SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

2019 Annual Meeting Syllabus

November 8-9, 2019

Swissôtel Chicago · Chicago, Illinois

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

American Society of Anesthesiologists™

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Program Information

Target Audience

This meeting is designed for anesthesiologists in Chair, Core Program Director, 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.

Statement of Need

Topics for this meeting were selected by various methods. Suggestions for topics were derived from evaluations of the 2018 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 2019 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 7, 2019. After October 7, 2019, late registration fees will be applied. Your registration fee is separate from the departmental membership dues that must be paid each year. Please include your ASA membership number with your registration to claim CME credits.

ACCME Accreditation and Designation Statements

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of American Society of Anesthesiologists and the Society of Academic Associations of Anesthesiology and Perioperative Medicine. 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 12.5 *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.

Disclosure Policy

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

Special Needs

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

Cancellation Policy

Cancellation of a meeting registration must be submitted in writing and will be accepted up until October 7, 2019. 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 identify ways to overcome challenges in innovations.
- Fellowship directors will be able to identify ways to keep programs up-to-date and how to effectively recruit fellows.
- Residency directors will be able to identify which education techniques are successful.
- Participants will have a greater understanding of communication styles and how to effectively communicate to others.

Hotel & Transportation Information

Swissôtel Chicago

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

Local Airports

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

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

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

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

The hotel does not provide shuttle service.

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

Parking

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

Baggage Check and Discounted Bus Transportation from Hotel to Airport

There will be a complimentary baggage check for all attendees on Saturday, November 9 located at the bottom of the escalators near the Zurich ballroom.

SAAAPM is again offering bus transportation to both O'Hare and Midway airports, immediately following the meeting. If you have not already pre-purchased your ticket, there are a limited amount of tickets left for $10 per ticket. Please check availability and purchase your ticket at registration.

Future Meeting Dates

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

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

Faculty Disclosures

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Name	Commercial Interest	Nature of Relationship
Mohammed M. Minhaj, MD, MBA, FASA	Raydiant Oximetry	Self
Andrew J. Patterson, MD, PhD	Bard Medical	Consulting Fees
Ronald G. Pearl, MD, PhD	Portola	Consulting Fees
	Clew	Consulting Fees
Douglas C. Shook, MD, FASE	Edwards Lifesciences	Honoraria
	Boston Scientific	Honoraria
	Baylis	Honoraria
Warren Ston Sandberg, MD, PhD	Edwards Life Sciences	Consulting Fees

All remaining faculty, planners and staff have reported no relevant financial relationships with commercial interests. See “Faculty Disclosure” document in the ASA LMS for more details.

guidebook & Claiming CME Credit

Guidebook Mobile App

The SAAAPM 2019 Annual Meeting has gone mobile using Guidebook!

We strongly encourage you to download our mobile guide to enhance your experience at the SAAAPM 2019 Annual Meeting. You’ll be able to plan your day with a personalized schedule and download all the meeting materials. **There will be no paper handouts provided.**

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/guide/169505.

You can get the guide via one of the methods below:

- Download ‘Guidebook’ from the Apple App Store or the Android Marketplace
- Visit https://guidebook.com/g/saaapm2019/ from your phone’s browser
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From the Guidebook application, tap “Download Guides” then “Redeem Code”.

Enter the code **SAAAPM2019** and the guide will download to your device!

Directions for Claiming CME Credits

Please follow these directions to access the course, claim your credits, complete the program evaluation(s) and print your 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 2019 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.

Please note: Participants must claim credits for this course by December 31, 2019. You will NOT be able to claim credits after this date.

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AAAC Concurrent Session

Friday, November 8

All AAAC presentations held in Zurich ABC unless otherwise noted.

7:00 – 8:00am	**Continental Breakfast** *(Zurich Foyer)*
8:00 – 10:00am	**The Challenge of Innovations in Anesthesiology and Health Care** *Moderator: Ronald G. Pearl, MD, PhD*
8:00 – 8:30am	**The Move to Value Based Care** Kevin S. Cook, MSBA
8:30 – 8:55am	**How Innovations in Information Technology Will Change Anesthesiology** Warren Ston Sandberg, MD, PhD
8:55 – 9:20am	**Academic Chairs and Health Care Systems** Aman Mahajan, MD, PhD, MBA
9:20 – 9:40am	**Q&A**
9:40 – 10:10am	**Break** *(Zurich Foyer)*
10:10 – 10:50am	**Mistakes Made; Lessons Learned** *Moderator: Ronald G. Pearl, MD, PhD*
10:10 – 10:23am	Vesna Jevtovic-Todorovic, MD, PhD, MBA
10:23 – 10:36am	B. Scott Segal, MD, MHCM
10:36 – 10:50am	Steven J. Lisco, MD, FCCM, FCCP
10:50 – 11:10am	**The Demise of Hahnemann University Hospital: Venture Capitalism and the For-Profit Environment in Academic Medicine** *Michael Green, DO, MBA, FASA*
11:10 – 11:20am	**Q&A**
11:20 – 11:40am	**Extending the Role of the Anesthesiologist** Joanne M. Conroy, MD
11:40 – 11:45am	**Q&A**
11:45 – 12:00pm	**RRC Update** *Cynthia A. Wong, MD*
12:00 – 1:15pm	**Box Lunch & Business Meeting** (Ticket Required – Pick Up Lunch in Zurich Foyer)
12:30 – 12:45am	**FAER Update** James C. Eisenach, MD
12:45 – 1:15pm	**AAAC Business Meeting & Introduction of All New and Interim Chairs** *Moderator: Jeanine P. Wiener-Kronish, MD*
1:15 – 5:00pm	**Afternoon Session** *Moderator: Douglas R. Bacon, MD, MA*
1:15 – 2:00pm	**Perfect Storm** Charles W. Whitten, MD
2:00 – 2:15pm	**Q&A**
2:15 – 3:20pm	**Optimizing Departmental Organization and Culture**
2:15 – 2:30pm	**Retreat! Retreat! Marching Forward for Departmental Success** David A. Zvara, MD
2:30 – 2:50pm	**The Departmental Newsletter for Shaping Culture** Robert E. Johnstone, MD, FASA
2:50 – 3:15pm	**Delegation & Cooperation: Section Heads, Vice Chairs, & Chairs of Other Departments** John F. Butterworth, IV, MD
3:15 – 3:20pm	**Q&A**
3:20 – 3:50pm	**Break** *(Zurich Foyer)*
3:50 – 5:00pm	**Managing Your Faculty**
3:50 – 4:10pm	**Tips on Recruitment** Jill M. Mhyre, MD
4:10 – 4:30pm	**Retaining the Best (Faculty)** Michael H. Wall, MD, FCCM
4:30 – 4:50pm	**Tenured, but Tired?** Vesna Jevtovic-Todorovic, MD, PhD, MBA
4:50 – 5:00pm	**Q&A**
5:30 – 7:30pm	**SAAAPM Reception** *(Zurich Foyer)*

AACPD Concurrent Session

Friday, November 8

All AACPD presentations held in Zurich DEFG unless otherwise noted.

7:00 – 8:00am	**Continental Breakfast** *(Zurich Foyer)*
8:00 – 8:45am	**Updates from ABA ITE/BASIC (With AAPAE)** *Moderator: Manuel Pardo, Jr., MD*
8:00 – 8:20am	**ABA Update** *David O. Warner, MD*
	ITE and Assessment Update *Robert Gaiser, MD*
8:20 – 8:45am	**Q&A**
8:45 – 9:30am	**How I Implement the ABA Leave Policy (With AAPAE)** *Moderator: Charles A. Napolitano, MD, PhD* Mark A. Hagemeier, JD David Stahl, MD Kristina R. Sullivan, MD
9:30 – 10:00am	**Updates from RRC (With AAPAE)** *Moderator: Manuel Pardo, Jr., MD*
9:30 – 9:50am	**RRC Update** Cheryl Gross, MA, CAE Cynthia A. Wong, MD
9:50 – 10:00am	**Q&A**
10:00 – 10:30am	**Break** *(Zurich Foyer)*
10:30 – 11:00am	**Session – NRMP Update** *Moderator: Harendra Arora, MD, FASA, MBA*
10:30 – 10:45am	**NRMP Update** Jeanette L. Calli, MS
10:45 – 11:00am	**Q&A**
11:00am – 12:00pm	**Lessons Learned Panel** *Moderator: Joy L. Hawkins, MD* Andrea Dutoit, MD Shelley George, MD Timothy R. Long, MD
12:00 – 1:00pm	**Box Lunch & Business Meeting** (Ticket Required – Pick Up Lunch in Zurich Foyer)
12:00 – 12:15pm	**Grab Lunch**
12:15 – 1:00pm	**AACPD Business Meeting** *Moderator: Manuel Pardo, Jr., MD*
1:00 – 1:30pm	**AACPD Meet & Greet with New Program Directors** *Moderator: Jed T. Wolpaw, MD, MEd*
1:30 – 2:00pm	**Best Practices in Assessing Milestones** *Moderator: John D. Mitchell, MD*
1:30 – 1:40pm	Debra Jean Szeluga, MD, PhD
1:40 – 1:50pm	Pedro P. Tanaka, MD, PhD, MACM
1:50 – 2:00pm	Glenn E. Woodworth, MD
2:00 – 3:30pm	**The Annual Program Evaluation: From Button Checking to Improving Your Program (With AAPAE)** *Moderator: Herodotos Ellinas, MD* Dawn Dillman, MD Gina B. Hendren, MD Lara Zisblatt, EdD, MA, PMME
3:30 – 4:00pm	**Break** *(Zurich Foyer)*
4:00 – 5:00pm	**Everything You Always Wanted to Know About Other Programs… (With AAPAE)** *Moderators: Michael Wiisanen, MD & Timothy R. Long, MD*
5:30 – 7:30pm	**SAAAPM Reception** *(Zurich Foyer)*

AASPD Concurrent Session

AASPD
ASSOCIATION OF ANESTHESIOLOGY SUBSPECIALTY PROGRAM DIRECTORS

Friday, November 8

All AASPD presentations held in Vevey 1, 2, 3 unless otherwise noted.

7:00 – 8:00am **Continental Breakfast** *(Zurich Foyer)*

8:00 – 8:05am **Welcome and Announcements**
Moderator: Mark Stafford-Smith, MD, CM, FRCPC, FASE

8:05 – 9:00am **Keeping Yourself and Your Program Up-to-Date**
Moderator: Magdalena Anitescu, MD, PhD

8:05 – 8:25am **How to Prepare for Your Self-Study Site Visit, and Other ACGME Pearls from the New RRC Chair**
Cynthia A. Wong, MD

8:25 – 8:45am **Scholarly Activity and a Teaching Portfolio: Is Anyone Focusing on Developing the PDs, and What About Your Educators?**
Andrew J. Patterson, MD, PhD

8:45 – 9:00am **Q&A**

9:00 – 10:00am **How to Recruit the Right Fellow**
Moderator: Mark Stafford-Smith, MD, CM, FRCPC, FASE

9:00 – 9:30am **Pro-Con Debate: Fellowship Applications Should Not Request Test Scores (ITE, USMLE, etc.)**
Pro: Amy Miller Juve, EdD, MEd
Con: John B. Eck, MD

9:30 – 9:50am **Beyond Scores: Qualities of a Successful Candidate**
Douglas C. Shook, MD, FASE

9:50 – 10:00am **Q&A**

10:00 – 10:30am **Break** *(Vevey Foyer)*

10:30 – 12:30pm **Breakouts**

10:30 – 11:30am **Block 1 (Select 1)**

Breakout 1: How to Develop a Teaching Portfolio *(Vevey 1, 2, 3)*
Moderator #1: Erin K. Hennessey, MD
Moderator #2: Jennifer E. Dominguez, MD, MHS
Moderator #3: Ankeet D. Udani, MD, MSEd

Breakout 2: How to Be an Effective Mentor / Mentee *(Montreux 2)*
Moderator #1: Ellen Y. Choi, MD
Moderator #2: Shanna Sykes Hill, MD

Breakout 3: Tracking Graduates & Reaching Out to Alumni *(Montreux 3)*
Moderator #1: Lynn R. Kohan, MD
Moderator #2: Edward R. Mariano, MD, MAS

Breakout 4: Teaching the Business of Medicine and Practice Management *(Vevey 4)*
Moderator #1: Rene Przkora, MD, PhD
Moderator #2: M. Concetta Lupa, MD

11:30 – 12:30pm **Block 2 (Select 1)**

Breakout 1: How to Develop a Teaching Portfolio *(Vevey 1, 2, 3)*
Moderator #1: Erin K. Hennessey, MD
Moderator #2: Jennifer E. Dominguez, MD, MHS
Moderator #3: Ankeet D. Udani, MD, MSEd

Breakout 2: How to Be an Effective Mentor / Mentee *(Montreux 2)*
Moderator #1: Ellen Y. Choi, MD
Moderator #2: Shanna Sykes Hill, MD

Breakout 3: Tracking Graduates & Reaching Out to Alumni *(Montreux 3)*
Moderator #1: Lynn R. Kohan, MD
Moderator #2: Edward R. Mariano, MD, MAS

Breakout 4: Teaching the Business of Medicine and Practice Management *(Vevey 4)*
Moderator #1: Rene Przkora, MD, PhD
Moderator #2: M. Concetta Lupa, MD

12:30 – 1:30pm **Box Lunch & Business Meeting** (Ticket Required – Pick Up Lunch in Zurich Foyer)

12:30 – 1:00pm **Lunch**

1:00 – 1:30pm **AASPD Business Meeting**
Moderator: Mark Stafford-Smith, MD, CM, FRCPC, FASE

1:30 – 2:15pm **Updates from the Subspecialties**
Moderator: Mark Stafford-Smith, MD, CM, FRCPC, FASE

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

Critical Care Medicine
Nicholas Sadovnikoff, MD, FCCM, HEC-C

Pain Medicine
Magdalena Anitescu, MD, PhD

Pediatric Anesthesiology
Franklyn P. Cladis, MD

ACTA
Douglas C. Shook, MD, FASE

OB Anesthesia
Jennifer E. Dominguez, MD, MHS

2:15 – 2:45pm **Break** *(Vevey Foyer)*

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

Adult Cardiothoracic *(Montreux 2)*
Douglas C. Shook, MD, FASE

Critical Care Medicine *(Vevey 4)*
Nicholas Sadovnikoff, MD, FCCM, HEC-C

Obstetric *(Montreux 2)*
Jennifer E. Dominguez, MD, MHS

Pain Medicine *(Vevey 1, 2, 3)*
Magdalena Anitescu, MD, PhD
Scott Brancolini, MD, MPH
Rene Przkora, MD, PhD

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

Regional Anesthesia *(Monte Rosa)*
Christina L. Jeng, MD, FASA
Edward R. Mariano, MD, MAS

