation and Assessment Completion

Lara Zisblatt, EdD, MA, PMME

November 2, 2018

SAAAPM AAPAE

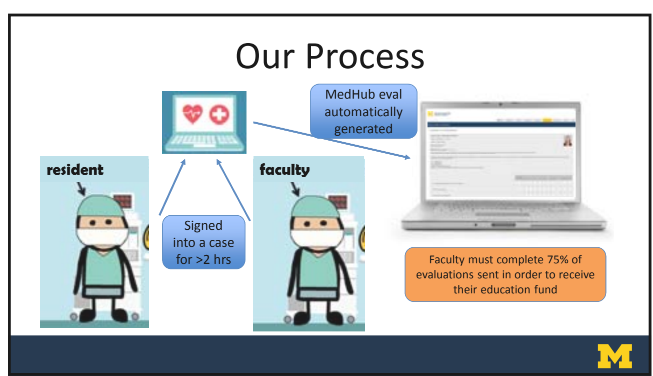
Disclosures

- I have nothing to disclose

Objectives

- Describe how motivation theory can help inform strategies for engaging faculty in evaluation and assessment
- Identify the benefits and risks of different strategies to engage faculty in evaluation and assessment

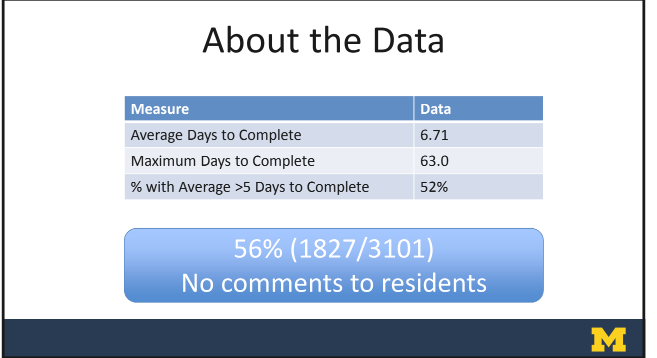
Our Process



How to improve completion rates?

- Automated electronic reminders (Blum, 2006; Rusa, 2009; Shah, 2007)
- Financial compensation (Studies??)
- Education – Training (Mitchell 2017)

Completion Rate



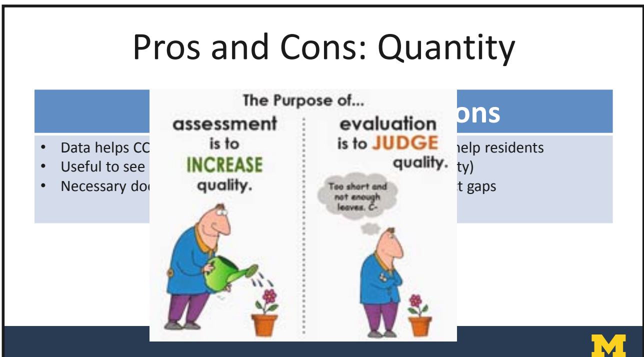
About the Data

Measure	Data
Average Days to Complete	6.71
Maximum Days to Complete	63.0
% with Average >5 Days to Complete	52%

56% (1827/3101)
No comments to residents

Quantity vs. Quality

- "There was no overall correlation between the number of evaluations per resident and the residents' perception of feedback from faculty" -Blankush, 2017

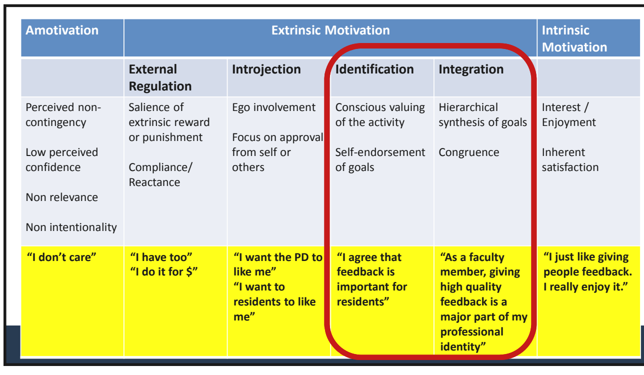


Self-Determination Theory (Deci & Ryan)

- Intrinsic (vs.) Extrinsic Motivation
- Different amounts and different kinds of motivation
  - Level of motivation
  - Orientation of motivation
- **Quality of experience and performance** very different when one is behaving for intrinsic vs. extrinsic reasons

Motivation Definitions

- **Intrinsic**: You do it because you like it
  - Facilitate intrinsic motivation: Positive Feedback, Feeling competent, Autonomy
- **Extrinsic**: You do it for some outside goal
  - Money



Amotivation	Extrinsic Motivation				Intrinsic Motivation
	External Regulation	Introjection	Identification	Integration	
Perceived non-contingency Low perceived confidence Non relevance Non intentionality	Salience of extrinsic reward or punishment Compliance/ Reactance	Ego involvement Focus on approval from self or others	Conscious valuing of the activity Self-endorsement of goals	Hierarchical synthesis of goals Congruence	Interest / Enjoyment Inherent satisfaction
"I don't care"	"I have too" "I do it for $"	"I want the PD to like me" "I want to residents to like me"	"I agree that feedback is important for residents"	"As a faculty member, giving high quality feedback is a major part of my professional identity"	"I just like giving people feedback. I really enjoy it."

Why motivation matters

Take home points

- Electronic reminders help
- Be careful how you incentivize
- Nothing beats a faculty group that believes in the importance of evaluation and feedback

HANDOUT

Introduction to the Faculty Development Changes in the Core Requirements

Amy DiLorenzo, MA

11/03/2018
10:00am – 10:30am

Back to Schedule

HANDOUT

Panel Discussion About Current Support of Faculty Development: Large Program

Chris Ashley Fox, PhD

11/03/2018
10:30am – 11:15am

Back to Schedule

HANDOUT

Panel Discussion About Current Support of Faculty Development: Medium Program

Jane R. Maugeri, C-TAGME

11/03/2018
10:30am – 11:15am

Back to Schedule

Support of Faculty Development

Jane R. Maugeri, C-TAGME
Residency Education Coordinator
SKMC at Thomas Jefferson University Hospitals

Disclosure

- **I have no actual or potential conflict of interest in relation to this program/presentation**

The Department of Anesthesiology at Thomas Jefferson University Hospital

- ACGME Accredited Residency
- Size of Program
  - 55 Residents
    - 10 Categorical and 5 Advanced Positions filled in the Match
    - 1 ACGME Accredited CT Fellow and 2 ACGME Accredited Pain Fellows
  - 84 Faculty Members

Overview

- Faculty Development: A Medium Program Perspective:
  - How is Faculty Development Organized
  - What Role do I play in Faculty Development
  - Selection of Topics: Topics Presented
  - Faculty Attendance and Participation
  - Frequency of Sessions and Learning Opportunities
  - Time and Location
  - Department or Hospital / University
  - Future Plans

Resources

- Faculty Development Program
  - Self-directed learning modules
  - On-Campus Workshops
- Faculty Mentoring Faculty
- Departmental Didactics
- Innovative Learning
  - Improv Instructor
  - Jeopardy-Interactive
  - Audience Response(ARS)
- Small Groups
- Objective Structured Teaching (OSTE)

Obstacles

- Financial
- Time
- Senior to Junior Faculty
- Willingness

- How is Faculty Development Organized
  - Research / Scholarship/Professional Development/ Leadership
    - Structure/ Resources
    - Development of Future Faculty: Residents are the potential Faculty of tomorrow
    - Accountability/ Measure Improvement and Impact
- What Role do I play in Faculty Development

Back to Schedule

- Selection of Topics
- Faculty Attendance and Participation and Evaluation
  - New Innovations
  - Scanner for attendance
- Evaluation
  - Conduct Systematic review of Faculty Development Initiatives
    - Improvement of teaching effectiveness

- Frequency of Sessions and Learning Opportunities
  - Everyday
- Time and Location

- Department or Hospital / University
  - Institutions must support programs by providing initial and ongoing faculty development.
    - Jefferson provides numerous and varied opportunities
  - Department
    - Weekly / Daily
- Future Plans:
  - Improv Sessions-in process
  - Continued robust didactics
  - Interactive Sessions

Brainstorming Objectives

- Learning to provide Feedback
- Learning how to Teach
- Innovative Ideas to provide Support for Faculty Development
- Time: Incorporating Faculty Development into each day
- Resources
- Documentation
- Putting into Action
- Goals and Objectives

Summarize

Back to Schedule

HANDOUT

Panel Discussion About Current Support of Faculty Development: Small Program

Betty Leslie Warner, C-TAGME

11/03/2018
10:30am – 11:15am

Current Support of Faculty Development in a Small Anesthesiology Residency Program

Betty Leslie Warner, C-TAGME
Division of Anesthesiology and Pain Management
Cleveland Clinic Florida

Saturday, 3 November 2018

Program Size: 5/5/5/5*
Current full complement will be attained with 2019 match.

Core Faculty: 23 (includes 2 at off-site rotations)

Program Initial Accreditation: September 2016
First Residents: July 2017

The above information is provided to afford perspective on the size of our program and the point from which our main focus on faculty development originated.

Our department has been in the process of transitioning from a private/community-based department to an academic program with the commencement of the 2017-2018 year. In addition to being a small program, we also are in the very early stages of development.

In consideration of the above, this session will cover

- the direction we have taken in reviewing the initial state of our scholarly activity at the outset
- research of the avenues for increasing scholarly activity
- our approach to enhancing faculty development
- barriers to obtaining these goals
- possible ideas and opportunities that could be initiated
- wish list for resources

Objective:
Differentiating support of faculty development in large vs. medium vs. small residency training programs

HANDOUT

Integration of Technology Tools to Improve Education

Chris Ashley Fox, PhD
Ashley Grantham, PhD

11/03/2018
11:30am – 12:00pm

Integration of technology tools to improve education in anesthesiology

Chris Fox, PhD
Ashley Grantham, PhD

Learning objectives

At the end of this session, participants will be able to:

- List instructional technology tools that can be used to enhance anesthesiology education
- Describe strategies for integrating instructional technology into anesthesiology education
- Name benefits of integrating instructional technology into anesthesiology education

Trends in medical education and instructional technology

1. The explosion of new information
2. The digitization of all information
3. New generations of learners
4. The emergence of new instructional technologies
5. Accelerating change

Robin, B.R., McNeil, S.G., Cook, D.A., Argarwal, K.L. & Singhai, G.R. (2011). Preparing for the changing role of instructional technologies in medical education. *Academic Medicine, 86*(4), 435-439.

Benefits of integrating instructional technology

- Fosters self-directed learning
- Standardizes content and delivery
- Can be more flexible
- Can help hold learners' interest through interactivity

Ruiz, J.G., Mintzer, M.J., & Leipzig, R.M. (2006). The impact of e-learning in medical education. *Academic Medicine, 81*(3), 207-212.

Instructional technology examples

- Learning management systems
  - Moodle, Sakai, Canvas
- Classroom technology
  - SMART boards, clickers
- Social media
  - Twitter, Facebook

Instructional technology examples

- Apps
  - WhatsApp, PollEverywhere
- Residency management systems
  - MedHub, New Innovations
- Media and presentation tools
  - Podcasts, YouTube

What are you using at your institution?

A case study: Medical College of Wisconsin

Recommendations for integrating instructional technology

1. Use technology to support learning
2. Focus on fundamentals
3. Allocate a variety of resources
4. Support and recognize faculty as they adopt new technologies
5. Foster collaboration

Robin, B.R., McNeil, S.G., Cook, D.A., Argarwal, K.L. & Singhai, G.R. (2011). Preparing for the changing role of instructional technologies in medical education. *Academic Medicine, 86*(4), 435-439.

Potential barriers to instructional technology integration

- Interest in integrating instructional technology
- Faculty proficiency with instructional technology
- Resources available to support implementation
    - Faculty and staff time
    - Training
    - Support

Butler, D.L., & Selbom, M. (2002). Barriers to adopting technology. *Educause Quarterly, 2* (1), 22-28.

Activity: Making a plan

Questions?

References

Butler, D.L., & Selbom, M. (2002). Barriers to adopting technology. *Educause Quarterly, 2* (1), 22-28.

Robin, B.R., McNeil, S.G., Cook, D.A., Argarwal, K.L. & Singhai, G.R. (2011). Preparing for the changing role of instructional technologies in medical education. *Academic Medicine, 86*(4), 435-439.

Ruiz, J.G., Mintzer, M.J., & Leipzig, R.M. (2006). The impact of e-learning in medical education. *Academic Medicine, 81*(3), 207-212.

HANDOUT

Update on Clinical Research Consortium

Jeanine P. Wiener-Kronish, MD

11/03/2018
7:00am – 7:10am

Back to Schedule

Clinical Trials and Networking

AUA website under research awards

- **Initiative for Multicenter Pragmatic Anesthesiology Clinical Trials' (IMPACT)**
- This award was established by leaders of academic anesthesiology organizations that recognized there was a need to conduct large pragmatic trials in order to answer important questions in anesthesiology-related research.
- Although there are several successful anesthesiology clinical trial networks around the world, there is no collaborative network in the United States. In an initial attempt to address this important opportunity, a consortium of academic anesthesiology organizations launched an initiative in 2018 to stimulate pragmatic research in the US.
- This effort was conceptualized and endorsed by organizations, which have as a common goal the advancement of knowledge in anesthesiology and the enhancement of care in perioperative medicine, critical care, pain management, and peri- and post-partum care. These organizations included:
- Association of University Anesthesiologists **(AUA)**
- Early-Stage Anesthesiology Scholars **(eSAS)**
- The Foundation for Anesthesia Education and Research **(FAER)**
- The International Anesthesia Research Society **(IARS)**
- The Society of Critical Care Anesthesiologists **(SOCCA)**
- Multicenter Perioperative Outcomes Group **(MPOG)**
- Canadian Perioperative Anesthesia Clinical Trials Group **(PACT)**
- This year the call for letter of intents will open on Monday, October 1, 2018 and close on November 16, 2018 at 11:59 pm EST. Please click here to access our online application portal and to view submission guidelines and details.

IMPACT

- **Multicenter Pragmatic Anesthesiology Clinical Trials' (IMPACT) Program Sunday May 19, 2019, Montreal, Canada**
- Join us in hosting our second 'Initiative for Multicenter Pragmatic Anesthesiology Clinical Trials' (IMPACT) program in Montreal on Sunday May 19, 2019 during the IARS, AUA, SOCCA Annual meetings.
- We plan to showcase promising pragmatic trials from some of tomorrow's leaders in anesthesiology research. This important meeting will be open to those interested in anesthesiology-related clinical and translational science. The agenda for symposium will include:
- Panel on innovative and efficient approaches to multicenter clinical trials.
- Presentation and review of three selected clinical trial protocols. The review will include constructive feedback regarding clarity of hypotheses, merit of research methods, and feasibility. The goal of the review panel is to address issues common to many proposals to ensure an educational experience for all investigators who attend the symposium, in addition to those whose proposals are selected.
- **Call for Letter of Intents – for 2019 IMPACT Award**

- **Michael Aziz, MD**
  Optimized Opioid Management or Usual Treatment to Reduce Persistent Opioid Use Following Surgery (OPT-OUT).
  Professor
  Anesthesiology & Preoperative Medicine
  Oregon Health & Science University
- **Randall Blank, MD, PhD**
  Individualized Intraoperative Protective Ventilation using an Open Lung Approach with Driving Pressure Limitation.
  Associate Professor of Anesthesiology
  Chief, Thoracic Anesthesia
  Department of Anesthesiology
  University of Virginia Health System
- **Frederic T. (Josh) Billings IV, MD, MSc**
  Intraoperative Normoxia versus Hyperoxia during Maintenance Anesthesia to Reduce Postoperative Complications.
  Associate Professor of Anesthesiology and Medicine
  Co-director, BH Robbins Scholars Physician-Scientist Development Program
  Vanderbilt University

GUIDELINES

- Letters of Intent should include:
- Descriptive title of proposed research
- Name, address, and telephone number of the Principal Investigator(s)
- Names of other key personnel
- Participating institutions
- Number and title of the funding opportunity
- Specific Aims
- **Clinical Trial Categories**
- The clinical trials should focus on any or all of the following areas:
- Operating Room Management
- Pain Management
- Peri- and Postpartum Care
- Perioperative Critical Care
- Postoperative Management
- Preoperative Care/Optimization

Back to Schedule

HANDOUT

Approaches to Residency and Research

Dawn Dillman, MD

11/03/2018
7:10am – 7:30am

Back to Schedule

Innovative Programs

Dawn Dillman, MD
Professor, Vice-Chair of Education
Oregon Health & Science University

Objectives

- Describe an innovative structure for combining residency and fellowship or research time.
- Identify barriers to administration and completion of the program.
- Describe outcomes of the program over the past 10 years.

2

What is an Innovative Fellowship Program?

- The ACGME has developed a process for programs in all specialties to develop innovations in graduate medical education
- Programs need to apply for ACGME approval prior to beginning the program: http://www.acgme.org/acWebsite/navpages/nav_program_experimentation.asp

3

Why Innovate?

- Continued growth and relevance of specialty
- Maintain our leadership in patient safety and outcomes
- Practice changes, health care reform, reimbursements, non-physician providers

4

Fellowships and Anesthesiology

- Educate the next generation of core anesthesiologists and subspecialists
- Provide the academic/researchers of the next generation

5

CCM Fellowships

- In 2017, anesthesiology residency programs graduated 1587 residents from 149 approved programs
- 171 anesthesiology graduates completed fellowship training in 58 approved anesthesiology programs in critical care medicine (CCM)
- This compares to 655 internal medicine graduates completing CCM training (or combined Pulmonary medicine CCM) in 189 approved programs, and 239 general surgery CCM graduates in 121 approved programs, and 167 pediatric CCM graduates from 66 programs*

* *American Medical Association. FREIDA Online. https://freida.ama-assn.org/freida/. Accessed Sept 24, 2018*

6

Back to Schedule

Research

- Call to action in multiple publications and forums in 2006-7 to increase research productivity in anesthesiology
- Anesthesiology with second lowest NIH funding/faculty at that time

7

Oregon Scholars Program

- Proposed method of increasing anesthesiology research included increasing opportunity for research in residency
- Most of our applicants listed CCM as a career interest in their ERAS application
- Many OHSU residents that had this interest decided to enter practice rather than a fellowship citing 2 reasons
  - Financial
  - Rigor of 12 straight months doing CCM

8

Oregon Scholars Program

- In 2005 we assessed our strengths and decided to develop an innovative program combining our core residency program with a research fellowship or CCM fellowship
- Our department had strength in these areas and would be able to offer this program without impacting our core residency program
- Approved by the ACGME and ABA in 2006, first class entered in July of 2006

9

Oregon Scholars Program

- The OSP is a focused, educational approach to develop researchers and intensivists in anesthesiology
- The OSP has 2 tracks: research or CCM

10

Oregon Scholars Program Resident Selection

- Residents selected for OSP positions are evaluated using the same academic criteria as for our core program
- In addition, we look for evidence of commitment to fellowship training in research or CCM by reviewing their personal statements, letters of recommendation, personal interviews, and curriculum vitae

11

Oregon Scholars Program Resident Selection

- 2 CCM and 1 Research position/year
- Residents are chosen through the NRMP
- Applicants who match to the OSP positions are in distinct programs in our department and are unable to transfer to the traditional program unless there is an unexpected opening

12

Back to Schedule

Research Rotation Organization

- Residents find mentors in CA1 year and come up with projects during CA2 year.
- 12 months of research in CA3 year.
- Up to additional 6 months of research in CA4 year.

13

Research Didactics

- Residents are relieved from the OR to participate in the weekly departmental research conference highlighting basic and clinical research within the department
- FAER scholar to ASA CA1 year
- IARS meeting CA2 year
- Optional WARC meeting CA1-3

14

CCM Rotation Organization, Early

- **Initial structure:** "Add on" the fellow rotations to CA-3 and CA-4 years
- Feedback: Too big a gap between resident ICU rotations in CA-1 year and fellow ICU rotations in CA-3&4 year
- Solution: Add additional resident rotations in the ICU for OSP

  CBY: 2 ICU rotations

  CA-1: 2 ICU rotations

  CA-2: 2 ICU rotations

CCM Rotation Organization, Later

- Problem: CA-4 year looked like a fellowship
  - 6 blocks core ICU + 2-3 blocks fellow elective
  - Only 3-4 blocks of general anesthesia
- RRC Requirement: 6 fellow level ICU rotations in the final year of training
- Solution: Move 3 months ICU electives to CA-3 year
  - CA-3 year: 6 months Anes + 3 months CC elective + 3 months core ICU
  - CA-4 year: 6 months Anes + 6 months core ICU

CCM Didactics

- Residents are relieved from the OR to participate in the multidisciplinary CCM daily didactics for July, and then weekly didactics and monthly journal club.
- POCUS bootcamp to prepare for US Certification
- Fosters professional identity formation
- SOCCA in CA2 year

Oregon Scholars Program/CCM

Year	Months of Clinical Anesthesia Training	Months of Critical Care Training
CA1 (PGY 2)	12	2 (as resident)
CA2 (PGY 3)	12	2 (as resident)
CA3 (PGY 4)	9	3 (as CCM fellow)
CA4 (PGY 5)	6	6 (as CCM fellow)
Totals	**39 (includes 3 months of electives as CCM fellow)**	**12 (9 as CCM Fellow)**

Clinical base year rotations will satisfy all requirements including two months of critical care rotations as PGY 1 (CB). *Residents who did not have two months of critical care medicine in the CB year will receive 1-2 additional months as needed to provide a total of six months of CCM experience as residents prior to the CA3 year.)*

The three months of critical care electives that are part of the CCM fellowship training are included in the months of clinical anesthesia training column and will be distributed over the CA3 and CA4 years of the program.

18

OSP Experience to Date

- We have averaged more than 200 applicants from US medical schools per year for the 3 OSP positions.
- Since the OSP began in 2006, we have filled all available positions except 1 research position
- We currently have 11 scholars in the anesthesiology/CCM track and 2 in the anesthesiology/research track at the PGY-2-PGY-5 levels. Accepted one transfer in to CCM.
- Three scholars have left the program and moved to a traditional residency position. This was accomplished by a lateral transfer by a classmate who desired to enter the CCM program each time

OSP Outcomes

- We have not seen any resistance from our traditional residents or fellows to accepting the scholars as fellows in the critical care units
- There have been increasing requests to transfer into the OSP program
- There has been no differences in overall academic performance as determined by our RECCC or ITE scores compared with traditional residents

OSP CCM graduates 2010-2018

- 20 CCM graduates (of 25 OSP graduates)
- 9 are practicing CCM as part of their current positions (8 academic, 1 community practice)
- 4 completed a cardiac anesthesia, and one completed a pediatric fellowship after completing the OSP CCM program

OSP Research graduates

- 4 FAER grants in residency
- Graduate 1 &2 – Community practice
- Graduate 3 - Academic practice (initial 50% research)
- Graduate 4 – Academic practice (50% research)
- Graduate 5- Academic practice (40% research)

Issues: Variability in program

- Initially residents entered into the OSP and then decided after CA1 year which track
- Variability in resident numbers made it hard to establish a consistent culture for either the CCM or the research track
- Change to set program match numbers with reversion to traditional program if unmatched

Issues: Fellow recognition

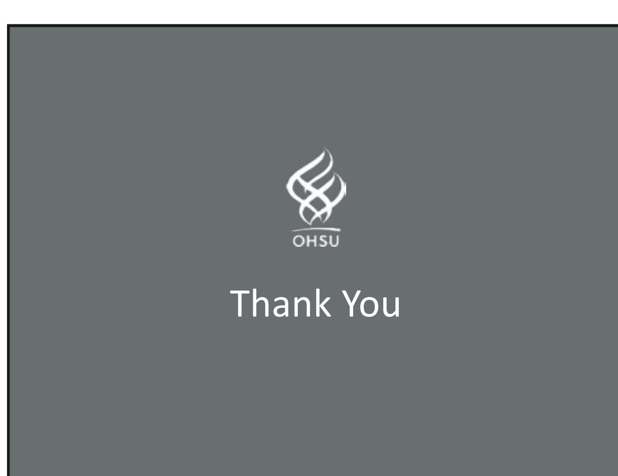
- Non-anesthesia critical care faculty perceptions
  - Education
  - More distinction between resident rotation vs fellow rotation
  - Addition of name badge holders with fellow title
  - Addition of fellow title on white coat and name badge

Issues: Program Identity

- CCM OSP residents did not feel like they had an ability to address problems unique to their program
- Chief resident for each OSP track was added, and they serve on the program evaluation committee

Thanks to…

- Jeff Kirsch
- Chris Swide
- Miko Enomoto
- Amy Miller Juve
- Emily Baird
- Ryan Fink



HANDOUT

Approaches to Residency and Research

Aaron Norris, MD, PhD

11/03/2018
7:30am – 7:50am

Back to Schedule

Post Graduate Training of Anesthesiologist-Scientists

Aaron Norris, MD, PhD
Assistant Program Director for Research and Scholarship
Department of Anesthesiology
Washington University in St.Louis

Disclosures:

None

Overview

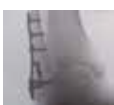
Define the Challenge:
- Institutional challenges to research by anesthesiologists
- National level trends and history of concerns regarding Physician-Scientist and Anesthesiologist-Scientists

Opportunities:
- Increase in number of research-oriented applicants to anesthesiology programs

Programs for Training Anesthesiologist-Scientists at Washington University:
- Current programs
  - ASAP and Scholar Tracks
- Mentoring structure
- Lessons learned to date

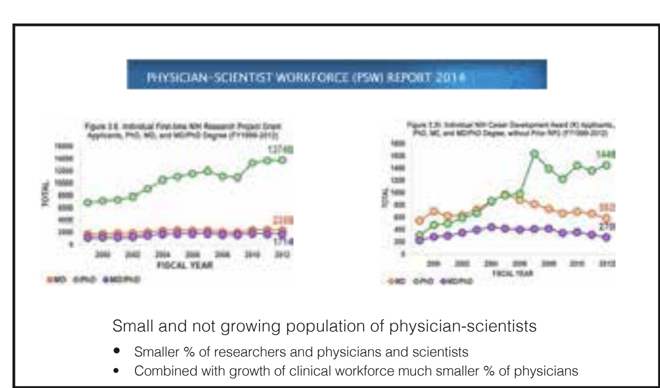
NIMH Director's experience with ~~perioperative care~~ surgery and related research

- Chronicles experience of healthcare, having a fracture surgically repaired
- Compares the tools for mental health to that of the orthopedist
- Discusses treatment of depression using ketamine
- Does NOT mention anesthesia care or anesthesiologist

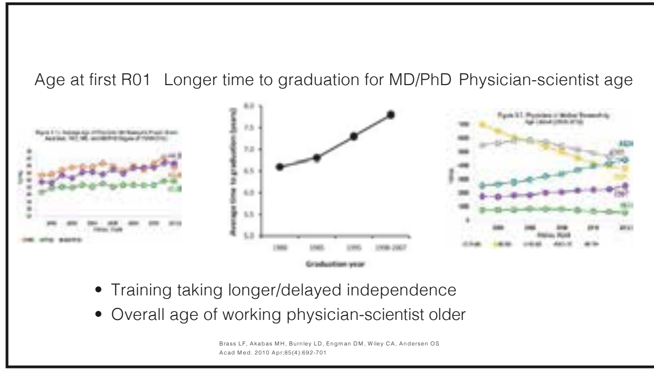


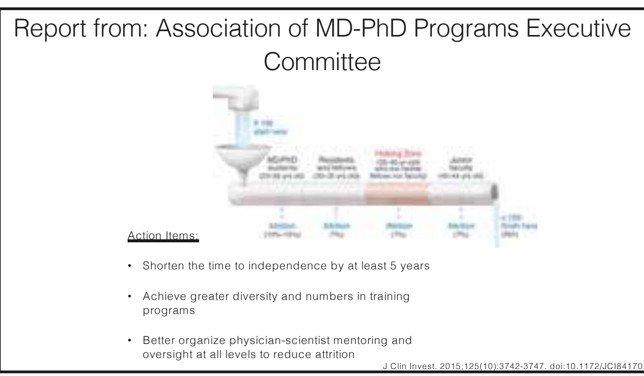
Additional cultural challenges

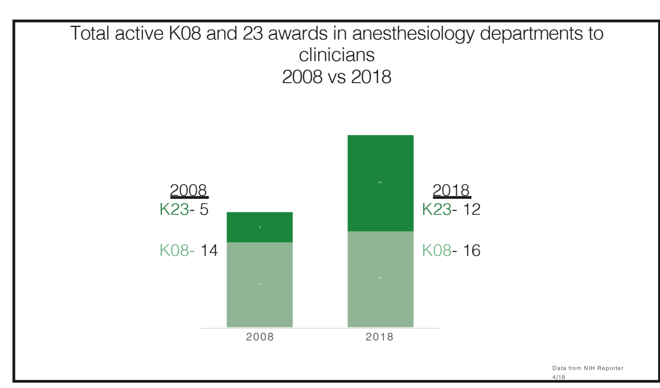
- What is the scope of research that is acceptable for an anesthesiologist?
- Need to collaborate and be accepted by other specialties (neurology, cardiology, psychiatry) for many lines of investigation
- Anesthesiology not seen as a viable path for aspiring physician-scientists
- Practice of anesthesiology poorly understood by other medical specialties



Small and not growing population of physician-scientists
- Smaller % of researchers and physicians and scientists
- Combined with growth of clinical workforce much smaller % of physicians







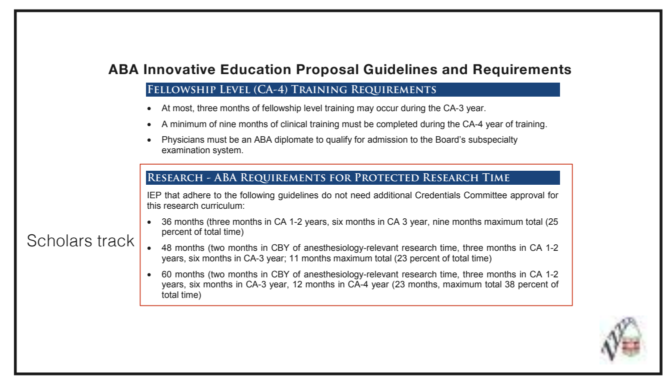
Obstacles

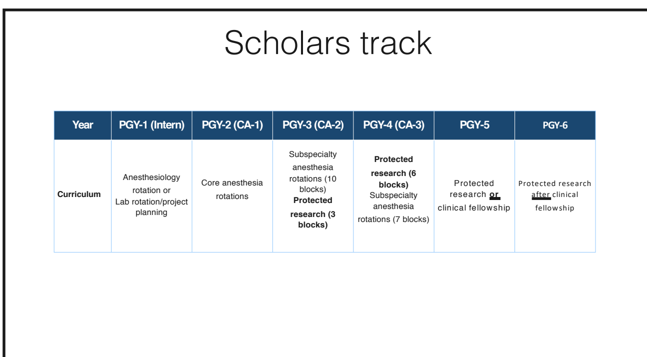
- Time in training increased
- Longer times to independence
- Financial disincentives
  - Debt burden
  - Delayed income
- External pressures on academic anesthesiology departments
- Aging population of working physician-scientists
- Scarcity of mentors within anesthesiology
- Difficult abrupt transitions between clinical and scientific training
- Ability to recruit medical students interested in research to anesthesiology

Opportunities

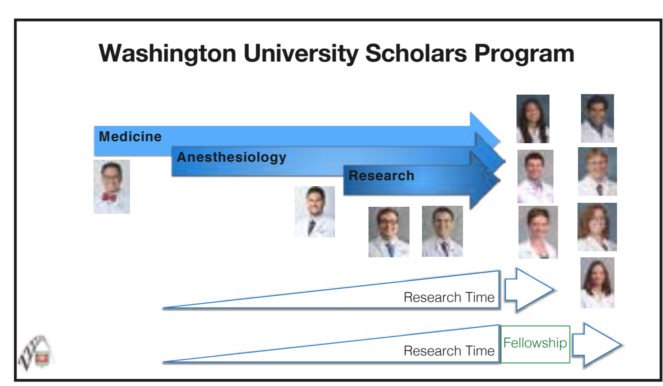
- Apparent marked increase in interest in research-oriented residency
- Sustained increase in research track applicants to anesthesiology
- Growing community of early Stage Anesthesiology Scholars (eSAS)
- Opioid abuse epidemic increased awareness and concern around pain management
- New technologies for tracking and quantifying patient trajectories

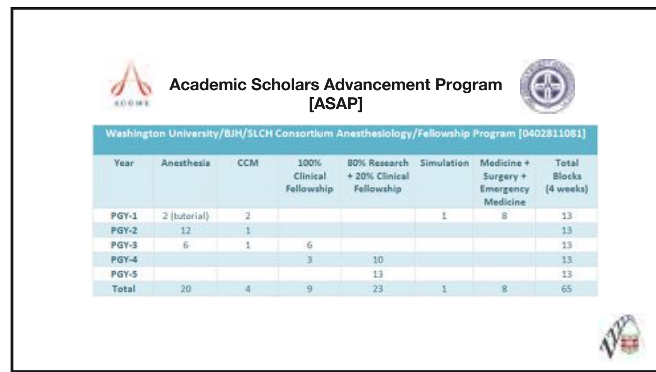
Back to Schedule




Scholars track

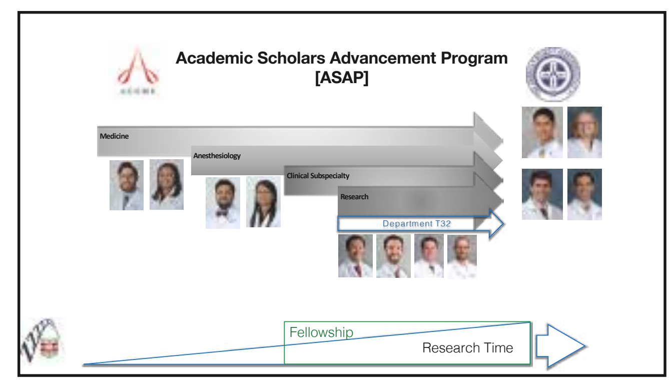
Year	PGY-1 (Intern)	PGY-2 (CA-1)	PGY-3 (CA-2)	PGY-4 (CA-3)	PGY-5	PGY-6
Curriculum	Anesthesiology rotation or Lab rotation/project planning	Core anesthesia rotations	Subspecialty anesthesia rotations (10 blocks) **Protected research (3 blocks)**	**Protected research (6 blocks)** Subspecialty anesthesia rotations (7 blocks)	Protected research **or** clinical fellowship	Protected research **after** clinical fellowship