5:30 – 7:30pm **SAAAPM Reception** *(Zurich Foyer)*

AAPAE Concurrent Session

AAPAE
ASSOCIATION OF ANESTHESIOLOGY PROGRAM ADMINISTRATORS AND EDUCATORS

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

THURSDAY, NOVEMBER 7

7:00 – 9:00pm	**AAPAE Member Social at Lizzie McNeil's**

FRIDAY, NOVEMBER 8

7:00 – 8:00am	**Continental Breakfast** *(Zurich Foyer)*
8:00 – 8:45am	**Updates from ABA ITE/BASIC (With AACPD)** *See AACPD Schedule*
8:45 – 9:30am	**How I Implement the ABA Leave Policy (With AACPD)** *See AACPD Schedule*
9:30 – 10:00am	**Updates from RRC (With AACPD)** *See AACPD Schedule*
10:00am	**AAPAE Move to St. Gallen**
10:00 – 10:20am	**Break** *(Zurich Foyer)*
10:20 – 10:30 am	**Welcome** Leslie Coker Fowler, MEd
10:30 – 12:00pm	**Entrustable Professional Activities** *Moderator: Amy Miller Juve, EdD, MEd*
10:30 – 11:00am	**Overview of EPAs, Workplace-Based Assessment** Glenn E. Woodworth, MD
11:00 – 11:30am	**Anesthesia EPA Process** Glenn E. Woodworth, MD
11:30 – 12:00pm	**Implementation of EPAs @ Program Level** Sally Ann Mitchell, EdD, MMSc
12:00 – 1:00pm	**Box Lunch & Business Meeting** (Ticket Required – Pick Up Lunch in Zurich Foyer) **AAPAE Council**
12:00 – 12:45pm	**Lunch**
12:45 – 1:00pm	**AAPAE Business Meeting**
1:00 – 1:50pm	**Troika Consulting Activity** *Moderator: Amy Miller Juve, EdD, MEd*
1:50 – 2:00pm	**AAPAE to Join AACPD**
2:00 – 3:30pm	**The Annual Program Evaluation: From Button Checking to Improving Your Program (With AACPD)** *See AACPD Schedule*
3:30 – 4:00pm	**Break** *(Zurich Foyer)*
4:00 – 5:00pm	**Everything You Always Wanted to Know About Other Programs… (With AACPD)** *See AACPD Schedule*
5:30 – 7:30pm	**SAAAPM Reception** *(Zurich Foyer)*

SATURDAY, NOVEMBER 9

7:00 – 7:30am	**Continental Breakfast** *(Zurich Foyer)*
7:30 – 8:00am	**SAAAPM Business Meeting**
8:00 – 9:00am	**Data Visualization** *Moderator: Fei Chen, PhD, MEd* Faye Haggar, EdD Ashley Grantham, PhD
9:00 – 10:15am	**Roundtables: 6 Tables & Topics** 1. **Journal Club** *Moderator: Ashley Grantham, PhD* 2. **Starting in Research/ Career Advancement for Scholars/Educators** *Moderator: Fei Chen, PhD, MEd* 3. **Wellness: Faculty/Coordinator/Resident** *Moderator: David Cohen, EdD* 4. **Recruitment: Role of Program Coordinator in Decisions** *Moderator: Kimberly Fredricksen, BS* 5. **TAGME/Career Advancement** *Moderator: Elisabeth A. Hudson, BS, C-TAGME* 6. **Milestone Assessment: Role of the Program Coordinator** *Moderator: TBD*
10:15am	**Join SAAAPM** *See SAAAPM Schedule*

SAAAPM Presentations

SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Saturday, November 9

All SAAAPM presentations held in Zurich unless otherwise noted.

7:00 – 7:30am	**Continental Breakfast** *(Zurich Foyer)*
7:30 – 8:00am	**SAAAPM Business Meeting**
8:00 – 8:30am	**ASA Update** Mary Dale Peterson, MD, FASA, MSHCA, FACHE
8:30 – 8:45am	**Q&A**
8:45 – 8:55am	**Introduction** Jeanine P. Wiener-Kronish, MD
8:55 – 10:15am	**Communication Matters** *Moderator: Daniel Saddawi-Konefka, MD, MBA*
8:55 – 9:00am	**Introduction** Daniel Saddawi-Konefka, MD, MBA
9:00 – 9:20am	**Why Communication Matters and Why it Fails** Amy Lu, MD, MPH
9:20 – 9:40am	**Giving and Receiving Feedback: Creating a Culture to Foster Feedback While Maintaining a Safe Work and Learning Environment** Keith Baker, MD, PhD
9:40 – 10:00am	**The Millennial Challenge** Teresa A. Mulaikal, MD
10:00 – 10:15am	**Q&A**
10:15 – 10:45am	**Break** *(Zurich Foyer)*
10:45 – 11:45am	**Communication Styles** *Moderator: Daryl Oakes, MD*
10:45 – 10:50am	**Introduction** Daryl Oakes, MD
10:50 – 11:30am	**Influencing through Communication Styles** Janet M. Shlaes, PhD, MBA, MA
11:30 – 11:45am	**Group Activity Debrief & Q&A**
11:45am – 12:15pm	**Box Lunch** (Ticket Required – Pick Up Lunch in Zurich Foyer)
12:15 – 1:10pm	**Negotiations** *Moderator: Dawn Dillman, MD*
12:15 – 12:20pm	**Introduction** Dawn Dillman, MD
12:20 – 1:00pm	**Practical Leadership Skills: Negotiation** Laureen L. Hill, MD, MBA
1:00 – 1:10pm	**Q&A**
1:10 – 2:30pm	**Dealing with Difficult Situations** *Moderator: Maya Jalbout Hastie, MD, EdD*
1:10 – 1:15pm	**Introduction** Maya Jalbout Hastie, MD, EdD
1:15 – 1:35pm	**Gossip or Fake News** Abiona V. Berkeley, MD, JD
1:35 – 1:55pm	**The Difficult Colleague** Mohammed M. Minhaj, MD, MBA, FASA
1:55 – 2:15pm	**Managing Conflict** Jonathan Hastie, MD
2:15 – 2:30pm	**Q&A**
2:30pm	**Event Ends**
2:45pm	**SAAAPM Hosted Buses Depart for Airports**

HANDOUT

The Move to Value Based Care

Kevin S. Cook, MSBA

11/08/2019
8:00am - 8:30am

Learning Objectives:

- Understand the strategic position, mission, and scope of the University of Mississippi Medical Center
- Introduce the concept of Disruptive Innovation and technology
- Describe how the University of Mississippi Medical Center is addressing the threats and opportunities of disruptive innovation in healthcare
- Introduce 100 Day Workouts as a methodology that aids in creating a more nimble and effective organization

1

Innovation and Culture Change in Healthcare

Kevin Cook
CEO University of Mississippi Medical Center Health System

The University of Mississippi MEDICAL CENTER

2

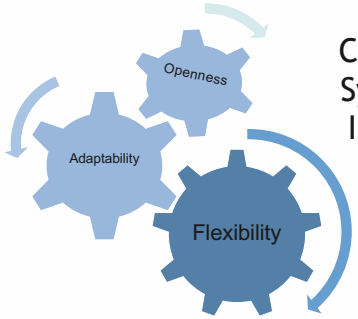
UMMC Overview

- **Established in 1955**
- **Mississippi's Only Academic Medical Center**
- **Threefold Mission:**
  - Education
  - Research
  - Clinical
- **Clinical**
  - University Hospital & Health System
    - 722 Beds
    - 700+ Practicing Providers
    - Over 125 Specialties
    - 32,000 inpatient admissions annually
    - 500,000+ outpatient & emergency department visits annually
    - Level I Trauma Center
    - Transplant Center
    - Children's Healthcare of Mississippi
  - University Hospital- Grenada
  - Holmes County Hospital

3

UMMC's Current Network

4



Culture and Systems for Innovation

5

New Skill Sets for Senior Leaders

6

Encyclopedia Britannica

- Founded 1768
- 1990 sales of $650 Million
- The Rise of the CD-ROM
- Sales peaked in 1990 at 120,000
- By 1994, 55,000 were sold
- In 1996, company was sold at a Bankruptcy price

7

8

Because  Happens

9

10

Disruption

- You can be making rational decisions in the context of old models, and miss the sea change around you.
- Profitability may be maintained even as the foundations of that profitability are eaten away.
- The disruptive innovation may be of poorer quality, and lesser cost…. All that matters is consumers find it appealing.

The Disruption Machine, The New Yorker, June 23, 2014

11

How has UMMC responded?

- Solid Operational Foundation
- The Improvement of Quality as defined by publicly reported metrics
- A statewide strategy for Pediatrics
- Solve the Metro Jackson Market first for Adult Services
- Drive innovation as a Core Competency

12

Innovation as a Core Competency

- Incremental improvement should be part of the organization's operational DNA.
- Senior Leaders should expect innovation from all levels of management.
- Get Comfortable with being Uncomfortable

13

100 Day Workouts

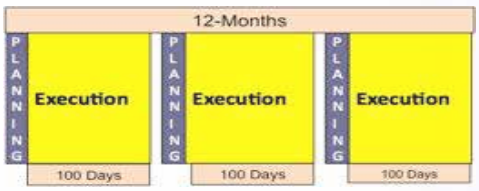
- A method for driving innovation at the unit level.
- Embeds Rapid Cycle Testing into the organization.
- Increases speed of execution and tempo throughout the organization.
- Forces middle management to "up their game".
- Is flexible and can be used to increase the focus on already existing goals.

14

100 Day Workout:

Highly structured organization change model

100 - Day Workout Cycle



25% Planning : 75% Execution

15

Accountable Change Model Characteristics

- **Goal-setting & use of data for speed of action**
  - Initiative metric direct linkage to someone's cost center
  - Narrow scope to be achievable in 100 days
  - Activity/ "# of changes" metric (e.g. 2 changes per manager/month)
- **Accountability Structure**
  - Kick-off: ¾-day each trimester
  - Monthly accountability check-ins: 2-3 hours
  - Managers organized into collaborative groups vs siloes
  - Real-time implementation tracking (EXCELerator)
  - Apply to both physician-driven & manager-driven
  - Designed to have fun

16

Accountable Change Model Characteristics (cont'd)

- **Cultural Evolution**
  - Making change the safer alternative vs safer to protect the status quo
  - Speed to implementation vs analysis, analysis, analysis
  - Manger training focusing on how to drive change/reduce barriers to change
  - Senior leader behaviors build manager confidence
  - Senior leader behaviors "make heroes" of change agents & consequences for low performers
  - Lean/Six Sigma Black Belts/ Quality Professionals emphasis shift from "more analysis" mindset to "managing resistance to change" mindset
  - Attack Bureaucracy Vigorously

17

HANDOUT

How Innovations in Information Technology Will Change Anesthesiology

Warren Ston Sandberg, MD, PhD

11/08/2019
8:30am - 8:55am

How Innovations in Information Technology Will Change Anesthesiology

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

1

Disclosures

- Edwards Lifesciences - consulting

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

2

Objectives

At the end of this presentation the learner will be able to

- Distinguish near-term probable impacts of information technology on anesthesiology from longer term prospects
- Implement process controls for OR anesthesia (before payers do) and measure outcome improvements
- Use IT tools to track and manage the health-system impact of Perioperative Medicine initiatives
- Think a patient awake

3

Effectiveness Improvement Imperative

- Anesthesia is:
  - Commonly regarded as a safety leader
  - Only specialty built around administration of dangerous drugs
- Yet:
  - Safety taken for granted because failure is rare
  - Costs are very high
- We have a mandate to improve, but how can we figure out what to do?

4

A Proposition

- Excellent clinical skills, professionalism and medical knowledge (& the rest of the CCs) are *required* for a place at the table.
- To stay off the menu - need to offer something that can't be commoditized.
  - That wouldn't be 'caring', 'professionalism', 'ownership', 'vigilance' - the other guys have all that just as much!
- We need to leverage our current costs over more 'benefit' and transform our specialty to lock in the change.

5

Some Things We WON'T be Doing Soon

6

Things We WON'T be Doing Soon

Using Rating Systems to Score Anesthesiologists

7

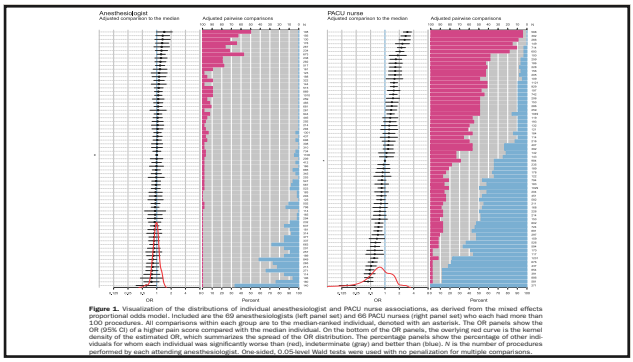
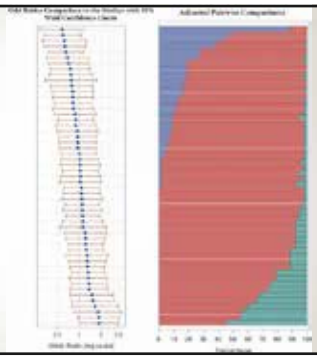


Figure 1. Visualization of the distributions of individual anesthesiologist and PACU nurse associations, as derived from the mixed effects proportional odds model. Included are the 69 anesthesiologists (left panel set) and 66 PACU nurses (right panel set) who each had more than 100 procedures. All comparisons within each group are to the median-ranked individual, denoted with an asterisk. The OR panels show the OR (95% CI) of a higher pain score compared with the median individual. On the bottom of the OR panels, the overlying red curve is the kernel density of the estimated OR, which summarizes the spread of the OR distribution. The percentage panels show the percentage of other individuals for whom each individual was significantly worse than (red), indeterminate (gray) and better than (blue). *N* is the number of procedures performed by each attending anesthesiologist. One-sided, 0.05-level Wald tests were used with no penalization for multiple comparisons.

8

Composite of Satisfaction with Anesthesia Care

- Unadjusted for practice location or specialty



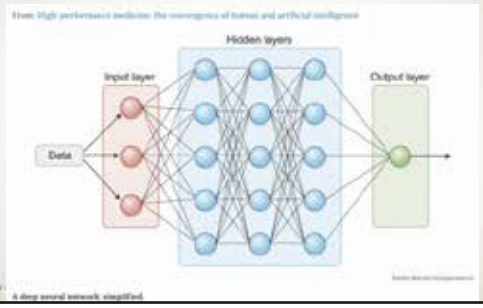
9

Things We WON'T be Doing Soon

Using AI to Replace Anesthesiologists

10

Artificial Intelligence



A deep neural network, simplified.

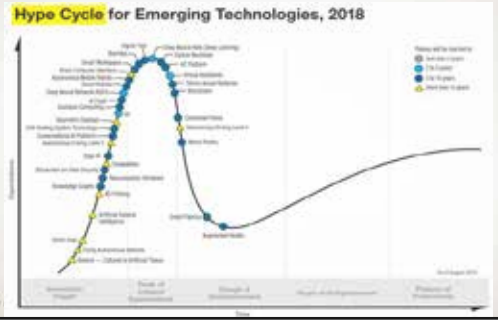
11

Artificial Intelligence

Anesthesiology TOC October 2019

12

Not so fast…



13

Major Pitfalls

- Distributional shift:
  - The algorithm will learn from the training data
    - …which may not represent the population
  - and then give output based on the training data
- Black Box decision making
  - Level of confidence not always shown/known
  - Fail safe or unsafe?
  - Automation complacency
- Adapt to changing practice?