Academic Scholars Advancement Program [ASAP]

Washington University/BJH/SLCH Consortium Anesthesiology/Fellowship Program [0402811081]

Year	Anesthesia	CCM	100% Clinical Fellowship	80% Research + 20% Clinical Fellowship	Simulation	Medicine + Surgery + Emergency Medicine	Total Blocks (4 weeks)
PGY-1	2 (tutorial)	2			1	8	13
PGY-2	12	1					13
PGY-3	6	1	6				13
PGY-4			3	10			13
PGY-5				13			13
Total	20	4	9	23	1	8	65



Approach to Mentorship

Clinical focus

Research focus

Clinical mentorship and monitoring:
- Promote and monitor clinical development
- Residency program and fellowship directors
- Assigned clinical faculty mentor
- Evaluation of milestone achievement
- Clinical simulation testing days

Approach to Mentorship

Clinical focus

Research focus

Research mentorship and monitoring:
- Early focus on identifying mentor and research interests
- Promote reading of literature to establish knowledge base
- Done by program director and assistant program directors at 6-month evals
- Primary mentors inside and outside of department based on research interests

Approach to Mentorship

Clinical focus

Research focus

Scholarship oversight committee: Meet q6 months

Departmental Representation

Michael Avidan MBBS (clinical)
Alex Evers MD (basic)
Aaron Norris MD PhD(Assistant PD)
Ben Palanca MD PhD
Simon Haroutounian PhD (clinical)
Yu-Qing Cao PhD (basic)
Primary mentor for resident

Community

- Develop and maintain community of early stage investigators locally
- Connect junior and established investigators
- Build collaborations with other departments and early stage physician-scientists
- Support medical and MD/PhD students interested in anesthesiology

Community building for trainees

Started with monthly journal club/wip
- Difficult to maintain faculty and resident engagement
- Diverse research interests

Developed into 3 annual events for all research residents and recent graduates
- Fall Residency Research Retreat
  - Half day event with rapid-fire short presentations by interns and all residents that have had research time
- Interview and recruitment weekend
- Resident invited speaker

Matched Residents 2012-2018

Scholars track
Total: 11
MD/PhD: 5
Masters degree: 2
Women: 4
Men:7

ASAP
Total: 14
MD/PhD: 13
Masters degree: 1
Women: 3
Men:11

Back to Schedule

Outcomes 2012-2018

Scholars track
Graduates: 5
Fellowships: 7 of 7*
Faculty at WashU: 3 of 5
100% academic
100% of those completed clinical training had extramural funding

ASAP
Graduates: 4
Fellowships: required
Faculty at WashU: 4 of 4
100% academic
75% of those completed clinical training had extramural funding

Post graduation funding:
- IARS MTRG
- FAER MTGR
- FAER RFG
- K08
- PhARMA Foundation

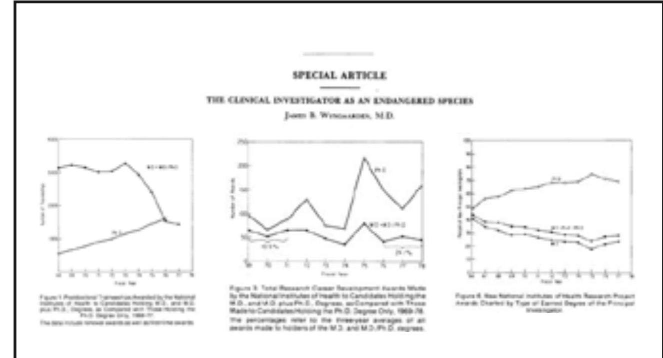
Outcomes 2012-2018

Scholars track
Fellowship Choices:
- Pain: 3 (1 Stanford)
- ICU: 1
- Peds: 1
- Neuro: 1
- Transplant: 1 (UCLA)
- CT: 1 (UCLA)
- AP/Regional: 1 (following research year)

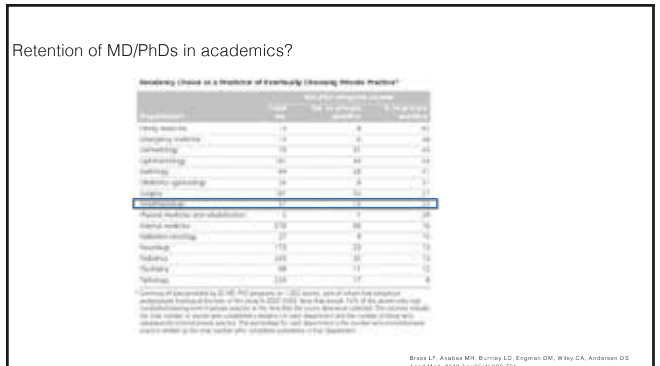
ASAP
Fellowship Choices:
- Pain: 2
- CT: 2
- ICU: 2
- Peds: 1
- Transplant: 1

Lessons Learned

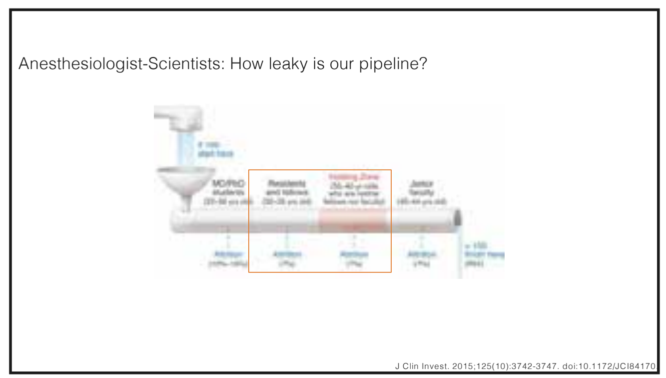
- Important to maintain close connection of resident, department and mentor
- Dynamic committee meeting based on progression
- Fluid transition from clinical training to research important
- Start early and closely monitor progression
- Need for clear milestones in both clinical and research domains
- Critical to carefully recruit candidates to accelerated pathways
- Flexibility is important
- High rate of clinical fellowships among those on the Scholars track

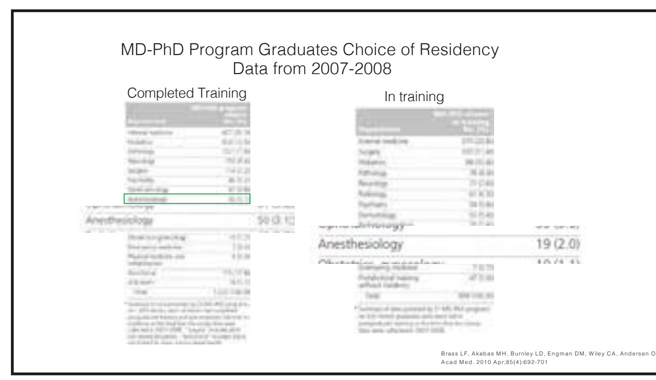


Retention of MD/PhDs in academics?



Brass LF, Akabas MH, Burnley LD, Engman DM, Wiley CA, Andersen OS
Acad Med. 2010 Apr;85(4):692-701


Anesthesiologist-Scientists: How leaky is our pipeline?
J Clin Invest. 2015;125(10):3742-3747. doi:10.1172/JCI84170


MD-PhD Program Graduates Choice of Residency
Data from 2007-2008
Completed Training
In training
Anesthesiology
Anesthesiology
19 (2.0)
Brass LF, Akabas MH, Burnley LD, Engman DM, Wiley CA, Andersen O
Acad Med. 2010 Apr;85(4):692-701

Back to Schedule

HANDOUT

Approaches to Residency and Research

Judith Hellman, MD

11/03/2018
7:50am – 8:10am

Back to Schedule

UCSF: RESEARCH DURING RESIDENCY

Outline

- Overview of UCSF Anesthesia research training program
  - Pathway to Scientific Independence (PSI)
- Describe opportunities for research for UCSF Anesthesia Residents
  - Research Scholars Track
  - Categorical Residency

UCSF Anesthesia's Pathway to Scientific Independence (PSI)

- Goal: To train and develop anesthesiologist physician-scientists to research independence
- Provides a clear pathway to a significant research career
  - Protected research time (75-80%, multiple years)
  - Mentor matching
  - Milestone requirements (presentations, manuscripts, grant proposals)
  - Coursework
- Points of Entry
  - Research Resident Scholar Track (CA1-CA4)
  - Categorical Residency (CA1-CA3)
  - Post-doctoral fellowship
  - Junior faculty

UCSF PSI: Key Players

Vice Chairs for Research

Bill Young

Jeanine Wiener-Kronish

Residency Director

Manny Pardo

Anesthesia Chairs

Ronald Miller

Mervyn Maze

Michael Gropper

Research Administrator

Claire Harmon

Bill Young, M.D. 1954-2013

Sapere Aude!: the 2009 Excellence in Research Lecture. Anesthesiology. 2010 Apr;112(4):802-9

Mr. Piano Man: Reflections on the Life of Physician, Scientist, and Humanitarian, William L. Young, MD (1954–2013)
Warner, David S. MD*; Lanier, William L. MD†,‡
Journal of Neurosurgical Anesthesiology: January 2014 - Volume 26 - Issue 1 - p 1–3
doi: 10.1097/ANA.0000000000000006
In Memoriam

Facets Required for Successful Research Training and Development

- Commitment to research at all levels
  - Trainee
  - Department
  - Institution
- Mentors
  - Research mentor(s)
  - Career mentor(s)
- Training plan
  - Coursework
  - Education in writing papers and grants
  - Participation in local, regional, and national research meetings

Back to Schedule

Points of Entry into Anesthesiology Research Training at UCSF

- Residency
  - Categorical Residency
  - Innovative Research Tracks
- Fellowship
- Junior Faculty

Research During Residency

Categorical Residency with Research Time

- 2 residents/year
- Up to 6 months research time
- Research in CA2 and/or CA3 year
- Minimal clinical responsibilities
  - +/- 1d/week clinical work
  - Call

UCSF Research Scholar Track

- For residents that have decided to pursue a career as a physician-scientist
- Basic features
  - Early mentor pairing
  - Research starting early during residency (CA-2)
  - 80% protected time during research blocks
  - Educational and Research in Programs seminar series
- Research focuses are broad
  - Basic, Translational, Clinical
  - Research Tracks
    - Critical Care, Neurosciences, Pain and Addiction, Vascular Biology and Bioengineering, Human Genetics and Bioinformatics
    - Dedicated leader for each track

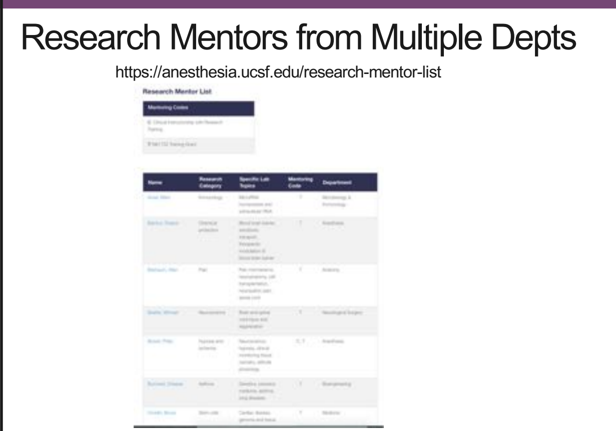
UCSF Research Scholars Track - Specifics

- 4 year residency (CA1-CA4)
  - Internship at UCSF
- Research in CA2-CA4 years
  - 3-12 months/year in 1-12 month blocks
  - 19 Total research months
- Stipend to support research
- Protected research time post-residency
- Clinical work during research rotations
  - ~ 4 days/month
  - Call
- Website: https://anesthesia.ucsf.edu/research-scholars

Mentors

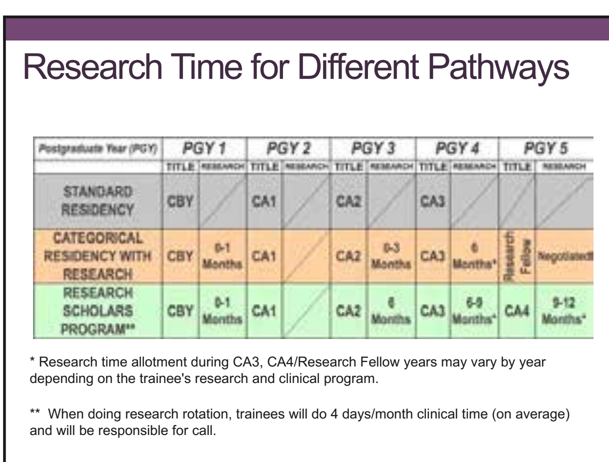
- Mentors can be inside or outside department
- Mentors are vetted by research training program director
  - Mentoring track record
  - Viability of research program
- Trainees encouraged to meet multiple potential mentors as well as members of their research groups

Back to Schedule



Application, Interviews, and Selection of Residents for Research Scholars Track

- Applicants
  - Select Research Scholars Track during application
  - Encouraged to list Categorical and Research Scholars Tracks on match list
- Selecting Candidates to Interview
  - Must have strong research background
    - MD/PhD or MS are good indicators
    - -OR- Substantial research time before or during medical school
  - Strong clinical evaluations necessary
- Match List
  - Clear dedication to research as part of career
  - Evidence of past productivity in research
  - Strong letters from research advisors/mentors
  - Evidence of clinical competence - Well-ranked on Categorical list



Research Time for Different Pathways

Postgraduate Year (PGY)	PGY 1		PGY 2		PGY 3		PGY 4		PGY 5	
	TITLE	RESEARCH	TITLE	RESEARCH	TITLE	RESEARCH	TITLE	RESEARCH	TITLE	RESEARCH
STANDARD RESIDENCY	CBY		CA1		CA2		CA3			
CATEGORICAL RESIDENCY WITH RESEARCH	CBY	0-1 Months	CA1		CA2	0-3 Months	CA3	6 Months*	Research Fellow	Negotiated
RESEARCH SCHOLARS PROGRAM**	CBY	0-1 Months	CA1		CA2	6 Months	CA3	6-9 Months*	CA4	9-12 Months*

* Research time allotment during CA3, CA4/Research Fellow years may vary by year depending on the trainee's research and clinical program.

** When doing research rotation, trainees will do 4 days/month clinical time (on average) and will be responsible for call.

CATEGORICAL *VS* INNOVATIVE TRACKS

Why one over the other?

Advantages of Categorical Residency Route

- Individuals with a research background can continue with their research or explore a new research direction during residency
- Individuals without research experience can explore research
  - This group represents a pool of potential anesthesiologist researchers
- Can set the stage for further research training after residency
- No extension of residency
  - Relevant for those doing clinical fellowships after residency
  - Geographic considerations (i.e.: plan to move post-residency)

Advantages of Research Scholars Track

- Early engagement in research
  - Identification of research mentor by end of CA1 year
  - Begin research project during CA2 year
  - Up to 24 months total of research during residency
- Yearly research stipend
- Continued limited clinical activity during research months (20%)
  - Build and maintain clinical skills
- Research farther along by completion of residency →earlier independence

Back to Schedule

Outcomes of Research Scholars Track

- 13 residents on Research Scholars Track
  - 7 Completed Residency → ALL ARE IN ACADEMICS AND DOING RESEARCH
  - 5 Current Residents
  - 1 Changed to Critical Care track after 1st 6 month block
- Topics – Basic-Translational-Clinical – Multiple topics
- Early Successes
  - Catherine Chen, MD – Faculty, UCSF
    - Grants: FAER RFG and MRTG
    - Publications during residency: 1st author NEJM 2015
  - Elizabeth Whitlock, MD, MS – Faculty, UCSF
    - Assistant Professor, UCSF
    - Grants: FAER MRTG, NIH GEMSTAR
    - Publications: 1st author British Medical Journal 2015
  - Paul Riegelhaupt, MD, PhD – Faculty, Cornell
    - Grants: FAER MRTG
    - Publications: Neuron 2014

Residency → Post-Residency → Independence

- Residency
  - 4 years (CA1-CA4)

  Support: Departmental stipend, FAER (RFG)
- Postdoctoral Fellowship
  - 2-3 years

  Support: Departmental, NIH T32, FAER (RFG)
- Junior Faculty
  - 2-7 years

  Support: Departmental, FAER (MRTG), IARS, AHA, K08, K23, etc

Up to14 years from entry onto PSI to 1st major independent grant (i.e.:R01)!

Thank You!!

Back to Schedule

HANDOUT

Approaches to Residency and Research

Vivianne L. Tawfik, MD, PhD

11/03/2018
8:10am – 8:30am

Back to Schedule

The future of academic anesthesia

*THE **FUTURE OF ANESTHESIOLOGY** IS HIGHLY **DEPENDENT ON THE SUCCESS OF YOUNG INVESTIGATORS** AS THEY DEVELOP INDEPENDENT CAREERS INVOLVING BASIC AND CLINICAL INVESTIGATION.*

*A **LEADING PRIORITY** OF ANESTHESIOLOGY MUST BE TO **NURTURE THE ACADEMIC CAREERS** OF PHYSICIAN SCIENTISTS WITHIN THE SPECIALTY.*

Schwinn DA, Balser JR.
Anesthesiology 2006.

Stanford University

Anesthesiologist-scientist: Endangered species?

Table 1. Total NIH Funding to Anesthesiology Departments Has Risen Steadily since the Mid-1990s in Absolute Dollars but Still Remains < 1.0% Total NIH

	Anesthesiology				
Year	$, Millions	No. of Grants	No. of Departments Funded*	Total NIH, $, Millions	Anesthesiology, % Total NIH
1975	6.1	61	26	871	0.7%
1980	6.9	91	25	1,480	0.6%
1985	12.3	96	35	2,460	0.5%
1990	19.6	134	35	3,300	0.6%
1995	34.1	170	43	4,870	0.7%
2000	59.5	248	48	7,440	0.8%
2003	97.2	320	55	10,800	0.9%

Funding to Anesthesia departments represents only 1% of NIH budget
But…Anesthesiologists make up 6% of physician workforce

Only 40% of Anesthesia departments had one or more NIH grants

Schwinn DA, Balser JR.
Anesthesiology 2006.

Stanford University

Resident research programs at Stanford

- **ABA Clinician-Scientist Track (CST)**
  - 2006-2009
  - Offered up to 6 months of research during residency
- **Research Elective (RE)**
  - 2012-present
  - Offers 1-3 months of research upon approval of mentored proposal
- Fellowship in Anesthesia Research and Medicine (FARM)
  - 2009-present
  - Offers up to 9 months research during residency, followed by 1-year research fellowship

Stanford University

Research Elective

- Requirements for submission:
  - Name of faculty mentor
  - Number of months requested (1-2 months) and preferred block(s) (this should be coordinated with faculty mentor)
  - **One-two page proposal with **specific plan** for research time developed with faculty mentor**
- Please keep in mind that there are very specific requirements to ensure that this time is productive, including **IRB approval** (if needed) before you start the month of research, presenting the project at our weekly research seminar (R&D) to get feedback and submitting an abstract to WARC.

Stanford University

Resident research programs at Stanford

- ABA Clinician-Scientist Track (CST)
  - 2006-2009
  - Offered up to 6 months of research during residency
- Research Elective (RE)
  - 2012-present
  - Offers 1-3 months of research upon approval of mentored proposal
- **Fellowship in Anesthesia Research and Medicine (FARM)**
  - 2009-present
  - Offers up to 9 months research during residency, followed by 1-year research fellowship

Stanford University

Back to Schedule

FARM Expectations

- CA-1: Investigate potential labs/projects; excel as an anesthesia resident
- CA-2: Begin initial studies; obtain preliminary data; excel as an anesthesia resident
- CA-3: Continue research; apply for institutional T32; excel as an anesthesia resident
- Fellowship: 80% commitment to research; 1 day/week in OR as attending; apply for funding +/- clinical subspecialty fellowship
- And then…work towards independence as an investigator, obtain faculty position, mentor other trainees, apply for funding ☺

Stanford University

Study Aim

For anesthesia residents interested in research, to determine what factors predict increased academic productivity following residency?

Stanford University

Methods of the current study

- IRB exemption obtained
- **Quantitative Study:**
  - Retrospective analysis of 49 residents between 2006 and 2017 who completed anesthesia residency at Stanford and participated in one of three research programs (CST, RE, FARM)
  - Primary outcome was modified scholarly activity point (mSAP)
    - Data obtained from CVs and publicly available information up to July 2018
    - Used one way ANOVA to evaluate statistical significance
    - Multivariable regression to analyze resident and program factors associated with higher post-residency productivity
  - Other data collected includes
    - Gender
    - Practice setting
    - Formal research degrees
- **Qualitative Study:**
  - Conducted structured interviews with FARM graduates to evaluate strengths and weaknesses of program

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Scholarly activity points (SAP) offer an objective measure of academic productivity

- Scholarly Activity Points
  - Established by Emerick et al. at University of Pittsburgh
  - Assign points to abstracts, manuscripts, book chapters, grant submissions, and patents
    - Accounts for individual's involvement and project impact

Emerick et al. *Br J Anaesth* 2013.
Glassick *Acad Med* 2000.

Stanford University

Scholarly activity points (SAP) offer an objective measure of academic productivity

Sample SAP:
Manuscripts: 150 points
a) Peer reviewed (x1.0)
b) Second author (x0.5)
c) Original research (x1.0)
d) Impact Factor: 4.14 (x4.14)

Manuscript SAPs = 150 × (modifier 1.0 × modifier 2.0 × modifier 3.0 × modifier 4.0)
→ Modifier 1.0. Peer-reviewed publication: Yes (×1.0); No (×0.5)
→ Modifier 2.0. Authorship: first author (×1.0); colleagues (×0.5)
→ Modifier 3.0. Category: original research (×1.0); review article (×0.75); case report (×0.5)
→ Modifier 4.0. IF: IF>0.5, then (×IF); 0<IF≤0.5 or no IF, then (×0.5)

SAP TOTAL: 150 x 1 x 1 x 0.5 x 4.14 = 310.5

- Manuscripts and grants account for approximately 88% of the total SAP
- We were unable to obtain records of scholarly activity for many in the Clinician-Scientist Track.
- All SAPs in this study reflect only manuscripts and grant submissions.

Emerick et al. *Br J Anaesth* 2013.
Glassick *Acad Med* 2000.

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Conclusions

- Any research time during residency is associated with
  1. Pursuit of academic practice
  2. Higher levels of scholarly activity throughout career
- Research prior to residency predicts higher post-residency scholarly activity as does participation in a formal research track
  - Additional support/training may be necessary to facilitate scholarly activity in research track residents without previous formal research training (i.e. PhD)

Stanford University

Acknowledgments

- **Elena Haight**
- Eric Sun
- John Brock-Utne
- Pedro Tanaka
- Alex Macario
- Rona Giffard
- Ron Pearl
- Janine Roberts
- Past & Current Residents at Stanford

Funding
- NIH NINDS K08
- Foundation for Anesthesia Education and Research
- Stanford Anesthesia Start-up Funds

Stanford University

Back to Schedule

HANDOUT

How to Successfully Apply for a T-32

Yan Xu, PhD

11/03/2018
8:40am – 8:55am

Tips for Writing a Successful T32 Application

Yan Xu, Ph.D.
Peter M. Winter Chair Professor
Vice Chair for Basic Sciences
Department of Anesthesiology and Perioperative Medicine
University of Pittsburgh School of Medicine

SAAAPM, November 3, 2018

Learning Objectives

Attendees will learn:

- Why T32?
  - Benefits to the department and specialty
- What are the minimum requirements?
  - Essential components within department and institution
  - Qualifications of program directors and mentors
  - Trainee pool
- Practical aspects of putting everything together
  - To-do list breakdown
  - Required forms and an effective way to compile them
- How to communicate effectively with potential reviewers
  - Understanding review criteria
  - Advertise your program effectively

Academic Anesthesiology

Academic Missions

- Educate next generation of physician scientists
- Advance new frontiers beyond the confines of traditional anesthesia provision
- Lead future intellectual and scientific pursuits
- Bridge new research discoveries to improving perioperative patient care

What is a T32?

- a.k.a. Ruth L. Kirschstein National Research Service Award (NRSA)
- a.k.a. Institutional Research Training Grant
- Peer-reviewed research training
- Designed for physician scientists (residency+)
- Postdoctoral trainees (PhD or MD/PhD) interested in an anesthesiology-related career path

16 Anesthesiology T32s in US

Columbia (Yr 26; $267K)	UCSF (Yr 22; $265K)
Duke (Yr 23; $288K)	U. of Michigan (Yr 05; $157K)
Johns Hopkins (Yr 13; $408K)	U. of Pennsylvania (Yr 04; $298K)
Harvard (Yr 41; $597K)	U. of Pittsburgh (Yr 12, $232K)
Med College of Wisconsin (Yr 09; $194K)	U. of Washington (Yr 10; $225K)
Stanford (Yr 09; $297K)	Vanderbilt (Yr 06; $280K)
SUNY, Buffalo (Yr 07; $201K)	Wash U. (Yr 05; $268K)
UCSD (Yr 02; $133K)	Yale (Yr 10; $199K)

The longest running T32 program in anesthesiology: 41 years

Potential for Future Growth?

- How about other anesthesia departments?
- How many T32s are ideal for our specialty?
- Compared to other medical disciplines:
  - Dept. of Medicine at UCSF alone: 15 T32s
  - Dept. of Psychiatry at Columbia: 8 T32s
  - Dept. of Psychiatry at U Pittsburgh: 7 T32s

Challenges in Academic Medicine

- Reduced clinical volumes & reimbursements
- Shrinking operating margins for education and research
- Declining NIH buying power
- Too many are competing for too few grants
- Low T32-to-R01 transition rate

Source: beckershospitalreview.com

Back to Schedule

T32 Benefits

- Set a higher standard for peer-reviewed research in anesthesiology
- Cornerstone and catalyst for research training in residency programs
- Elevate academic standing of our specialty
- Create a peer group for the next generation of academic leaders

Investigator Compositions in Anes Departments with T32

Anesthesiology Departments with T32 Programs

Number of Faculty: 0, 25, 50, 75, 100, 200, 300

NIH Funding Rank: 2, 3, 4, 5, 6, 8, 9, 10, 11, 13, 18, 24, 52

148.5

36.4

12.4

13 PhDs

36 MDs or MD/PhDs

149 FTE

Data from FY 2014

Original Investigations in Education

Facilitation of Resident Scholarly Activity

Strategy and Outcome Analyses Using Historical Resident Cohorts and a Rank-to-Match Population

Tetsuro Sakai, M.D., Ph.D., Trent D. Emerick, M.D., David G. Metro, M.D., Rita M. Patel, M.D., Sandra C. Hirsch, M.B.A., Daniel G. Winger, M.S., Yan Xu, Ph.D.

ABSTRACT

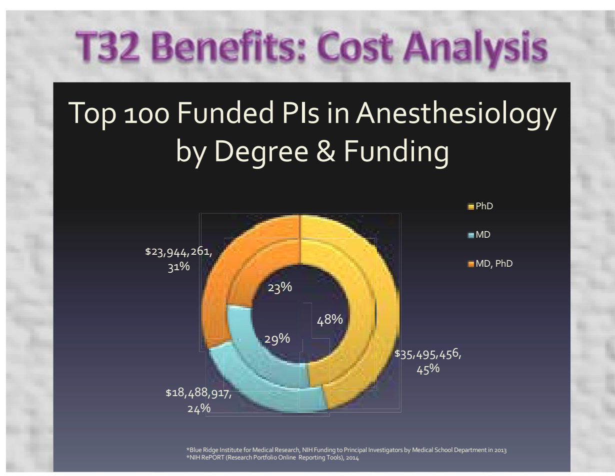
Background: Facilitation of residents' scholarly activities is indispensable to the future of medical specialties. Research education initiatives and their outcomes, however, have rarely been reported.

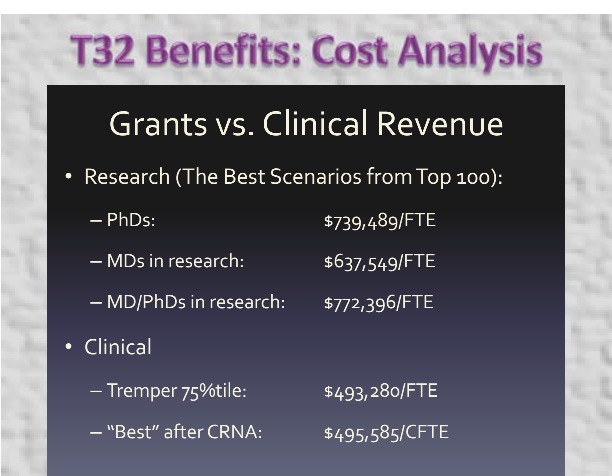
Methods: Since academic year 2006, research education initiatives, including research lectures, research problem–based learning discussions, and an elective research rotation under a new research director's supervision, have been used. The effectiveness of the initiatives was evaluated by comparing the number of residents and faculty mentors involved in residents' research activity (Preinitiative [2003–2006] *vs.* Postinitiative [2007–2011]). The residents' current postgraduation practices were also compared. To minimize potential historical confounding factors, peer-reviewed publications based on work performed during residency, which were written by residents who graduated from the program in academic year 2009 to academic year 2011, were further compared with those of rank-to-match residents, who were on the residency ranking list during the same academic years, and could have been matched with the program of the authors had the residents ranked it high enough on their list.

Results: The Postinitiative group showed greater resident research involvement compared with the Preinitiative group (89.2% [58 in 65 residents] *vs.* 64.8% [35 in 54]; $P = 0.0013$) and greater faculty involvement (23.9% [161 in 673 faculty per year] *vs.* 9.2% [55 in 595]; $P < 0.0001$). Choice of academic practice did not increase (50.8% [Post] *vs.* 40.7% [Pre]; $P = 0.36$). Graduated residents (n = 38) published more often than the rank-to-match residents (n = 220) (55.3% [21 residents] *vs.* 13.2% [29]; $P < 0.0001$, odds ratio 8.1 with 95% CI of 3.9 to 17.2).

Conclusion: Research education initiatives increased residents' research involvement. (Anesthesiology 2014; 120:111-9)

Back to Schedule





T32: Minimum Requirements

- Senior research leaders
- Academic environment within institution
- Dept. infrastructure supportive of resident research
- Effective recruitment strategies and strong trainee pool
- Chair's commitment to research excellence

Administrative Structure of Research Training in Anesthesiology and Pain Medicine

Oversight Committee: A Mahajan: Chair, P. Davis, A. Levine, S. Reis

Program Director: Y. Xu
Program Administrator: S. Hirsch

External Advisory Board: A. Evers, R. Giffard, D. Schwinn

Principal Training Faculty (35 members)

Trainees

Executive Committee: Y. Xu: Chair, M.S. Gold, D. Metro, R.M. Patel, T. Sakai

Trainee Advisory & Evaluation Committee

Back to Schedule

Sections in T32 Applications

- Background
  - Rationale
  - Relevant institution/department history
  - Relationship to other training activities
- Program Plan
  - Administration structure and program director(s)
  - Training faculty
    - One paragraph for each faculty mentor's research interest & project(s)
    - Interaction among faculty members
  - Proposed training
    - Number of slots and duration of training
    - Training methods and summary of coursework
    - Research ethics and required training modules
  - Institutional training environment and resources

Sections in T32 Applications (cont'd)

- Program Evaluation
  - Advisory and evaluation structure
  - Career development plan and milestones
  - Self and progress assessment tools (note: appendices are not allowed)
  - External advisors
- Recruitment and Retention to Enhance Diversity
  - University policy on diversity (URM, gender, and disabilities)
  - Disability resources and services
  - Proposed recruitment strategies and candidate pool
  - Retention strategies and career building pathways
- Instruction in Responsible Conduct of Research
  - RCR requirements and monitoring
  - Faculty participation
  - Duration and frequency
- Trainees' Achievements

7 Required Data Tables

- Table 1. Participating Departments & Programs
  - Insight into training environment
  - Critical mass of trainees and faculty
- Table 2. Participating Faculty
  - Junior vs. senior composition; research areas; department affiliation
  - Past training experience and records
- Table 3. Other Training-Related Support to Faculty
  - Assessing interaction and overlaps, as well as institutional environment
- Table 4. Research Support to Faculty
  - Evidence of research strength
  - Availability of funds to support trainees' research
  - Appropriateness of faculty to serve as advisors

Required Data Tables (cont'd)

- Table 5B. Publications of Those in Training
  - Indicator of trainees' productivity
  - Research quality and authorship priority of trainees
- Table 6B. Applicants and Entrants for Past Five Years
  - Characteristics of the applicants
  - Assessing admission process and competitiveness
- Table 8C. Program Outcomes
  - Provide information on effectiveness of the training program

- NIH table templates (rationale & detailed instructions) are available on SAAAPM website.

Advertisement:
Getting & Keeping Reviewers' Attention

Communicating with Reviewers: Overall Impact Score

- How will your program exert a sustained, powerful influence on the field

- Likelihood that program will prepare individuals for successful, productive scientific research careers

Back to Schedule

Clearly Address 5 Review Criteria

- Training program and environment
  - How different from other programs; focus areas and relevance to anesthesiology
  - Institutional commitment and resources
- Program director(s) and PI(s)
  - Scientific expertise and administrative/leadership/training experience
  - PD/PI effort commitment; justification for multiple PDs
- Preceptors or mentors
  - Multidisciplinary; MDs & PhDs; basic & clinical; strong training record
- Trainees or candidates/scholars
  - Competitive pools; selection criteria; recruitment strategies; resident research
- Training record
  - Trainee productivity; rigorous evaluation for quality and effectiveness
  - Milestones and career plans; feedbacks from trainees

Successful T32:

Train physician scientists for the long-term health of the anesthesiology profession

OMB Number 0925-0001 and 0925-0002 (Rev. 03/18 Approved Through 03/31/2020)

Table 1. Census of Participating Departments and Interdepartmental Programs

Rationale

This table provides insight into the environment in which the proposed training will take place. It allows reviewers to assess whether the program has the "critical mass" of trainees and faculty and, in the case of interdepartmental programs, representation/distribution of scientific disciplines, to be effective.

Instructions

Part I. Predoctorates

For the current academic year, provide the total number of faculty members, predoctorates, and postdoctorates in each participating department and interdepartmental program, **regardless** of whether this is a predoctoral or postdoctoral program application. Faculty members should be counted more than once if they participate in a departmental as well as an interdepartmental program(s). Predoctorates and postdoctorates should be counted only once and in association with a single department or interdepartmental program.

For each participating department, division, or interdepartmental program enter the following counts for the current academic year:

1. **Participating Department or Program.** List the name of the Department, Division, or Interdepartmental Program.
2. **Total Faculty.** Provide the total number of current faculty members. In the Total row, count each faculty member only once and enter, in bold font, the total number of ***unique*** faculty members across the participating departments and interdepartmental programs.
3. **Participating Faculty.** Provide the total number of faculty members who will participate in the proposed training program. In the Total row, count each faculty member only once and enter, in bold font, the total number of ***unique*** participating faculty members across the participating departments and interdepartmental programs. (Where faculty members are included in the counts for both a department and a program, or have appointments in more than one participating department, the total number of ***unique*** faculty will be less than the sum across participating departments and programs.)
4. **Total Predoctorates.** Enter the total number of predoctorates. In the Total row, sum across departments and interdepartmental programs and enter, in bold font, the total number of predoctorates for this column.
5. **Total Predoctorates Supported by any HHS Award.** Provide the total number of predoctorates who are currently supported by **any** HHS training award (e.g., NIH T32, T90/R90, F30, F31, AHRQ T32, CDC T03). In the Total row, sum across departments and interdepartmental programs and enter, in bold font, the total number of predoctorates for this column.
6. **Total Predoctorates with Participating Faculty.** Provide the total number of predoctorates with those faculty who are participating in the proposed training program. In the Total row, sum across departments and interdepartmental programs and enter, in bold font, the total number of predoctorates for this column.
7. **Eligible Predoctorates with Participating Faculty.** Provide the total number of predoctorates who are with participating faculty, and who are eligible for support under the proposed award. In most cases (i.e., a T32 application), this number will reflect students who are citizens or non-citizen nationals of the U.S. or permanent residents. In the Total row, sum across departments and interdepartmental programs and enter, in bold font, the total number of predoctorates for this column.
8. **Training Grant Eligible (TGE) Predoctorates Supported by this Training Grant (Renewals, Revisions Only).** If this is a renewal or revision application, enter the total number of TGE or training-grant eligible (i.e., U.S. citizens, non-citizen nationals of the U.S. or permanent residents) predoctorates currently supported by **this** training grant. (If this is a resubmission application following a gap in funding, the number entered here may be zero.) In the Total row, sum across departments and interdepartmental programs and enter, in bold font, the total number of predoctorates for this column. If not a renewal or revision application, do not include this column.
9. **Predoctorates Supported by this Training Grant (R90 Only Renewals/Revisions).** If this is a renewal or revision application of a T90/R90 award, enter the total number of predoctorates currently supported on the R90 award component. In the Total row, sum across departments and interdepartmental programs and enter, in bold font, the total number of predoctorates for this column. If not a renewal or revision of a T90/R90 award, do not include this column.

Back to Schedule

Part II. Postdoctorates

For the current academic year, provide the total number of faculty members, predoctorates, and postdoctorates in each participating department and interdepartmental program, **regardless** of whether this is a predoctoral or postdoctoral program application. Faculty members should be counted more than once if they participate in a departmental as well as an interdepartmental program(s). Predoctorates and postdoctorates should be counted only once and in association with a single department or interdepartmental program.

For each participating department, division or interdepartmental program enter the following counts for the current academic year:

1. **Participating Department or Program.** List the name of Department, Division or Program.
2. **Total Faculty.** Provide the total number of current faculty members. In the Total row, count each faculty member only once and enter, in bold font, the total number of ***unique*** faculty members across the participating departments and interdepartmental programs. (Where faculty members are included in the counts for both a department and a program, or have appointments in more than one participating department, the total number of ***unique*** faculty will be less than the sum across participating departments and programs.)
3. **Participating Faculty.** Provide the total number of faculty members who will participate in the proposed training program. In the Total row, count each faculty member only once and enter, in bold font, the total number of ***unique*** participating faculty members across the participating departments and interdepartmental programs.
4. **Total Postdoctorates.** Provide the total number of postdoctorates. In the Total row, sum across departments and interdepartmental programs and enter, in bold font, the total number of postdoctorates for this column.
5. **Total Postdoctorates Supported by any HHS Training Award.** Provide the total number of postdoctorates who are currently supported by **any** HHS training award (e.g., T32, T90/R90, F32, AHRQ T32, CDC T03). In the Total row, sum across departments and interdepartmental programs and enter, in bold font, the total number of postdoctorates for this column.
6. **Total Postdoctorates with Participating Faculty.** Provide the total number of postdoctorates with those faculty who are participating in the proposed training program. In the Total row, sum across departments and interdepartmental programs and enter, in bold font, the total number of postdoctorates for this column.
7. **Eligible Postdoctorates with Participating Faculty.** Provide the total number of postdoctorates who are with participating faculty and who are eligible for support under the proposed award. In most cases (e.g. a T32 application), this number will reflect individuals who are citizens or non-citizen nationals of the U.S. or permanent residents. In the Total row, sum across departments and interdepartmental programs and enter, in bold font, the total number of postdoctorates for this column.
8. **Training Grant Eligible (TGE) Postdoctorates Supported by this Training Grant (Renewals/ Revisions).** If this is a renewal or revision application, enter the total number of TGE postdoctorates currently supported by **this** training grant. (If this is a resubmission application following a gap in funding, the number entered here may be zero.) In the Total row, sum across departments and interdepartmental programs and enter, in bold font, the total number of postdoctorates for this column. If not a renewal or revision application, do not include this column.
9. **Postdoctorates Supported by this Training Grant (R90 Only Renewals/ Revisions).** If this is a renewal or revision application of a T90/R90 award, enter the total number of postdoctorates currently supported on the R90 award component. In the Total row, sum across departments and interdepartmental programs and enter, in bold font, the total number of postdoctorates for this column. If not a renewal or revision of a T90/R90 award, do not include this column.

Summarize these data in the Background Section of the Research Training Program Plan. Use the narrative to describe the organization of the proposed training program, the participating departments and interdepartmental programs, and the extent to which faculty, graduate students, and/or postdoctorates from those departments/interdepartmental programs participate in the programmatic activities to be supported by the training grant.

Sample Table 1. Census of Participating Departments and Interdepartmental Programs

Part I. Predoctorates

Participating Department or Program	Total Faculty	Participating Faculty	Total Predoctorates	Total Predoctorates Supported by any HHS Training Award	Total Predoctorates with Participating Faculty	Eligible Predoctorates with Participating Faculty	TGE Predoctorates Supported by this Training Grant (Renewals/ Revisions)	Predoctorates Supported by this Training Grant (R90 Only Renewals/ Revisions)
Department of Biochemistry	45	14	38	15	12	6	2	0
Neuroscience Program	32	20	31	20	14	7	4	1
Department of Pharmacology	25	5	30	10	5	3	3	0
Total	**102**	**39**	**99**	**45**	**31**	**16**	**9**	**1**

Part II. Postdoctorates

Participating Department or Program	Total Faculty	Participating Faculty	Total Postdoctorates	Total Postdoctorates Supported by any HHS Training Award	Total Postdoctorates with Participating Faculty	Eligible Postdoctorates with Participating Faculty	TGE Postdoctorates Supported by this Training Grant (Renewals/ Revisions)	Postdoctorates Supported by this Training Grant (R90 Only Renewals/ Revisions)
Department of Biochemistry	45	14	24	10	9	5	2	0
Neuroscience Program	32	20	27	20	12	5	3	1
Department of Pharmacology	25	5	15	8	5	3	2	0
Total	**102**	**39**	**66**	**38**	**26**	**13**	**7**	**1**

Table 2. Participating Faculty Members

Rationale

This information allows reviewers to assess the distribution of participating faculty by rank (junior vs. senior), by research interests, and by department or interdepartmental program. In addition, data on the mentoring records of faculty permit an evaluation of the experience of participating faculty in facilitating the progression of predoctorates and postdoctorates in their careers. The data concisely summarize information about the training faculty.

Instructions

List participating faculty in alphabetical order by last name. For each participating faculty member, provide:

1. **Name.** Include the full name in the format Last Name, First Name and Middle Initial.
2. **Degree(s).** Provide the faculty member's terminal degree(s).
3. **Rank.** Provide the academic rank held by each faculty (e.g., Asst. Prof. for Assistant Professor, Assoc. Prof. for Associate Professor, Prof. for Professor, Res. Asst. Prof. for Research Assistant Professor, Instructor).
4. **Primary Department or Program.** List the primary affiliation (department, interdepartmental program, or other academic unit).
5. **Research Interest.** Provide the faculty member's research interest relevant to the proposed training program.
6. **Training Role.** Provide up to three role(s) for each faculty in the proposed training program, selected from the following options: PD/PI, Preceptor, Executive Committee member (Exec. Comm.), Other Committee member (Other Comm.), Other.

Mentoring Record (Items 7-12). For the last 10 years, provide the record for mentoring predoctorates and postdoctorates who have been or are currently engaged in research training under the faculty member's primary supervision. Exclude predoctorates doing research rotations, and clinical interns and residents unless they have been or are currently engaged in full-time, mentored research training in the faculty member's research group.

7. **Predoctorates in Training.** Provide the number of predoctorates who are currently in training.
8. **Predoctorates Graduated.** Provide the number of predoctorates who were awarded their doctoral degree during the last 10 years.
9. **Predoctorates Continued in Research or Related Careers.** Provide the number of predoctorates who were awarded their doctoral degree during the last 10 years and who currently are engaged in a research-intensive or research-related career. Research-related positions generally require a doctoral degree, and may include activities such as teaching, administering research or higher education programs, science policy, and technology transfer.
10. **Postdoctorates in Training.** Provide the number of postdoctorates who are currently in training in the faculty member's laboratory.
11. **Postdoctorates Completed Training.** Provide the number of postdoctorates who completed postdoctoral training in the faculty member's laboratory during the last 10 years.
12. **Postdoctorates Continued in Research or Related Careers.** Provide the number of postdoctorates who completed postdoctoral training during the last 10 years and who currently are engaged in a research-intensive or research-related career.

Summarize these data in the Research Training Program Plan, within the Background Section and the Program Faculty Section of the Program Plan. Use the narrative to describe the distribution of participating faculty by academic rank, department or interdepartmental program, areas of research emphasis, and the rationale for the faculty selected to participate in the training grant. Analyze the data in terms of the overall experience of the faculty in training predoctorates and/or postdoctorates. Comment on the inclusion of faculty whose mentoring records may suggest limited, recent training experience at either training level (predoctoral or postdoctoral).

Sample Table 2. Participating Faculty Members

Name	Degree(s)	Rank	Primary Department or Program	Research Interest	Training Role	Pre-doctorates In Training	Pre-doctorates Graduated	Predoctorates Continued in Research or Related Careers	Post-doctorates In Training	Post-doctorates Completed Training	Postdoctorates Continued in Research or Related Careers
Abrams-Johnson, Jane	PhD	Asst. Prof.	Pharmacology	Regulation of Synthesis of Biogenic Amines	Preceptor Other Comm	1	2	2	1	0	0
Jones, Lisa S.	PhD	Res. Asst. Prof.	Biochemistry	Protein Structure, Folding, and Immunogenicity	Preceptor Exec Comm	3	3	3	4	2	2
Sandoz, Miguel J.	MD, PhD	Assoc. Prof.	Neuroscience	Developmental Genetics in Drosophila	Preceptor	4	6	5	4	8	6
Thomas, James C.	PhD	Prof.	Biochemistry	Molecular and Genetic Analysis of RNA Viruses	PD/PI	7	10	9	8	15	14

Table 3. Federal Institutional Research Training Grants and Related Support Available to Participating Faculty Members

Rationale

This table will permit an evaluation of the current level of support for related research training and the extent to which the proposed training grant has overlap in participating faculty. This information is useful in assessing the institutional environment and determining the number of training positions to be awarded.

Instructions

For all currently active, federal institutional training (e.g., NIH T32, T35, AHRQ T32), career development, and research education (e.g., NIH R25, K12/KL2, TL1) support available to the participating faculty members, list the following:

1. **Grant Title.** Provide the full grant title. Do not list all training and related grants at the participating institution(s); list only those with any overlapping faculty (i.e., including any of the same faculty members participating in the proposed training program).
2. **Award Number.** Provide the full award number.
3. **Project Period.** Provide project period dates inclusive of the entire project period, in the format MM/YYYY-MM/YYYY
4. **PD/PI.** Provide the name of the PD/PI(s), in the format Last Name, First Name and Middle Initial.
5. **Number of Predoctoral Positions.** Provide the number of full-time predoctoral training positions. In the Total row, sum the number of predoctoral positions across all awards and enter the total in bold font.
6. **Number of Postdoctoral Positions.** Provide the number of full-time postdoctoral training positions. In the Total row, sum the number of postdoctoral positions across all awards and enter the total in bold font.
7. **Number of Short-Term Positions.** Provide the number of short-term training positions. In the Total row, sum the number of short-term positions across all awards and enter the total in bold font.
8. **Number of Participating Faculty (Number Overlapping).** Provide the total number of participating faculty members and, parenthetically, the number of participating faculty members who are also named in this application (overlapping faculty).
9. **Names of Overlapping Faculty.** List the last names of all overlapping faculty.

Summarize these data in the Background Section of the Research Training Program Plan. Use the narrative to summarize the level of research training support at the institution and describe any relevant restrictions on that support (e.g., whether it is targeted to specific groups of trainees, such as early- or late-stage graduate students, medical students, etc.). Provide an explanation for instances where the tabular data indicate that there may be substantial overlap of participating faculty.

Sample Table 3. Federal Institutional Research Training Grants and Related Support Available to Participating Faculty Members

Grant Title	Award Number	Project Period	PD/PI	Number of Predoctoral Positions	Number of Postdoctoral Positions	Number of Short-Term Positions	Number of Participating Faculty (Number Overlapping)	Names of Overlapping Faculty
Bioimmunotherapy Training Grant	T32 CA05964-11	07/2011-06/2016	Thomas, James C.	12	0	0	25 (6)	Abelson Brown Fields Johnson Sung Watson
Genetic Basis of Mental Illness	T32 MH02708-07	07/2010-06/2015	Johnson, Albert P.	4	4	2	7 (2)	Johnson Watson
Research Education Program for Residents in Psychiatry	R25 MH09876-06	07/2013-06/2018	Mendez, V. Roberto	0	6	0	33 (3)	Mendez Rivers Truesdale
Career Development in Pediatric Mental Health	K12 HD01234-09	07/2012-06/2017	Sterman, Patricia S.	0	4	0	19 (1)	Rubin
Total				**16**	**14**	**2**		

Table 4. Research Support of Participating Faculty Members

Rationale

This table provides evidence of the strength of the research environment, the availability of funds to support research conducted by the trainees, and the appropriateness of the participating faculty in terms of their active research support.

Instructions

For each faculty member, list the following:

1. **Faculty Member.** List participating faculty members in alphabetical order by last name, in the format Last Name, First Name and Middle Initial.
2. **Funding Source.** List the funding source as NIH, AHRQ, NSF, Other Federal (Other Fed), University (Univ), Foundation (Fdn), None, or Other. If none, state "None." **Exclude applications pending review or award.**
3. **Grant Number.** For each participating faculty member, provide the full grant number for the currently active research grant support in which the faculty member has a role of PD/PI or, in the case of a multi-project grant or cooperative agreement, Project or Core Lead. If the source of the research support is part of a multi-project grant or cooperative agreement (e.g., P01, P50, U10, U19, U54), provide the relevant information only for that component for which the faculty member is responsible. Include research grants from all sources that will provide the context for the planned research training experiences. Exclude institutional research training grants, institutional career development grants, and research education grants.
4. **Role on Project.** Provide the role of the faculty member on the research project grant (i.e., PD/PI). In the case of a multi-project grant or cooperative agreement, where faculty members may be leading projects or cores, enter the role, "Project Lead."
5. **Grant Title.** Provide the Grant Title.
6. **Project Period.** List the inclusive dates of the entire project period (in the format MM/YYYY-MM/YYYY).
7. **Current Year Direct Costs.** Provide the direct costs for the current budget period. Calculate and provide the average grant support per Participating Faculty Member in the last row.

Summarize these data in the Program Plan (Program Faculty Section) of the Research Training Program Plan. Analyze the data in terms of total and average grant support. Comment on the inclusion of faculty without research grant support in the proposed training program and explain how the research of trainees who may work with these faculty members would be supported.

Sample Table 4. Research Support of Participating Faculty Members

Faculty Member	Funding Source	Grant Number	Role on Project	Grant Title	Project Period	Current Year Direct Costs
Jones, Janine L.	NIH	1 R01 GM76259-01	PD/PI	Structure and Function of Acetylcholine Receptors	06/2014-05/2018	$190,000
Jones, Janine L.	NIH	5 K08 AI00091-03	PD/PI	Purification & Identification of Receptors	11/2012-11/2017	$140,000
Ehlers, Roger G.	Univ		PD/PI	University start-up funds	08/2014-07/2017	$350,000
Mack, Thomas R.	Fdn		PD/PI	Control of Angiogenesis	03/2011-02/2015	$185,000
Mack, Thomas R.	NSF	PCM 80-12935	PD/PI	Cell Culture Center	12/2012-11/2015	$180,000
Mack, Thomas R.	NIH	1 P01 HL71802-05	Project PI	Subproject 4: Oncogenic Kit Receptor Signaling in vivo	10/2011-09/2015	$165,000
Smith, James P.	None					
Zachary, Andrew	NIH	1 U01 AI28507-02	PD/PI	Human Monoclonal Antibodies as a Therapy for Staphylococcal Enterotoxin	07/2013-06/2018	$200,000
Average Grant Support per Participating Faculty Member						**$282,000**

Table 5B. Publications of Those in Training: Postdoctoral

Rationale

This information provides an indicator of the ability of each faculty member to foster trainee productivity through generation of publishable results and allows assessment of the research quality and authorship priority of trainees.

Instructions

For each trainee, list the following:

1. **Faculty Member.** Sort postdoctorates by faculty member. List each faculty member in the format Last Name, First Name and Middle Initial.
2. **Trainee Name.** List each trainee in the format Last Name, First Name and Middle Initial.
    - **New applications.** For each participating faculty member in a **new** application, list all publications of representative, previous postdoctorates from the last 10 years and **all** current postdoctorates. Only include individuals who would have been eligible for appointment to this training program.
    - **Renewal/revision applications.** For each participating faculty member in a renewal/revision application, list the publications of trainees appointed to the training grant, including all current trainees and those appointed to the grant for up to the past 10 years, with the exception of those appointed to short-term training positions.
3. **Past or Current Trainee.** Sort postdoctorates by faculty member. For each faculty member, group past postdoctorates separately from current postdoctorates. Sort each group by their year of entry into postdoctoral training with the faculty member or in association with the program.
4. **Training Period.** Indicate the year that postdoctorates entered into training with the current faculty member or in association with the program and the year they completed or left the training program, in the format YYYY-YYYY. For current postdoctorates, report the year they started the program or began working with the current faculty member and indicate that training is still underway by using the format YYYY-Present.
5. **Publication (Authors, Year, Title, Journal, Volume, Inclusive Pages).** List publications in chronological order followed by abstract-only publications. List all publications of postdoctorates resulting from their period of training in the faculty member's laboratory or in association with the current training program. **Do not list publications resulting from work done prior to joining the training program or arising from research initiated after the completion of the program.** List abstract-only publications **only** if a more complete publication has not appeared and label these clearly as abstracts. **Boldface** the postdoctorate's name in the author list.
    - For postdoctorates without a publication, indicate "No Publications." Provide one of the following explanatory phrases: new entrant, leave of absence, change of research supervisor, left program, other.

Summarize these data in the Program Plan section of the Research Training Program Plan including, for example, the average number of papers published by postdoctorates, the number as first author, and the number of postdoctorates who completed training without any peer-reviewed publications.

Sample Table 5B. Publications of Those in Training: Postdoctoral

Faculty Member	Trainee Name	Past or Current Trainee	Training Period	Publication (Authors, Year, Title, Journal, Volume, Inclusive Pages)
Berg, Lawrence P.	Thomas, Patrick D.	Past	2003-2006	Miter, M.H., Owens, R., **Thomas, P.**, and Berg, L., 2006, Insulin Deficiency in Diabetic Rats, J. Nutrition, 373:350-378.
Chew, Jason B.	Greenstuff, Marisa P.	Current	2012-Present	**Greenstuff, M.**, and Chew, J., 2014, Non-digestible fibre influences bioavailability of vitamins, J. Pharm Sci. (In press).
Easygai, Franchesca	Taylor, Doris W.	Past	2010-2013	No Publications: Change of Research Supervisor
Newpeeye, Pamela W.	Fall, Winfred	Past	2012-2014	No Publications: Leave of Absence

Table 6B. Applicants, Entrants, and Their Characteristics for the Past Five Years: Postdoctoral

Rationale

These data permit the evaluation of the ability of participating departments/interdepartmental programs to recruit trainees. These data are useful in assessing the selectivity of the admissions process, the competitiveness of the training program, and the appropriate number of training positions to be awarded.

Instructions

Part I. Counts

In **Part I** of this table, list the following counts for each major degree type (i.e., PhDs, MDs, Dual Degree Holders, including individuals holding the MD/PhD, DDS/PhD, DVM/PhD, or other dual degrees, and Other Degree Holders) for each of the past 5 years. Depending on the grant cycle, users may choose to report by academic or grant year, but should always begin with the most recently completed year.

1. **Most Recently Completed Year.** Enter the most recently completed year in the format “Most Recently Completed Year: 2013-2014”
2. **Total Applicant Pool.** Number of individuals who formally applied for training
3. **Applicants Eligible for Support.** Number of individuals who formally applied for training and were eligible for support from this grant (In most cases, eligible individuals will be those who are citizens or non-citizen nationals of the U.S. or permanent residents; see the Funding Opportunity Announcement for specific guidance.).
4. **New Entrants to the Program.** Number of new entrants to the department/interdepartmental program)
5. **New Entrants Eligible for Support.** Number of new entrants to the department/interdepartmental program who were eligible for support from this grant
6. **New Entrants Appointed to this Grant (Renewal/Revision Applications Only).** Number of new entrants appointed to this grant (If this is not a Renewal/Revision application, do not include this column.)

Include only those postdoctoral applicants who could be considered candidates for the proposed training program.

Summarize these data in the Program Plan (Trainee Candidate Section) of the Research Training Program Plan. Analyze the data in terms of the overall numbers of potential trainees, their sources, their credentials and eligibility for support, and enrollment trends. The narrative should clearly describe the recruitment process for postdoctoral trainees (e.g., whether candidates are selected from individuals in the laboratories of proposed faculty members or whether there is a formal application process to the training program).

For each additional year, enter the prior year in the format “Previous Year: 2012-2013” until all five years are completed, and complete the sections as described above. In the final section of **Part I**, provide the mean count for each column.

Part II. Characteristics

In **Part II** of the table, provide the following information about the characteristics of entrants and applicants, for each of the past 5 years (e.g., academic or grant years), beginning with the most recently completed year:

1. **Mean Number of Publications (range).** For each category of applicants and entrants as defined in Part I, items 2-6, enter the mean number of publications calculated to one decimal place (e.g., 2.5) and range (e.g., 0-6), at the time of application to the program.
2. **Mean Number of First-Author Publications (range).** For each category of applicants and entrants as defined in Part I items 2-6, enter the mean number (calculated to one decimal place) and range of first-author publications at the time of application to the program.
3. **Prior Institutions.** For each category of entrants as defined in Part I, items 4-6, enter the names of their prior institutions. For postdoctorates, this will be the names of their doctoral degree-granting institutions. If more than one entrant has the same prior institution, list the institution only once, followed by the number of entrants in parentheses.
4. **Percent with a Disability.** For each category of entrants as defined in Part I, items 4-6, enter the percent of individuals with disabilities, defined as those with a physical or mental impairment that substantially limits one or more major life activities.
5. **Percent from Underrepresented Racial and Ethnic Groups.** For each category of entrants as defined in Part I, item 4) to item 6), enter the percent of individuals from racial and ethnic groups that have been shown by the National Science Foundation to be underrepresented in biomedical research on a national basis (i.e., Black or African Americans, Hispanic or Latinos, American Indians or Alaska Natives, Native Hawaiians and other Pacific Islanders).

For each additional year, enter the prior year in the format “Previous Year: 2012-2013” until all five years are completed, and complete the sections as described above. In the final section of **Part II**, provide the mean values for all years of support.

Summarize these data in the Program Plan (Trainee Candidate Section) of the Research Training Program Plan. Analyze the data in terms of the overall numbers of potential trainees, their credentials, characteristics, and eligibility for support, and enrollment trends.

Sample Table 6B. Applicants, Entrants, and Their Characteristics for the Past Five Years: Postdoctoral

Part I. Counts

Most Recently Completed Year: 2013-2014	Total Applicant Pool	Applicants Eligible for Support	New Entrants to the Program	New Entrants Eligible for Support	New Entrants Appointed to this Grant (Renewal/Revision Applications Only)
PhDs	25	15	6	5	4
MDs	4	1	0	0	0
Dual-Degree Holders	3	3	2	2	2
Other Degree Holders	0	0	0	0	0
Total	**32**	**19**	**8**	**7**	**6**

Previous Year: 2012-2013	Total Applicant Pool	Applicants Eligible for Support	New Entrants to the Program	New Entrants Eligible for Support	New Entrants Appointed to this Grant (Renewal/Revision Applications Only)
PhDs	23	10	5	4	3
MDs	5	2	1	1	1
Dual-Degree Holders	3	3	3	3	3
Other Degree Holders	0	0	0	0	0
Total	**31**	**15**	**9**	**8**	**7**

Previous Year: 2011-2012	Total Applicant Pool	Applicants Eligible for Support	New Entrants to the Program	New Entrants Eligible for Support	New Entrants Appointed to this Grant (Renewal/Revision Applications Only)
PhDs	28	18	8	6	4
MDs	4	2	1	1	1
Dual-Degree Holders	2	2	2	2	2
Other Degree Holders	0	0	0	0	0
Total	**34**	**22**	**11**	**9**	**7**

Previous Year: 2010-2011	Total Applicant Pool	Applicants Eligible for Support	New Entrants to the Program	New Entrants Eligible for Support	New Entrants Appointed to this Grant (Renewal/Revision Applications Only)
PhDs	20	12	7	7	6
MDs	4	1	0	0	0
Dual-Degree Holders	3	3	2	2	2
Other Degree Holders	0	0	0	0	0
Total	**27**	**16**	**9**	**9**	**8**

Previous Year: 2009-2010	Total Applicant Pool	Applicants Eligible for Support	New Entrants to the Program	New Entrants Eligible for Support	New Entrants Appointed to this Grant (Renewal/Revision Applications Only)
PhDs	25	16	8	6	5
MDs	3	1	0	0	0
Dual-Degree Holders	1	1	1	1	1
Other Degree Holders	0	0	0	0	0
Total	**29**	**18**	**9**	**7**	**6**

Means Across All Years	Total Applicant Pool	Applicants Eligible for Support	New Entrants to the Program	New Entrants Eligible for Support	New Entrants Appointed to this Grant (Renewal/Revision Applications Only)
PhDs	24	14	7	6	4
MDs	4	1	0	0	0
Dual-Degree Holders	2	2	2	2	2
Other Degree Holders	0	0	0	0	0
Total	**30**	**17**	**9**	**8**	**6**

Part II. Characteristics

Most Recently Completed Year: 2013-2014	Total Applicant Pool	Applicants Eligible for Support	New Entrants to the Program	New Entrants Eligible for Support	New Entrants Appointed to this Grant (Renewal/Revision Applications Only)
Mean Number of Publications (range)	3.5 (1-9)	4.0 (1-9)	4.0 (1-9)	4.0 (1-7)	4.0 (3-7)
Mean Number of First-Author Publications (range)	2.0 (1-3)	2.4 (2-3)	2.5 (2-3)	2.5 (2-3)	2.0 (2-3)
Prior Institutions			New York Univ. Boston Univ.(4) Univ. of Iowa (3)	Boston Univ. (4) Univ. of Iowa (3)	Boston Univ. (3) Univ. of Iowa (3)
Percent with a Disability			10%	—	—
Percent from Underrepresented Racial & Ethnic Groups			33%	50%	50%

Previous Year: 2012-2013	Total Applicant Pool	Applicants Eligible for Support	New Entrants to the Program	New Entrants Eligible for Support	New Entrants Appointed to this Grant (Renewal/Revision Applications Only)
Mean Number of Publications (range)	3.4 (1-8)	3.8 (1-8)	3.8 (1-8)	3.9 (2-8)	3.9 (2-8)
Mean Number of First-Author Publications (range)	1.8 (1-3)	2.0 (1-3)	2.1 (1-3)	2.2 (1-3)	2.2 (1-3)
Prior Institutions			U. Vermont (3) Ohio State (4) U. Arkansas UCSD	U. Vermont (3) Ohio State (3) U. Arkansas UCSD	U. Vermont (3) Ohio State (4) U. Arkansas
Percent with a Disability			0%	—	—
Percent from Underrepresented Racial & Ethnic Groups			20%	33%	33%

Previous Year: 2011-2012	Total Applicant Pool	Applicants Eligible for Support	New Entrants to the Program	New Entrants Eligible for Support	New Entrants Appointed to this Grant (Renewal/Revision Applications Only)
Mean Number of Publications (range)	3.6 (1-9)	3.8 (1-9)	3.8 (2-9)	3.9 (2-9)	3.9 (2-9)
Mean Number of First-Author Publications (range)	1.7 (1-3)	1.8 (1-3)	1.9 (1-3)	1.9 (1-3)	1.9 (1-3)
Prior Institutions			Georgetown (3) Ohio State (2) U. Arkansas (2) U. Utah (4)	Georgetown (3) Ohio State (2) U. Arkansas U. Utah (3)	Georgetown (2) Ohio State (2) U. Arkansas U. Utah (2)
Percent with a Disability			0%	—	—
Percent from Underrepresented Racial & Ethnic Groups			25%	25%	25%

Previous Year: 2010-2011	Total Applicant Pool	Applicants Eligible for Support	New Entrants to the Program	New Entrants Eligible for Support	New Entrants Appointed to this Grant (Renewal/Revision Applications Only)
Mean Number of Publications (range)	3.5 (1-9)	4.0 (1-9)	4.0 (1-9)	4.0 (2-9)	4.0 (3-8)
Mean Number of First-Author Publications (range)	2.0 (1-3)	2.4 (2-3)	2.5 (2-3)	2.5 (2-3)	2.5 (2-3)
Prior Institutions			Georgetown (3) Ohio State (2) U. Nevada (2) UNC (2)	Georgetown (3) Ohio State U. Nevada (2) UNC	Georgetown (2) Ohio State U. Nevada (2) UNC
Percent with a Disability			33%	33%	33%
Percent from Underrepresented Racial & Ethnic Groups			33%	33%	33%

Previous Year: 2009-2010	Total Applicant Pool	Applicants Eligible for Support	New Entrants to the Program	New Entrants Eligible for Support	New Entrants Appointed to this Grant (Renewal/Revision Applications Only)
Mean Number of Publications (range)	3.2 (1-7)	3.5 (1-7)	3.6 (2-7)	3.6 (2-7)	3.7 (3-7)
Mean Number of First-Author Publications (range)	2.0 (1-3)	2.3 (1-3)	2.4 (1-3)	2.4 (1-3)	2.5 (1-3)
Prior Institutions			U. Vermont (3) Ohio State (4) U. Arkansas UCSD	U. Vermont (2) Ohio State (3) U. Arkansas UCSD	U. Vermont (2) Ohio State (3) U. Arkansas
Percent with a Disability			0%	—	—
Percent from Underrepresented Racial & Ethnic Groups			20%	33%	33%

Means Across All Years	Total Applicant Pool	Applicants Eligible for Support	New Entrants to the Program	New Entrants Eligible for Support	New Entrants Appointed to this Grant (Renewal/Revision Applications Only)
Mean Number of Publications	3.4	3.8	3.8	3.9	3.9
Mean Number of First-Author Publications	1.9	2.2	2.3	2.3	2.2
Percent with a Disability			0%	0%	0%
Percent from Underrepresented Racial & Ethnic Groups			25%	35%	35%

Table 8C. Program Outcomes: Postdoctoral

Rationale

For new applications, this table provides information on the effectiveness of the proposed training program.

For renewal applications, this table provides detailed information about how postdoctoral training positions are used (i.e., distribution by year in program, distribution by faculty member, years of support per trainee). The data also permit an evaluation of the effectiveness of the supported training program in achieving the training objectives of the prior award period(s) for up to 15 years.

Instructions

Part I. Those Appointed to the Training Grant

In **Part I**, list sequentially, by year of entry into the postdoctoral research training program, all trainees who have been supported by this grant at any time during the last 15 years, including those who did not complete the training program for any reason. If the grant has been active for less than 15 years, list all trainees to date.