14

But Anesthesiologists Can Use AI Productively

15

Relentless Execution of Common Sense

16

Modelling to Scope an ASC

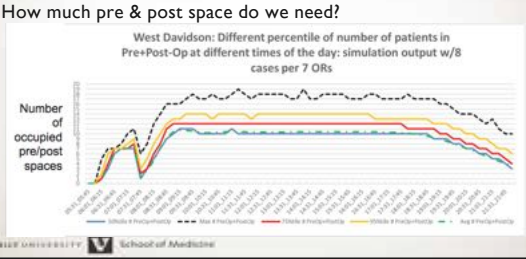
- How many ORs can we build?
- How much pre & post space do we need?

Answer: it depends on how many cases per OR, the case duration and how long the patients spend in pre- & post-op spaces

17

Modelling to Scope an ASC

- How many ORs can we build?
- How much pre & post space do we need?



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Disruption in Anesthesia?

19

Some Things We WILL Be Doing Soon

20

Things We WILL Be Doing Soon

Scoring and Incentivizing Clinicians on Process Performance

21

Glucose: A Modest Success Story

- *Described solution happens AUTOMATICALLY*
- Hit 'problem list' for any diagnosis of DM
- Hit 'VPIMS' for insulin administration
- Hit 'lab system' for [glucose]
- Run semi-continuously
  - Every 90' for diabetics
  - Every 60' for patients receiving insulin
- Remind providers when lab data are missing

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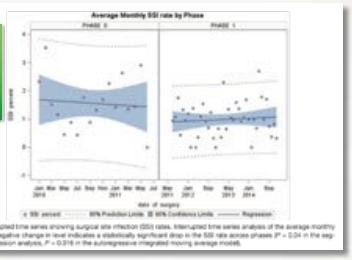
[Glucose]: A Modest Success Story

Reduced the wound infection rate



- Multiple strategies to 'eliminate' observed effect…

Anesthesiology 126:431-441 (2017)

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Glucose Monitoring

- Initially implemented in VPIMS
- Saved & re-implemented in Epic
- Improved glycemic control
- Demonstrated reduction in SSIs over 3.5 years

Ehrenfeld JM, Wanderer JP, Terekhov M, Rothman BS, Sandberg WS. A Perioperative Systems Design to Improve Intraoperative Glucose Monitoring Is Associated with a Reduction in Surgical Site Infections in a Diabetic Patient Population. Anesthesiology. 2017 Mar;126(3):431-440

24

Things We WILL Be Doing Soon

Getting Control of Clinical Processes
Up- and Downstream of the OR

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ERAS for Colorectal Surgery

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ERAS+ for Colorectal Surgery

- Development of decision-to-post discharge pathway for colorectal surgery patients
- Multidisciplinary initiative in collaboration with colorectal surgeons
- Target: One day off LOS (all pts; *more potential*)
- Full hospital: Every 4-5 patients across fixed floor bed cost base allows addition of a 5th or 6th case
- Falls straight to the bottom line

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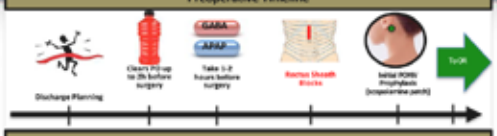
PCS Care Plan: Colorectal ERAS Components

Preoperative Timeline



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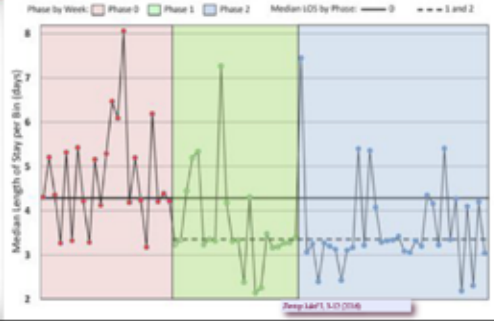
Length of Stay Control Chart



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What About Medical Outcomes?

- Difference in difference analysis: NSQIP complications

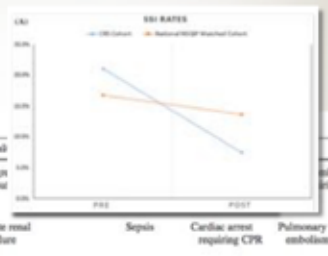

Table 1 NSQIP complications by category

SSI	Respiratory	Transfusion	Renal
Organ/space SSI	On ventilator > 48 h	Transfusion intraop/post-op (72 h of surgery start time)	Progressive renal insufficiency
Superficial incisional SSI	Unplanned intubation		Acute renal failure
Deep incisional SSI	Pneumonia		Sepsis
			Cardiac arrest requiring CPR
			Pulmonary embolism

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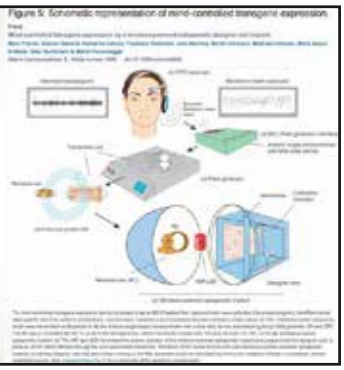
~~ERAS for Colorectal Surgery~~
Enhanced Recovery for All Surgery

31

What Does the Distant Future Hold?

32

Someday You Could Think A Patient Awake



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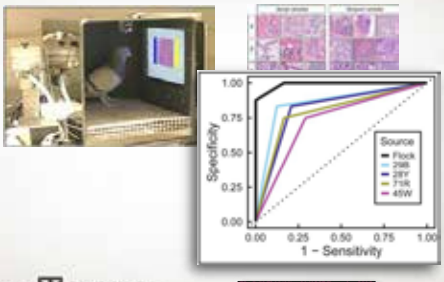
Or Be Displaced by a Pigeon



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My Ending Proposal:

- What separates '-ologists' from '-ists' are:
  - Complexity (management of)
    - Individual case level
    - System level (as 'physicians to the system')
      - Management
      - Leadership
      - Policy
  - Creation of new knowledge that improves the science and the process
  - Propagation into wide, sustained practice

35

HANDOUT

Academic Chairs and Health Care Systems

Aman Mahajan, MD, PhD, MBA

11/08/2019
8:55am - 9:20am

UPMC LIFE CHANGING MEDICINE

Academic Chairs and Departments in Large Health Care Systems

Aman Mahajan MD PhD MBA
Peter and Eva Safar Professor and Chair
Department of Anesthesiology and Perioperative Medicine
Professor of Biomedical Informatics and Bioengineering
Swanson School of Engineering
Executive Director, UPMC Perioperative & Surgical Services Line
University of Pittsburgh and UPMC

1

Assigned Objective:

What should Chairs (and departments) do when health systems grow and acquire new hospitals

Role of Anesthesiologists (and departments) in delivering Value based Healthcare for health systems

2

Disclosures: Grants and Funding

- NIH NHLBI, R01-HL136836 (PI)
- NIH NIDA, R44-DA049630 (PI)
- US Air Force Research Laboratories (PI)
- Canadian National Institute of Health Research (Co-I)

- Sensydia Inc.
- EP Dynamics Inc.
- Hytek Medical Inc.

} Founder/Inventor/Board

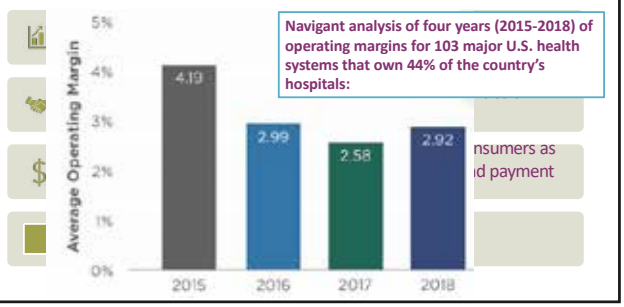
3

Academic Medicine/healthcare Landscape

HCOs	Mega Groups	Outpatient shift	Delivery Models
Disruptive Public Policy	Disruptive Technology	Patient Voice	Consumerism
Population Health	Cost Structure	Value Proposition	Funds flow
Health System integration	Payment➔ Quality	Competition	Funding for Research & Education

4

Key Drivers and Trends



Navigant analysis of four years (2015-2018) of operating margins for 103 major U.S. health systems that own 44% of the country's hospitals:

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d payment

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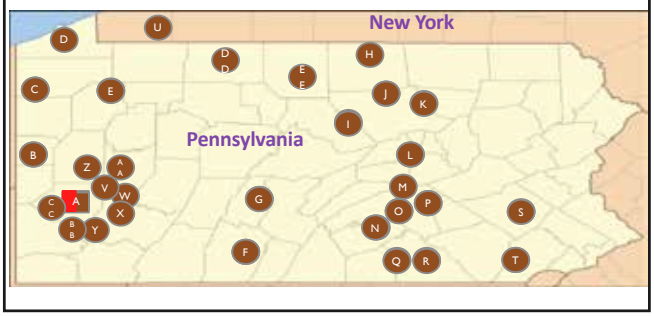
UPMC Hospitals- Health Systems- Health Networks



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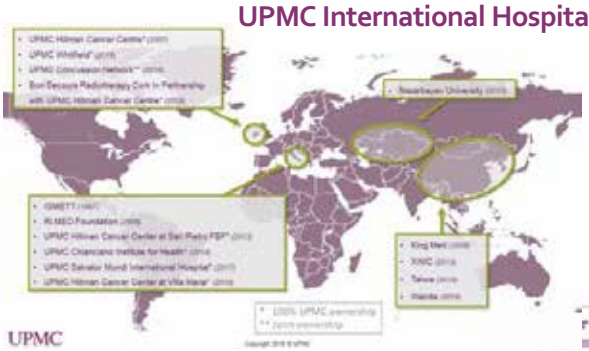
UPMC International Hospital



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Role of Chairs (and departments) as Health Systems Evolve/Expand

- Integration of AMC and Community hospitals culture
- Leadership and Organization of New Entrants and Affiliates
- Cost management and Standardization of Operations
- Network Management and Regionalization
- Value-based care/ Clinical Pathways
- Innovation

Research
Teaching
Mentorship
Faculty Development

8

University vs. Community

Box 1
Differences between AMCs and private practice models

	Academic Medical Center	Private Practice
1	Tertiary/quaternary care of patients for advanced or experimental therapies	Flexibility in clinical practice pattern/style with lesser acuity and complexity
2	Tertiary care	Lesser Acuity
3	Researchy/Scholarly	Near 100% clinical
4	Training residents etc	Learning business aspects
5	Non salary benefits like NC time	Higher Comp & form corp.
6	Mentorship	Indv/professional associations
7	Dept duties	Physician Autonomy
8	Colleagues at other academic institutions to further career goals	limited opportunities for career mentorship
9	Participation in hospital or departmental administration and policy is expected	Physician Autonomy

Regev A, Mahajan A. Integrating Academic and Private Practices. Anesthesiology. C
36 (2018) 321–33

9

Hybrids solve some unmet needs

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Integration models and considerations

Health System/Dept. Acquisition and employment and full integration

- Dilution of academic faculty brand
- Can community physician succeed in academia
- Department assumes risk of promotions and retentions
- Site specific vs rotating scheduling, credentialing, operations?

Health System Hospital Acquisition but Separate Anesth Group Practices

- Define value for groups in "Limited integration"
- What is your level of Oversight for these groups?
- Cost Structure, Compensation and benefits structure, Operations
- Governance and role of community group in department

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Regev A, Mahajan A. Integrating Academic and Private Practices. Anesthesiology. C
36 (2018) 321–33

11

Delivering Benefits of Integration to Community Practices

- Management infrastructure, OR management expertise
- Information technology and data analytics driven practice
- Implementation of evidence-based standardized protocols and best practices
- Access to risk management, quality management and compliance programs
- Leadership development and compensation opportunities
- Educational opportunities- Residency/Fellowship training

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Regev A, Mahajan A. Integrating Academic and Private Practices. Anesthesiology. C
36 (2018) 321–33

12

Community Hospitals: Common Perspectives

- Integration leads to loss of autonomy
- Taxation to support the academic mission
- Downward pressure on physician compensations

13

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UPMC-Hamot

Department of Anesthesiology Review

A 424-bed tertiary care medical facility provides medical and surgical care to the residents of Erie County and surrounding areas.

The operational leadership at UPP Anesthesiology was requested to provide an analysis of UPMC-Hamot Department of Anesthesiology staffing and management and Operating Room efficiency and management, with a request to search for opportunity to reduce Department of Anesthesiology cost and improve performance.

14

Challenge to Integration: Culture

Leadership style | Shared beliefs & expectations | Solution to external and internal problems | Communication patterns | Values, tradition, heritage | Mission statements, symbols | Rules and regulations | Assumptions and perceptions

Regev A, Mahajan A. Integrating Academic and Private Practices. Anesthesiology. C
36 (2018) 321–33

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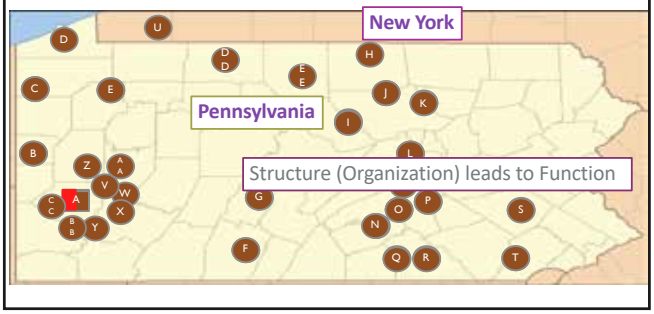
Managing Care Across a Network



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Acquisition or Partnership of Community Hospitals: Shared Responsibility; Shared Authority

Quality/Value
Operational Efficiencies
Cost/Expenses
Billing/Compliance
Recruitment /Retentions
Training

Designated Authority
Clear Roles and Reporting
Central Oversight
Aligned Incentives
Data Analytics
Performance Management Systems

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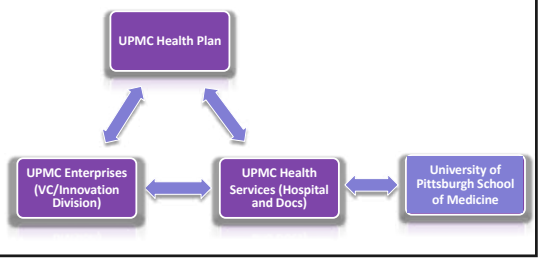
Integrated Delivery and Financial System Healthcare IDFS



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Key opportunities for adding value in perioperative care for a Health Network:

- Use of data and Digital Technology for Quality & Operations improvement.
- Lifestyle modification before surgery
- Segmentation of patients based on Complexity
- Standardization of in-hospital perioperative care and value-based pathways
- Regionalization of Clinical Services and Network Management

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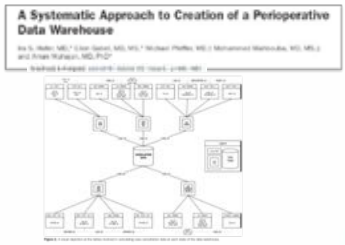
Perioperative data sciences: Clinical, Operational, and Financial Data Integration



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Perioperative Data Analytics: better understanding of outcomes and cost and health care delivery