For each trainee, provide:

1. **Trainee.** Provide the trainee name in the format Last Name, First Name and Middle Initial.
2. **Doctoral Degree(s) and Year(s).** Provide the trainee's doctoral degree(s) and the year(s) awarded.
3. **Faculty Member.** In the format of Last Name, First Name and Middle Initial., provide up to two primary research training faculty acting as mentors (for trainees, these will be training grant faculty). If not yet selected, indicate "TBD" (to be determined).
4. **Start Date.** Provide the calendar month and year of entry into postdoctoral research program in the format MM/YYYY. The entering year is the first year of postdoctoral research experience, excluding non-research clinical training (for trainees, this date may precede the appointment to the training grant).
5. **Summary of Support During Training.** Provide the primary source and type of support during each twelve-month period of training, using TY1 for Training Year 1, TY2 for Training Year 2, etc. Do not list individual mentored career development awards here; they will be captured under grant support obtained as a PD/PI. For NIH support, list the awarding component and the activity (e.g., CA R01). **Bold** the grant being reported in this application. For other sources and types of support, use the categories below, and report only the primary source and type of support for each training year.

   Sources of Support

   - Research grant (RG)
   - Fellowship (F)
   - Training Grant (TG)
   - Other

   Types of Support

   - NSF
   - Other Federal (Other Fed)
   - University (Univ)
   - Foundation (Fdn)
   - Non-US
   - Other

6. **Degree(s) resulting from Postdoctoral training and Year(s).** If applicable, provide any degrees resulting from the postdoctoral training and the year awarded. If the training program does not offer degrees, indicate "none." Trainees currently in the program should be designated "in training."
7. **Topic of Research Project.** Provide the topic of the research project.
8. **Initial Position, Department, Institution, Activity; and Current Position, Department, Institution, Activity.** For trainees who have completed or left the program, their initial and current positions, department, and institution. If individuals hold joint appointments/positions, list only the primary position. If information is not available, report "unknown." Classify each position as predominantly Research-intensive, Research-related, Further Training, or Other. Research-related positions generally require a doctoral degree, and may include activities such as teaching, administering research or higher education programs, science policy, or technology transfer.
9. **Subsequent Grant(s)/Role/Year Awarded.** If applicable, subsequent fellowship, career development or research grant support obtained from any source, whether as PD/PI or in another senior role (i.e., co-investigator, faculty collaborator, or staff scientist). For NIH and other HHS support, list the awarding component, activity, role, and year (e.g., GM R01/Staff Scientist/2011). Up to five grants may be listed.

Part II. Those Clearly Associated with the Training Grant

In Part II, if applicable, list any **current** postdoctorates clearly associated with the training grant who have been supported by NIH funds other than this training grant, and provide the information described in Part I, items 1-9, above, for each. "Clearly associated" postdoctorates are those with a training experience identical to those appointed to this training grant, but who are supported by other forms of NIH or HHS funding (e.g., fellowships or research grants). Note that, for some postdoctoral programs, Part II may not be applicable.

Part III. Recent Graduates

In **Part III** (**only for new applications and predoctoral renewal/revision applications requesting an expansion to postdoctoral support**), list sequentially all postdoctorates **completing** the proposed program in the last five years who would have been eligible for appointment, if an NIH training or related award were available (in most cases, these will be U.S. citizens or permanent residents). For each postdoctorate, provide the information described in Part I, items 1-4 and 6-9, above.

Summarize the data from Parts I-III (as applicable) in the Research Training Program Plan, either in the Program Plan Section or the Progress Report Section, as appropriate.

For Research Performance Progress Reports (RPPRs), provide updated trainee information in Part I, reflecting new appointments and other changes over the reporting period. Do not include data that are older than 15 years. In Part II, if applicable, provide updated information on clearly associated postdoctorates, reflecting new entrants and other changes over the reporting period. In each subsequent year, continue to add new entrants and provide updated information about current and past postdoctorates until 15 years of data have been completed; do not include data older than 15 years. Summarize these data in the RPPR, in the Accomplishments Section, in responding to the question, "What opportunities for training and professional development has the project provided?".

Sample Table 8C. Program Outcomes: Postdoctoral

Part I. Those Appointed to the Training Grant

Trainee	Doctoral Degree(s) and Year(s)	Faculty Member	Start Date	Summary of Support During Training	Degree(s) Resulting from Postdoctoral Training and Year(s)	Topic of Research Project	Initial Position Department Institution Activity	Current Position Department Institution Activity	Subsequent Grant(s)/Role/ Year Awarded
Sanchez, Gregory B.	PhD 2007	Brown, James	07/2007	TY 1: **HL T32** TY 2: **HL T32** TY 3: CA R01 TY 4: CA R01	None	Uterine cancer and developmental biology	Staff Scientist Radiology MGH Research-Intensive	Assistant Professor Radiology University of Arizona Research-Intensive	CA K99/PI/2011 CA R00/PI/2013
Cox, Jennifer H.	MD 2003 PhD 2003	Doe, John	08/2008	TY 1: **HL T32** TY 2: **HL T32**	MPH 2009	Molecular and functional dissection of hematopoietic stem cell niche	Instructor Internal Medicine Columbia Research-Related	Associate Professor Hematology Rutgers Research-Intensive	DK K08/PI/2011 DK R01/ Faculty Collaborator/2013

Part II. Those Clearly Associated with the Training Grant

Trainee	Doctoral Degree(s) and Year(s)	Faculty Member	Start Date	Summary of Support During Training	Degree(s) Resulting from Postdoctoral Training and Year(s)	Topic of Research Project	Initial Position Department Institution Activity	Current Position Department Institution Activity	Subsequent Grant(s)/Role/ Year Awarded
McInnes, Julie	MD 2004	Welte, Duncan	07/2009	TY 1: **HD K12** TY 2: **HD K12**	MPH 2011	Maternal Depression related to hospitalization in a Neonatal Intensive Care Unit	Assistant Professor Pediatrics Yale Research-Related	Associate Professor Pediatrics Yale Research-Intensive	HS R01/PI/2013

Part III. Recent Graduates (Only For New Applications and Predoctoral Renewal/Revision Applications Requesting Postdoctoral Support)

Trainee	Doctoral Degree(s) and Year(s)	Faculty Member	Start Date	Summary of Support During Training	Degree(s) Resulting from Postdoctoral Training and Year(s)	Topic of Research Project	Initial Position Department Institution Activity	Current Position Department Institution Activity	Subsequent Grant(s)/Role/ Year Awarded
Roosevelt, Albert S.	PhD 2006	McIver, Rosalie	01/2007		None	Estrogen receptors and ovarian cancer	Assistant Professor Biology University of Colorado Research-Intensive	Assistant Professor Biology University of Colorado Research-Intensive	CA R21/PI/2013
Taylor, Susanna G.	PhD 2005MD 2007	Welte, Duncan	07/2008		None	New inhibitors for cancer imaging	Staff Scientist Radiology Massachusetts General Hospital Research-Intensive	Staff Scientist Radiology Massachusetts General Hospital Research-Intensive	NSF/PI/2014

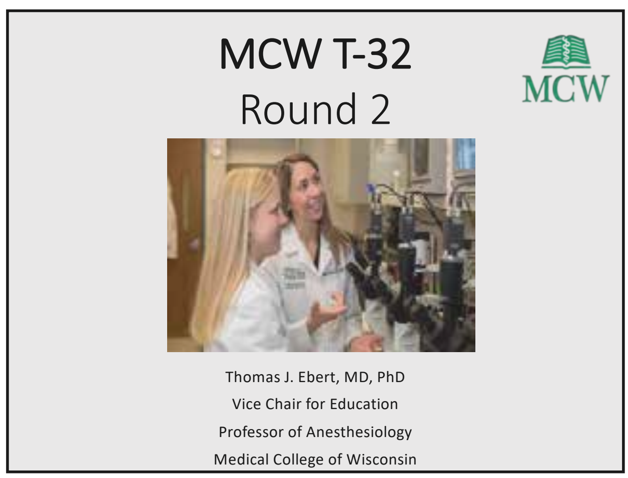
Back to Schedule

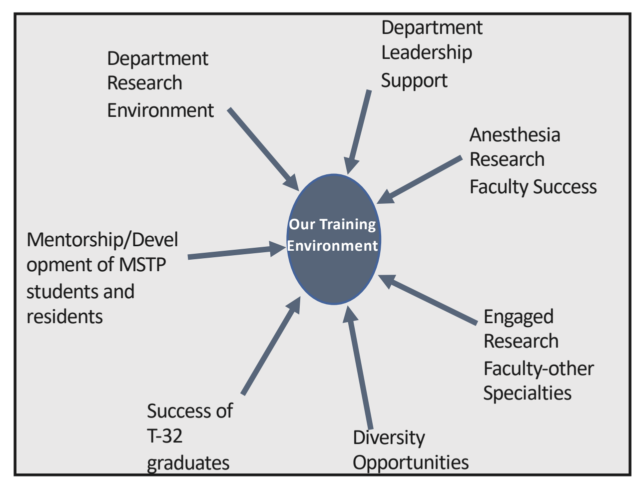
HANDOUT

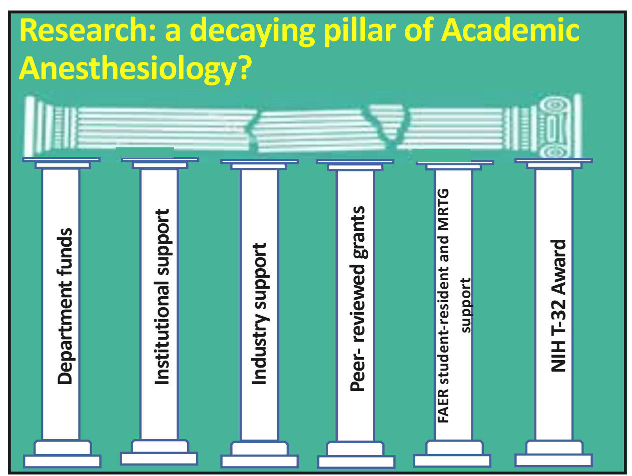
How to Successfully Apply for a T-32

Thomas J. Ebert, MD, PhD

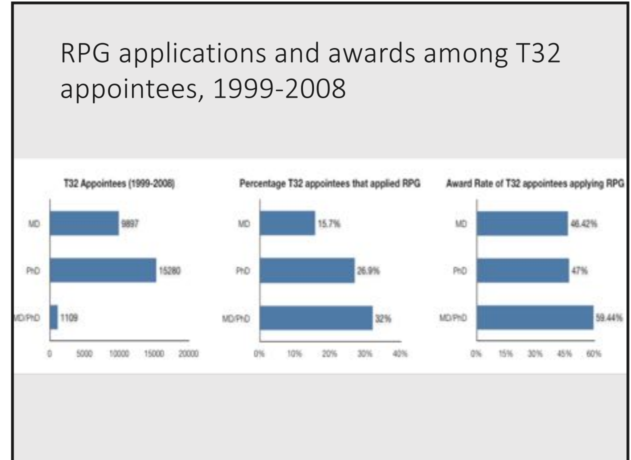
11/03/2018
8:55am – 9:10am

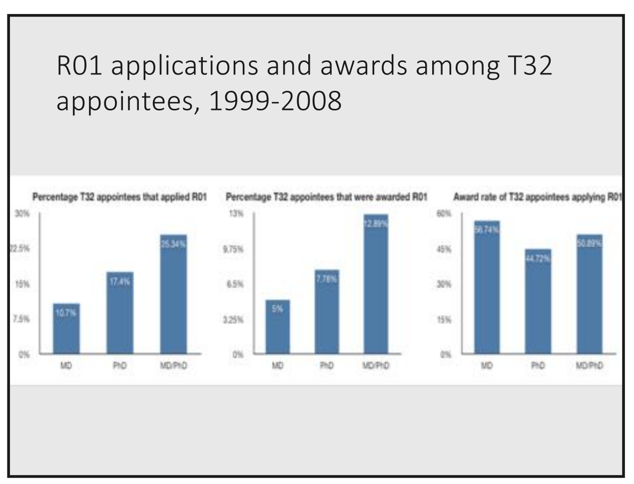

MCW T-32
Round 2
MCW
Thomas J. Ebert, MD, PhD
Vice Chair for Education
Professor of Anesthesiology
Medical College of Wisconsin

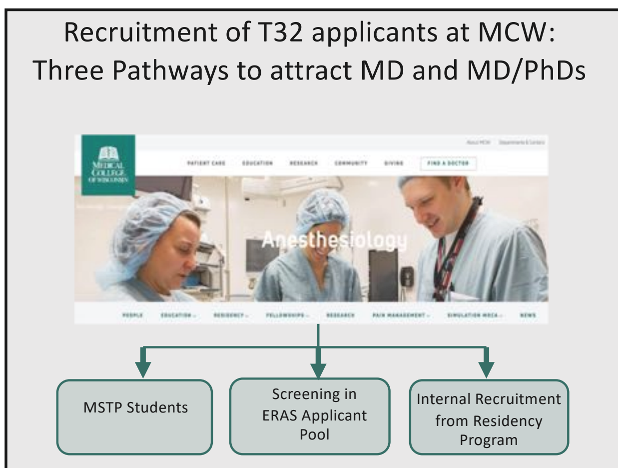

Department Research Environment
Department Leadership Support
Anesthesia Research Faculty Success
Our Training Environment
Mentorship/Development of MSTP students and residents
Engaged Research Faculty-other Specialties
Success of T-32 graduates
Diversity Opportunities

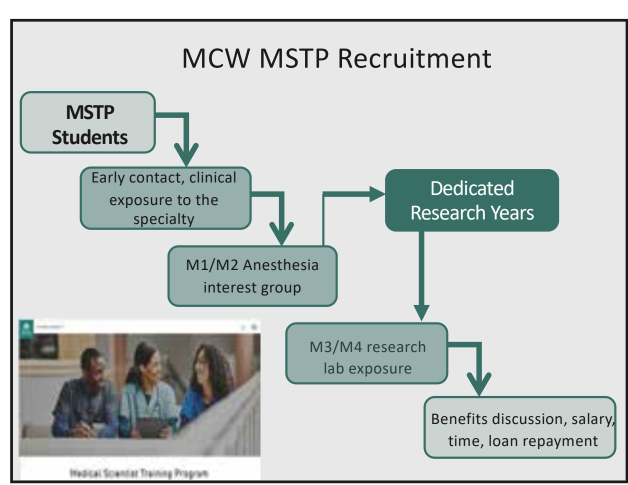

Research: a decaying pillar of Academic Anesthesiology?
Department funds
Institutional support
Industry support
Peer- reviewed grants
FAER student-resident and MRTG support
NIH T-32 Award

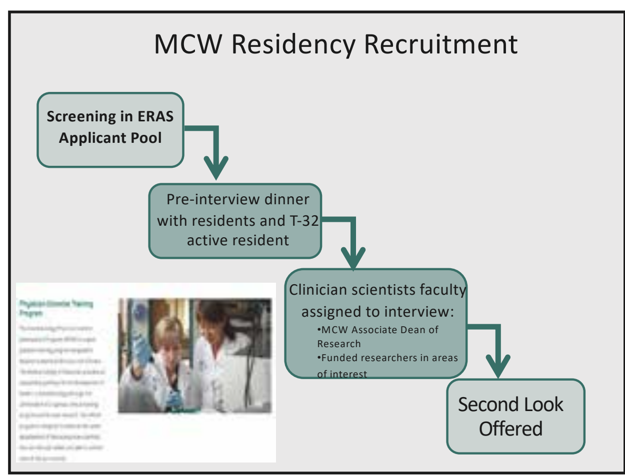
New MCW application for T-32 support:
Innovate to be competitive
Innovate with
- the design for protected research time
-applicant pool and recruitment

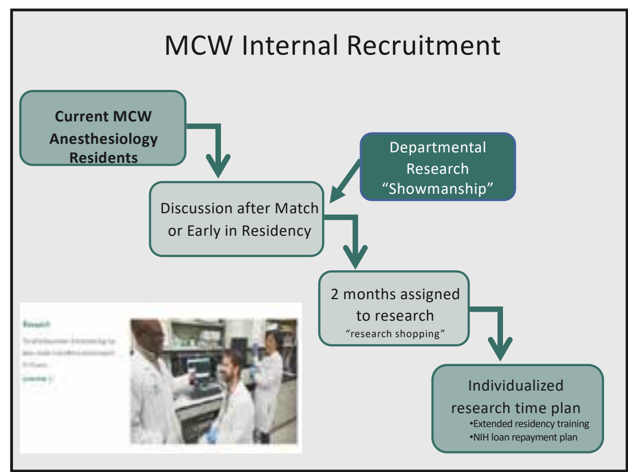

RPG applications and awards among T32 appointees, 1999-2008
T32 Appointees (1999-2008)
MD 9897
PhD 15280
MD/PhD 1109
0 5000 10000 15000 20000
Percentage T32 appointees that applied RPG
MD 15.7%
PhD 26.9%
MD/PhD 32%
0% 10% 20% 30% 40%
Award Rate of T32 appointees applying RPG
MD 46.42%
PhD 47%
MD/PhD 59.44%
0% 15% 30% 45% 60%


R01 applications and awards among T32 appointees, 1999-2008
Percentage T32 appointees that applied R01
MD 10.7%
PhD 17.4%
MD/PhD 25.34%
Percentage T32 appointees that were awarded R01
MD 5%
PhD 7.78%
MD/PhD 12.89%
Award rate of T32 appointees applying R01
MD 56.74%
PhD 44.72%
MD/PhD 50.89%









Generating Enthusiasm for Scientific Discovery within the Residency

- T-32 awardees present at Grand Rounds
- Grand Rounds presentations from our own Research Faculty
- Journal clubs led by T-32 awardees
- Friday PEARLs
- V. Professor Program- Meet with residents with research interest and T-32 awardees

NIH Loan Repayment opportunity

- Encourages outstanding health professionals to pursue careers in biomedical, behavioral, social, and clinical research by repaying $35,000 per year of student loan debt for up to 3 years for those employed in a research capacity.
- MCW T-32 pathway with integration of research during 5 years of residency allows maximum LRP from the NIH

Anesthesiology Physician Scientist Development Program Sample Schedule

Block	PGY1	PGY2	PGY3	PGY4	PGY5
1	Med Wards	FMLH	Peds Anes	Regional	VA Anes
2	EM	FMLH	Peds Anes	Neuro Anes	Cardiac
3	SICU	Regional	FMLH Anes	Peds Anes	Pain
4	**Research**	VA Anes	FMLH Anes	Peds Anes	PACU
5	**Research**	FMLH	**Research**	Practice Mgmt	Regional
6	CT surgery	OB Anes	**Research**	CVICU	FMLH Anes
7	Pre-Op clinic	FMLH	**Research**	**Research**	Peds Anes
8	MICU	**Research**	**Research**	**Research**	OB Anes
9	SICU	**Research**	**Research**	**Research**	**Research**
10	Pain Mgmt	**Research**	SICU	**Research**	**Research**
11	Anes	**Research**	Pain	**Research**	**Research**
12	Anes	**Research**	OB Anes	OOOR	**Research**
13	Vacation	3+1wk CME	3+1wk CME	3+1wk CME	3+1wk CME

Training accreditation challenge with integrated research throughout 4 CA years of residency.

- ABA 6 months reporting system- 36 months of training
- GME office, payroll, and T-32 funding

MCW T-32 success

MD/PhD graduates and Leadership support for clinician scientist junior faculty

- Julie Freed, MD, PhD – 1st yr. faculty member
  - Fellow to Faculty contract with75% protected time x 3 yr., lab support
  - Cardiac fellowship completed, K award submitted in spring of the fellowship year
  - FAER-mentored research training grant-awarded
  - KL2-funded but declined (for K08)
  - Named healthy heart grant, funded –medical innovation and research
  - NIAID R21-not funded
  - NIA R21 submitted
  - NIH-R25-submitted
- The Pipeline - T-32 graduates with fellow to faculty contracts in place
  - Chris Roberts, MD, PhD, in CC fellowship # of publications = 10
  - William Gross, MD, PhD, in Neuro-Anesth fellowship, # of publications = 14

Back to Schedule

HANDOUT

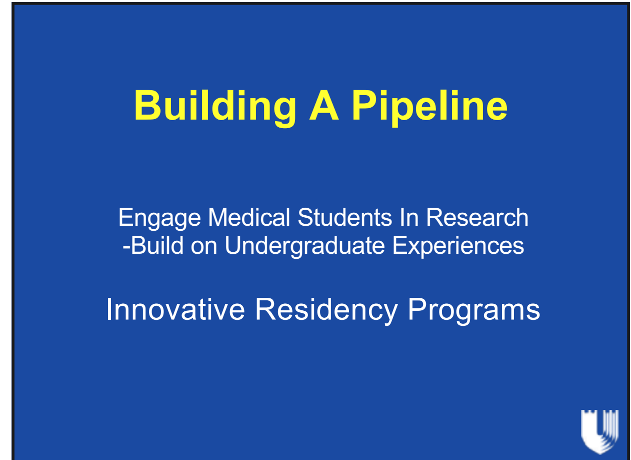
How to Successfully Apply for a T-32

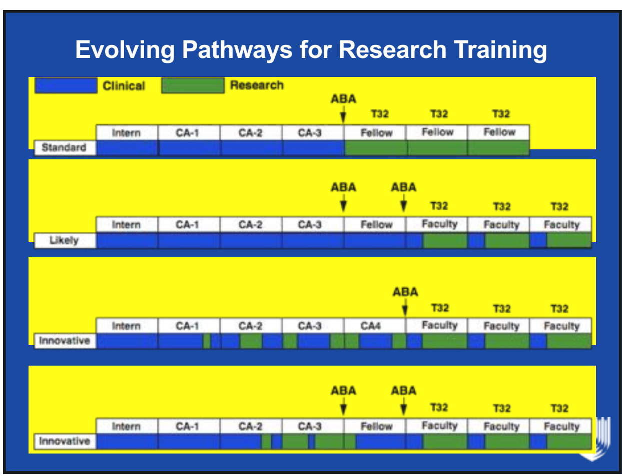
David S. Warner, MD

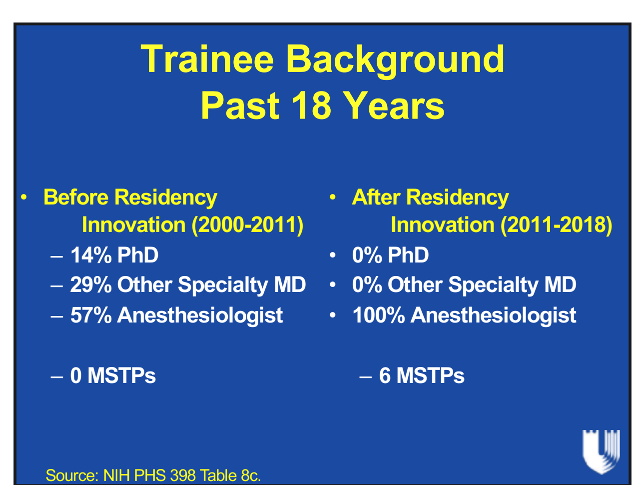
11/03/2018
9:10am – 9:25am

Attracting Anesthesiologists To Research Training

- Serious problem
- Increasingly more sophisticated tools/knowledge required for anesthesia practice
- Increasingly more sophisticated tools/knowledge required for research
- Average age of PI obtaining first R01 = 46 years







Back to Schedule

Trainee Diversity: NIH Definitions

- Under-represented minorities
  - Black or African-American
  - Hispanic or Latino
  - American Indian or Alaska Native
  - Native Hawaiian or Pacific Islander
- Disability
- Disadvantaged Backgrounds

Trainee Diversity

- Plan for recruitment must be established and executed
- Recruitment success is monitored by NIH
- Probation or discontinuation of funding (it does happen!)
- Prior to residency innovation program
  - 1 URM in 17 years
  - Resulted in probationary status lasting 5 years
- After residency innovation program
  - 4 URM in 7 years

Trainee Diversity

Is This Success Linked To The Innovative Residency Program?

Trainee Diversity

Only, indirectly

1 of 4 URM derived from ACES program

Harnessing The Peer-Reviewed T32 As A Cornerstone of Academic Training

- ✓ Mentor Qualifications Reviewed and Approved By VC-Research, Chair, Program Director
- ✓ Written Career Development Plan
  - ✓ Reviewed and Approved by Mentor, VC-Research, Chair, Program Director
- ✓ Research Progress Updates (RPU)
  - ✓ Quarterly Written Progress Report
  - ✓ Semi-Annual Oral Progress Report With Mentor Present
    - ✓ Public and private feedback to trainee
- ✓ Required Participation in Departmental Research Events
- ✓ Support For Formal Coursework/Enrollment in Degree Granting Programs
- ✓ Formal Department-Wide Mentoring Program with Semi-Annual Feedback To VC-Faculty Development
- ✓ Annual Individual Private Meeting With Chair and VC-Research
- ✓ Compensation Associated With Academic Productivity
- ✓ Extramural Grant Review Program
- ✓ Formal biostastical analysis and locked data repository before manuscript submission

Is This Level of Monitoring Appropriate?

Conclusion: People Want To Be Part Of It

Where Are We Going?

Expectations are increasing for accelerated progress

- ACES residents submit grant applications
- K application expected early in T32
- Hard decisions are being made for those with insufficient progress

Too early to tell conversion to R success rate

With improved pipeline, we have more product. How much can we absorb?

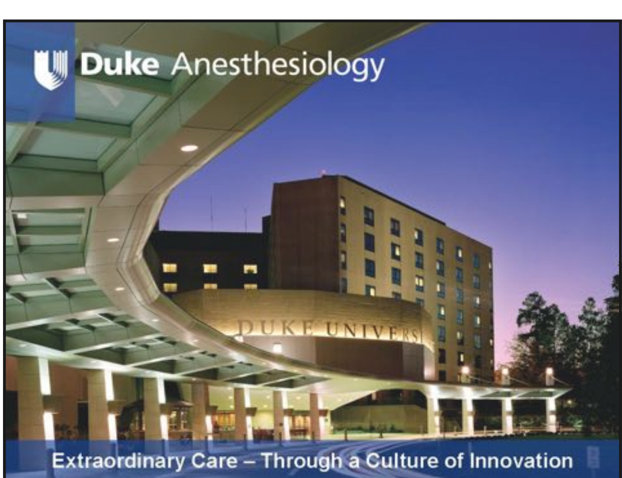
Greater selectivity of those enrolled in ACES and T32 to bring consistency to departmental areas of expertise and mission

Program Is Quite Similar to FAER Funding Structure!

1) Engage medical students in research

2) Sustain investigative growth during residency

3) Junior faculty programs to continue development as investigators



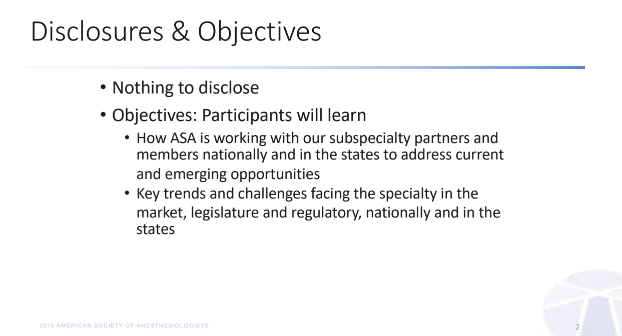
HANDOUT

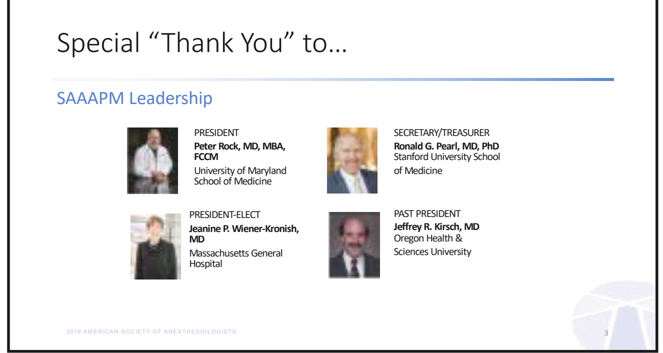
ASA Update

Linda J. Mason, MD, FASA

11/03/2018
9:30am – 9:45am

ASA and SAAAPM: Partnering for a Better Future
Linda Mason, M.D., FASA, ASA President
Director, Pediatric Anesthesiology, Loma Linda University Medical Center
11/3/2018
American Society of Anesthesiologists
asahq.org


Disclosures & Objectives
• Nothing to disclose
• Objectives: Participants will learn
• How ASA is working with our subspecialty partners and members nationally and in the states to address current and emerging opportunities
• Key trends and challenges facing the specialty in the market, legislature and regulatory, nationally and in the states


Special "Thank You" to...
SAAAPM Leadership
PRESIDENT
Peter Rock, MD, MBA, FCCM
University of Maryland School of Medicine
SECRETARY/TREASURER
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PAST PRESIDENT
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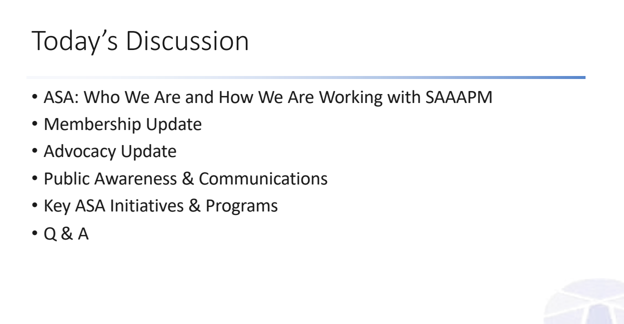
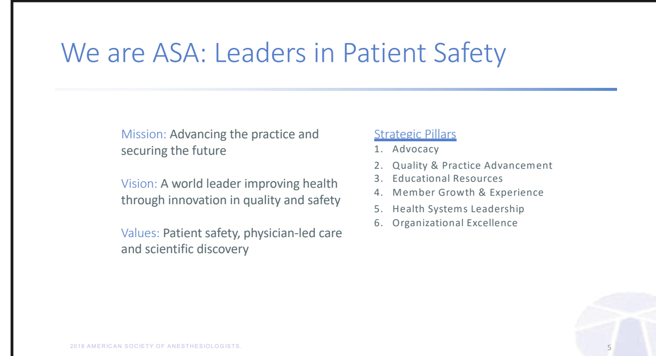
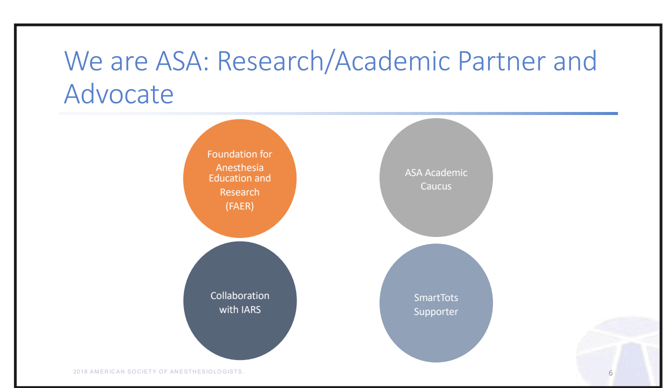
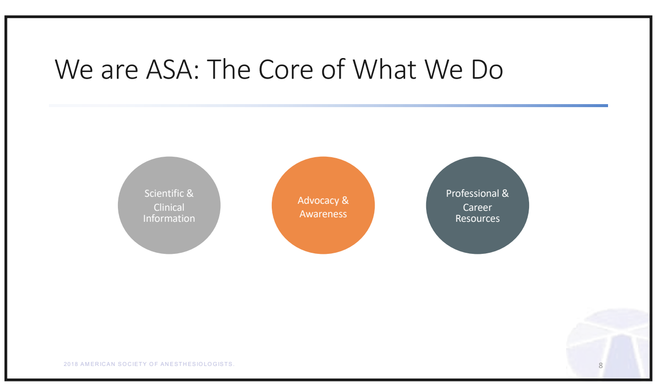
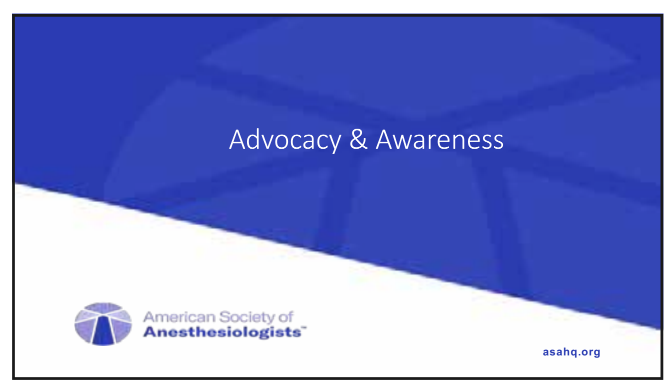

Today's Discussion
• ASA: Who We Are and How We Are Working with SAAAPM
• Membership Update
• Advocacy Update
• Public Awareness & Communications
• Key ASA Initiatives & Programs
• Q & A

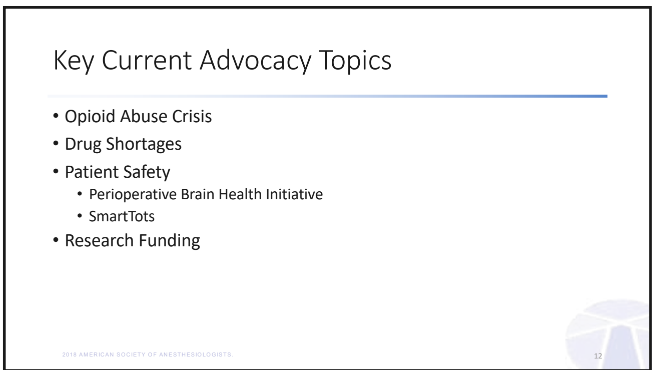

We are ASA: Leaders in Patient Safety
Mission: Advancing the practice and securing the future
Vision: A world leader improving health through innovation in quality and safety
Values: Patient safety, physician-led care and scientific discovery
Strategic Pillars
1. Advocacy
2. Quality & Practice Advancement
3. Educational Resources
4. Member Growth & Experience
5. Health Systems Leadership
6. Organizational Excellence


We are ASA: Research/Academic Partner and Advocate
Foundation for Anesthesia Education and Research (FAER)
ASA Academic Caucus
Collaboration with IARS
SmartTots Supporter

Back to Schedule

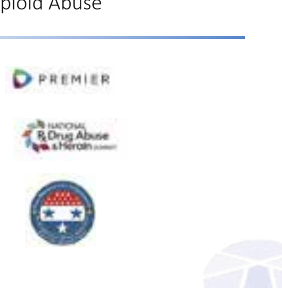






A Leadership Role in Fight Against Opioid Abuse

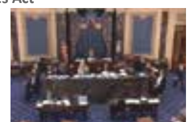
- Premier/ASA Pilot Project
- Sponsor of the National Rx Drug Abuse and Heroin Summit
- Administration Efforts
  - Comments to the President's Commission
  - CMS Summit on the Opioid Crisis
  - White House Opioid Summit
  - Meeting with lead administration staff
  - HHS Pain Management Best Practices Interagency Task Force
- State Efforts
  - Republican Governor's Association Annual Meeting presentation



Success in Congress

SUPPORT for Patients and Communities Act

- ✓ Support for hospitals and other acute care settings for developing alternatives to opioids; grant program and technical assistance
- ✓ Technical Expert Panel to develop best practices for pain management and alternatives to opioids
- ✓ Provisions to speed NIH research
- ✓ Support for PDMPs
- ✓ Grants for drug take-back and disposal programs
- ✓ Study on prescribing limits



President Trump Signed H.R. 5718, the Perioperative Reduction of Opioids (PRO) Act on October 24, 2018

Tackling the Drug Shortage Issue

- Drug shortages have exploded
- Sterile injectables
  - Injectable opioids
  - Local anesthetics
- Previous efforts not permanent
  - Food and Drug Administration Safety and Innovation Act (FDASIA) of 2012
  - Food and Drug Administration (FDA), Office of Drug Shortage Efforts
- ASA is working with the FDA Drug Shortages Team and Congress

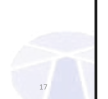
OUT OF STOCK

What Do We Know?

- Production disruptions
- Foreign manufacturers are reluctant to ramp up production
- New generics take a long time to get FDA approval

ASA Drug Shortage Survey

- Are you experiencing shortage on a consistent basis?
  - Yes = 98.4%
  - No = 1.6%
  - n = 2272
- Is it affecting how you care for patients?
  - Yes = 95.2%
  - No = 4.8%
  - n = 2272



Top 10 Drugs Identified

1) Hydromorphone (dilaudid)
2) Fentanyl
3) Bupivacaine
4) Morphine
5) Epinephrine
6) Neostigmine
7) Ropivacaine
8) Rocuronium
9) Labetalol
10) Glycopyrrolate

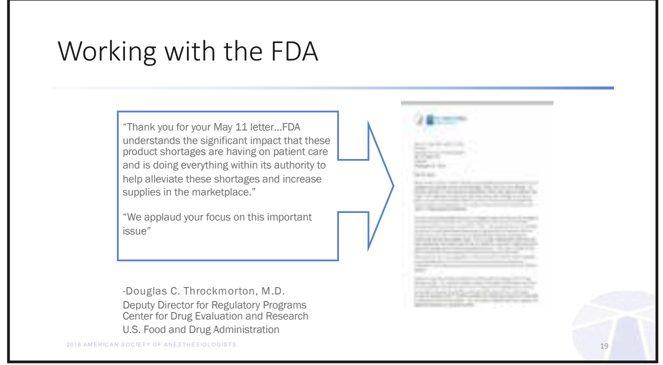
Ensuring Public Awareness of the Shortages

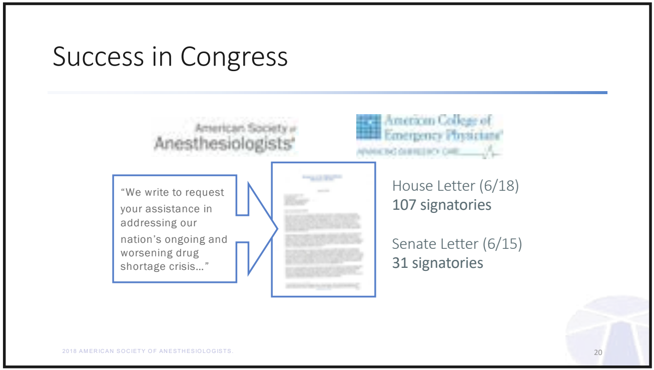
"Dr. Jim Grant, president of the 53,000-member ASA, says there is reason to be worried. He says every day when they begin work, "we go in [asking], 'What do we have today, what don't we have today?"

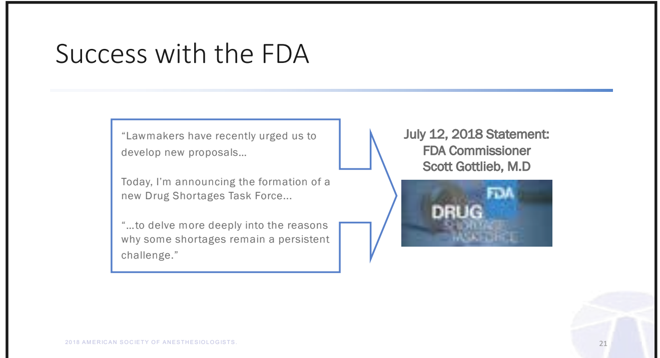
- NPR, July 20, 2018

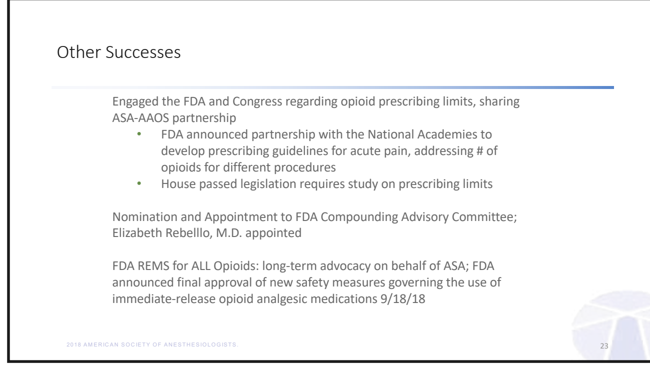
npr

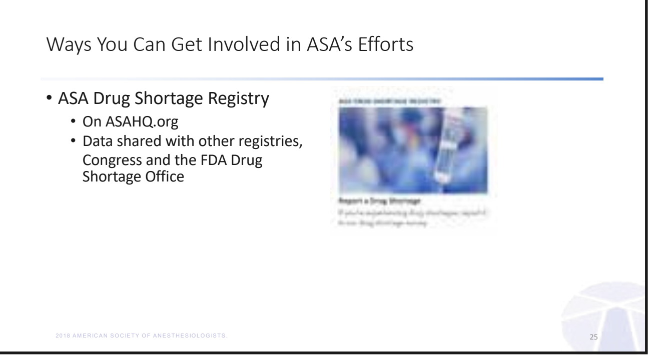
Back to Schedule





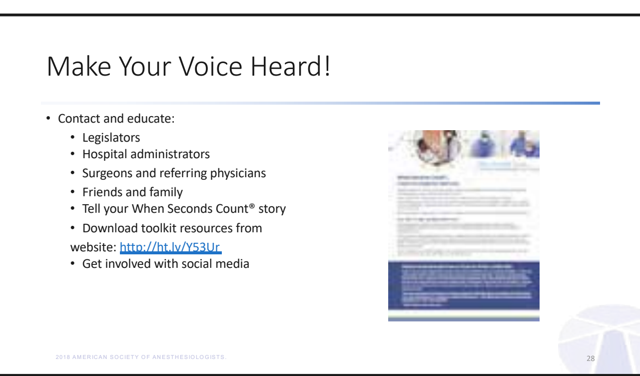





Ways You Can Get Involved in ASA's Efforts
• ASA Drug Shortage Registry
• On ASAHQ.org
• Data shared with other registries, Congress and the FDA Drug Shortage Office
25

Enhancing ASA's Visibility in Patient Safety and Research
THE AD HOC GROUP FOR MEDICAL RESEARCH
PERIOPERATIVE
BRAIN HEALTH
INITIATIVE
26

Enhancing ASA's Visibility in Patient Safety and Research
Resident Scholar Kenisha Muse, M.D. represented ASA at the Rally for Medical Research
27


Make Your Voice Heard!
• Contact and educate:
• Legislators
• Hospital administrators
• Surgeons and referring physicians
• Friends and family
• Tell your When Seconds Count® story
• Download toolkit resources from website: http://ht.ly/Y53Ur
• Get involved with social media
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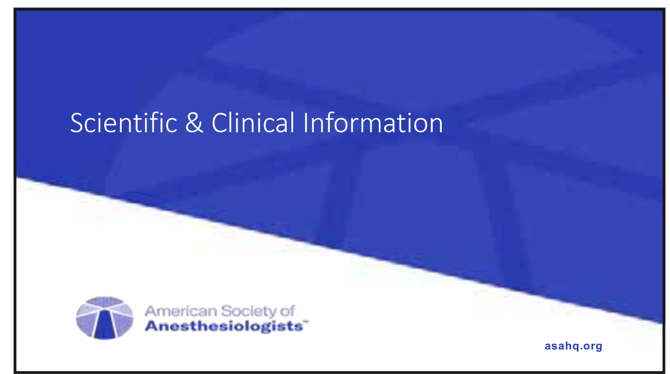
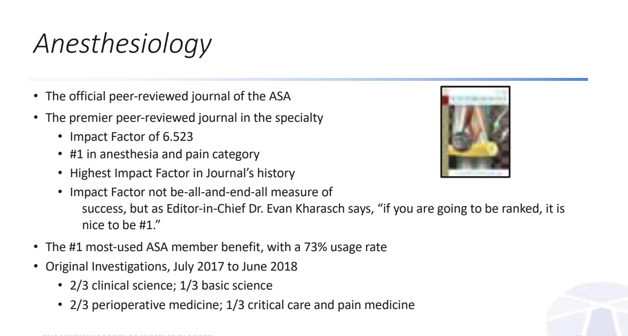
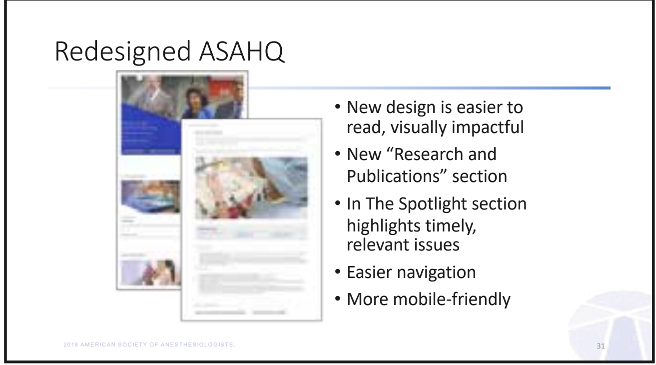
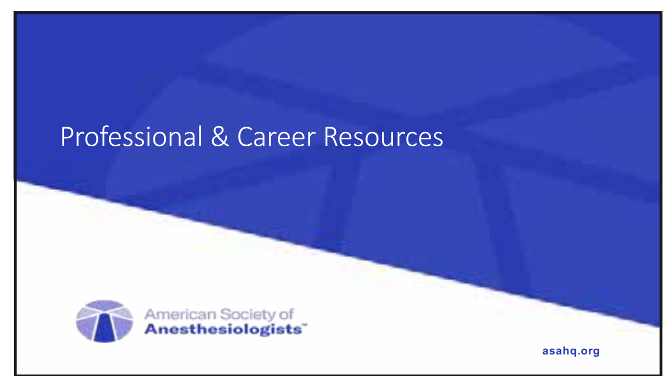

Scientific & Clinical Information
American Society of Anesthesiologists
asahq.org


Anesthesiology
• The official peer-reviewed journal of the ASA
• The premier peer-reviewed journal in the specialty
• Impact Factor of 6.523
• #1 in anesthesia and pain category
• Highest Impact Factor in Journal's history
• Impact Factor not be-all-and-end-all measure of success, but as Editor-in-Chief Dr. Evan Kharasch says, "if you are going to be ranked, it is nice to be #1."
• The #1 most-used ASA member benefit, with a 73% usage rate
• Original Investigations, July 2017 to June 2018
• 2/3 clinical science; 1/3 basic science
• 2/3 perioperative medicine; 1/3 critical care and pain medicine
30





Professional Resources

- ASA continues to grow its roster of benefits, products and services aimed at improving your professional performance
  - Practice Management resources
  - Quality & Registry products
  - Group Practice Solutions

Career Resources

- Additionally, ASA is ramping up its portfolio of benefits, products and services to help you reach your career goals
  - New non-clinical "soft skills" training modules for resident programs and others
  - ASA-ACHE Physician Leadership Development Collaborative
    - Partnership with ACHE
    - ASA courses count toward FACHE if member is also in ACHE
  - Advanced cohort added to our Executive Physician Leadership Program with Northwestern University's Kellogg School of Management
    - 4-day program for physician leaders who have completed the introductory program or who are already in senior executive positions
    - Launches in 2019
  - ASA adding Wellness resources to ASAHQ.org
  - New Career Center launching very soon on ASAHQ.org

Back to Schedule

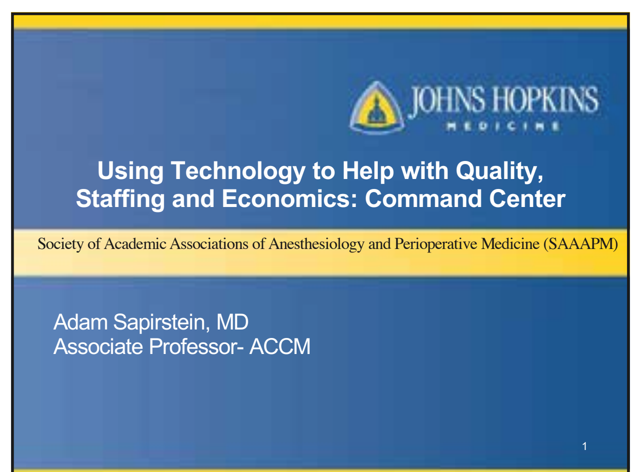
HANDOUT

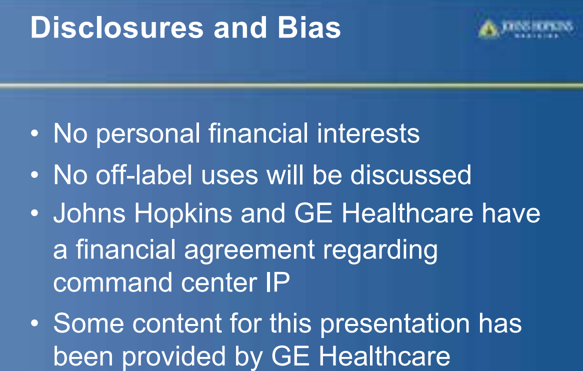
Using Technology to Help with Quality, Staffing and Economics: Command Center

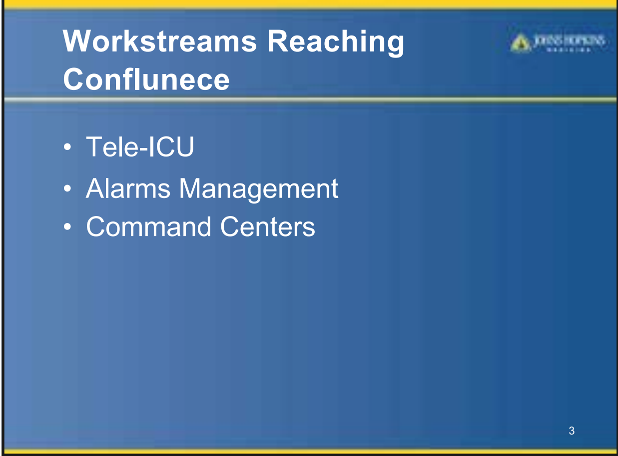
Adam Sapirstein, MD

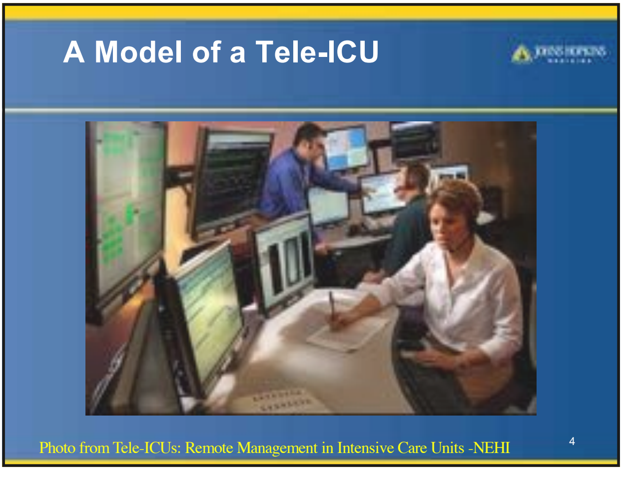
11/03/2018
10:00am – 10:15am

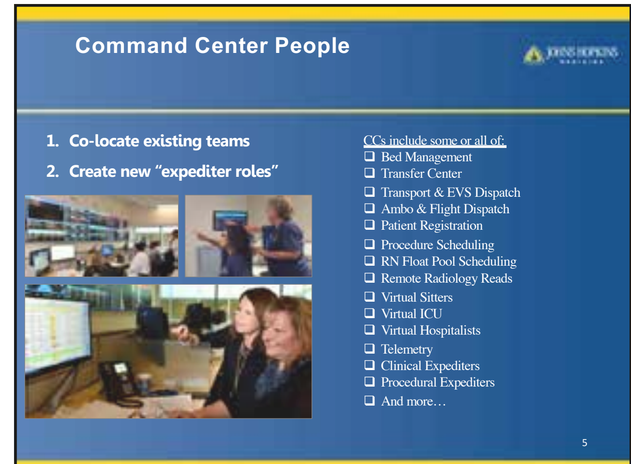
Back to Schedule

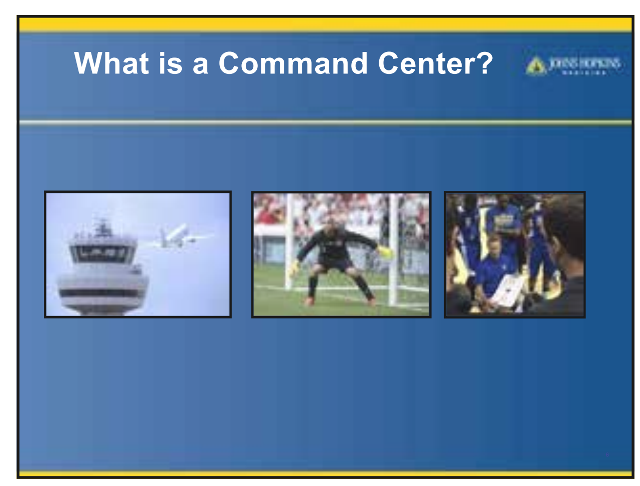




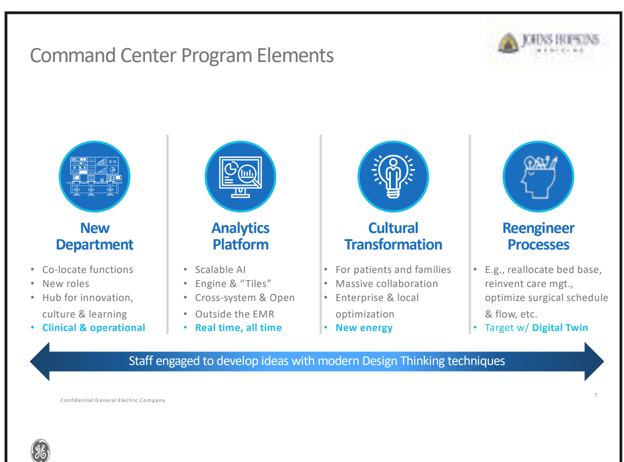


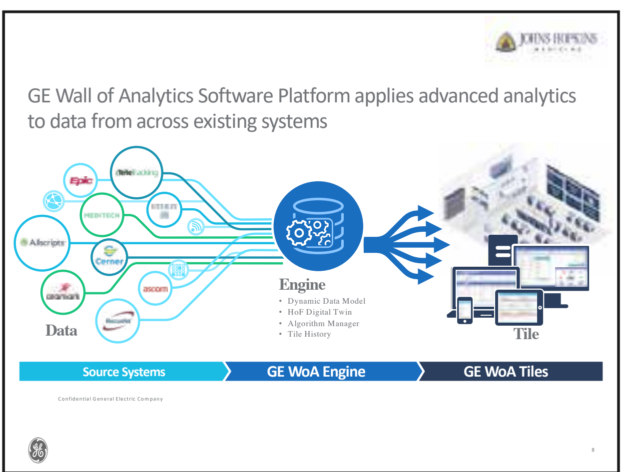


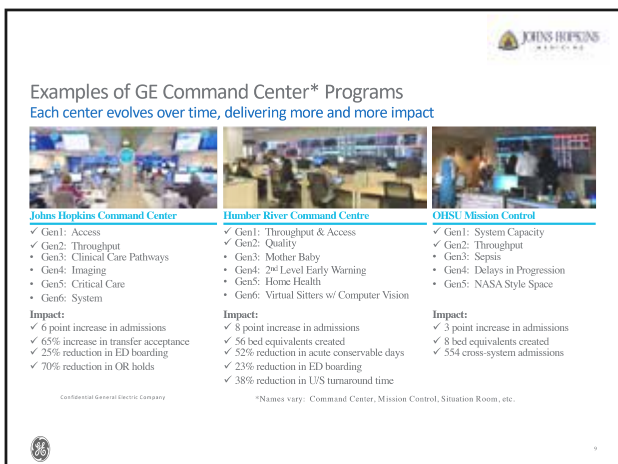


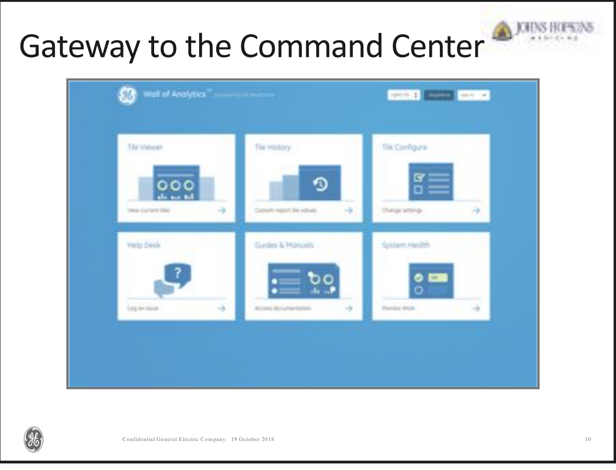


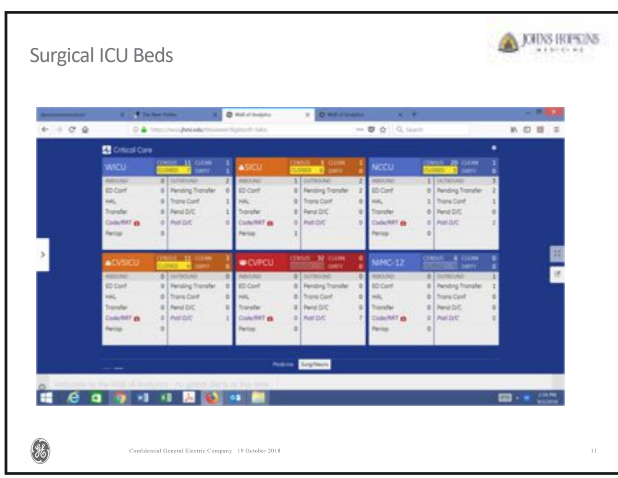
Back to Schedule

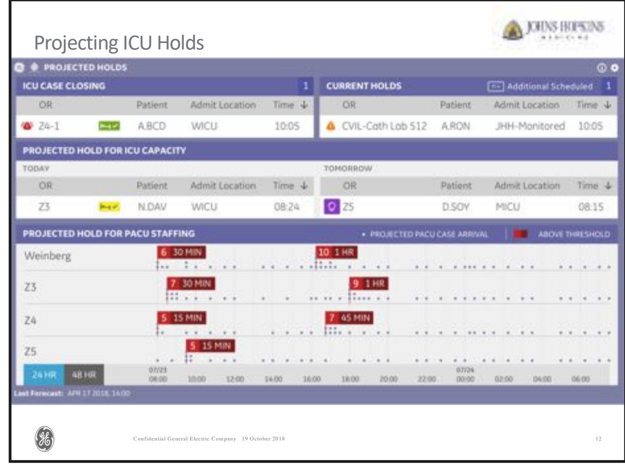












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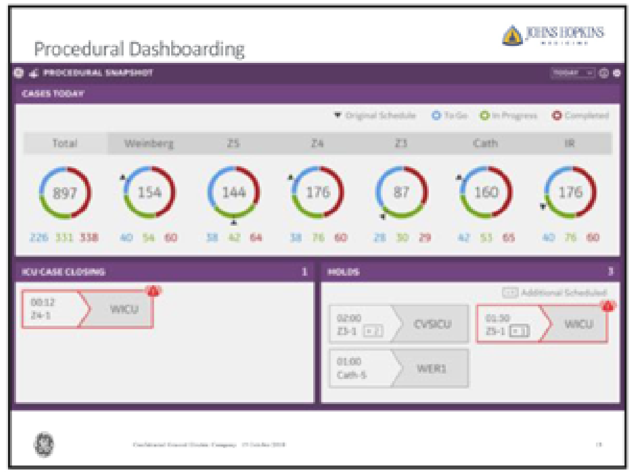

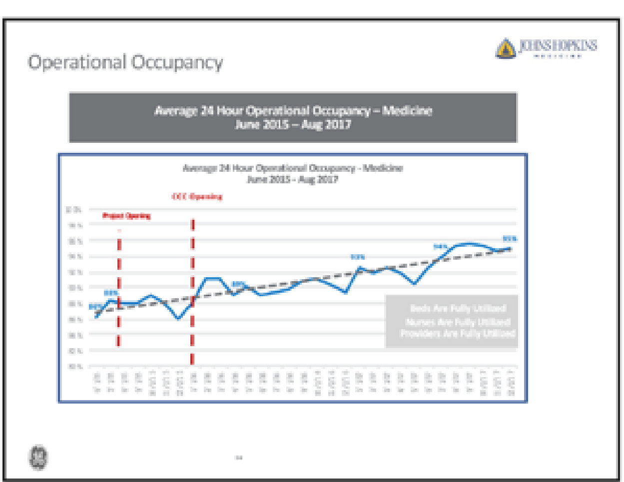

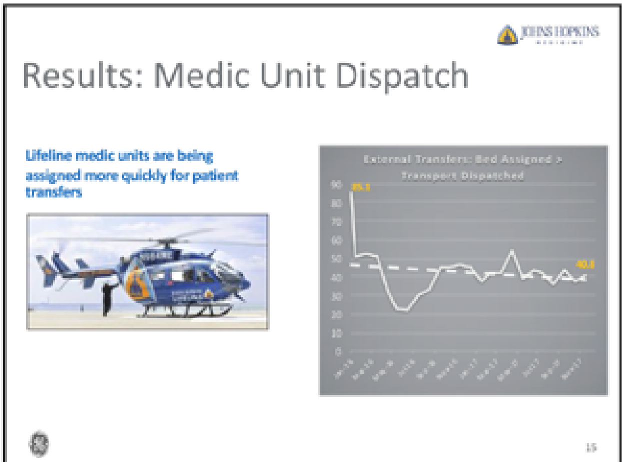

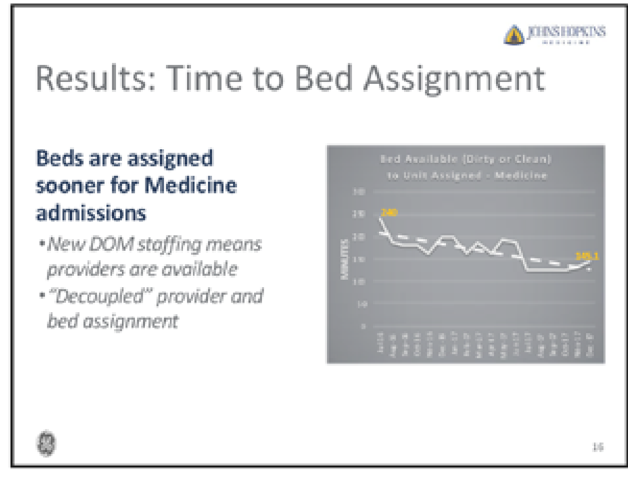

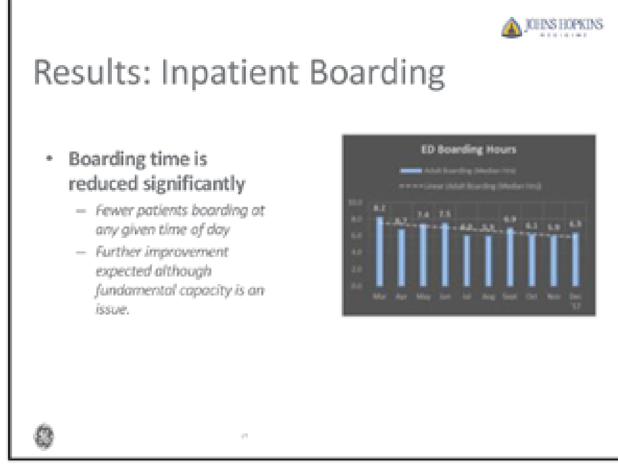

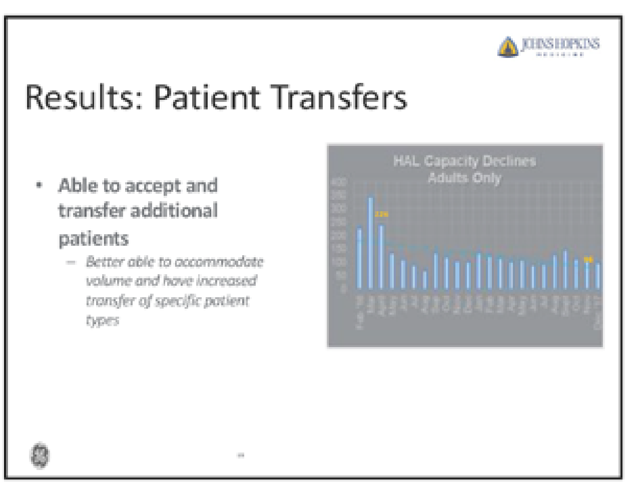

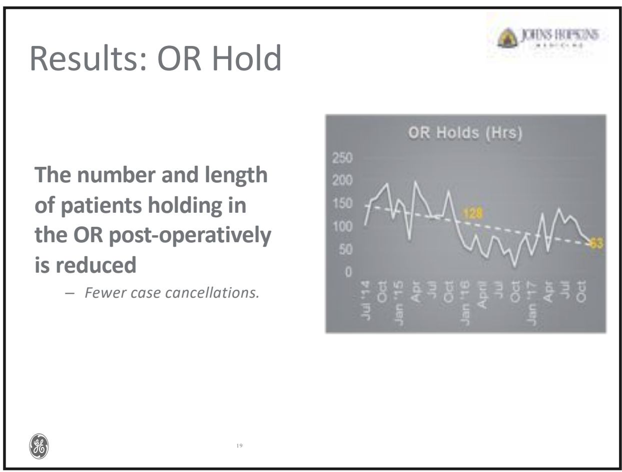

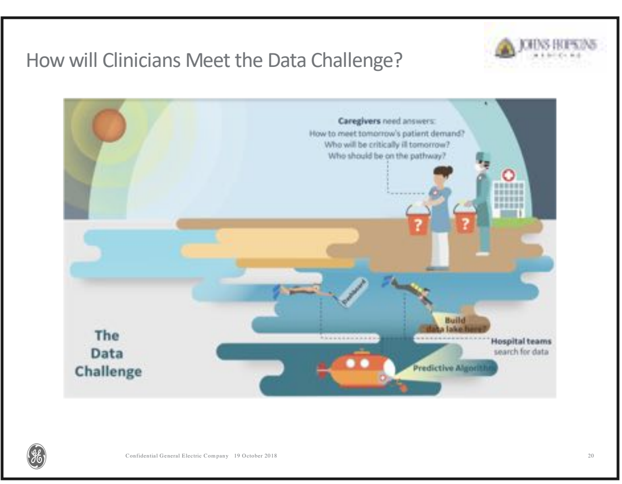

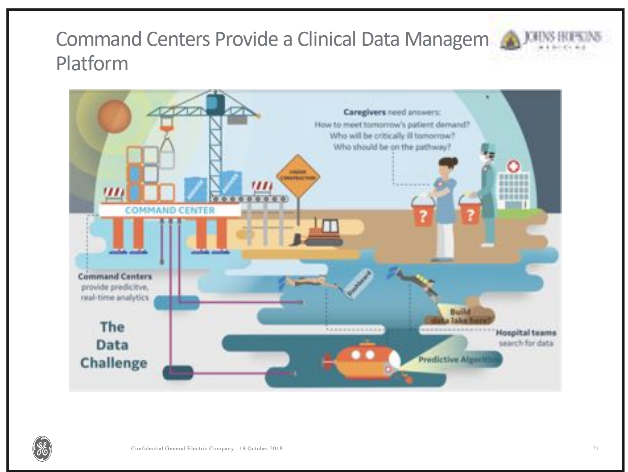

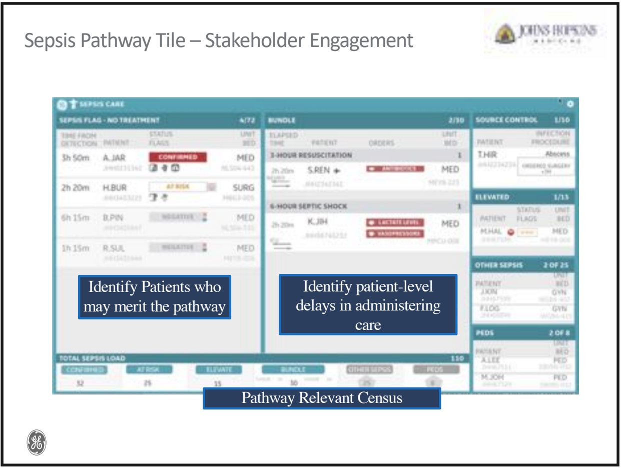

Acknowledgements

- GE Healthcare: Jeff Terry, Bree Bush, Andy Day, Ann Cole, Leo Dias, Tamas Fixler
- JHH: Jim Scheulen, Mary Margarette Jacobs, Dr. Dave Efron
- OHSU: Dr. James Heilman, Dr. Matthias Merkel, Susan Yoder, Jen Packer