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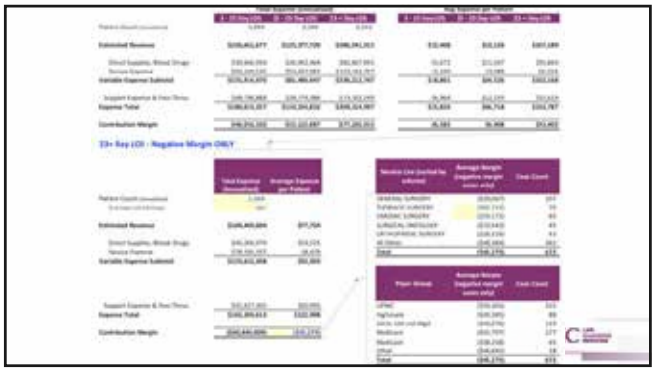

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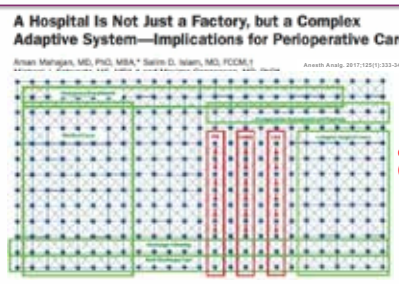
Creating Value: Segmentation of Patients



Complex Adaptive System (High Complexity Care)

Standardized (Factory) Approach

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Two Distinct Populations
Two Distinct Opportunities

Standardized (Factory) Approach

Low Complexity Surgeries:

- High Volume, low variance
- Lower risk
- Potential gains are related to high efficiency, not only better clinical care
- Care coordination / Discharge disposition / LEAN

Complex Adaptive System

High Complexity Surgeries:

- Low Volume, high variance
- High incidence of postoperative complications
- Improving clinical outcome through network of experts
- Not well suited for Factory Like approach- Need adaptive approach

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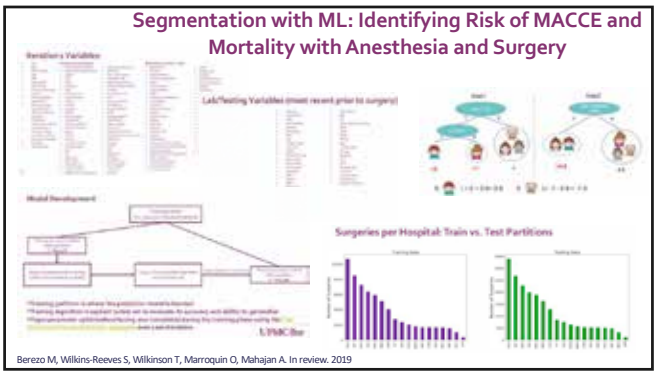
Segmentation with ML: Identifying Risk of MACCE and Mortality with Anesthesia and Surgery

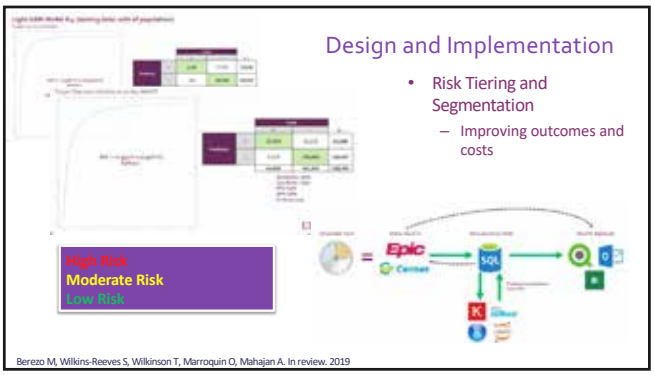


Berezo M, Wilkins-Reeves S, Wilkinson T, Marroquin O, Mahajan A. In review. 2019

25

Design and Implementation

- Risk Tiering and Segmentation
  - Improving outcomes and costs



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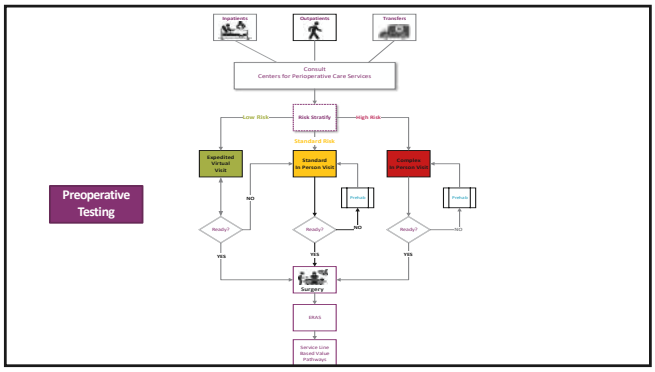

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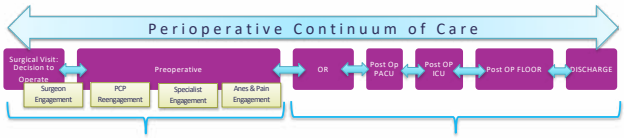
UPMC Perioperative Services Care Delivery Model



Center for Perioperative Care

- Coordination of resources and care plans
- Risk Stratification and Risk Optimization
  - Low Risk- FAST TRACK
  - High risk patients
    - Modifiable risk factor mitigation through prehabilitation
    - Shared decision making
    - Goals of care decisions
- Initiation of care pathways (ERAS)

Complex Care Teams

- High risk patients
- Continuation of care pathways common to patients
- Coordination of resources and care plans
- Continued mitigation of risk factors throughout the stay

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Protocol Driven Personalized Care: Value-based Care across all Hospitals

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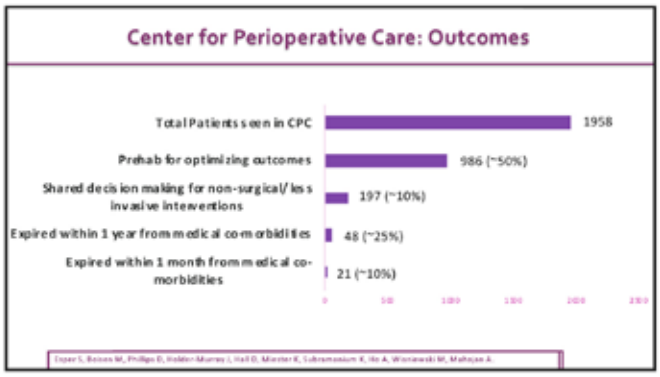

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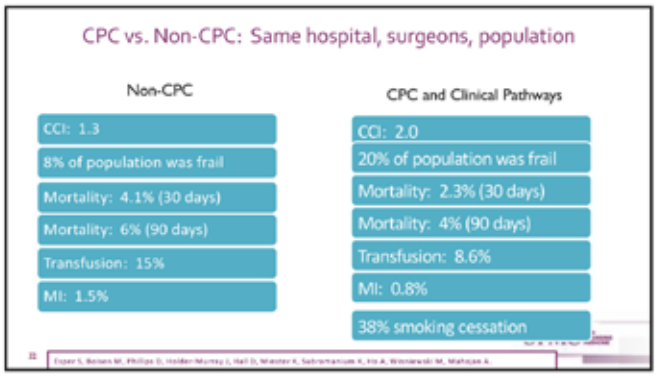

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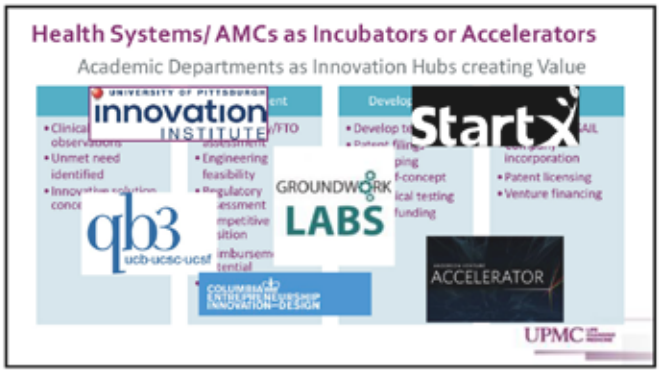

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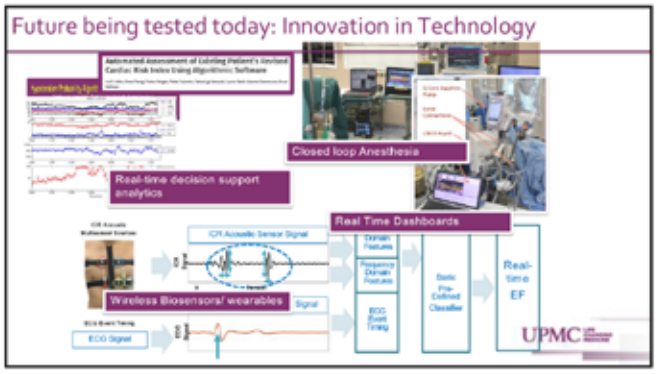

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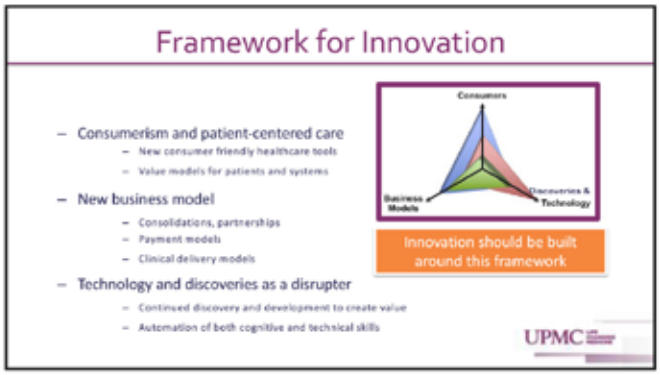

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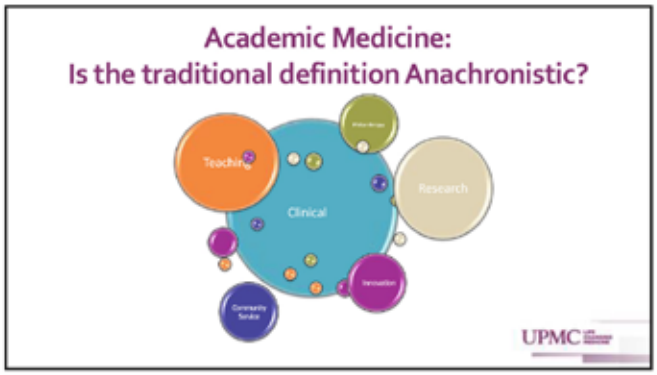


36

HANDOUT

Mistakes Made; Lessons Learned

Vesna Jevtovic-Todorovic, MD, PhD, MBA

11/08/2019
10:10am - 10:23am

University of Colorado
Anschutz Medical Campus

Mistakes Made; LESSONS LEARNED

Vesna Jevtovic-Todorovic, MD, PhD, MBA

CU Medicine Professor of Anesthesiology and Pharmacology
Chair, Department of Anesthesiology
University of Colorado School of Medicine

1

New Chair - Beware!

Five mistakes that got in my way the first two years as a chair:

- Being too friendly;
- Avoiding conflict and delaying difficult conversations;
- Not delegating enough;
- Not giving feedback in real time;
- Not giving enough time to myself to rejuvenate.

2

Being Too Friendly

"The art of leadership is saying no, not yes. It is very easy to say yes." - Tony Blair

- I wanted to be friendly and approachable to my faculty and staff;
- I learned that some people were tempted to take advantage of my friendliness;
- It took me a while to strike a fine balance between being able to socialize with my faculty and staff while being in charge;
- I have to remind myself to set clear boundaries.

3

Avoiding Conflict

"Do what is right, not what is easy."

Do not associate conflict with negative thoughts;

'Constructive' conflict could be helpful in building trustworthy and productive relationships;

- It's not the conflict itself that is the problem. We have to move away from seeing conflict as a bad thing.
- Whatever you do, do it in private.

4

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

5

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.

6

Not Giving Enough Time to Myself to Rejuvenate

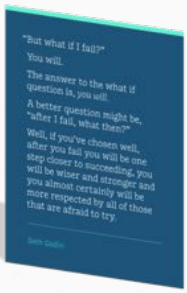
"Be strong enough to stand alone, smart enough to know when you need help, and brave enough to ask for it." – **Ziad K. Abdelnour**

- A good night's sleep is not overrated;
- Don't gobble your food – Take a moment to enjoy every bite;
- Exercise and spend time with those you love;
- There is always tomorrow - trust me – the issues will wait!

7

My daily question during the first two years of my leadership –

What if I fail?



8

HANDOUT

Mistakes Made; Lessons Learned

B. Scott Segal, MD, MHCM

11/08/2019
10:23am - 10:36am

Another mistake

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

Preliminaries

- No disclosures
- Events are fresh and not completely over—your discretion please

What happened (1)

- Department provided specialty anesthesia services at an outside hospital for many years
  - Facility was competitor
  - Main WF hospital did not provide the clinical service
  - Section in Department quite ensconced at outside facility
  - Members rarely or never worked at main hospital
- Institution decided to start providing the clinical service
- Section would be providing care at both locations

What happened (2)

- Intense secrecy around plans
  - NDAs
  - Section Head, junior faculty member, Chair represented anesthesiology in steering committee and workstreams
  - Section Head fully briefed; expected she was informing Section
- Growing anxiety among Section faculty
  - Eventually brought directly to Chair
  - Concerns raised about future integrity of Section
  - Chair reassured Section in meeting 2 days later, fully intended for group to remain intact and cover both locations
    - "By far the best outcome"

What happened (3)

- Section Head asked for meeting with President, Chair
  - Disclosed desire to be independent, affiliated group
    - President declined emphatically
  - Asked for guarantees of ongoing independence, autonomy
  - Compromise agreement reached
- Other facility distributed RFP for anesthesia services
  - WF, three other entities invited to respond
  - WF responded, emphasizing decades-long excellence
  - After long delay, facility chose another respondent

What happened (4)

- Subsequently discovered Section had engaged attorney
- Ultimately 5 faculty resigned and joined private practice RFP winner, others remained and moved to WF
- Service launched at WF with tremendous early success
  - Major financial blow to other facility
  - Significant loss of clinical anesthesia income to WF
  - Faculty group rebuilding at WF
  - Residents, fellows pulling out and back to WF
  - Fully separate by end of 2019

Lessons learned (learning…)

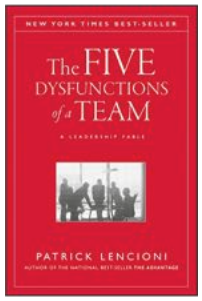
- The paramount importance of trust
- The importance of face time
- Listening to weak (“soft”) signals
- We are being managed as leaders

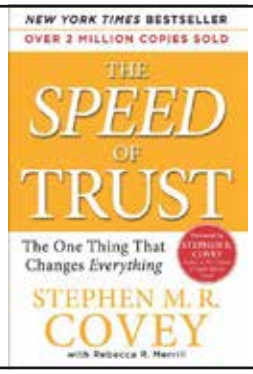
Доверяй, но проверяй **Doveryai, no proveryai**

Trust, but verify

Trust is everything

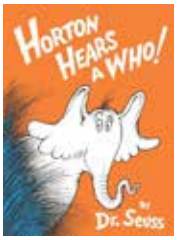
- “Leave us alone”
  “Because [the Section] has a separate practice plan, an exclusive contract to provide anesthesia services…and covers workload 24/7 with only Section anesthesiologists, the Section has a manpower model separate from that of the main Department of Anesthesiology.” --memo to me on arrival
- Trust in leadership
  - Institutional insistence on secrecy eroded already fragile trust
- Trust as the basis for team functioning