Back to Schedule

HANDOUT

Using Technology to Help with Quality, Staffing and Economics: Pre-Ops at Home

Nirav V. Kamdar, MD, MPP

11/03/2018
10:15am – 10:30am

Using Technology to Help with Quality, Staffing and Economics: Pre-Ops at Home

The Economic Reality: Disruption of the Healthcare Clinic by technology

- The costs of United States (US) healthcare continues to escalate despite recent healthcare reforms
- Administrative and overhead costs are a major reason for elevated healthcare costs in the US compared to other industrial nations [1]
- Brick and mortar clinic locations for patient care are expensive with respect to space, overhead and staffing costs.
- Medical systems need to scale in size and geography in the setting of lower overall reimbursements, which forces patients to access the healthcare system from increasingly larger distances [2]
- Technology has always been a market enabler for disruptive business models to deliver products and services for less overhead cost[3]
- Steep rise in mobile technology adoption provides a platform for disruptive healthcare models not only for medicine but particularly for anesthesiologists

The Business Case for Virtual Pre-Ops:

A new, highly connected, healthcare consumer

- The 30-49 year old demographic will be accessing the healthcare system with greater frequency in the next two decades
- Smartphone adoption in this demographic has increased to over 89%[4]
- This demographic expects "just-in-time" delivery of services as demonstrated by the market demand for "Uberized" services (i.e. rideshares, freelance work, haircuts, massages, grocery delivery, package delivery)
- Smartphone technology enables high-fidelity interactions across the mobile phone network and cloud including high-quality photos, video interaction, text-enabled chat devices
- Smartphones are easily connected to peripheral devices such as credit card readers, microphones, and even ECGs and stethoscopes that can integrate data into the mobile phone

Follow the Money: Larger investments into virtual clinics and telemedicine

- Large employers are looking to contract with health systems that offer alternative access to their customers[5]
- Over 71% of employers are offering services for telemedicine to their customers[5]
- Healthcare clinics that have first mover advantages in telemedicine technology (i.e. One Medical Group and Forward) have receive increasingly larger investments by venture capital companies[6]
- The healthcare system is investing more resources towards bundled care pathways – an important tenet into achieving value-based healthcare processes

The Pre-Operative Clinic: Anesthesia's opportunity to incorporate technology for disruption

- Almost half of inpatient stays are due to an operative procedure[7]
- Pre-operative assessments by anesthesiologists show promise for decreasing inpatient mortality for elective surgery[8]
- The pre-operative clinic is our major outpatient portal with patients (other than chronic pain clinics)
- The optimal business model for pre-operative clinics is still challenging to create, which necessitates technology use to decrease the administrative and staffing costs

Virtual Pre-Ops in Anesthesia: Past, Present and Future

The Past: Anesthesia's vast experience with telemedicine

- Anesthesiology has over a decade of experience with telemedicine
- First case series for virtual preoperative anesthesia consultation was in 2004 with 10 patients using a mobile viewing monitor with a mounted camera and operated by a nurse at a remote consulting site[9]
- In 2011, Galvez and Rehman reviewed the few existing pilot projects using telemedicine for pre-operative consultation [10]
- In 2013, Applegate and colleagues conducted a randomized controlled trial of using virtual pre-ops on 200 patients scheduled for head and neck surgery and demonstrated cost-savings with respect to decreased travel costs, lost work days, and childcare without cancellations or surgical delays [11]
- A case report exists for telemedicine-based airway assessment[12]
- In 2015, Roberts and colleagues demonstrated patient perceptions with virtual preoperative anesthesia clinics in the remote Northern Territory of Australia amongst 27 patients [13]

The Present: Virtual Pre-Ops at UCLA

- Patients can conduct virtual preoperative assessments via desktop, laptop, tablet, and mobile phone
- We have conducted over 250 virtual pre-ops with patients at home or from their work office in 2017-2018
- Virtual visits have become the default form of assessment for pre-operative evaluation
- Anesthesiology has the highest use rate for virtual clinics across the UCLA health system
- Evaluations are completed within 30 minutes (including documentation) using only an attending anesthesiologist and resident. Additional staff was unnecessary for the evaluations
- Airway assessments and image capture of the airway are integrated directly into the EHR chart and in the pre-operative documentation
- Virtual pre-ops were initially conducted using the HIPAA-compliant Zoom.com platform. UCLA now has integrated its virtual visits directly into the EPIC-based EHR.

- Case cancellation rate was 1.51% and the encounters significantly altered pre-operative management in 3.02% of cases.
- Patients saved over 10,000 one-way miles in driving to UCLA in 2018 which accounts for more than $5000 out-of-pocket patient dollars saved.

The Patient Experience: High Satisfaction Rates

- 97.5% describe being "satisfied" or "very satisfied" with their virtual pre-op evaluation
- 87.5% prefer a virtual visit over a traditional, in-person, anesthesia assessment
- 93.8% of patients could clearly hear and see the anesthesiologist during the evaluation
- The patient access of the virtual pre-op link to the video portal was the greatest impediment to full patient satisfaction with the service

High Mobile Integration: Patient Entered Flow Sheets

- At consultation, many patients have their mobile accessory devices activated to share data directly with the EHR using "patient entered flow sheets"
- Accessory devices include Bluetooth-enabled glucometers, weight scales, smartwatches, actigraphs, and pulse-oximetry monitors.

Case Examples: From Pre-habilitation to pain management to surgical follow-up

Case 1: Remotely monitoring diuresis in a patient with congestive heart failure scheduled for elective surgery.
Case 2: Anticipating chronic pain exacerbation using step counts
Case 3: Post-surgical quality of life assessment using patient-entered flowsheets in a patient with a complicated post-surgical course.

Financing Virtual Visits: The Reimbursement Paradox

- Medicare, largely, does not support or reimburse "store and forward" telemedicine activities by telemedicine programs except for Alaska and Hawaii.
- Medicare does reimburse live, virtual patient interactions as well as 30-minute or more remote monitoring of patients at select, rural, care locations (Codes GVCI1 and GRAS1).
- Medicaid program reimbursement varies on a state-by-state basis
- CMS recently signaled proposals for remote physiologic monitoring and internet consultations [14]
- Controversy still exists for E&M billing that distinguishes itself from surgical DRG codes

The Future: Remote Patient Monitoring

- Large growth and investments into wearable technology
- Information technology and finance sectors are making large investments into healthcare including Apple, Google, Amazon, JP Morgan, and Berkshire Hathaway.
- Khosla Ventures and other investment firms taking risks with companies that use mobile technologies to monitor patients with chronic conditions

- Market is being flooded with mobile-integrated devices such as glucometers, smartwatches, movement analysis, sensor-enabled clothing, voice analysis, and ECG sensors.

Deep Learning: Artificial Intelligence and Beyond

- Much interest in Deep Learning by both academic institutes and industry[15] [16]
- Google Brain and Google AI teams claim that deep learning has the potential to transform and revolutionize healthcare[15]
- Immediate applications to anesthesiology include improved and novel risk stratification strategies for patients scheduled for surgery and difficult airway prediction using image analysis and machine learning.
- Deep learning techniques can apply computational methods such as back propagation[17] to find more subtle predictors for anesthesia risk such as MACE or difficult airway using large, multivariable, datasets and high-fidelity image and video analysis.
- Deep learning and AI may pave roads towards a AI—physician care team model for perioperative medicine and management

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Back to Schedule

HANDOUT

Using Technology to Help with Quality, Staffing and Economics: Monitoring Postoperative Patients Remotely

Kyan C. Safavi, MD, MBA

11/03/2018
10:30am – 10:45am

Disclosures

Equity ownership in Position Health, Inc.

2

A Case Example

45 yo M hx of HIV on HAART s/p emergent R open globe repair secondary to rock in eye when hammering.

Hospital Course
- Uncomplicated repair of globe in late evening Saturday
- Transferred to inpatient floor
- Began experiencing dyspnea (SpO2 high 80s intermittently), sinus tachycardia (130s).
- **Alert paged** out to SICU fellow at 01:00 AM Sunday for tachycardia and hypoxia

Post-Alert Page Course
- SICU Fellow reviewed chart and evaluated patient at bedside
- Patient had increased work of breathing, rhonchi, productive cough, 7L O2 requirement, MAP trending lower, and tachycardia. Also found to have several small ulcers in the oral mucosa. Also noted to have tingling of palmar surfaces of his hands bilaterally.
- Spoke with nursing team (previous plan was to wait until morning to discuss with medical hospitalist service). Ophthalmologist unaware of patient's decline.

3

A Case Example

Post-Alert Page Course
- Discussed with ophthalmologist
- SICU Fellow recommended that team to initiate immediate work-up including:
  - CBC
  - Lactate
  - Sputum culture, AFB
  - CD4
  - Viral load
  - Quant Gold
  - RPR
  - CXR
- CXR revealed bilateral infiltrates consistent with PNA; CD4 200; RPR positive
- SICU Fellow discussed with ophthalmology team and initiated:
  - Empiric antibiotics for CAP
  - IV fluid resuscitation
  - Nebulizers
  - ID consult
- Improved over the next 2 days
  - Vital signs normalized
  - Off of oxygen
  - Started on PCN for treatment of secondary syphilis, DPH alerted
  - Set home with PCN x 3 wks

4

Introduction

Remote Surveillance

- **Definition**
  - A strategy of collecting and digitally transmitting clinical data from a patient in a location different from where the clinician is located
  - Employs data from any combination of invasive and non-invasive monitors, wearable devices, biosensors, electronic health records (EHR), video cameras, and more[1,2]
- **Aim**
  - Enable clinicians to monitor, diagnose, and intervene in a variety of settings in order to increase the timeliness and safety of care
- **Opportunity**
  - Increase the value of anesthesiologists by expanding their roles as the hospital's experts in physiologic monitoring throughout the perioperative continuum
- **Important Considerations**
  - Few studies exist on how these technologies should be implemented, scaled, and made sustainable

5

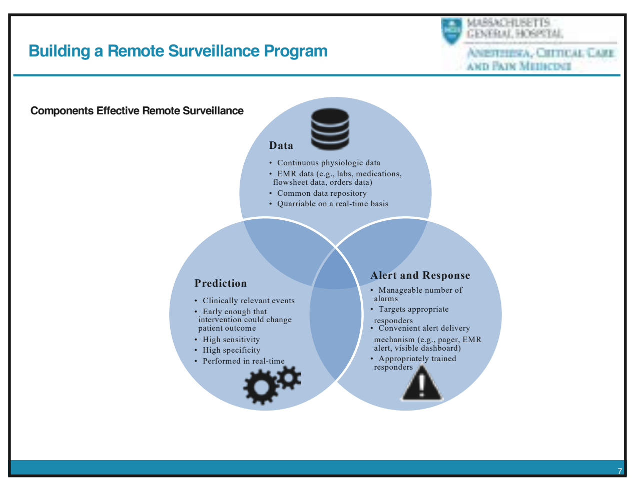
Introduction

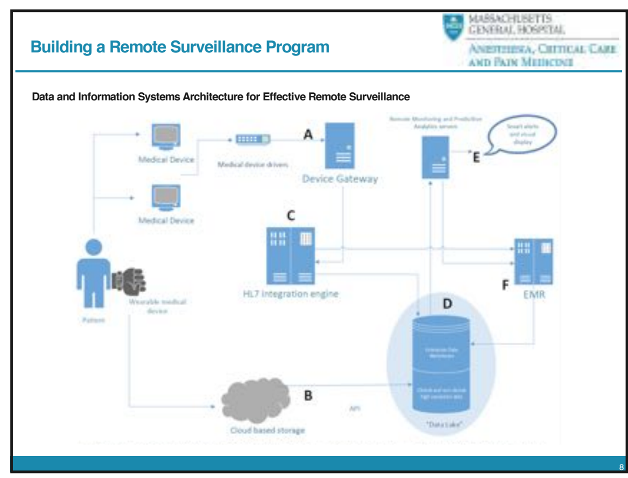
Why Now?

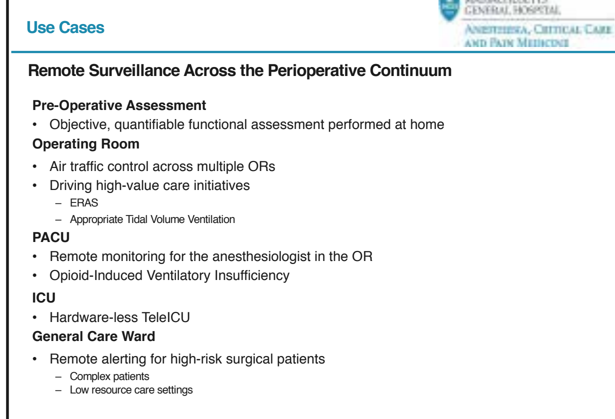
Old and New
- Although components of remote surveillance have been in development for nearly a decade, the coming together of multiple advances in health information and digital technology present the opportunity for broader applications.

Three Major Developments in Recent Years
- **Un-Siloing Data**
  - patient data previously siloed into different data systems in now collected, stored, and retrieved in a common system, increasing the volume, diversity, and accessibility of data related to the patient clinical state
- **Convenient Monitors**
  - newer continuous non-invasive physiologic monitors are convenient for patients, such that monitoring can be performed and data gleaned in a growing number of clinical settings—from their home prior to surgery, through their operation to the post-operative general care ward and back home again
- **Better Predictions**
  - more sophisticated prediction algorithms can automatically sort through massive amounts of clinical data and identify constellations associated with adverse clinical events so as to increase the specificity of alerts and reduce alarm fatigue.

6







Remote Surveillance Program: A High Risk Post-Op Setting

MASSACHUSETTS GENERAL HOSPITAL
ANESTHESIA, CRITICAL CARE AND PAIN MEDICINE

Rationale

- Our institution's surgical ICU is responsible for emergent airway and any critical care needs, should they arise, of a neighboring hospital that specializes in ENT and ophthalmologic care
- Many of these patients are surgically complex and medically comorbid
- Surgical staffing of the 24-bed inpatient unit is low on night and weekends
- Housestaff (PGY-2 or greater) are typically not located on the unit and lack experience in critical care

Aim

- Build a model of proactive consultative critical care in which intensivists provide guidance to surgical teams when there is evidence of acute clinical deterioration before an adverse event occurs.

Design

- Feasibility study
- Prospective case series

Measures

- Overall rate of alerts
- Rate of false positive; false negative alerts
- Clinical etiology of alerts
- Clinical response time
- Subsequent action by clinician
- Actionability of alert to improve care

10

Remote Surveillance Program: A High Risk Post-Op Setting

MASSACHUSETTS GENERAL HOSPITAL
ANESTHESIA, CRITICAL CARE AND PAIN MEDICINE

Background

- Monitoring was conducted over a **108-day period** from August to November, 2017.
- **Laboratory** and **vital sign data** were analyzed by the software **every 15 minutes** 24/7.
- Alerts were generated using a **software algorithm** pre-specified by the study team to detect evidence of acute clinical deterioration. If an alert was triggered, it was automatically delivered **via pager** to an intensivist
- **Retrospective chart review** was performed on patients for whom an alert was generated to assess the etiology of the alert and opportunities for the intensivist to improve care.

11

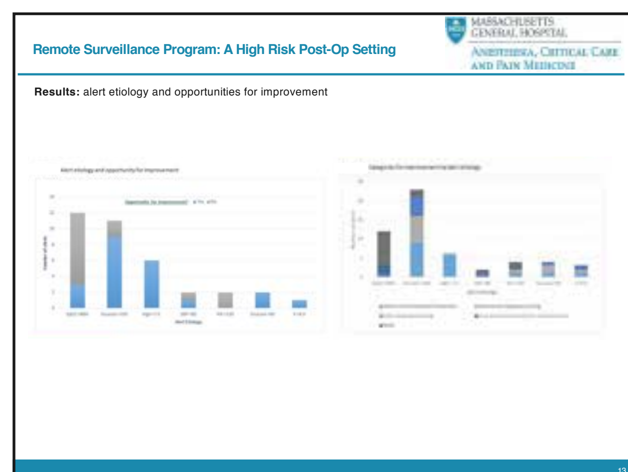
Remote Surveillance Program: A High Risk Post-Op Setting

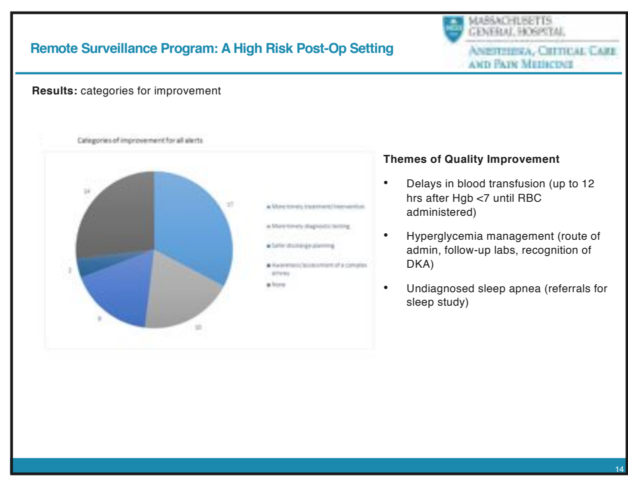
MASSACHUSETTS GENERAL HOSPITAL
ANESTHESIA, CRITICAL CARE AND PAIN MEDICINE

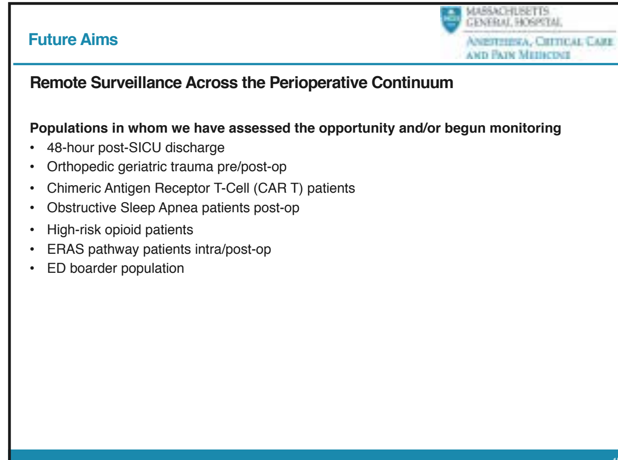
Results

- **817 patients** were monitored during the study period. **91,981 data items** were processed by the technology (**851.6 data items per day**)
- **43 alerts** were generated: on average **2.8 alerts per week**, 0.4 alerts per day
- There were **0 false negative alerts**
- There were **4 (8.9%) false positive alerts**
- 100% of alerts generated were subsequently received via page

12


MASSACHUSETTS GENERAL HOSPITAL
ANESTHESIA, CRITICAL CARE AND PAIN MEDICINE
Remote Surveillance Program: A High Risk Post-Op Setting
Results: alert etiology and opportunities for improvement
13


MASSACHUSETTS GENERAL HOSPITAL
ANESTHESIA, CRITICAL CARE AND PAIN MEDICINE
Remote Surveillance Program: A High Risk Post-Op Setting
Results: categories for improvement
Categories of improvement for all alerts
Themes of Quality Improvement
Delays in blood transfusion (up to 12 hrs after Hgb <7 until RBC administered)
Hyperglycemia management (route of admin, follow-up labs, recognition of DKA)
Undiagnosed sleep apnea (referrals for sleep study)
14


MASSACHUSETTS GENERAL HOSPITAL
ANESTHESIA, CRITICAL CARE AND PAIN MEDICINE
Future Aims
Remote Surveillance Across the Perioperative Continuum
Populations in whom we have assessed the opportunity and/or begun monitoring
48-hour post-SICU discharge
Orthopedic geriatric trauma pre/post-op
Chimeric Antigen Receptor T-Cell (CAR T) patients
Obstructive Sleep Apnea patients post-op
High-risk opioid patients
ERAS pathway patients intra/post-op
ED boarder population
15

Back to Schedule

HANDOUT

Innovative Ways of Using Simulation as a Development Tool: Selecting a New Chair

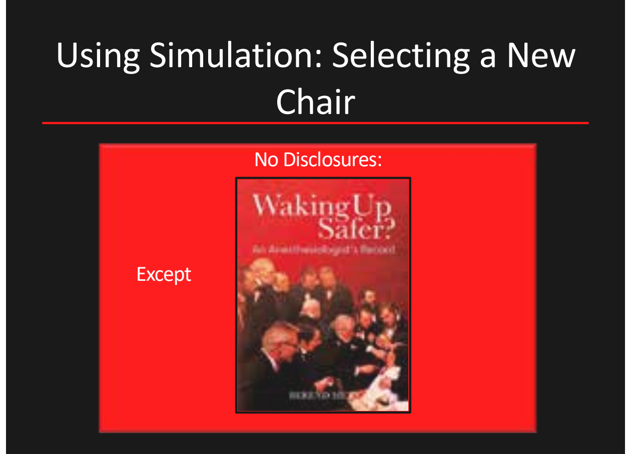
Berend Mets, MB, ChB, PhD, FRCA, FFA(SA)

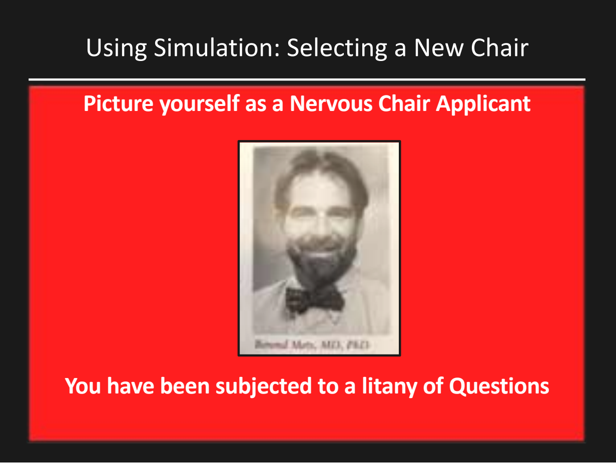
11/03/2018
11:00am – 11:20am

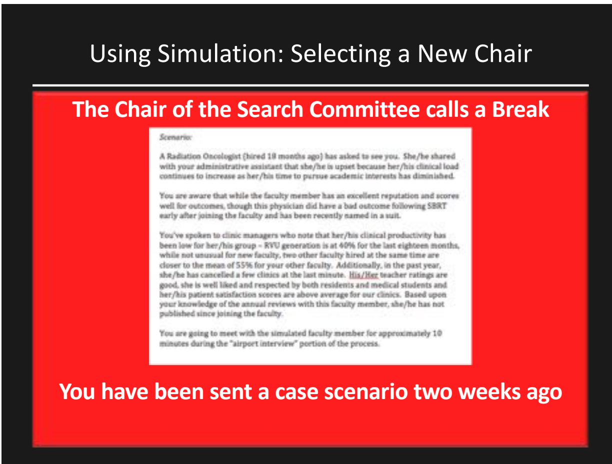
Using Simulation: Selecting a New Chair

Berend Mets, MB, ChB, PhD, FRCA, FFA(SA)

Eric A. Walker Professor & Chair
Anesthesiology
Penn State College of Medicine
Hershey Medical Center
Hershey, PA







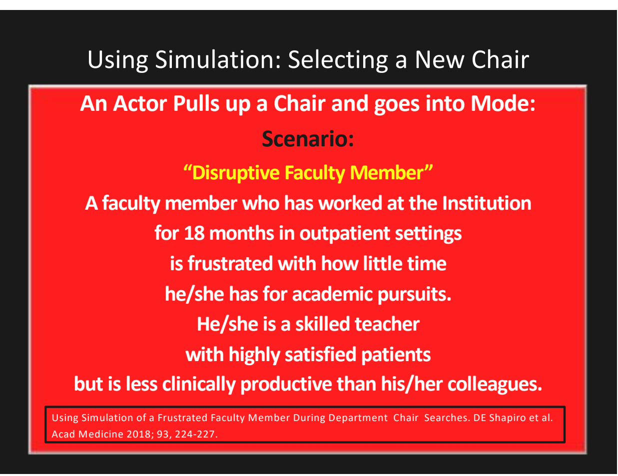
Scenario:

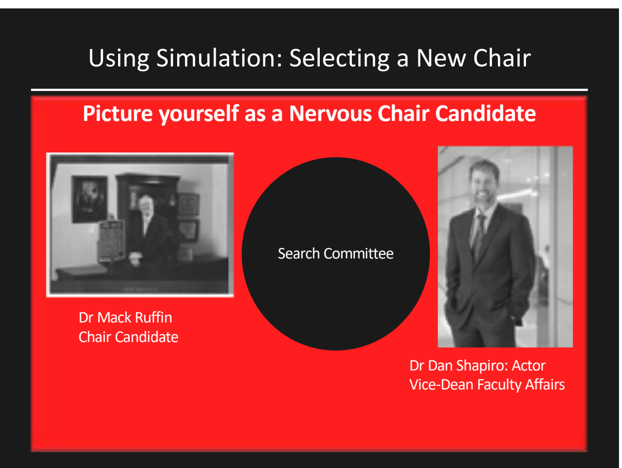
A Radiation Oncologist (hired 18 months ago) has asked to see you. She/he shared with your administrative assistant that she/he is upset because her/his clinical load continues to increase as her/his time to pursue academic interests has diminished.

You are aware that while the faculty member has an excellent reputation and scores well for outcomes, though this physician did have a bad outcome following SBRT early after joining the faculty and has been recently named in a suit.

You've spoken to clinic managers who note that her/his clinical productivity has been low for her/his group – RVU generation is at 40% for the last eighteen months, while not unusual for new faculty, two other faculty hired at the same time are closer to the mean of 55% for your other faculty. Additionally, in the past year, she/he has cancelled a few clinics at the last minute. His/Her teacher ratings are good, she is well liked and respected by both residents and medical students and her/his patient satisfaction scores are above average for our clinics. Based upon your knowledge of the annual reviews with this faculty member, she/he has not published since joining the faculty.

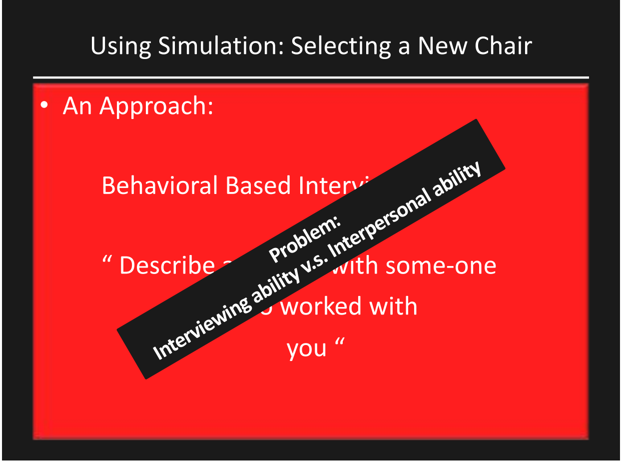
You are going to meet with the simulated faculty member for approximately 10 minutes during the "airport interview" portion of the process.




Using Simulation: Selecting a New Chair
Picture yourself as a Nervous Chair Candidate
Search Committee
Dr Mack Ruffin
Chair Candidate
Dr Dan Shapiro: Actor
Vice-Dean Faculty Affairs

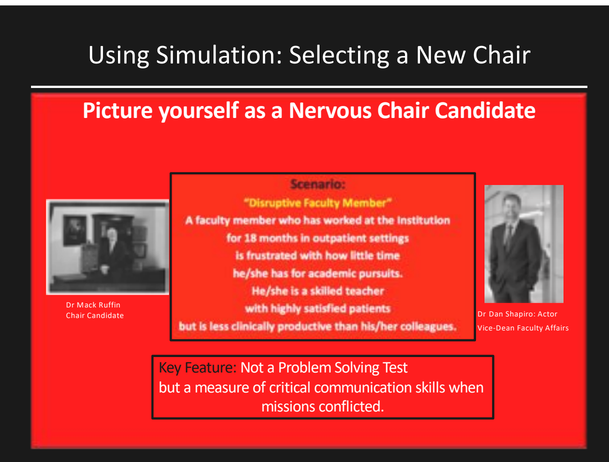
Using Simulation: Selecting a New Chair
Traditional Chairs Needed to be/have:
National Stature
Recruited from Prestigious Institution
Track Record in Research
Clinical Competency
Appreciation for Teaching
"Gets along with others"
Grigsby et.al. Acad Med 2004;79, 571-7

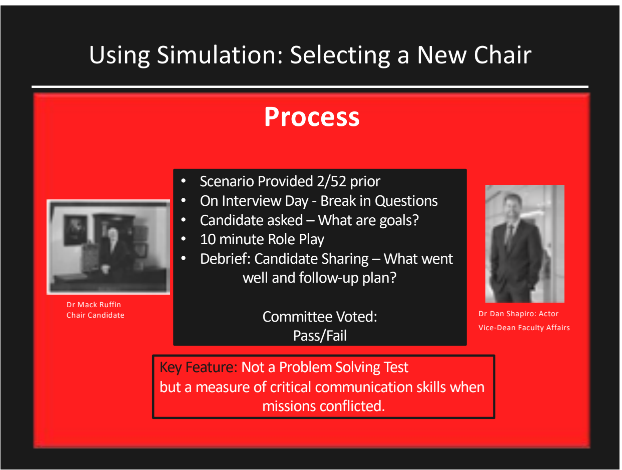
Using Simulation: Selecting a New Chair
Contemporary Chairs must also be:
Self Aware
Empathetic
Sense of Humor
Ability to inspire
Effective C
NOT TESTED !!!!!!
motional competence
Interpersonal &
Communication skills
National Stature
Recruited from Prestigious Institution
Track Record in Research
Clinical Competency
Appreciation for Teaching
"Gets along with others"
Grigsby et.al. Acad Med 2004;79, 571-7

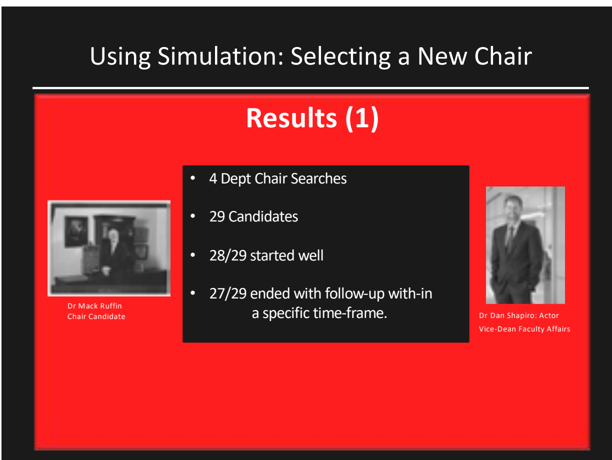

Using Simulation: Selecting a New Chair
An Approach:
Behavioral Based Interv
" Describe
with some-one
worked with
you "
Problem:
Interviewing ability v.s. Interpersonal ability

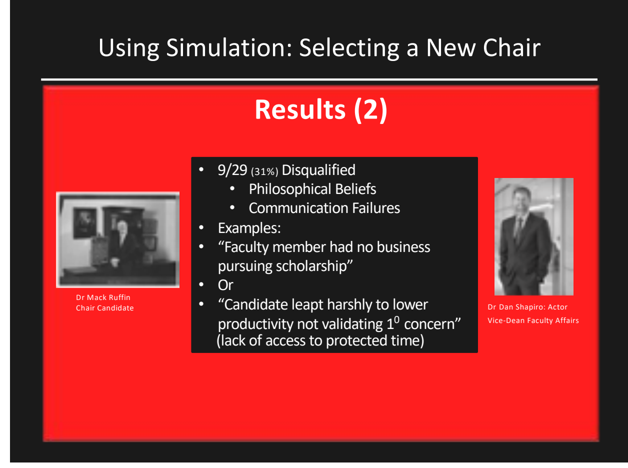
Using Simulation: Selecting a New Chair
Another Approach:
" Simulation Role Playing"
Used for 4 Chair Searches
Neurology
Family and Community Medicine
Pediatrics
Pathology
May 2015 - November 2016
Penn State University College of Medicine
Using Simulation of a Frustrated Faculty Member During Department Chair Searches. DE Shapiro et al.
Acad Medicine 2018; 93, 224-227.

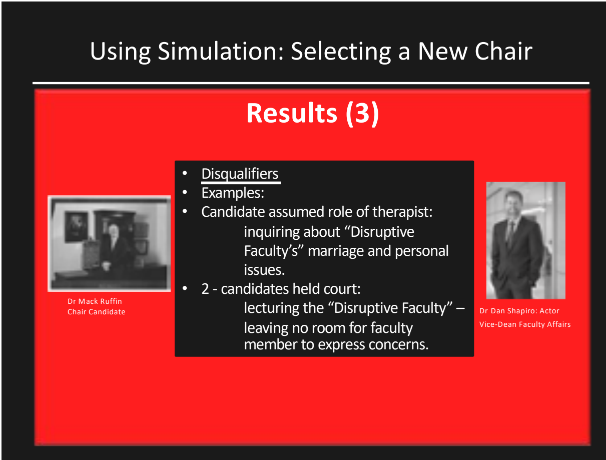
Using Simulation: Selecting a New Chair
" Simulation Role Playing"
Initial Goal: Proof of Concept
Would ?
Chair Candidates Engage
Search Committees and Dean find this a useful assessment
Using Simulation of a Frustrated Faculty Member During Department Chair Searches. DE Shapiro et al.
Acad Medicine 2018; 93, 224-227.