The importance of face time

The importance of "weak signals"



Beyond metrics? Utilizing 'soft intelligence' for healthcare quality and safety

Graham P. Martin [a,*], Lorna McKee [b], Mary Dixon-Woods [a]

[a] University of Leicester, United Kingdom
[b] Aberdeen University, United Kingdom

http://dx.doi.org/10.1016/j.socscimed.2015.07.027

Everyone is *always* managing up

Avoiding this mistake

- Poignant illustration of the importance of "soft skills"
- Develop and nurture trust, don't assume it
- Spend time face to face, even (maybe especially!) when all seems well
- Pay attention to weak signals, supplement data with active search for what isn't easy to see/hear
- Consider the inner position of the other party when interpreting their speech and actions

HANDOUT

Mistakes Made; Lessons Learned

Steven J. Lisco, MD, FCCM, FCCP

11/08/2019
10:36am - 10:50am

SAAAPM
SOCIETY OF ACADEMIC ASSOCIATIONS OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Mistakes Made; Lessons Learned

The Dangers of Incentives

Steven J. Lisco, MD, FCCM, FCCP
Myrna Newland, MD, Professor and Chair
steven.lisco@unmc.edu

University of Nebraska Medical Center

1

Disclosures

I have no relevant financial relationships to disclose

2

Objectives

- Recognize the problems inherent in "if-then" incentive programs
- Appreciate the difference between extrinsic and intrinsic motivation
- Understand how your compensation model drives faculty motivations

3

The Mistake

QUID PRO QUO

Evolution of the Compensation Plan

Base Pay + Fixed Call Pay = Salary

Base Pay + Academic Rank + Years of Service + Variable Call Pay = Salary

Base Pay + Academic Rank + Years of Service + Educational Performance + Administrative Responsibility + Compliance incentive + Clinical Effectiveness Bonus + Academic Productivity Bonus + Variable Call Pay = Salary

4

5

Complex Bonus System

Rewarding the Desired Behavior

Academic Variable Compensation
- Points based
- Four domains
- Each domain had 5 – 9 areas of eligibility.
- Required self reporting

Clinical Effectiveness Bonus
- Hospital KPI Triggers (Corporate Score Card)
- Quality Metrics
- Distributed based upon clinical FTE at department level

6

CARROT AND THE STICK

7

Initially it Worked

Happy Faculty >> Happy Chair

Happy Health System:
- Call became a commodity
  - No holes in the schedule
  - Reduced complaints about late hours
  - Improved off hour services

Happy Dean:
- Academic productivity increased
  - Publications
  - Abstracts
  - Meeting presentations
  - Grants

8

Until it Didn't

Incentives should be about superior performance

"If everything is incentivized, you really incentivize nothing. You might as well go to the beach."
----- David Lubarsky, MD, MBA
CEO UC Davis Health

Lubarsky. Anesth Analg 2005;100:490–2
Lubarsky, et. al., Anesthesiology 2019; 130:154–70

9

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So What Happened?

Response to extrinsic motivators is not universal

Routine Task Incentives
- Clinical productivity remained high
- Satisfaction with the call system was sustained

Creative Task Incentives
- Quid Pro Quo expected for educational material produced, lectures provided, any out of OR work…
- Desire for all administrative/committee tasks to be compensated
- Abstracts without subsequent publications increased

11

The Lesson

Behavioral Economics and Incentives

People always act in their rational self interest

Incentives almost always work perfectly to generate the desired behavior assuming the incentive is large enough

Failure often occurs when we fail to understand what wanted behavior is really desired

Lubarsky. Anesth Analg 2005;100:490–2

12

On the folly of rewarding A, while hoping for B

Steven Kerr

Dangers of Poorly Designed Incentive Systems

Reward A	Want B
Individual Effort	Teamwork
Efficiency	Quality
Clinical Billing	Academic Productivity

Kerr S. Academy of Management Journal 1975;18:769–83

13

Ideal Incentives

If more is spent on clinical tasks less will be spent on other academic activities

Should target an expected performance below which there is no incentive

Should Have (as much as possible) an unrestricted bonus pool

Should be noncompetitive

Should Have a variable component

Lubarsky. Anesth Analg 2005;100:490–2
Lubarsky, et. al., Anesthesiology 2019; 130:154–70

14

Nonclinical Incentives

Reward activities that you desire

Recognize importance of academic activities

Avoid rewarding all activities equally

You may be rewarding A but wanting B

Consider non-monetary rewards

15

Rewards

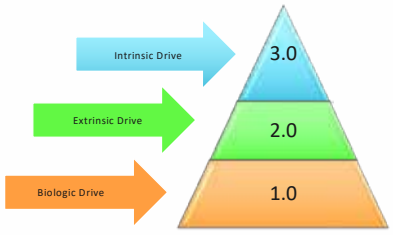
Rewarding clinical over nonclinical activities

While "if then" incentive systems clearly work they encourage faculty to spend more time pursuing dollars than academic success

16

Motivational Pyramid

Modified Maslow's Hierarchy of Human Needs



Pink D. Drive. New York, NY: Penguin Books; 2009: 1-10

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Motivation 2.0 – Extrinsic Drive

If-Then Incentive Programs

19

Carrots and Sticks

The Seven Deadly Flaws of Motivation 2.0

Extinguish intrinsic motivation

Diminish performance

Crush Creativity

Crowd out good behavior

Encourage cheating, shortcuts, and unethical behavior

Become addictive

Foster short-term thinking

Pink D. Drive. New York, NY: Penguin Books; 2009: 57

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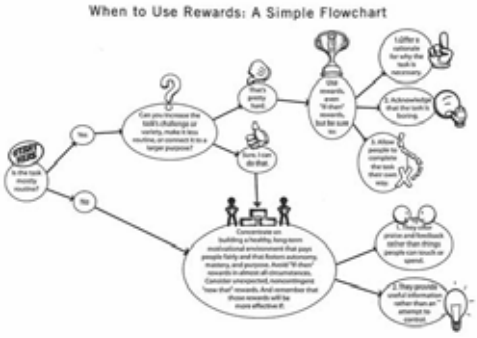

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Motivation 3.0 - Intrinsic Drive

Characteristics

22

Thoughts on Compensation

Best way to use money is to take money off the table

The more prominent salary, perks, benefits are in someone's work life the more they inhibit creativity and unravel performance

The most important aspect of any compensation package is fairness (it is not equity!)

- Ensure Internal and external fairness

23

Thoughts on Compensation

Pay More Than Average

Fair Wage-Effort Hypothesis
- workers proportionally withdraw effort as their actual wage falls short of their fair wage

Efficiency Wage Hypothesis
- paying people more increases their productivity

Pay-more-than-average
- Bypasses if-then rewards
- Eliminates concerns about unfairness

Akerlof GA and Yellen JL. *The Quarterly Journal of Economics* Vol. 105, No. 2 (May, 1990), pp. 255-283

24

Thoughts on Compensation

Make Performance Metrics Wide-Ranging, Relevant and Hard to Game

When the incentive for reaching metrics is modest rather than massive its less likely to narrow peoples focus or encourage them to game the system

Some people will inevitably try to game the system

Using a variety of measures that reflect the totality of work can transform often counterproductive "if-then" rewards into less controversial "now what" rewards

Pink D. Drive. New York, NY: Penguin Books; 2009: 181

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Summary

Finding the Right Balance of Extrinsic and Intrinsic Motivators

Both extrinsic and intrinsic motivators can be effective or ineffective depending on context and expectations

Pay people enough money to take money off the table, in fact pay them above average if you can

Avoid overly complex bonus systems

Consider the long term effects of your incentive systems

Do not allow your incentives to be conflated with compensation

26

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HANDOUT

The Demise of Hahnemann University Hospital: Venture Capitalism and the For-Profit Environment in Academic Medicine

Michael Green, DO, MBA, FASA

11/08/2019
10:50am - 11:10am

Jefferson Health

The For Profit Environment and Venture Capitalism in Academic Medicine- The rapid demise of Hahnemann University Hospital

Michael S. Green, DO, MBA, FASA
Professor and Vice-Chair
Department of Anesthesiology
Sidney Kimmel Medical College
Director of Perioperative Services
Thomas Jefferson University Hospital

1

Disclosure

- No financial relationships to disclose
  - However, a few financial damages

2

GOALS & OBJECTIVES

- Provide history regarding current environment and closure
- Timeline of activities
- Lessons Learned

3

Hahnemann Universi

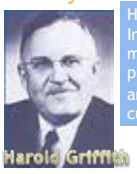
1848: Homeopathic College of PA
1850: Female Medical College of PA→

HAHNEMANN MEDICAL COLLEGE AND HOSP

1930s: Henry Ruth- ASA 1938- ABA- 1942 2nd
-First Editor and Chief of Anesthesiology

4

More Anesthesiology History!



HMC 1923
Introduction of musc
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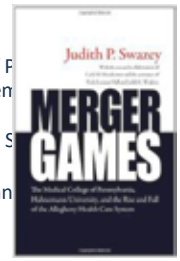
HMC 1941 and 1946 Hahnemann Residency graduate
Time magazine hailed the "grand old man" of anesthesia for inside the heart
Wrote the first monograph on Cardiac Anesthesia in 1956
Published 1st paper on anesthesia for mitral valve
Introduced method for hypothermic cooling

Widely recognized as a pioneer in the research, education and treatment of malignant hyperthermia

5

Modern Day Timeline

- Mid-1980's- MCP Purchased by AHERF of P
- 1993- AHERF enters into a "merger agreem Hahnemann Hospital
- 1994: Allegheny University of the Health S
- 1995-1998: $1.3 billion debt
- 1998: 1st US medical School to declare ban



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Tenet Healthcare

- Multinational investor-owned healthcare services company

68 | 21 | 470 | 85% | 47
115K | 32K | 33K | 11M | 90K
#147 | 50 | $19.2B | 800

7

Modern Day Timeline cont,

- 1998: Tenet Healthcare Corporation acqui
  Philadelphia area hospitals
- 2002: Officially renamed Drexel University
- Present day- 1 out of 72 practicing physicians graduated from Drexel University College of Medicine
- 2003: Tenet closes MCP hospital.
  - 7 of 9 other facilities closed

8

American Academic Health System

- Acquire ownership of Hahnemann and St. Christopher's Hospital for Children in January, 2018
  - Private Equity subsidiary company of Paladin Healthcare
  - 4 Los Angeles area hospitals and management contract for Howard University

PALADIN HEALTHCARE

AMERICAN ACADEMIC HEALTH SYSTEM

9

Los Angeles and Philadelphia

10

Institutional Inertia

11

AAHS Time at Hahnemann Hospital

- 1/11/2018- AAHS assumes operations
- Executive leadership turned over
  - April- CEO fired
  - June- DIO retires
  - July- CMO resignation
  - Aug- Barry Wolfman, Paladin President departs
  - Sept- CMO hired
    - Dec- CMO terminated
  - Jan 18- Dec 18- 5 different CEO's announced and terminated

12

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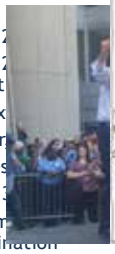
Timeline Contin



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  termination

15

Graduate Medical Education

- Overwhelming support from anesthesiology community in the interest of protecting residents
- June 27- ACGME notified
  - Institutional site visit occurred
  - ACGME submitted court filing requesting Hahnemann uphold policy for timely placement
- 583 residency positions in network
  - Tower health submits a 'Stalking Horse' bid for position- $7.5M
  - AAHS will not release residents

16

Graduate Medical Education

- July 29th- Residents are finally orphaned
  - Hospital in-patient census empty for weeks
- CMS residency positions sold in bankruptcy auction court for $55M to a consortium of 6 organizations
  - CMS provided 1 week to respond
  - CMS filed appeal stating that residency funded positions are not owned by institutions, but allocated by CMS. Have no negotiable value
  - No cash value exists- To be heard in Federal Court for decision

17

Bankruptcy Court

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Lessons Learned

- It can happen anytime, anywhere
- Governmental regulation limited power, State or Federal
- Bankruptcy court heavily favors corporate interests and satisfying business creditors over people
- Not a significant impact on Philadelphia health care, most major cities are 'over-bedded'
- Payer mix- Very challenging in For-Profit setting
- Great support from education community

19

Discussion

20

Jefferson Health.

HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

21

HANDOUT

Extending the Role of the Anesthesiologist

Joanne M. Conroy, MD

11/08/2019
11:20am - 11:40am

In the May 30, 2018 Catalyst article on Physician Leader Training, Nancy M. Kane and Linda A. Cyr did a great job nailing the importance of physicians as leaders and struggles our organizations face finding sufficient numbers to fill the increasing demand. There is plenty of evidence that clinical leadership is critical for improving our healthcare system. However, only 5% of hospitals are led by physicians, in part because of a shortage of qualified candidates. They describe many candidates for these roles as accidental leaders lacking formal training. Believe me, there are many barriers for physicians who generate significant clinical revenue to take an administrative role that might hurt the productivity of their sections and or require them to take a downward salary adjustment. Physicians themselves, refer to peers that move into management as becoming a suit or going to the dark side…perpetuating a “them versus us” mentality. This 20 min session with additional time for Q&A will review:

- What roles should anesthesia chairs consider as next steps in their careers
- What training, qualities and skills will make you successful in leadership roles
- When should you think about transitioning to a new role

HANDOUT

AAAC
ASSOCIATION OF ACADEMIC ANESTHESIA CHAIRS

RRC Update

Cynthia A. Wong, MD

11/08/2019
11:45am - 12:00pm

ACGME Review Committee for Anesthesiology Update

Cynthia Wong, MD, Chair

1

Disclosure

- No disclosures to report

2

Session Objectives

- Introduce new Review Committee members
- Summarize specialty 2019 Annual Program Review
- RC and ACGME Updates and Projects
  - *Program Requirement Changes*
  - *Milestones 2.0*
  - *Program Director Guide to the Common Program Requirements*
  - *New Resident Survey*

3

New Member - 2020

- Jill Mhyre, MD
- University of Arkansas for Medical Sciences
- Professor and Chair, Department of Anesthesiology

4

New Resident Member - 2020

- Johnny Jianing Wei, MD
- CA-1 Resident
- University of Kansas School of Medicine

5

The Stats

6

Trends in Core Anesthesiology Programs

Academic Year	# Approved Residents	# Core Programs
2018-2019	7,299	153
2017-2018	7,171	153
2016-2017	6,994	147
2015-2016	6,728	135
2014-2015	6,685	133
5-Year Trend	**↑ 9.2%**	**↑15.0%**

7

Core Anesthesiology Program Size

Number of Filled Positions	Number of Programs
0 Residents	2
1-24 Residents	43
25-49 Residents	52
50-74 Residents	34
74-99 Residents	15
100+ Residents	7

	Number of Positions
Range	0-111
Mode	31
Median	37
Mean	43

89.5% Fill

8

Subspecialty Programs – 2018-2019

Subspecialty	Number of Programs	Filled	Active Fellows
Adult Cardiothoracic	68	97.3%	153
Clinical Informatics	1	50.0%	1
Critical Care Medicine	62	78.5%	194
Regional Anesthesiology and Acute Pain Medicine	27	82.9%	63
Obstetric Anesthesiology	37	74.5%	46
Pain Medicine	103	92.3%	382
Pediatric Anesthesiology	60	84.6%	219

9

Anesthesiology Review Committee Activities – 2018-2019

10

Annual Anesthesiology RC Activities

- **The Review Committee meets to review:**
  - Applications
  - Permanent Complement Increase Requests
  - Annual Data
    - *Programs with Citations*
    - *Programs with Annual Data Indicators*
  - 10-Year Site Visit Reports

11

2018-2019 Annual Program Review

446 Programs Reviewed

- *425 Continued Accreditation*
- *3 CA with Warning*
- *17 Initial Accreditation*
- *1 Withhold*

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

12

Program Requirements

13

Pain Medicine Program Requirements

- **Multidisciplinary with Physical Medicine and Rehabilitation and Neurology**
- **Negotiation**

14

Pain Medicine Program Requirement Changes

- **To be eligible to apply for a program, sites only need to sponsor one residency in:**
  - *Anesthesiology, Physical Medicine and Rehabilitation, Child Neurology, or Neurology*

15

Pain Medicine Program Requirement Changes

- **There may be multiple Pain Medicine programs at a single institution**
  - *Must demonstrate commitment to multidisciplinary nature of the subspecialty with applicable faculty appointments*

16

CORE Requirements Proposed

- **Review and comment period open late November 2019**
- **Core Faculty Members**
  - Minimum of six core faculty members, not including program director

17

CORE Requirements Proposed

- **Coordinator Support**
  - *≤ 20 residents – 0.5 FTE*
  - *21-40 residents – 1.0 FTE*
  - *41-60 residents – 1.5 FTE*
  - *61-80 residents – 2.0 FTE*
  - *81-100 residents – 2.5 FTE*
  - *> 100 residents – 3.0 FTE*

18

We HEARD You!

- Proposed changes made to ensure consistency amongst Anesthesiology subspecialties
- Review and comment period open in late November
- Please review and let us know of concerns or recommended changes

19

General Subspecialty Changes Proposed

- Program director must devote at least 50% of time to subspecialty
- <5 fellows, 10% FTE non-clinical protected time
- 5 or more fellows, 20% FTE non-clinical protected time

20

General Subspecialty Changes Proposed

- **Program Director:**
  - *Current certification in Anesthesiology*
  - *Current certification in subspecialty, if available*
    - If not available, completion of fellowship or 3 years' service as a fellowship faculty member
  - *At least 3 years' post-fellowship service in subspecialty*

21

General Subspecialty Changes Proposed

- **Faculty**
  - *Varies by subspecialty*
- **3 core faculty members required**
  - *For programs with 4 or more fellows, there must be at least 1:1 core faculty-to-fellow ratio*

22

General Subspecialty Changes Proposed

- **Coordinator Support**
  - *At least 20 percent FTE for fellowships with a single fellow*
  - *For each fellow over one, must have additional 2% support for administrative time*

23

General Subspecialty Changes Proposed

- **Fellow Scholarly Activity**
  - *Must conduct or be substantially involved in scholarly project related to subspecialty suitable for publications*
  - *Disseminated through a variety of means, including publication and presentation at national or international meetings*
  - *Must have a faculty mentor overseeing the project*

24

Other Projects

25

Milestones 2.0

- **Initial meeting for core Anesthesiology held in Chicago – September 12-13, 2019**
  - *Anticipated 45-day Review and Comment period – late spring 2020*
- **Subspecialty revisions will follow**
  - *Will send self-nomination invitation to AASPD for dissemination*

26

Other Projects

- **New Program Director Guide to the Common Program Requirements – coming soon!**
- **New Resident Survey launching in January to encompass new Common Program Requirements**

27

Contact ACGME Staff – They want to help!

Cheryl Gross, MA, CAE, Executive Director
cgross@acgme.org ♦ 312-755-7417

Kerri Price, MLIS, Associate Executive Director
kprice@acgme.org ♦ 312-755-5023

Aimee Morales, Senior Accreditation Administrator
amorales@acgme.org ♦ 312-755-7419

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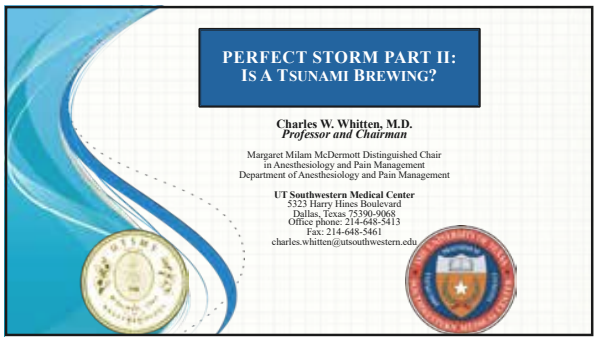
HANDOUT

Perfect Storm

Charles W. Whitten, MD

11/08/2019
1:15pm - 2:00pm

Perfect Storm Part II: Is a Tsunami Brewing



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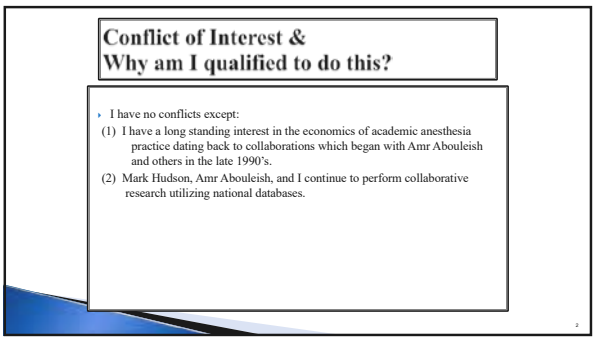

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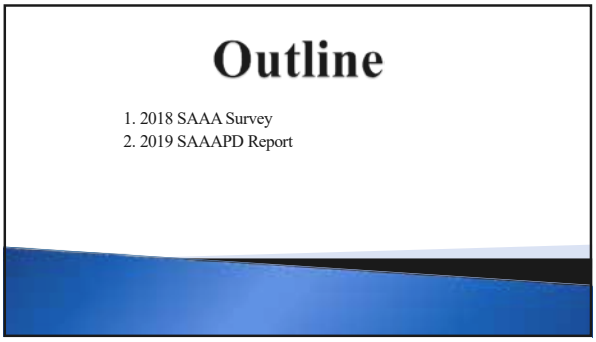

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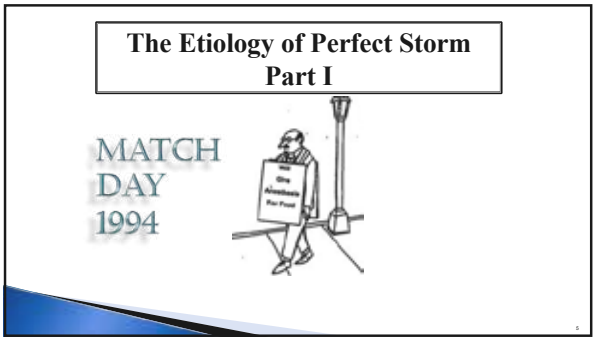

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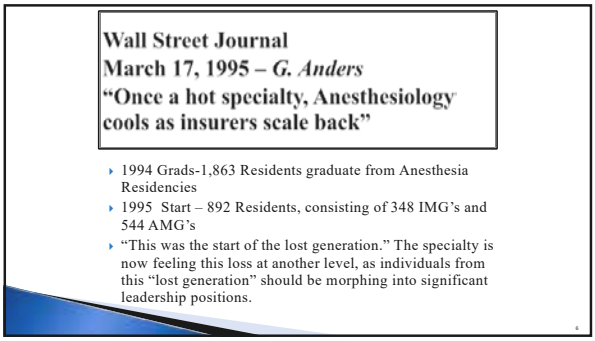

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Perfect Storm Part II: Is a Tsunami Brewing

Size of Residency Training Programs

- In 2018- 1,434 Senior Residents. A total of 6,346 Anesthesiology Residents are enrolled in 153 Core Residency Programs graduated
- **(44% women enrolled in all specialty and subspecialty training programs).**

Residency Production: Confounding Factors

- In 2018, we know that the following pursued ACGME fellowships:

Number of Programs (N)	Positions Filled	% Women
Critical Care Medicine (N=62)	194/246	36%
Pain Medicine (N=102)	381/409	22%
Pediatrics (N=60)	244/257	49%
Adult Cardiothoracic (N=66)	217/222	29%
OB (N=34)	45/59	62%
Clinical Informatics (N=1)	2/2	0%
Regional & Acute Pain (N=18)	50/59	38%
Total	**1,133/1,254**	

7

SAAA YEARLY SURVEY DATA 2018

n=88

8

2018 Department

Attending Physician FTEs	Mean	+/- SD	Median
Surgical Anesthesiologist FTEs	45.3	30.9	38.8
Acute Pain (In-Patient)	2.1	2.35	1.1
Chronic Pain (Out-Patient)	3.5	2.59	3.0
ICU	3.4	3.64	2.0
Pre-Op Clinic	1.1	0.96	1.0
Other	1.5	2.86	0.0
Total	**56.9**		

9

2018 Department (cont'd)

Academic Rank	Clinical Anesthesiology Faculty: Total *Mean*	Clinical Anesthesiology Faculty: Total FTEs *Mean*	Clinical Anesthesiology Faculty: Clinical FTEs *Mean*
Chair	1.0	1.0	0.3
Professor	8.8	8.3	5.3
Associate Professor	14.8	14.0	10.7
Assistant Professor	38.5	35.7	29.4
Instructor	5.8	5.1	3.9
Non Academic Clinical	4.1	3.2	3.0
Total	**73.0**	**67.3**	**52.7**

*52.7/67.3 – 78% (22% non-clinical)

10

National Clinical Coverage

	Mean	+/- SD	Median
How many OR's does your Department cover each day Monday- Friday?	45.7	23.7	40
How many Non-OR/Off Site locations does your Department cover each day Monday-Friday?	12.4	7.86	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?	3,586	4,556	2,500

11

OB Staffing

	Nights	Weekends
Separately Assigned MD	51%	50%
Crossover Faculty from Main OR	35%	34%
Other	2%	3%
No Answer	11%	11%

12

Perfect Storm Part II: Is a Tsunami Brewing

National Clinical Coverage

	Mean	+/- SD	Median
How many faculty do you have on each of these services per day on average, Monday - Friday in the daytime.			
OR	31.5	20.9	26
OB	1.7	1.33	1
ICU	2.2	1.93	2
Acute Pain	1.5	1.24	1
Pain Clinic	2.9	1.96	2.5
Pre-Op Clinic	1.1	0.88	1
Other	2.0	4.21	0
Total	**42.9**		

* Reflection of total faculty not clinical FTE

13

Department Clinical Sites Coverage Monday-Friday

	Mean	+/- SD	Median
ORs	45.7	23.7	40
Off Site	12.4	7.86	10
OB	1.7	1.33	1
ICU	2.2	1.93	2
APS	1.5	1.24	1
Pain	2.9	1.96	2.5
Pre-Op	1.1	0.88	1
Other	2.0	4.21	0
Total	**69.5**		

14

National Institutional Support

	Mean	+/- SD
Institutional Support ↑	$ 13,201,714	$ 8,872,979
Institutional Support / FTE ↑	$ 224,091	$ 150,271

15

Total Support

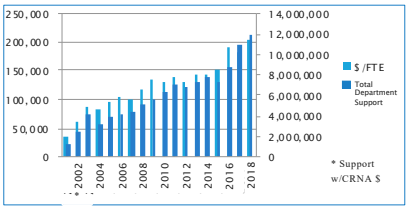
	25%	Median	75%
Total Support	$ 5,154,694	$ 11,895,000	$ 19,528,282
Total Support per FTE ↑	$ 118,489	$ 205,793	$ 307,638

Mean National Institutional Support

Total Support/FTE	2018	$ 224,091
	2017	$ 183,712
	2016	$ 190,584
	2015	$ 191,912
	2014	$ 196,441
	2013	$ 181,000

16

Total National Department Support (Without CRNA Support)



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Comparison of Economic Status by Departmental Size

≤40 (n=16) 88+ (n=26)

18

Perfect Storm Part II: Is a Tsunami Brewing

<40 n= 16	Mean	+/- SD	Median
Institutional Support ↑	$ 7,987,996	$ 5,870,159	$ 6,000,000
Institutional Support per FTE ↑	$ 320,119	$ 186,040	$ 241,677

88+ n= 26	Mean	+/- SD	Median
Institutional Support ↑	$ 17,674,189	$ 9,298,644	$ 18,505,216
Institutional Support per FTE ↑	$ 166,912	$ 90,147	$ 188,803

19

National Departmental Revenue Producers

	Mean	+/- SD	Median
ASA Unit Production	45.3	30.9	38.8
Chronic (Out-Patient) Pain	3.5	2.59	3.0
Clinical ICU	3.4	3.64	2.0
Acute (In-Patient) Pain	2.1	2.35	1.1
Pre-Op Clinic	1.1	0.96	1.0
Other	1.5	2.86	0
Total	**55.9**		

20

National Department Clinical Revenue

	Mean	+/- SD
ASA Units	$34,221,889	$28,290,073
ICU Units	$2,026,114	$2,765,891
Pain Units	$2,547,235	$2,995,337
Other	$1,547,126	$2,482,999
Total	**$40,342,364**	

21

National Collection / FTE

	Mean	+/- SD
ASA Units	$ 547,710	$ 428,312
ICU Units	$ 26,459	$ 31,605
Pain Units	$ 40,392	$ 67,491
Other	$ 25,851	$ 67,753

Is it a true reflection of clinical FTE??