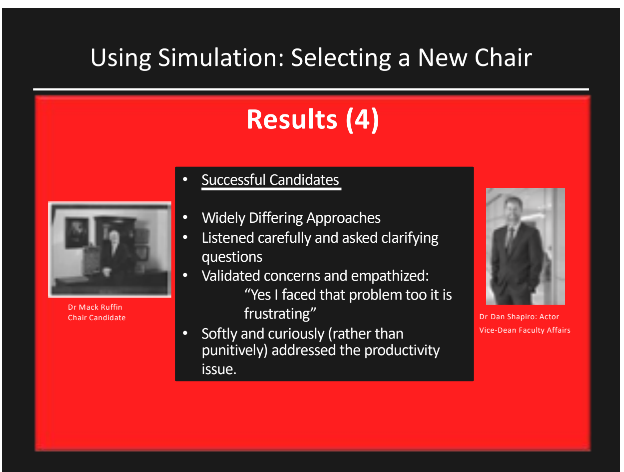

Using Simulation: Selecting a New Chair
Picture yourself as a Nervous Chair Candidate
Scenario:
"Disruptive Faculty Member"
A faculty member who has worked at the institution
for 18 months in outpatient settings
is frustrated with how little time
he/she has for academic pursuits.
He/she is a skilled teacher
with highly satisfied patients
but is less clinically productive than his/her colleagues.
Dr Mack Ruffin
Chair Candidate
Dr Dan Shapiro: Actor
Vice-Dean Faculty Affairs
Key Feature: Not a Problem Solving Test
but a measure of critical communication skills when missions conflicted.


Using Simulation: Selecting a New Chair
Process
Scenario Provided 2/52 prior
On Interview Day - Break in Questions
Candidate asked – What are goals?
10 minute Role Play
Debrief: Candidate Sharing – What went well and follow-up plan?
Committee Voted:
Pass/Fail
Dr Mack Ruffin
Chair Candidate
Dr Dan Shapiro: Actor
Vice-Dean Faculty Affairs
Key Feature: Not a Problem Solving Test
but a measure of critical communication skills when missions conflicted.

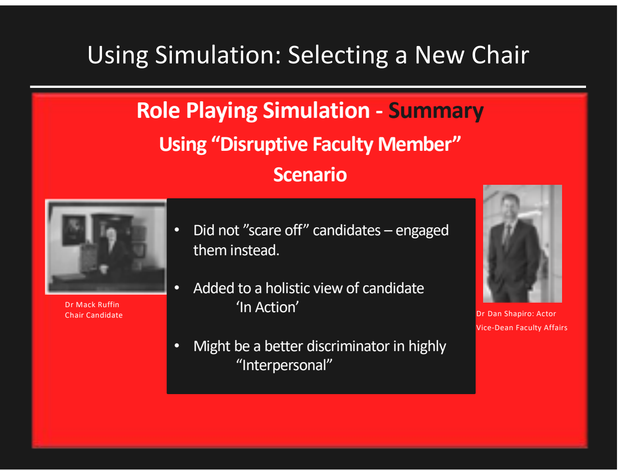

Using Simulation: Selecting a New Chair
Results (1)
4 Dept Chair Searches
29 Candidates
28/29 started well
27/29 ended with follow-up with-in a specific time-frame.
Dr Mack Ruffin
Chair Candidate
Dr Dan Shapiro: Actor
Vice-Dean Faculty Affairs


Using Simulation: Selecting a New Chair
Results (2)
9/29 (31%) Disqualified
Philosophical Beliefs
Communication Failures
Examples:
"Faculty member had no business pursuing scholarship"
Or
"Candidate leapt harshly to lower productivity not validating 1⁰ concern" (lack of access to protected time)
Dr Mack Ruffin
Chair Candidate
Dr Dan Shapiro: Actor
Vice-Dean Faculty Affairs


Using Simulation: Selecting a New Chair
Results (3)
Disqualifiers
Examples:
Candidate assumed role of therapist: inquiring about "Disruptive Faculty's" marriage and personal issues.
2 - candidates held court: lecturing the "Disruptive Faculty" – leaving no room for faculty member to express concerns.
Dr Mack Ruffin
Chair Candidate
Dr Dan Shapiro: Actor
Vice-Dean Faculty Affairs


Using Simulation: Selecting a New Chair
Results (4)
Successful Candidates
Widely Differing Approaches
Listened carefully and asked clarifying questions
Validated concerns and empathized: "Yes I faced that problem too it is frustrating"
Softly and curiously (rather than punitively) addressed the productivity issue.
Dr Mack Ruffin
Chair Candidate
Dr Dan Shapiro: Actor
Vice-Dean Faculty Affairs

Using Simulation: Selecting a New Chair
My Own Experience
Chair of Search Committee:
• Family and Community Medicine (Fall 2016)
• Radiation Oncology (Summer 2018)
Dr Mack Ruffin
Chair Candidate
Dr Dan Shapiro: Actor
Vice-Dean Faculty Affairs


Using Simulation: Selecting a New Chair
Role Playing Simulation - Summary
Using "Disruptive Faculty Member" Scenario
• Did not "scare off" candidates – engaged them instead.
• Added to a holistic view of candidate 'In Action'
• Might be a better discriminator in highly "Interpersonal"
Dr Mack Ruffin
Chair Candidate
Dr Dan Shapiro: Actor
Vice-Dean Faculty Affairs

Using Simulation: Selecting a New Chair
--Finis--

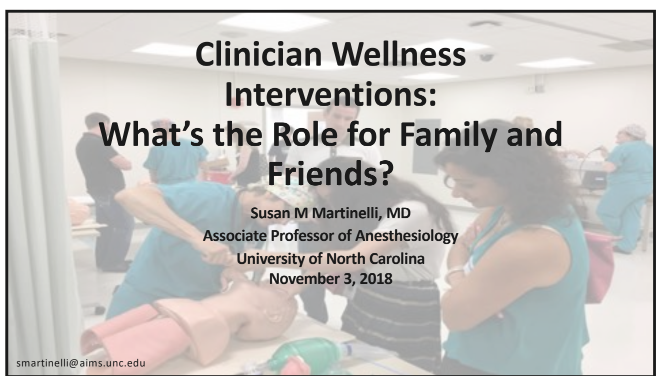
Back to Schedule

HANDOUT

Innovative Ways of Using Simulation as a Development Tool: Using Simulation to Educate Anesthesia Providers' Loved Ones/Support Persons About Anesthesia to Improve Relatedness to Providers

Susan M. Martinelli, MD, FASA

11/03/2018
11:20am – 11:40am



Clinician Wellness Interventions: What's the Role for Family and Friends?

Susan M Martinelli, MD
Associate Professor of Anesthesiology
University of North Carolina
November 3, 2018

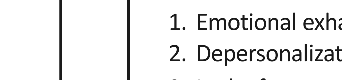
smartinelli@aims.unc.edu

Financial Disclosure

I do not have any relevant financial relationships with commercial interests that pertain to the content of the presentation

Objectives

- Discuss the prevalence of burnout in physicians
- Illustrate the effects of burnout
- Describe an intervention involving family & friends



What is Burnout?

1. Emotional exhaustion
2. Depersonalization
3. Lack of personal accomplishment

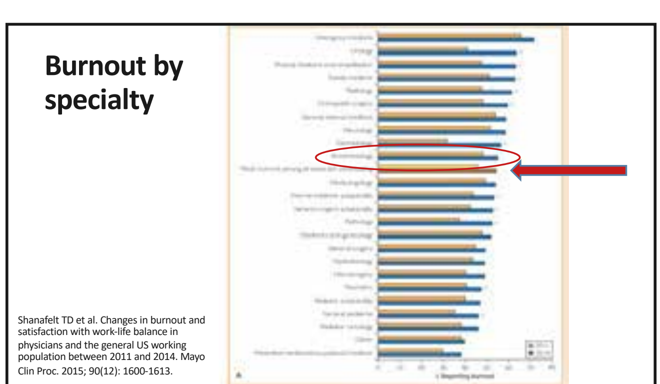
Maslach C, Jackson S, Leiter M. Maslach Burnout Inventory Manual. (3rd Ed) Consulting Psychologists Press, Palo Alto, CA (1996).

Burnout on the Rise: Physicians

	2011	2014
Burnout ⇧	45.5%	54.4%
Satisfaction with work life balance ⇩	48.5%	40.9%
Depression symptoms	38.2%	39.8%
Suicidal ideation	6.4%	6.4%

Shanafelt TD et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clin Proc. 2015; 90(12): 1600-1613.

Burnout by specialty



Shanafelt TD et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clin Proc. 2015; 90(12): 1600-1613.

Back to Schedule

Satisfaction with work-life balance by specialty

Shanafelt TD et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clin Proc. 2015; 90(12): 1600-1613.

Anesthesiology Residents

- High burnout risk
  - 41%
  - Risk factors
    - Working >70 hrs/wk
    - >5 drinks/wk
    - Female
- Positive depression screening
  - 22%
  - Risk factors
    - Working >70 hrs/wk
    - Smoking
    - >5 drinks/wk
    - Female

De Oliveira et al. The prevalence of burnout and depression and their association with adherence to safety and practice standards: a survey of United States Anesthesiology Trainees. Anesth Analg 2013; 117: 182-93.

Why is this important?

- Patient safety
- Substance abuse
- Physician suicide
- Financial implications
- Mandates

Patient Safety

- Internal medicine residents[1,2,3]
  - ↑burnout
    - ↑self perceived medical errors
- Pediatric residents[4]
  - ↑depression
    - ↑medication errors
- Anesthesia residents[5]
  - ↑burnout and depression
    - ↓best practice scores
    - ↑medication errors
- Surgeons[6]
  - ↑burnout
    - ↑medical errors

1. West CP et al. Association of resident fatigue and distress with perceived medical errors. JAMA. 2009; 302(12): 1294-1300.
2. Shanafelt TD et al. Burnout and self-reported patient care in an internal medicine residency program. Ann Intern Med. 2002; 136:358-367.
3. West CP. Association of perceived medical errors with resident distress and empathy. JAMA. 2006; 296:1071-1078.
4. Fahrenkopf AM et al. Rates of medication errors among depressed and burnt out residents: prospective cohort study. BMJ 2008; 336(7642): 488-91.
5. De Oliveira et al. The prevalence of burnout and depression and their association with adherence to safety and practice standards: a survey of United States Anesthesiology Trainees. Anesth Analg 2013; 117: 182-93.
6. Shanafelt TD et al. Burnout and medical errors among American surgeons. Ann Surg. 2010;251: 995-1000.

Substance Use Disorder (SUD)

Anesthesia residents 1975-2009

- 2.16 per 1000 resident years
  - 2.68 men
  - 0.65 women
- At least 11% with SUD died
- Estimated relapse 43%
  - Over 30 year career

Warner DO et al. Substance use disorder among anesthesiology residents, 1975-2009. JAMA. 2013; 310(21):2289-2296.

Physician suicide rates

- 300-400 physician suicides annually[1]
- Rates compared to general population[1,2]
  - Men 1-1.5
  - Women 2-4
- Little social support[1,3]

1. Eckleberry-Hunt J and Lick D. Physician depression and suicide: a shared responsibility. Teach Learn Med. 2015; 27(3):341-5.
2. Schernhammer ES and Colditz GA. Suicide rates among physicians: a quantitative and gender assessment. Am J Psychiatry. 2004; 161;2295-2302.
3. Crawshaw R et al. An epidemic of suicide among physicians on probation. JAMA. 1980; 243(19):1915-17.

Back to Schedule

Financial Implications

- Burnout
  - ↑physician turnover
    - Cost to replace physician $500,000-$1million
  - ↓productivity
  - ↑medical errors

Shanafelt T et al. The business case for investing in physician well-being. JAMA Intern Med. 2017; 177(12):1826-1832.

Mandates

- ACGME
  - Core program requirements: Wellbeing
- Anesthesiology Milestones
  - Professionalism 5: Responsibility to maintain personal, emotional, physical, and mental health

So what is the role for family and friends?

Psychological Well-Being

- Social relatedness
- Building of competence
- Autonomy

Associated with resident well-being

Raj KS. Well-being in residency: A systematic review. J Grad Med Educ 2016;8:674–84

Family & friends understanding of work related stress ↑ resident well-being

Hard for residents to communicate about their work with non medical people

Rappaport WD, Putnam CW, Witzke D, Amil B. Helping residents' families cope. Acad Med 1992;67:761
Bell M a, Smith PS, Brokaw JJ, Cushing HE. A Family Day program enhances knowledge about medical school culture and necessary supports. BMC Med Educ 2004;4:3.
Law M, Lam M, Wu D, Veinot P, Mylopoulos M. Changes in Personal Relationships During Residency and Their Effects on Resident Wellness. Acad Med 2017;XX:1.

Adverse Events and Errors

- Adverse events[1]
  - 72% of anesthesiologists sought support from spouse, family & friends
  - 88% felt that it would be helpful to talk to their own spouse/family
- Perceived errors[2]
  - 65% residents discuss with close family and friends

1. Gazoni FM et al. The impact of perioperative catastrophes on anesthesiologists. Anesth Analg. 2012; 114:596-603.
2. West CP et al. Asscoation of perceived medical errors with resident distress and empathy. JAMA. 2006; 296-1071-1078.

Back to Schedule

Academic Anesthesiology Chairs

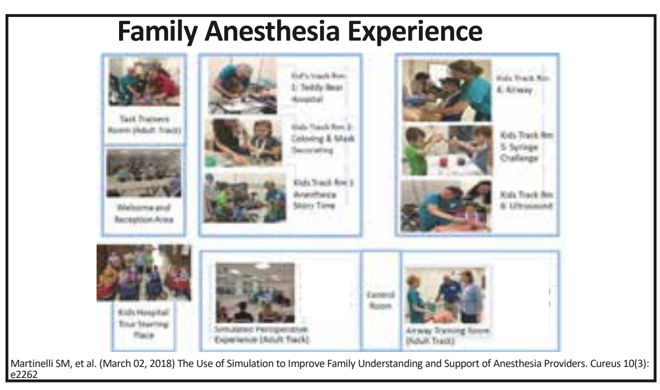
- ↓job satisfaction and ↓spousal support
  - Independent predictors of burnout
- ↓Spousal/support person support
  - 5.2x higher risk of burnout

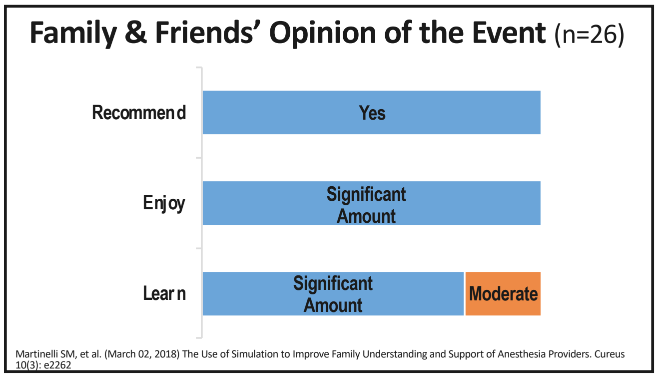
De Oliveira GS et al. High incidence of burnout in academic chairpersons of anesthesiology. Anesthesiology. 2011. Jan; 144(1):181-93.

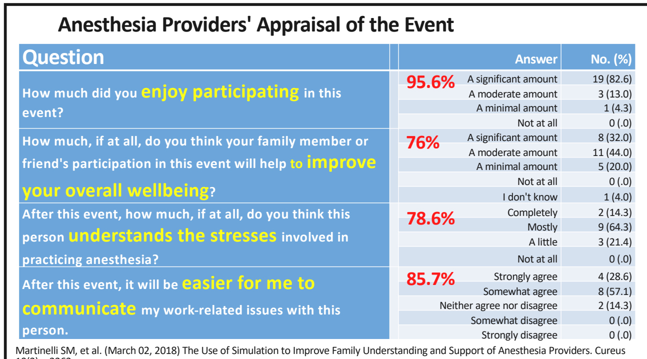
Aviation industry

- Pilot's ability to cope with stress
  - Stable home life
  - Good relationship with spouse
- Spouses included in training seminar
  - Well-received
  - Better able to understand and support pilot

Sloan SJ, Cooper CL. Stress coping strategies in commercial airline pilots. J Occup Med 1986;28:49–52.
Karlins M, Koh F, McCully L. The spousal factor in pilot stress. Aviat Space Environ Med 1989;November:1112–5.



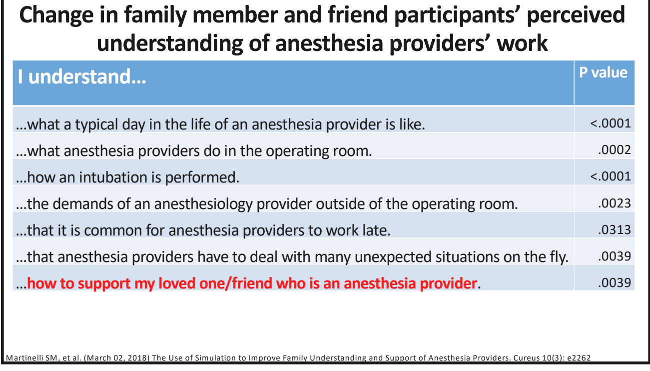




Anesthesia Providers' Appraisal of the Event

Question		Answer	No. (%)
How much did you enjoy participating in this event?	95.6%	A significant amount	19 (82.6)
		A moderate amount	3 (13.0)
		A minimal amount	1 (4.3)
		Not at all	0 (.0)
How much, if at all, do you think your family member or friend's participation in this event will help to improve your overall wellbeing?	76%	A significant amount	8 (32.0)
		A moderate amount	11 (44.0)
		A minimal amount	5 (20.0)
		Not at all	0 (.0)
		I don't know	1 (4.0)
After this event, how much, if at all, do you think this person understands the stresses involved in practicing anesthesia?	78.6%	Completely	2 (14.3)
		Mostly	9 (64.3)
		A little	3 (21.4)
		Not at all	0 (.0)
After this event, it will be easier for me to communicate my work-related issues with this person.	85.7%	Strongly agree	4 (28.6)
		Somewhat agree	8 (57.1)
		Neither agree nor disagree	2 (14.3)
		Somewhat disagree	0 (.0)
		Strongly disagree	0 (.0)

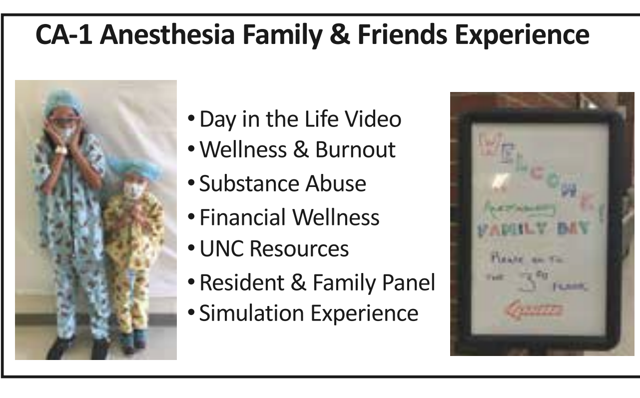
Martinelli SM, et al. (March 02, 2018) The Use of Simulation to Improve Family Understanding and Support of Anesthesia Providers. Cureus 10(3): e2262

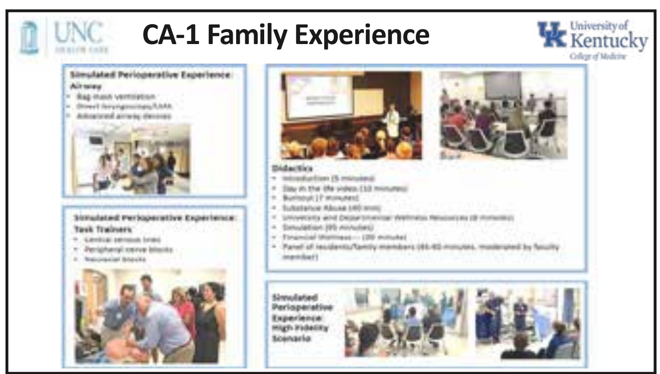


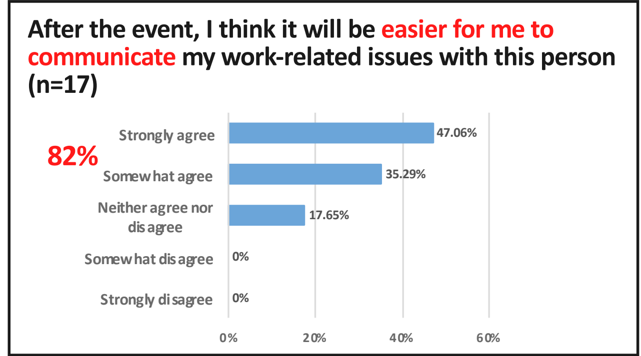
Change in family member and friend participants' perceived understanding of anesthesia providers' work

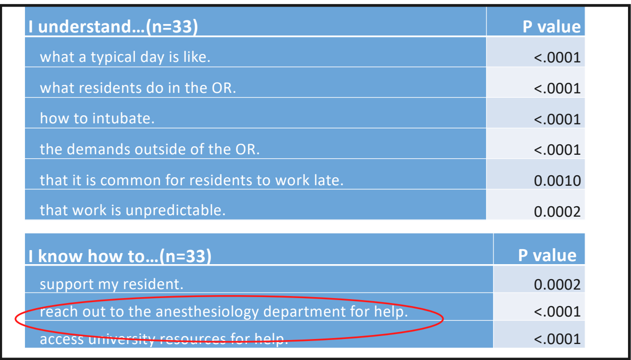
I understand...	P value
...what a typical day in the life of an anesthesia provider is like.	<.0001
...what anesthesia providers do in the operating room.	.0002
...how an intubation is performed.	<.0001
...the demands of an anesthesiology provider outside of the operating room.	.0023
...that it is common for anesthesia providers to work late.	.0313
...that anesthesia providers have to deal with many unexpected situations on the fly.	.0039
...how to support my loved one/friend who is an anesthesia provider.	.0039

Martinelli SM, et al. (March 02, 2018) The Use of Simulation to Improve Family Understanding and Support of Anesthesia Providers. Cureus 10(3): e2262



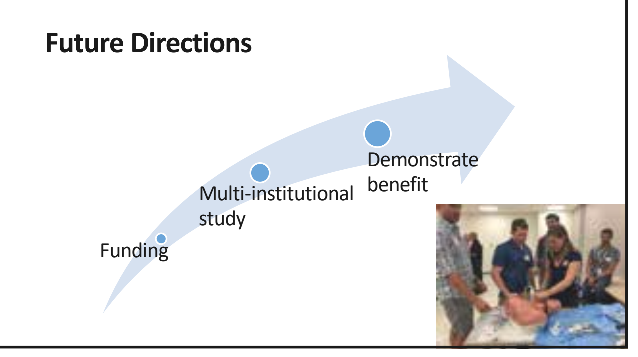






I understand...(n=33)	P value
what a typical day is like.	<.0001
what residents do in the OR.	<.0001
how to intubate.	<.0001
the demands outside of the OR.	<.0001
that it is common for residents to work late.	0.0010
that work is unpredictable.	0.0002

I know how to...(n=33)	P value
support my resident.	0.0002
reach out to the anesthesiology department for help.	<.0001
access university resources for help.	<.0001



Back to Schedule

HANDOUT

Innovative Ways of Using Simulation as a Development Tool: Using Simulation to Improve Leadership Skills

Arna Banerjee, MD, FCCM

11/03/2018
11:40am – 12:00pm

Back to Schedule

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Using Simulation to Improve Leadership Skills

ARNA BANERJEE, MD, FCCM
Associate Professor of Anesthesiology / Critical Care
Associate Professor of Surgery, Medical Education and Administration
Assistant Dean for Simulation in Medical Education
Director, Center for Experiential Learning and Assessment

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Music City, USA

I have no financial relationships with commercial support to disclose.

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Educational Objectives

Following this presentation, you should be able to:

1. Describe the elements of effective leadership
2. Articulate why and how simulation-based interventions can be used to improve leadership skills
3. Articulate how to use simulation-based techniques to teach leadership skills to a non-medical professional

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- Origin of words *lead, leader, leadership* is *"laid",* alluding 'path' or 'road'.
  - verb *læden = 'to travel'. A leader is an individual who* shows other travellers the path ahead
- Leadership has been described as the behavior of an individual when directing the activities of a group toward a shared goal.
- Leadership skills can be learned, developed, and perfected.
- Leadership skills are adaptable and can and should evolve over time.

Abdulaziz Al-Sawai. Leadership of Health Care Professionals. Where Do We Stand? Oman Med J. 2013 Jul; 28(4): 285–287.

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Nashville Health Care Council

- Helping senior health care leaders **define complex problems; identify solutions through collaboration; and foster leadership skills**.
- Individuals accepted into the program are: CEO, COO, CMO, CFO, CTO, CIO, C-suite leader. Chairman, President, Senior Vice President, Executive Vice President, Managing Partner, Managing Director, Principal or Co-Founder – healthcare organizations.

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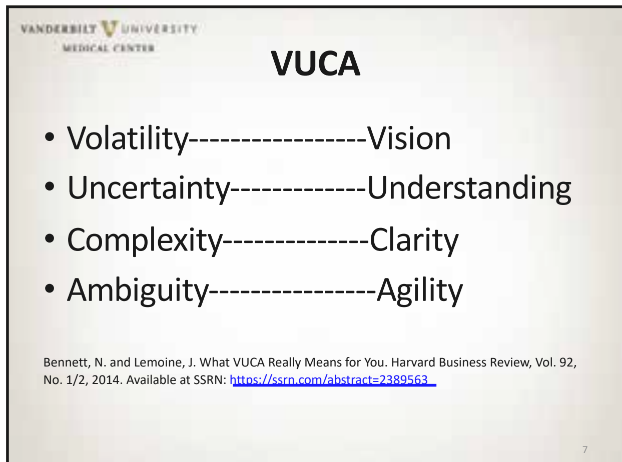
- Enhancing the classroom curriculum is an immersion component that exposes Fellows to behind-the-scenes looks at diverse aspects of the health care sector.
- We were asked to create an immersive experience using simulation to address the experiential elements of the curriculum.



Healthcare Leadership Competencies

- An organization that comprises several medical organizations in the U.S. has studied leadership extensively and found 5 core competencies:
  - Communication and Relationship Management
  - Facilitator/Vision
  - Professionalism
  - Business
  - Knowledge of the Healthcare Environment

http://www.healthcareleadershipalliance.org/Common%20Competencies%20for%20All%20Healthcare%20Managers.pdf

Colour Blind

- Colour BlindTM (RSVP Design, Johnstone, UK) was originally developed for air traffic control cadets.
- Team cognitive exercise

Colour Blind

- Team members all wear blindfolds
- Ensure total dependence upon the quality of their verbal communication.
- Group together gather information that will allow them to solve a puzzle.

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- They ascertain which two-colored and abnormally shaped pieces are missing from a set of 30 pieces (consisting of 6 shapes and 5 colors).

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Colour Blind - Objectives

- Refine skills that will help ensure common understanding (sense making) between team members.
- Emphasize the importance of checking and feedback.
- Demonstrate how communication can break down in teams, and to enable teams to identify and rectify such communication failures.

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De-briefing

- Sensemaking
  - Different team members will describe or understand the descriptions of the shapes in different ways. Team success depends on effective communication between team members.
  - These differences can stem from culture, gender, experience, etc.

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  - The team must develop methods to accurately identify and clarify information ambiguity. This can be accomplished through cross-checking and double-checking, for example.
  - The team will fail unless collectively (and individually) they develop a common understanding of the situation (called team situation awareness).

Back to Schedule

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- Process and Communication Management
  - Individual team members often have information that is critical to successful team performance
  - Everyone has something to contribute – you may have to elicit it from some members.
  - It is essential that all members of the team participate – teams cannot afford to have "social loafers" (those who intentionally do less work than other team members).

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- Diversity in Communication Styles and Needs
  - Different team members will describe or understand the descriptions of the shapes in different ways. Team success depends on effective communication between team members.
  - Team members should be able to adapt their communication style to accommodate the needs of other team members (or, by the way, especially patients and their families).

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MRS. FAIRBANKS

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Mrs. Fairbanks

- Locally developed - M. B. Weinger and Vanderbilt University School of Medicine (Nashville, TN)
- complex, multiparty negotiation role-play exercise that includes an elderly standardized patient (SP).

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Mrs. Fairbanks

- Assigned roles on a clinical care team making hospital discharge decisions about a geriatric patient.
  - charge nurse,
  - physical therapist,
  - hospitalist physician,
  - orthopedic surgeon
  - social worker

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Mrs. Fairbanks

- They must negotiate
  - the location to which the patient should be discharged
  - how to manage the patient's invalid spouse
  - the appropriate rehabilitation therapy regimen
  - how to manage the patient's insulin-dependent diabetes
  - how to manage the patient's refractory atrial fibrillation.

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Mrs. Fairbanks

- The team first meets together and tries to reach consensus on the five inter-related decisions based on their positions.
- The geriatric SP is then wheeled into the room.

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- The SP is trained to assume negotiation positions that are designed to be contrary
- Trainees re-negotiate with the patient, who has different preferences.
- The SP is trained to be appropriately but incompletely influenced to retreat from his/her inherent preferences.

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Mrs. Fairbanks - Objectives

- Understand the importance of and methods for team resolution of conflict situations.
- Understand and overcome barriers to effective communication.
- Effective information transfer (especially listening) - obtaining input and information from everyone on the team and from the patient.

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Mrs. Fairbanks - Objectives

- Importance of interpersonal and cultural differences, and their influence on team decision-making.
- Integrating patient preferences into care decisions especially when they are in conflict with the providers' preferences.

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Debrief

Exercise Observation Form

(for Faculty as well as the Medical Student role)

Session: ____________ **Exam Room:** ______

Student Assignments:

Hospitalist: ____________

Orthopedic Surgeon: ____________

Physical Therapist: ____________

Charge Nurse: ____________

Social Worker: ____________

Medical Student: ____________

Decisions Before & After Patient Enters Room:

	Before	After
Discharge facility		
Spouse facility		
PT/OT		
Diabetes		
Arrhythmia		

Notes for SP Improvement:

Debriefing Points:

- ❑ Engagement (role immersion)
- ❑ Participation
- ❑ Relationships and Coalitions
- ❑ Influence
- ❑ Role of anecdotal vs. real evidence
- ❑ Decision-making (how/why)
- ❑ Climate & Conflict
- ❑ Patient's Role & Influence
- ❑ Professionalism

Notes: ____________

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Debrief

- Separate the people from the problem

Think of each other as partners in negotiation rather than as adversaries.

- Focus on Interests Not on Positions
- Invent options for mutual gain
- Use Objective Criteria
- BATNA

Getting to YES; Negotiating agreement without giving in: Fisher / Ury Institute for Medical Simulation, Comprehensive Workshop, Boston

Back to Schedule

- Manikin based teamwork exercise
- Patient: Cecilia Langston
- Procedure: 3 vessel Coronary Artery Bypass Grafting
- After the sternum is closed, the anesthesiologist begins to awaken patient.
- Cardio-thoracic surgeon leaves the OR and reports to the family that the surgery has gone well with no complications

- After the CT surgeon leaves to talk to the family, the patient experiences a drop in Blood Pressure.
- The anesthesiology attending instructs the anesthesiology resident, “Hang the cell saver blood… put in under pressure but give only half because I see air at the top of the bag.” The anesthesiology resident hears the order except for the part about “give only half.”
- 15 minutes later, the patient arrests.
- The anesthesiology resident notices the IV line filled with air, the empty cell saver bag, the lack of BP and no cardiac electrical activity.
- He is devastated because he is very experience and he cannot believe that he has done this to the patient

Transactional versus Transformational Leadership

Transactional Leadership

- Operational oriented
- Motivates others to achieve goal

Transformational Leadership

- Team oriented
- Focuses on collaboration and shared vision

Essential Elements of ACRM

- **Communication & cooperation:** Assertiveness, willingness to challenge, & conflict resolution
- **Leadership & followership:** Adaptability & flexibility
- **Resource management:** Dynamic prioritization
- **Team situation awareness:** Cross-checking & feedback
- **Team decision making:** Error trapping

Back to Schedule

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- After 20 minutes of CPR, the patient regains normal Blood Pressure, Heart Rate and is hemodynamically stable.
- However, the patient no longer follows commands or opens eyes to stimulation.
- The anesthesiology attending and surgeon are busy with another case.

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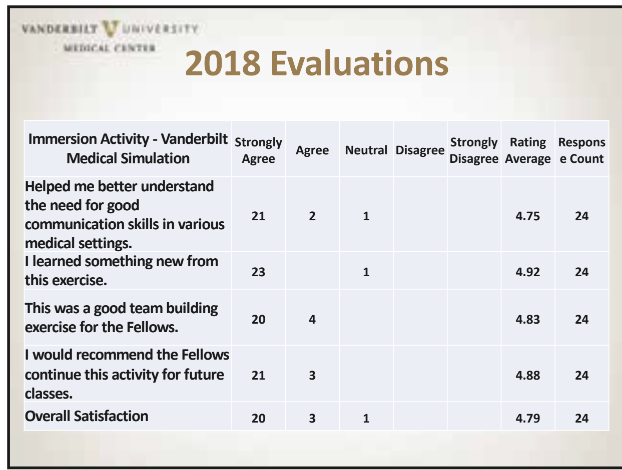
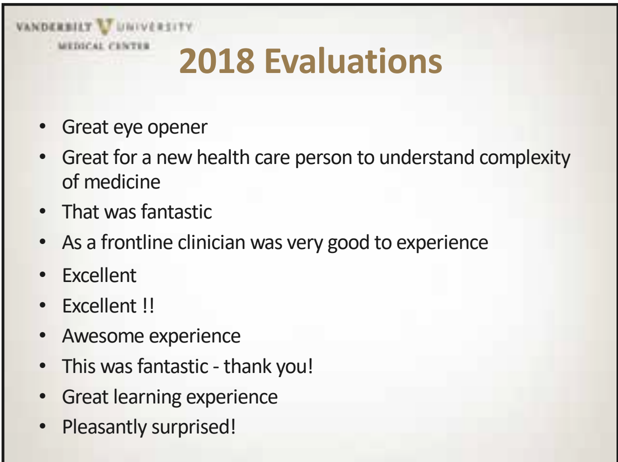
- The Attending Anesthesiologist is positive that enough time has elapsed for us to obtain a Neurological Exam
- He seems to feel that the patient may have had an anoxic brain injury
- You have to deliver this news to the brother (SP)



2018 Evaluations

Immersion Activity - Vanderbilt Medical Simulation	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Rating Average	Response Count
Helped me better understand the need for good communication skills in various medical settings.	21	2	1			4.75	24
I learned something new from this exercise.	23		1			4.92	24
This was a good team building exercise for the Fellows.	20	4				4.83	24
I would recommend the Fellows continue this activity for future classes.	21	3				4.88	24
Overall Satisfaction	20	3	1			4.79	24



HANDOUT

Identifying Implicit Bias & Introduction to Group Activity

Ellise Delphin, MD, MPH

11/03/2018
12:25pm – 12:45pm

Back to Schedule

Identifying Implicit Bias

Ellise Delphin MD, MPH
Albert Einstein College of Medicine
Montefiore Medical Center

Objectives

- To increase understanding of the basis of bias
- To provide a set of strategies and skills to prevent implicit bias from negatively impacting clinical encounters
- To enhance motivation to reduce bias

- No conflicts of interest

Whistling Vivaldi

"I turned out of my way into side streets to spare them the sense of being stalked……Out of nervousness I began to whistle…… I whistled tunes from the Beatles and Vivaldi's Four Seasons. The tension drained from people's bodies when they heard me. A few even smiled."

Brent Staples
University of Chicago

Provider Behavior

- Providers hold stereotypes that influence clinical decisions
- This frequently occurs outside of conscious awareness
- Providers interact less effectively with minority patients
- Health care disparities exist due to provider behavior

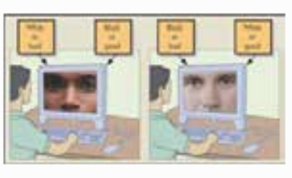
Implicit bias

- Brain's automatic, instant association of stereotypes or attitudes toward particular groups without our conscious awareness

Back to Schedule

Project Implicit – Implicit Association Test

- Measures the time differentials between how long it take participants to pair concepts in different ways
- Measures the unconscious associations people hold



Implicit Association Test

Percent of web respondents with each score

Strong automatic preference for other people compared to arab-muslims	12%
Moderate automatic preference for other people compared to arab-muslims	20%
Slight automatic preference for other people compared to arab-muslims	18%
Little to no automatic preference between arab-muslims and other people	25%
Slight automatic preference for arab-muslims compared to other people	12%
Moderate automatic preference for arab-muslims compared to other people	9%
Strong automatic preference for arab-muslims compared to other people	3%

Percent of web respondents with each score

Strong automatic preference for Young people compared to Old people	35%
Moderate automatic preference for Young people compared to Old people	29%
Slight automatic preference for Young people compared to Old people	16%
Little to no automatic preference between Young and Old people	14%
Slight automatic preference for Old people compared to Young people	4%
Moderate automatic preference for Old people compared to Young people	2%
Strong automatic preference for Old people compared to Young people	0.4%

Implicit Bias in Healthcare

- High levels of bias lead to less friendly and lower patient satisfaction
- Differential interpretation of clinical presentation – cardiac patients
- Differential treatment recommendations – painkillers and antiretroviral

- Godsil et al., 2014

Nonverbal bias among physicians

- Physicians in end of life care show different nonverbal communication toward black patients
  - Time spent with open body language
  - Time interacting with patients
  - Time touching patient
  - Physical distance from patients

- Elliot AM et al. (2016) Journal of Pain Symptom Management

Implicit Bias is:

- Increased by
  - Stress
  - Time Pressure
  - Multi-tasking
  - Lack of clear criteria for decision making
  - Ambiguous information
  - Lack of familiarity with group

Implicit Bias is:

- Not reduced by
  - Good intentions
  - External pressure
  - Suppressing bias
  - Avoiding people from other groups
  - Thinking you don't have bias

Back to Schedule

- Implicit biases are not permanent, they are malleable and can be changed by devoting intention, attention and time to developing new associations

Conceptual Framework

- **Motivation**
  - Internal motivation to respond without bias
- **Information**
  - Understanding the basis of bias
  - Understanding the historical context of bias
- **Emotion**
  - Enhancing provider confidence
  - Regulating emotional responses
- **Orientation**
  - Increasing perspective- talking and empathy
  - Building partnerships with patients

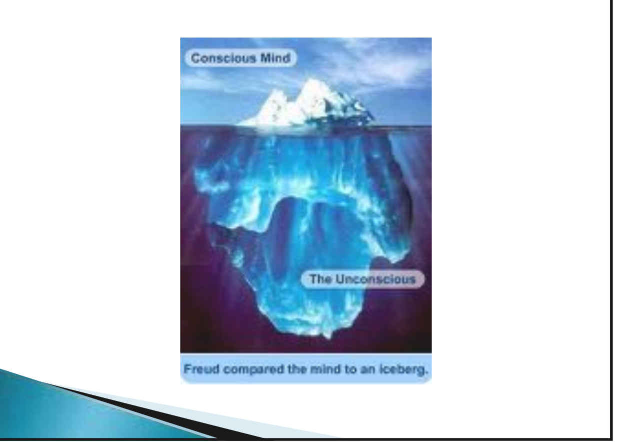
Internal motivation

- Awareness of personal unconscious bias
  - Implicit Association Test
    - https://implicit.harvard.edu
- Awareness of outcomes of bias
  - Racial disparities in quality of healthcare
  - Evidence that provider bias may contribute to disparities
- Nonthreatening private context

  - Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare 2002
  - Shulman et al., NEJM, 1999

Understanding the Basis of Bias

- Strategy of categorization that gives rise to stereotyping is a normal part of human cognition
  - Brain can process 11 million bits of information per second
  - Only 40 – 50 bits are conscious
- Categorization is necessary for survival but leads to stereotyping



Freud compared the mind to an iceberg.

Enhancing Provider Confidence

- Direct contact with members of minority groups
- Interactive, facilitated discussions among colleagues of different race and ethnicity
- Scripted interviews
- Evidence based practice protocols

Stereotype Threat

" is a situation predicament in which people are or feel themselves to be at risk of conforming to stereotypes about their social group. Stereotype threat has been shown to reduce performance of those belonging to the negatively stereotyped groups."

Stereotype Threat: Healthcare

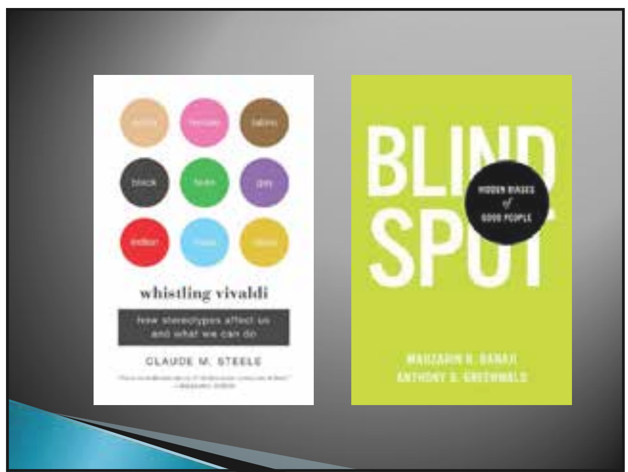
- Avoidance of healthcare
- Impaired communications with healthcare providers
- Poor adherence to treatment plan
- Discounting feedback – about elevated blood sugar levels or negative effects of smoking
- Dis-identification – viewing health promotion behaviors as white
    - Aronson et al., 2013
    - Burgess et al., 2010

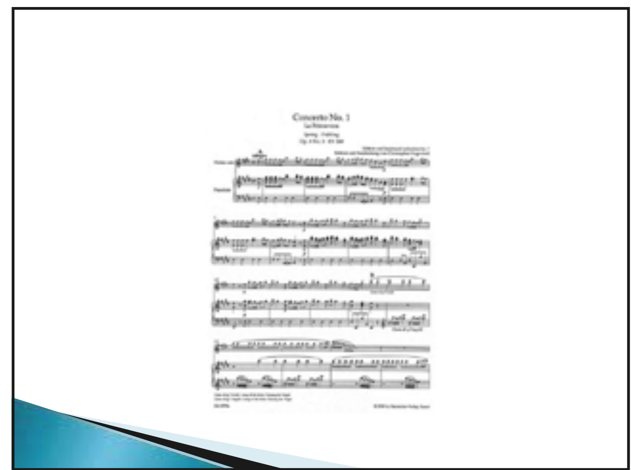
Interventions and Solutions

- Create an environment that is identity safe
- Increase feelings of social belonging
- Encourage self affirmation
- Remove triggers for stereotype threat
- Promote a growth mindset
- Give feedback that is trusted
    - Godsil et al. 2016

Overcoming Implicit Bias

- Diversity in workplace
- Counter stereotypic imaging
- Positive contact
- Motivation to be fair
- Improve conditions of decision making





HANDOUT

Equity and Inclusion: Group Activity and Discussion of Scenarios/Vignettes

Facilitator: Destiny Peery, JD/PhD

11/03/2018
12:45pm – 1:25pm

Story 1:

A white male patient with a brain tumor was seen in the office by his surgeon and stated that during the course of his care, he did not want any minorities or individuals of color taking care of him. It was documented in his chart and it was implied that the patient's line of thinking was attributed to personality changes because of his frontal tumor. On the day of surgery, it was restated by the patient and his family that he did not want any non-white providers. This request escalated to hospital leadership and caused OR delays. In the end, accommodations were made to honor the patients request and staffing at many levels was adjusted.

Story 2:

I am a PD of a large core residency program, a wife of a busy physician, and mother to two children. Clinically, I am one of only a few women in my busy subspecialty division. On numerous occasions, when I chose to stay with my case, rather than be relieved, one of my male colleagues made reference to the fact that I am an inferior mother because I chose to stay at work. Recently, he stated (in a lounge with surgeons, anesthesiology residents and my faculty colleagues) that "working moms can either be great physicians OR great moms, but not both and (my name redacted) has not figured that out yet."

Story 3:

A surgeon was addressing an anesthesiology resident to change the OR table position. The surgeon's words were "You, boy, girl, whatever you are, raise the table". The comment was reported to me as the PD by an OR staff member. The resident, when questioned, said "I didn't want to report it and make a big deal about it." The resident is an openly gay male. He stated "I am comfortable with my sexuality and I don't care what he thinks".

Questions to consider as you are discussing the stories:

- In your opinion, does this story contain an element(s) of bias? If so, what type(s) of bias (gender, sexual orientation, ability, age etc.). If not, why?
- How would you handle this situation if you were the attending, the learner (if there was a learner in your scenario), or others involved in this situation.
- Does your division, department, institution have policies and practices that address the type of behavior described in the story you were assigned. If so, what is/are the policy(ies)/practice(s)?
- Does your division, department, institution have policies/practices that unintentionally contribute to bias behavior as described in your assigned story? If so, please describe. Will/how will you address those policies and practices?
- If you perceive there is bias in your assigned story, what can you personally do to prevent this behavior form happening in the future?

Back to Schedule

HANDOUT

Practical Approaches to Strengthening Equity and Inclusion within Your Department Panel

Ronald L. Harter, MD

11/03/2018
1:25pm – 2:10pm

Beyond the (614)

Ronald L. Harter, M.D., Speaker
ASA House of Delegates

I have recruited a number of physicians to our department in my career, first as residency program director, recruiting residents through the National Resident Matching Program (NRMP), and for the last several years recruiting faculty members as chair of the department. As I scan the department's roster that lists personal contact information, I derive a sense of satisfaction as I note the large number of individuals whose cellphone numbers have an area code other than 614, which is the area code for the Columbus metropolitan area. Although it's great to see those who were "Born a Buckeye" and have chosen to remain in "The 614," I truly value the contributions to our department from those who have resided outside central Ohio for some portion of their education and training. The heterogeneity of experience and perspective offered by those who have learned something other than "The OSU Way" truly makes us a stronger and better department, of that I am certain.

Although the geographic diversity I just described is important, it represents just one facet of diversity in an organization. Increasingly, many of us are recognizing the value of actively recruiting to expand representation across all demographics, with the aspirational goal of ultimately mirroring the relative prevalence of any particular sector of our broader population. My experience has been that this process requires a level of conscious attention and effort to be successful. Simply articulating a goal to increase diversity is not enough. Building diversity needs to be approached strategically in order for it to succeed.

Ronald L. Harter, M.D., is Professor and Jacoby Chair, Department of Anesthesiology, The Ohio State University Wexner Medical Center, Columbus.

"As we have become increasingly successful in adding to the diversity of our residency program and of our faculty, our department's pool of candidates for each has correspondingly grown as well."

Although recruiting for diversity is important, it is really only the first step. As author and diversity advocate Vernā Myers first noted, "Diversity is being invited to the party. Inclusion is being asked to dance." As chair, I am ever mindful of the need to facilitate the career development of the members of our faculty, and I strive to connect them to opportunities that mesh well with their interests and expertise. It is critically important to recognize the large amount of variability in how aggressively a person will seek out such opportunities for advancement. In particular, as noted in the book *Women Don't Ask*, by Linda Babcock and Sara Laschever, men tend to ask for things they want – in terms of compensation, promotion, etc. – two or three times as often as women do. Once I became aware of this, I started asking female faculty members if they were interested in a particular leadership opportunity, rather than only selecting from among the list of faculty who approached me to express interest. I had previously been unknowingly selecting from a biased sample comprising only those (virtually always male) faculty members who approached me. Ever since I learned of this phenomenon, I have appointed – and will continue to appoint – a number of our talented female faculty to important leadership roles in the department, with positive results.

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Another important lesson that I learned relatively recently is that we are all subject to develop inherent biases that can unconsciously impact our decisions regarding who to hire or who to promote within the organization. The self-realization that you indeed possess various biases is initially painful to accept. However, once it is recognized, the newfound self-awareness can facilitate more balanced choices thereafter. As you read this, you may well be thinking, "Me? Bias? Never!" Certainly, that had been my self-assessment as well for many years. However, I urge you, if you haven't previously done so, to take a few minutes to perform one or more Implicit Association Tests (IAT) found at this link: **implicit.harvard.edu/implicit/takeatest.html**. Once you get past the initial revelation that you indeed may have inherent biases, don't give yourself too much grief about it. Being exposed, essentially since birth, to so many images and depictions of people of a particular demographic fulfilling a certain role does impact the connections and associations our mind creates for us. The near-constant stream of such depictions inevitably contributes to the biases that are present in our society. Taking one or more IATs won't "cure" your inherent bias. It will, however, cause you to be more aware of the biases you unconsciously possess, which ideally will allow you to factor that into your decision-making processes.

In addition to simply being the right thing to do, recruiting for diversity and inclusion offers a strategic advantage. As we have become increasingly successful in adding to the diversity of our residency program and of our faculty, our department's pool of candidates for each has correspondingly grown as well. We are now far more likely to successfully recruit the best talent, rather than selecting from a more narrow pool of recruits. Extrapolating this to our specialty, each of us has an opportunity to expand the pool of future physicians entering our specialty, and many of us have the opportunity to facilitate their successful career trajectories. As noted in the May issue of the *ASA Monitor* (pages 54-56), our nation's population is growing increasingly diverse. Our specialty has an opportunity to broaden its applicant pool in the years ahead, allowing our specialty to more closely reflect the diversity within medicine and more broadly in society. If we can be successful in that effort, it will benefit our specialty and our patients.

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Back to Schedule

HANDOUT

Practical Approaches to Strengthening Equity and Inclusion within Your Department Panel

Michael H. Wall, MD, FCCM

11/03/2018
1:25pm – 2:10pm

Back to Schedule

Practical Approaches to Strengthening Equity and Inclusion within Your Department

Michael H. Wall, M.D., F.C.C.M
JJ Buckley Professor and Chairman
Department of Anesthesiology
University of Minnesota

The Minnesota Approach

- Why do this at all?
- Leadership development
- Role models
- "Active inclusion"
- Next steps
- *I have no disclosures or conflicts of interest*

Why do this at all?

- It is the "right thing to do"
- Diverse committees function better and make better decisions
- Diverse boards and companies perform better
- One of the goals of our land grant university is to:
  - "Have the students, faculty and staff at least represent the diversity of our state…"

Leadership Development

- Our first step was forming a Diversity Committee
  - 5 years ago we had no organized program
  - We had to star somewhere….
  - We stared with all Professor and Associate Professor female faculty
  - We focused mainly on male/female diversity as our department is 50% female and 50% male, so we called it the "Women in Leadership Committee"
  - Tasked with identifying and selecting more diverse people for roles within and outside of the department

Leadership Development

- UoM's "Leadership Academy"
  - 1 year long "mini MBA/MHA"
  - Each department can have 1 faculty per year participate
  - The Diversity Committee helps pick person every year and we alternate women and men
- ASA's Executive Physician Leadership Program
  - We send 2 faculty per year
  - Diversity Committee helps pick one male and one female per year

Role Models

- Grand Rounds
  - 50% of speakers every year are women and 50% are men
- Visiting professors
  - 50% of speakers every year are men and 50% are women

Role Models

- Women in Leadership Program
  - We invite all the Female VP to participate in our WIL program (~4 per year)
  - Dinner at faculties home
  - Invite all female faculty, fellows, residents and medical students (on rotation)
  - Some have had facilitators, some more "loose"
  - Well received

Active Inclusion

- Annual Van Bergen Lecture
  - Alternate women and men every other year
  - Women giving this lecture also do the WIL program (above)
    - It is a busy few days!

Active Inclusion

- Departmental Committees
  - Strive for 50/50 mix of members and committee chairs
- Medical School, Hospital, System and University Committees
  - We actively reach out, recruit and personally encourage participation

Active Inclusion

- ABA Applied (Oral Board) Examiners and committees
  - We nominate 50% men and 50% women
- AUA/ACA etc nominations
  - We nominate or alternate 50% women and 50% men
- Societies
  - We actively reach out and personally encourage participation

Next Steps

- Diversity Committee
  - Now that we are more ethnically diverse we probably need to change the make up of our committee
- 'Women in Leadership"
  - This has been popular at the UoM, and we know there is a problem with women in academic medicine
  - However, maybe we need to make this more inclusive too?
  - Maybe it is "Diversity in Leadership" Program??

MEDICAL SCHOOL | UNIVERSITY OF MINNESOTA

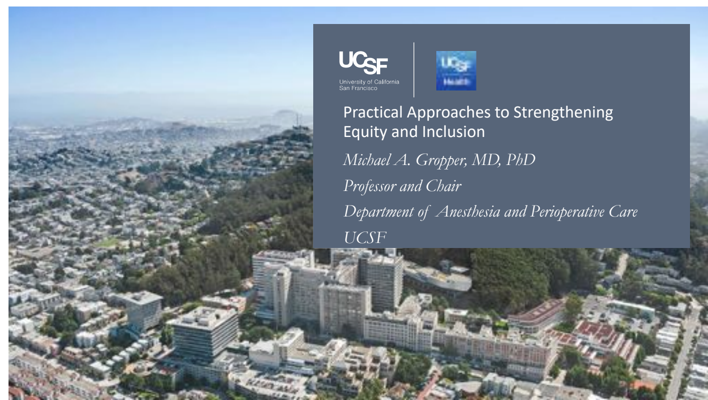
HANDOUT

Practical Approaches to Strengthening Equity and Inclusion within Your Department Panel

Michael A. Gropper, MD, PhD

11/03/2018
1:25pm – 2:10pm

Back to Schedule



Definitions:

- Diversity: Unique characteristics, perspectives and life experiences that define us as individuals
- Equity: Fair treatment, access, opportunity, and advancement of all individuals
- Inclusion: Creating an environment where all individuals contribute fully and feel valued, engaged and supported to reach their

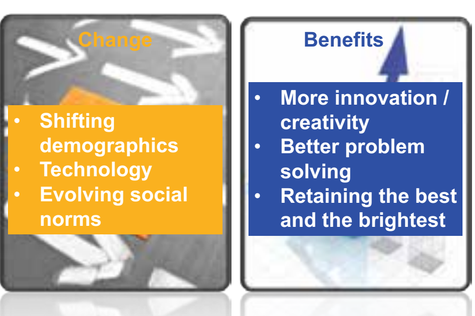
9

Privilege defined

- **Privilege** is a special right, or advantage available only to a particular person or group of people.
  - Two common examples used to talk about privilege: access to higher education and housing
- Privilege can also be emotional or psychological – sense of belonging or worth in society
- ***White privilege*** has been described as an "invisible package of unearned assets which whites can count on cashing in each day, but about which whites are meant to remain oblivious. White privilege is like an invisible weightless knapsack of special provisions, assurance, tools, maps, guides, codebooks, passports, visas, clothes, compass, emergency gear and blank checks." (McIntosh, p.55)

26

THE BUSINESS CASE INCLUDES:



Economic Benefits of Diversity

- Companies in the top quartile for racial and ethnic diversity are 35 percent more likely to have financial returns above their respective national industry medians.
- Companies in the top quartile for gender diversity are 15 percent more likely to have financial returns above their respective national industry medians.
- Companies in the bottom quartile both for gender and for ethnicity and race are statistically less likely to achieve above-average financial returns than the average companies in the data set (that is, bottom-quartile companies are lagging rather than merely not leading).
- In the United States, there is a linear relationship between racial and ethnic diversity and better financial performance: for every 10 percent increase in racial and ethnic diversity on the senior-executive team, earnings before interest and taxes (EBIT) rise 0.8 percent.

https://www.mckinsey.com/business-functions/organization/our-insights/why-diversity-matters

Economic Benefits of Diversity

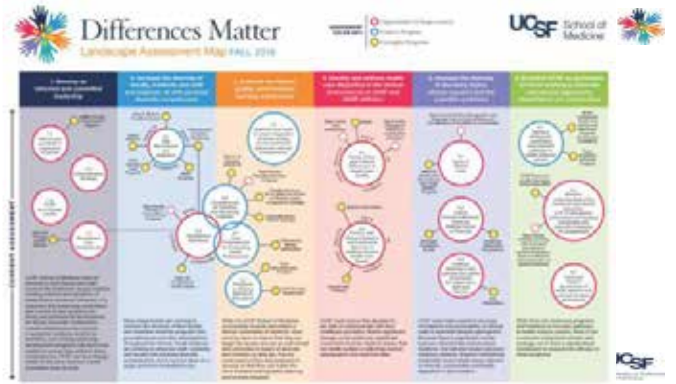
- Racial and ethnic diversity has a stronger impact on financial performance in the United States than gender diversity, perhaps because earlier efforts to increase women's representation in the top levels of business have already yielded positive results.
- In the United Kingdom, greater gender diversity on the senior-executive team corresponded to the highest performance uplift in our data set: for every 10 percent increase in gender diversity, EBIT rose by 3.5 percent.
- While certain industries perform better on gender diversity and other industries on ethnic and racial diversity, no industry or company is in the top quartile on both dimensions.
- The unequal performance of companies in the same industry and the same country implies that diversity is a competitive differentiator shifting market share toward more diverse companies.

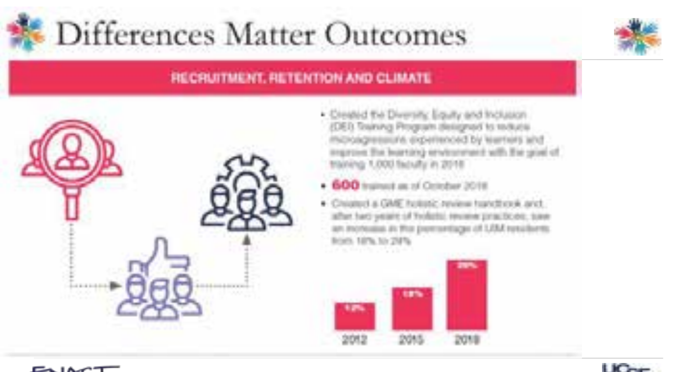
https://www.mckinsey.com/business-functions/organization/our-insights/why-diversity-matters

Back to Schedule

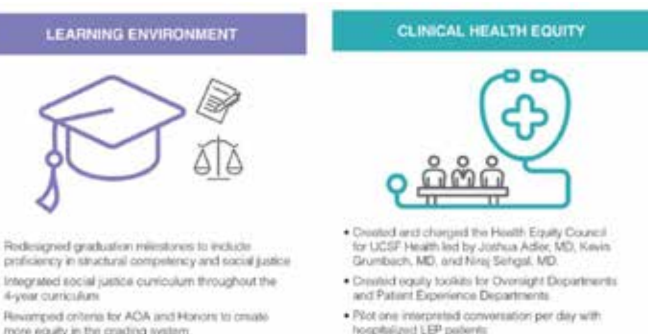
Examples of microaggressions at UCSF:

7

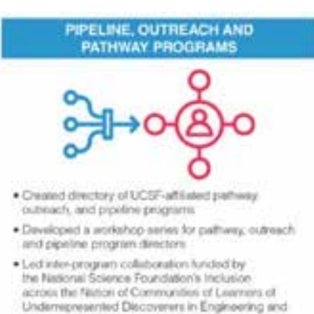




Differences Matter

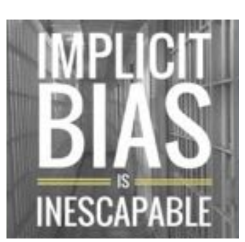


Differences Matter



Implicit bias

- The tendency to *automatically* associate people with certain characteristics or evaluations based upon the stereotypical characteristics of the groups into which they are placed.



12

Back to Schedule

TYPES OF MICRO AGGRESSIONS

Studies reveal the pervasive and on-going nature of micro aggression.

The intersections among the isms (e.g. sexism, racism, heterosexism, ageism) are identified as part of a larger system of inequality.

Modes fall into three main categories: verbal, physical and symbolic

- **Verbal** – both insults and back-handed compliments
- **Physical** – body language, touching, eye contact
- **Symbolic** – visual messages, cues

Source: Dr. Pamela Hopkins, "Women's Experiences of Micro Aggressive Acts: Meaning Making and Copies Strategies" 2012. Used by permission.

13

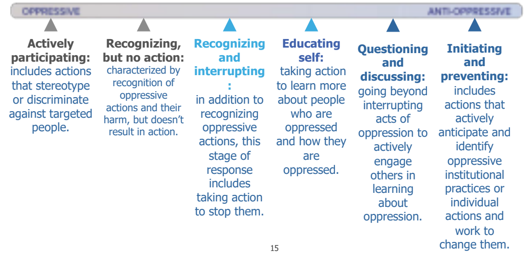
Definition of oppression:

Oppression is individual, institutional or societal behavior of dehumanizing, suppressing or exploiting a group of people based on their social category

14

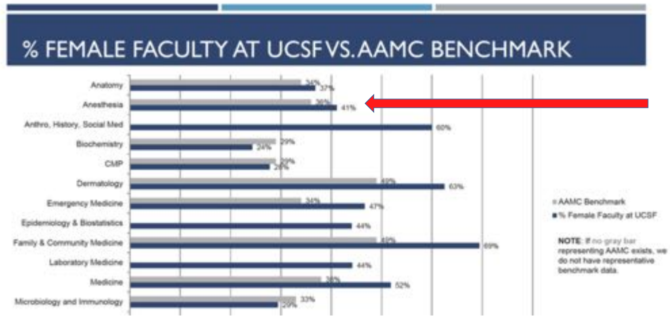
ANTI-OPPRESSION CONTINUUM

There are 6 stages of response described on this continuum.
The action moves from being extremely oppressive on one end of the continuum, to extremely anti-oppressive on the other.

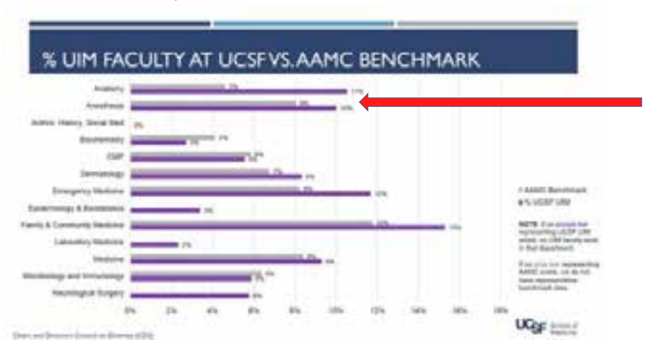


15

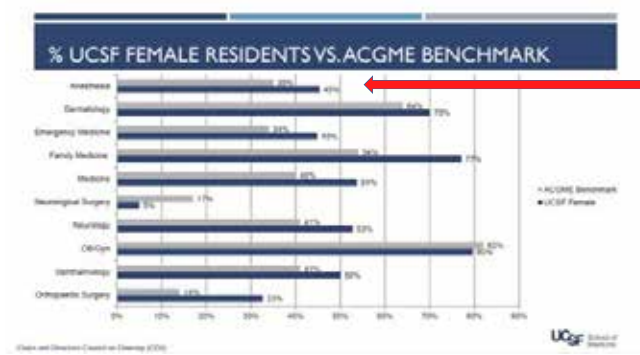
How to improve: You have to know your data!



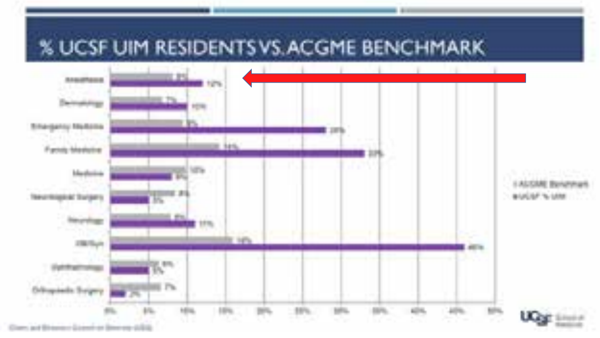
You have to know your data



You have to know your data



You have to know your data



First step: Self-awareness

- The ability to accurately recognize one's emotions and thoughts and their influence on behavior.
- This includes accurately assessing one's strengths and limitations.

Becoming an Inclusive Leader:

- **Role Model Behavior – practice ally behavior**
- Education – educate self & others; be curious
- Address fears – practice courageous conversations
- **Consider experiences of being the only one; address exclusionary actions immediately**
- Proactively *get out of comfort zone* – see what it's like to experience what others experience
- Know the key demographics of your partners and take that into account for decision making
- **Make mistakes and then honor, talk to and acknowledge them**
- Increase diversity across multiple dimensions in the organization – embed this in daily leadership practices
- **Take personal accountability**

54

21

THE INCLUSIVE LEADER: PERSONAL ACCOUNTABILITY

Self-Examine
Forgive
Own
Recognize
Learn
Take Action
NOTICE
CHOOSE
ACT
Hide
Resist
Rationalize
Blame
Deny
Ignore

Adapted from: The Power of Personal Accountability, by Mark Samuel & Sophie Chiche, Xephor Press, 2004

ENACT LEADERSHIP

55

22

UCSF

Diversity, Equity, and Inclusion Champion Training

- One day, interactive, training with faculty, staff
- I committed to 40% of faculty to train in one year
- Mandated for departmental senior leadership
- Provided clinical credit to faculty with high clinical commitments

THE INCLUSIVE LEADER ACTIONS

- **Role Model Behavior – practice ally behavior**
- Education – educate self & others; be curious
- Address fears – practice courageous conversations
- **Consider experiences of being the only one; address exclusionary actions immediately**
- Proactively *get out of comfort zone* – see what it's like to experience what others experience
- Know the key demographics of your partners and take that into account for decision making
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- **Take personal accountability**

54

24

Back to Schedule

Compensation Equity

- Make your compensation plan transparent
- Establish standardized base salaries depending on academic rank
- Be aware of unequal access to clinical incentives
- Avoid "citizenship bonuses" or other types of compensation that are purely subjective
    - Even research incentives can have bias
- Understand the impact of maternity leave on female faculty
    - "stop the clock"
- Be aware of inequities in recruitment packages
    - Startup funds, lab space, etc

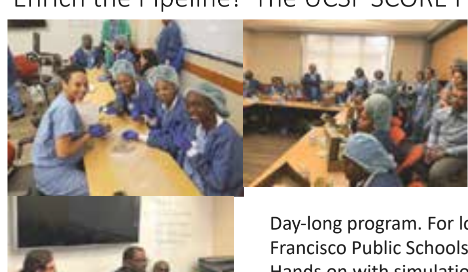
Leadership Equity

- Form a committee for any significant leadership position in your department
- Ensure that every committee is composed of at least 50% women or UIM faculty
- Examine your senior leadership
- Invest in leadership training for your young and mid-career women and UIM faculty
- Invest in coaching

Watson Scholars Program

- The UCSF School of Medicine Dean's Diversity Fund was established in 2015 to support the recruitment and retention of faculty who share the university's commitment to diversity and service to underserved or vulnerable populations. Each year eight faculty members are selected. Those faculty who are selected will be named the John A. Watson Scholars in honor of John A. Watson, PhD, a pioneer for diversity, an inspiring mentor, and a tenacious scientist whose service to the UCSF School of Medicine spanned forty-six years.
- $75K/year for 3 years for career development

Enrich the Pipeline! The UCSF SCORE Program



Day-long program. For low-income San Francisco Public Schools Students
Hands on with simulation
Visit to OR and ICU
Lunch with UIM faculty, staff, leaders at UCSF

Achieving greater diversity, equity, and inclusion is not just the right thing to do, it's inextricably linked to the mission, values, processes, relationships and results . . . of most organizations doing business today

Thank you!

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