22

Billing Production National	Mean	+/- SD	Median
Total Anesthesia Units Billed	801,507	439,187	735,113
Total Anesthesia Units Billed Per FTE ↑	13,580	13,563	11,555

Billing Data	Mean	+/- SD
What is your average $ amount collected per unit?	$ 45.99	$ 34.60

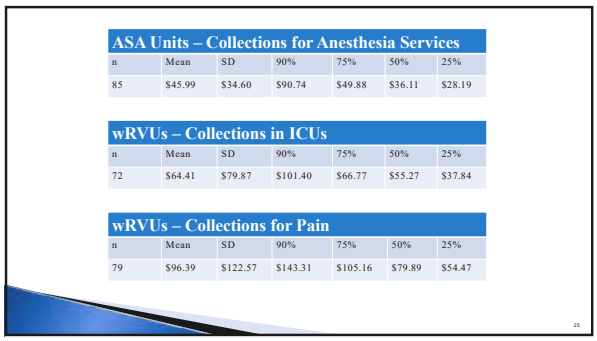
23

Number of Units Billed	Mean	+/- SD
ASA Units	801,507	439,187
ICU Work Units	29,880	37,204
Pain Work Units	26,718	21,421
Other	20,914	35,971

Billing – Collection Mean Summary	Mean	+/- SD	Median
ASA (Base and Time) units billed for anesthesia service	$45.99	$34.60	$36.11
Work units in ICUs (wRVUs)	$64.41	$79.87	$55.27
Units for Pain (wRVUs)	$96.39	$122.57	$79.89
Any other billed services	$65.79	$54.24	$60.10

24

Perfect Storm Part II: Is a Tsunami Brewing



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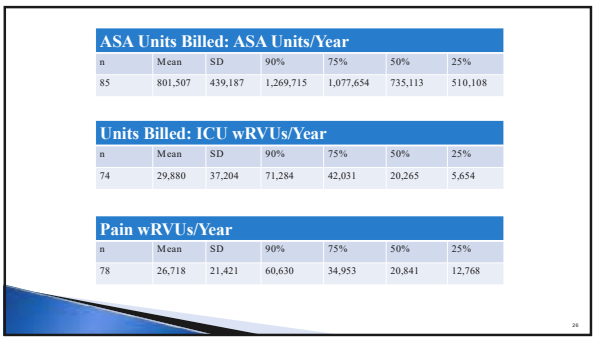

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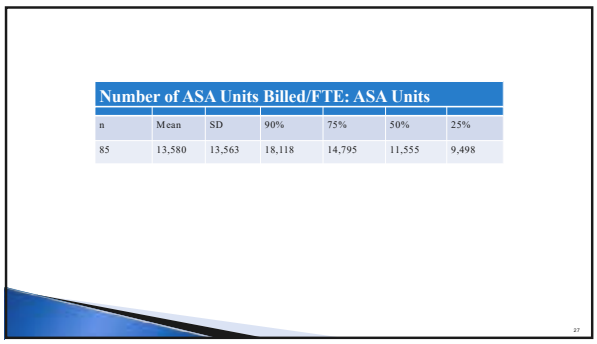

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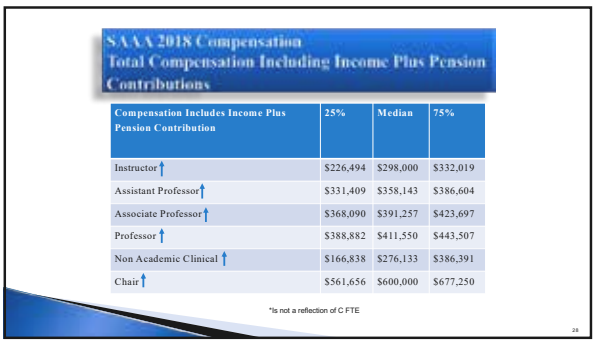

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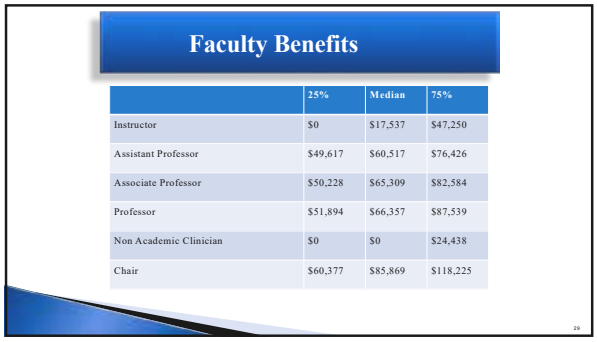

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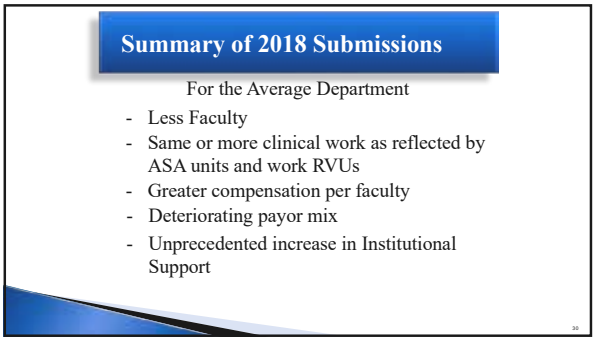

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Perfect Storm Part II: Is a Tsunami Brewing

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

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Anesthesiology Group Clinical Productivity: Measuring, Comparing, Benchmarking

- Measuring:
  - Develop metrics that work for your department
  - Essential: Need to know what the metric values and devalues
  - Dashboard: Used to identify areas to look at more closely
- Comparing
  - Done within a department by comparing facilities
  - Best if similar type of facilities
  - Can adjust for non-anesthesia factors
  - Often done by comparing the same facility to previous years
- Benchmarking
  - Need national data benchmarks
  - Metrics defined the same way for all groups
  - Not as granular as internal metrics
  - Limited comparisons
  - Need to benchmark to similar facilities (type and size) since you can't control non-anesthesia factors

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Covers Measuring, Comparing, Benchmarking

33

BENCHMARKING DATA FOR SAAAPD

- 2003 Data
  Anesth Analg 96: 802-812; 2003
  Abouleish AE, Prough DS, Barker SJ, Whitten CW, Uchida T, Apfelbaum JL. Organizational Factors Affect Comparisons of Clinical Productivity of Academic Anesthesiology Departments.
- 2013 SAAA Report
  http://anesth.utmb.edu/Public/publications/SAAAReport.pdf
- 2019 SAAAPD Report: Surgical Anesthesia

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2019 SAAPD REPORT

- Designed to report data by facilities
- Provides median values for all facilities, then type of facilities, and size of facilities
- Then breakout for each category and subcategories that includes Mean, 10th, 25th, 50th, 75th, and 90th percentile
- Allows for benchmarking your facility three ways: to all, to same type, and to same size

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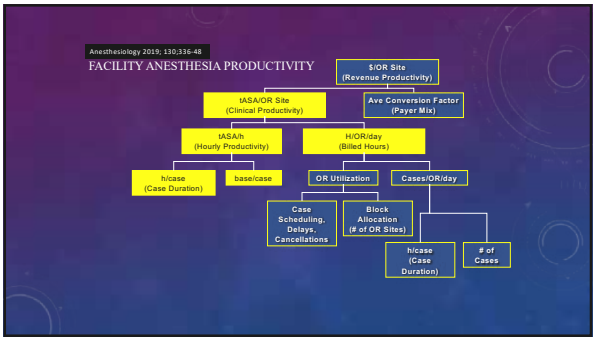

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Perfect Storm Part II: Is a Tsunami Brewing

2019 SAAAPD REPORT: MEDIAN BY FACILITY TYPE

	All Facilities	AMC	Community	Children	ASC
n	140	69	26	7	38
tASA/case	13.9	15.9	12.0	13.9	8.8
Base/case	5.8	6.3	5.3	6.3	4.4
h/case	2.0	2.3	1.9	2.0	1.1
h/OR/d	6.5	7.3	5.8	6.3	4.4
case/OR/d	3.2	3.1	3.4	3.0	3.7
tASA/OR	11,546	12,592	11,164	12,364	8,911
tASA/h	7.0	6.8	7.2	7.3	7.8

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2019 SAAAPD REPORT: MEDIAN BY FACILITY SIZE: USE SIMILAR FACILITY TYPES

	All Facilities	AMC	Community	Children	ASC
n	140	69	26	7	38
tASA/case	13.9	15.9	12.0	13.9	8.8
Base/case	5.8	6.3	5.3	6.3	4.4
h/case	2.0	2.3	1.9	2.0	1.1
h/OR/d	6.5	7.3	5.8	6.3	4.4
case/OR/d	3.2	3.1	3.4	3.0	3.7
tASA/OR	11,546	12,592	11,164	12,364	8,911
tASA/h	7.0	6.8	7.2	7.3	7.8

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2019 SAAAPD REPORT: MEDIAN BY NUMBER OF ANESTHETIZING SITES

	ASC<10	nonASC <10	nonASC 10-19	nonASC 20-39	nonASC 40 or more
n	34	23	16	28	35
tASA/case	8.7	12.8	14.6	14.5	16.1
Base/case	4.3	5.1	6.2	5.9	6.7
h/case	1.1	2.0	2.1	2.2	2.4
h/OR/d	4.5	5.7	7.0	7.5	7.1
case/OR/d	4.1	3.0	3.2	3.3	3.1
tASA/OR	9,019	11,452	12,746	12,719	12,290
tASA/h	7.6	7.2	7.2	6.7	6.9

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MEDIAN TASA/OR DOES NOT MEAN MEDIAN OTHER MEASUREMENTS

	AMC (n=69) Median	Group 1	Group 2	Group 3
Sites	39	57.75	25.00	42.00
Staffing Ratio	1.8	1.3	2.3	1.6
tASA/case	15.9	15.4	15.9	14.3
Base/case	6.3	6.5	6.7	8.3
h/case	2.3	2.2	2.3	1.5
h/OR/d	7.3	7.2	7.3	5.3
case/OR/d	3.1	3.2	3.2	3.5
tASA/OR	12,592	12,398	12,592	12,624
tASA/h	6.8	6.9	6.9	9.6

40

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Perfect Storm Part II: Is a Tsunami Brewing

MEDIAN TASA/OR DOES NOT MEAN MEDIAN OTHER MEASUREMENTS

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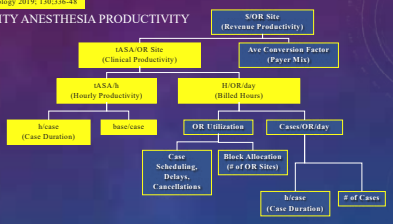
43

Anesthesiology 2019; 130:336-48

FACILITY ANESTHESIA PRODUCTIVITY



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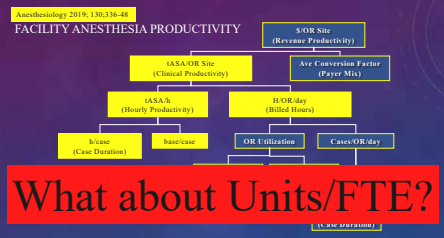
Anesthesiology 2019; 130:336-48

FACILITY ANESTHESIA PRODUCTIVITY



What about Units/FTE?

45

"PER FTE" MEASUREMENTS IN ANESTHESIOLOGY CLINICAL PRODUCTIVITY CAN BE MISLEADING

- 2019 SAAPD Report
- ASC only
- MD only vs. >2.0 staffing ratio
- Per MD means per anesthesiologist in the OR that day
- Per MD does not equal Per FTE

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"PER FTE" MEASUREMENTS IN ANESTHESIOLOGY CLINICAL PRODUCTIVITY CAN BE MISLEADING

- 2019 SAAPD Report
- ASC only
- MD only vs. >2.0 staffing ratio
- Per MD means per anesthesiologist in the OR that day
- Per MD does not equal Per FTE

	MD only	Staffing ratio >2
Cases/MD		
tASA/MD		
H billed/day/MD		

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"PER FTE" MEASUREMENTS IN ANESTHESIOLOGY CLINICAL PRODUCTIVITY CAN BE MISLEADING

- 2019 SAAPD Report
- ASC only
- MD only vs. >2.0 staffing ratio
- Per MD means per anesthesiologist in the OR that day
- Per MD does not equal Per FTE

	MD only	Staffing ratio >2
Cases/MD	984.2	2,886.5
tASA/MD	8,765	26,033
H billed/day/MD	4.7	12.1

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Perfect Storm Part II: Is a Tsunami Brewing

"PER FTE" MEASUREMENTS IN ANESTHESIOLOGY CLINICAL PRODUCTIVITY CAN BE MISLEADING

- 2019 SAAPD Report
- ASC only
- MD only vs. >2.0 staffing ratio
- Per MD means per anesthesiologist in the OR that day
- Per MD does not equal Per FTE

	MD only	Staffing ratio >2
Cases/MD	984.2	2,886.5
Cases/OR	984.2	1,124.8
tASA/MD	8,765	26,033
tASA/OR	9,241	8,931
H billed/day/MD	4.7	12.1
H billed/day/OR	4.7	4.6

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"PER FTE" MEASUREMENTS IN ANESTHESIOLOGY CLINICAL PRODUCTIVITY CAN BE MISLEADING

- 2019 SAAPD Report
- ASC only
- MD only vs. >2.0 staffing ratio
- Unfortunately, deans, consultants, administrators want "units per FTE".
  No meaningful benchmarking because of factors that affect "units per FTE"
  Can use internally if control factors …

	MD only	Staffing ratio >2
Cases/MD	984.2	2,886.5
tASA/OR	9,241	8,931
H billed/day/MD	4.7	12.1
H billed/day/OR	4.7	4.6

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tASA/FTE MEASUREMENT: PRODUCTIVITY FROM ANESTHESIA CARE (NON OB)

Measurement does not include:
- other billable work (Lines, OB, acute pain, chronic pain, ICU, Consults)
- non-billable work (DSU preop, PACU, Schedule Runner)

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tASA/FTE MEASUREMENT: PRODUCTIVITY FROM ANESTHESIA CARE (NON OB)

$$\frac{tASA}{FTE} =$$

Measurement does not include:
- other billable work (Lines, OB, acute pain, chronic pain, ICU, Consults)
- non-billable work (DSU preop, PACU, Schedule Runner)

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tASA/FTE MEASUREMENT: PRODUCTIVITY FROM ANESTHESIA CARE (NON OB)

$$\frac{tASA}{FTE} = \frac{tASA}{OR}$$

Measurement does not include:
- other billable work (Lines, OB, acute pain, chronic pain, ICU, Consults)
- non-billable work (DSU preop, PACU, Schedule Runner)

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tASA/FTE MEASUREMENT: PRODUCTIVITY FROM ANESTHESIA CARE (NON OB)

$$\frac{tASA}{FTE} = \frac{tASA}{OR} \times \frac{OR}{ORFTE}$$

Measurement does not include:
- other billable work (Lines, OB, acute pain, chronic pain, ICU, Consults)
- non-billable work (DSU preop, PACU, Schedule Runner)

ORFTE = regular weekdays providing surgical anesthesia / total workdays available
FTE = full time equivalent

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Perfect Storm Part II: Is a Tsunami Brewing

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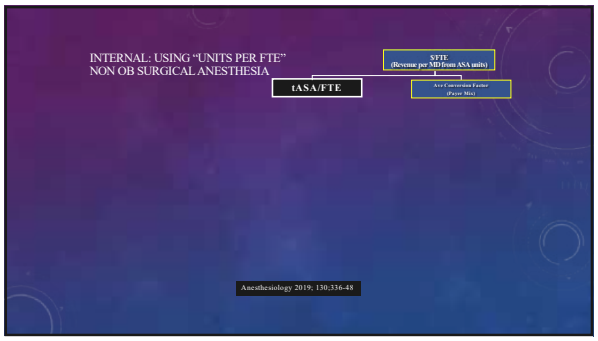

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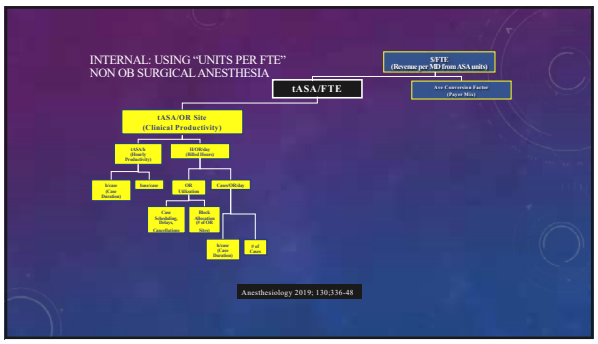

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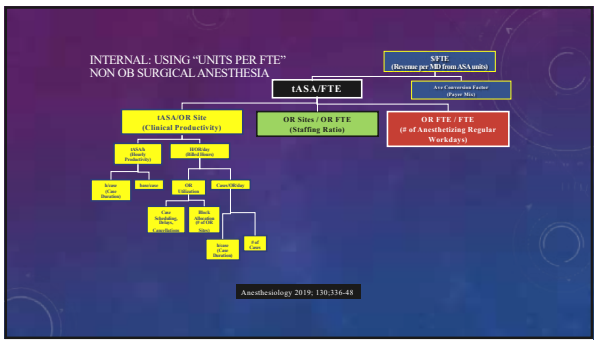

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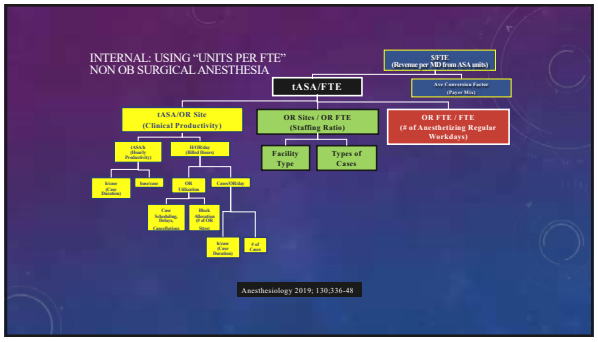

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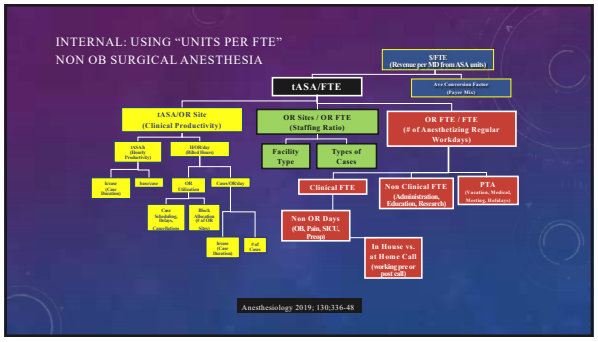

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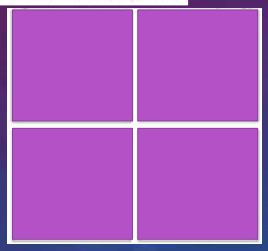
Perfect Storm Part II: Is a Tsunami Brewing

Figure 3. Correlation of tASA/FTE with factors impacting productivity



Hudson ME, Lebovitz EE. Measuring clinical productivity. Anesthesiology Clin 2018; 36(2): 143-60

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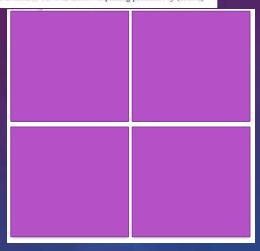
Figure 3. Correlation of tASA/FTE with factors impacting productivity (cont.d)



Hudson ME, Lebovitz EE. Measuring clinical productivity. Anesthesiology Clin 2018; 36(2): 143-60

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OB ANESTHESIOLOGY

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	Small	Low Medium	High Medium	Large
Deliveries/year	0-1,199	1,200-2,399	2,400-3,599	≥3,600
C-sections/year	0-359	360-719	720-1,079	≥1,080
Epidurals/year	0-719	720-1,439	1,140-2,159	≥2,160

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SUMMARY OF KEY FINDINGS OF OB

1. % Epidurals: The Small facilities had slightly lower % ranging from 52-59% median values, while all the other groupings had median values ranging from 59-66%.

2. % C-sections: Smallest facilities had the highest median values ranging 37-38%, while the other facilities ranged from 28%-32% (except one with 38%).

3. As expected, dedicated staffing for the labor and delivery unit was different depending on size of workload. Although findings different slightly by which grouping one used, the following is based on total deliveries/year grouping.

   a. Small Groups had a high percentage of facilities with no dedicated clinician providing obstetric anesthesia during the day or in-house on call.

   b. Low Medium groups had >80% of facilities with an anesthesiologist assigned to obstetric anesthesia during the day, but about half had an anesthesiologist assigned on call in-house.

65

SUMMARY OF KEY FINDINGS OF OB *(CONT'D)*

   c. High Medium groups almost all had an anesthesiologist assigned during the day, but only about half had an anesthesiologist in-house on call.

   d. Large groups had 100% anesthesiologist assigned to obstetric anesthesia during the day and 94% had an anesthesiologist in-house on call.

3. 24/7 tubal ligations are typically provided in about half of facilities, except for small facilities that are only offered in less 20% of the facilities.

4. Alternatives to epidurals – specifically Nitrous Oxide or PCA Remifentanil – are not offered as often within small facilities. In Large facilities, Nitrous Oxide was available in more than half of the facilities, and PCA Remifentanil 40-50%.

66

Perfect Storm Part II: Is a Tsunami Brewing

ICU

- Abouleish, Hudson and Whitten felt the data were "too dirty" to draw conclusions.
- Our recommendation is to repeat involving subject matter experts and beta testing

67

SUMMARY OF COMPARING PRODUCTIVITY

- Review Article: Anesthesiology February 2019 provides detailed discussion of how to do this and what each measurement is calculated and means
- SAAAPD 2019 Report provides benchmarking data (more than what was presented)
- "per FTE" measurements are only valid internally because of the many non-anesthesiologist factors

68

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.

69

REALITY

Healing is an Art

Medicine is a Science

Healthcare is a Business

70

HANDOUT

Retreat! Retreat! Marching Forward for Departmental Success

David A. Zvara, MD

11/08/2019
2:15pm - 2:30pm

Retreat! Retreat!
Marching Forward for Departmental Success.

David A. Zvara, M.D., FASA
Professor and Chair, Anesthesiology
COO, UNC Faculty Practice
The University of North Carolina at Chapel Hill

SAAAPM
November 8, 2019

1) Lecture Objectives
    a. The participant will gain an understanding of the importance of defining the intent of the retreat before any event is planned.
    b. The participant will be given a step-by-step guide on planning, preparing and delivering a retreat experience for the faculty.
    c. The speaker will share tips, tricks and techniques to ensure success at a retreat event.

2) Lecture Outline
    a. How to Plan, Prepare and Deliver a Killer Retreat
        i. Initial steps
            1. Evaluating the need for a retreat
            2. Evaluating the receptivity of the Department
            3. Selecting a date and a venue
        ii. Envisioning your desired outcome
            1. Define the goals of the retreat in your mind
                a. Motivation, morale, cohesion, operational?
            2. The death trap of informational retreats
        iii. Obtaining Buy-in from the faculty
            1. Using a survey to sample faculty pulse
            2. Using work groups in pre-retreat work tasks
            3. Confronting truth. Are you ready?
        iv. Developing actionable plans
            1. Post retreat work groups
            2. Defining measurable goals.
            3. Post retreat reporting
        v. Tricks, tips and techniques for success
            1. Things I've learned. Mistakes I've made.

HANDOUT

The Departmental Newsletter for Shaping Culture

Robert E. Johnstone, MD, FASA

11/08/2019
2:30pm - 2:50pm

Shaping Department Culture with a Newsletter

Robert Johnstone, MD, FASA
Department of Anesthesiology
West Virginia University

1

Agenda

- Newsletter content
- Newsletter style
- My experience
- Examples

No conflicts of interest

2

Newsletter content

What do you want people to be and do?
- *Enthusiastic, professional, publish, committees, simulation, reduce OR waste, learn ultrasound, reduce opioids, follow guidelines, etc?*

What department culture do you want?
- *Teams, hierarchical, goal-oriented, etc*

Report activities and accomplishments that you want to promote, that advance desired culture.

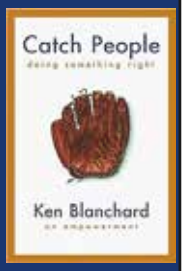
Capture department and institution successes.

"Write what you know." Mark Twain

3

One of the easiest and quickest ways a leader can improve workplace morale is to notice, encourage, and celebrate the good things that are happening.

People who feel good about themselves produce good results, and people who produce good results feel good about themselves.



Catch People Doing Something Right
Ken Blanchard

4

Newsletter style

Positive tone, active voice
Multiple short items in predictable format
To-the-point, keep it simple
Color picture on every page
Every picture should have a person in it
4-6 pages, every other week
No jokes
Focus on department members, not yourself

"If you can't explain it simply, you don't understand it well enough." Albert Einstein

5

My experience

35 years, +/- 2000 newsletters
Best from chair perspective
Work on it intermittently, add items throughout the week
Revise frequently
Print version primarily
Newsletter controls department narrative and focus

6


Anesthesiology Department Newsletter
West Virginia University
August 26, 2019

1. **Grand Rounds. Wednesdays 7-8am, Fukushima Auditorium, 1st floor HSC.**
   Aug 28 What special operations medics do (Okey Patteson Auditorium) **Phil Gonzales, MSHS***
   Sept 4 Point of care ultrasound for the anesthesia provider: Uses, pitfalls, future directions **Adam Adler, MD****

Notes
*Phillip Gonzales is 1LT (Ret) US Army Special Forces. He is the Advanced Medical Instructor for the Joint Army/Navy special Operations Combat Medical Training Center, Ft Bragg, NC. His presentation is also titled, "From Vietnam to the Amazon and all the wars in between". We will join Critical Care and Trauma Institute members in the Okey Patteson auditorium for this presentation.

1LT Phillip Gonzales

Adam Adler, MD is Assistant Professor of Anesthesiology, Baylor College of Medicine, Texas Children's Hospital. Dr. Adler did his anesthesiology residency at Baystate Medical Center – Tufts University. He did pediatric anesthesiology and pediatric cardiothoracic anesthesia fellowships at Childrens Hospital of Philadelphia.
Three publications of Dr. Adler:
Adler AC, McGee WT. Hemodynamic management: a physiologic optimization program. In: Rodriguez-Villar S and John AD, editors. *Critical Care*. Madrid: Marbar; 2016. p.470-482.
Adler AC, Greeley WJ, Conlin F, Feldman JM. Perioperative Anesthesiology UltraSonographic Evaluation (PAUSE): an algorithmic approach for the use of bedside ultrasound by anesthesiologists in the perioperative setting. *Journal of Cardiothoracic and Vascular Anesthesia* 2016;30(2):521-529.
Adler AC, Kadavalgundi R, Kawasaki Disease and Giant Coronary Artery Aneurysms: The Role of Echocardiography from Diagnosis Through Follow-up. *Echocardiography* 2016;33:1245-50.

Adam Acler, MD

2. **Cardiac anesthesia conference. Wednesdays, 6:20-6:50am, HVI 7th floor Board Room.** Heather Hayunga, MD coordinates this conference.
3. **Journal conference: Terra Cafe, Thurs, Sept 19, 6:30pm** – Todd Unger, MD coordinator. Faculty attending get two hours credit for the next-day relief list.
4. **CA 0/1 Lectures: Tuesdays, 1:30-4pm, Anesthesia Conference Room**

Aug 27	Obstetric anesthesia- epidural/spinal	Chap 41*	R. Driver, MD
Sept 3	Managing inadequate epidurals	Chap 41*	M. Vallejo, MD

Typical newsletter
Page 1

Lead with schedules

7

Page 2

Start news items

8

Page 3

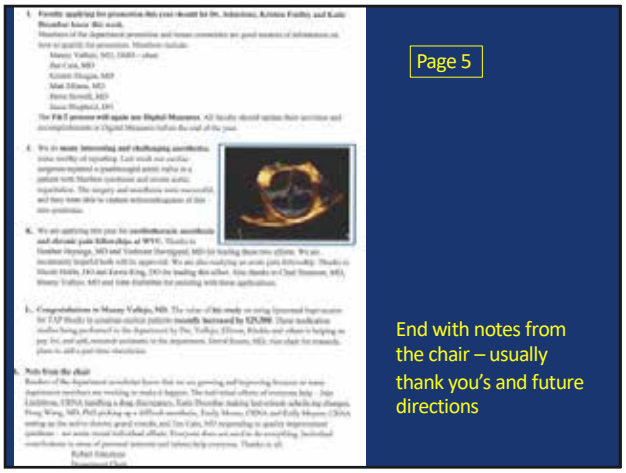
Alternate things people must do with items they have done successfully

9

Page 4

Picture on every page

10



Page 5

End with notes from the chair – usually thank you's and future directions

11

Overview of 6-page newsletter 9 23 2019

12

13

HANDOUT

Delegation & Cooperation: Section Heads, Vice Chairs, & Chairs of Other Departments

John F. Butterworth, IV, MD

11/08/2019
2:50pm - 3:15pm

Delegation & Cooperation: Section Heads, Vice Chairs, & Chairs of Other Departments

John F. Butterworth, IV, MD
Professor and Chairman
Department of Anesthesiology
VCU School of Medicine
PO Box 980695
Richmond, VA 23298-0695 USA
john.butterworth@vcuhealth.org

SAAA Nov 2019

1

I have no relevant conflicts to disclose

2

"You can't know too much, but you can say too much."
Calvin Coolidge

https://www.developgoodhabits.com/knowledge-quotes/ (accessed 9.9.2019)
https://www.archives.gov/research/census/presidents/coolidge.html (accessed 9.9.2019)

3

Objectives

- To discuss how best to interact with Vice Chairs, Section Directors and fellow Department Chairs
- To discuss effective delegation
  - Positive vignettes
  - Negative vignettes
- To discuss effective cooperation
  - Positive vignettes
  - Negative vignettes

4

Delegation & Cooperation: Section Heads, Vice Chairs & Chairs of Other Departments

- How do delegation and cooperation relate to the success of a department chair?
  - You are not that smart
  - Your time is not unlimited
  - You are going to need all the help and support that you can obtain
- No one likes to work with or for a micromanager

5

Benefits of Delegation

- Acknowledges the value & skills of your staff
- Allows subordinates to be creative
- Helps subordinates develop talents and new skills
- Provides important tests in anticipation of succession planning
- Improves communication & morale within and outside your department
- Builds teams, teamwork, engagement and leads to a collective sense of success
- Gives the Chair more time for "Chair Stuff"

6

Barriers to Delegation

- "If you want it done right do it yourself"
- "It takes less time to do it myself"
- "They may screw it up"
- Lack of understanding of differences between authority and responsibility
  - Authority: 25,000 employees of FaceBook develop, program & market the product
  - Responsibility: Zuckerberg said: "I started this place. I run it…I am responsible for what happens here."
- Delegation not a path to plausible deniability for your or your organizations failures

7

When Should A Task Be Delegated?

- Your delegate can represent you effectively
- Decisions will not require your assent at every turn (finances, personnel, space, etc)
- Important for the subordinate's development
  - Learning opportunity
  - Leadership opportunity
  - Opportunity to develop new relationships outside the department/school/health system

8

What Sorts of Tasks Can Be Delegated?

- Clinical director
  - Day to day OR staffing
  - Day to day running of the OR
- Vice Chair for Research
  - Distribution of departmental funding
  - Assignments for Research Resident
- Section Heads
  - Rules for "specialty call"
  - Interactions with related specialties
- Program Directors (issues too numerous…)

9

When Should A Task Not Be Delegated?

- You are the thought leader, expert, or the one with the most experience; your absence will impede the project (use this excuse sparingly)
- You will be dragged into the decision making regardless of your good intentions (use this excuse sparingly)
- Project profile is so high that your absence would lead to unwanted conversations with the dean/CEO

10

In What Sorts of Tasks Must the Chair Remain Involved?

- Disputes among direct reports that they cannot or will not resolve among themselves (but do not be a "helicopter parent")
- Legitimate concerns about fairness or competence of a direct report
- Issues that should be addressed by a direct report but in which they have a "higher ranking" challenger from another department

11

In What Sorts of Tasks Must the Chair Remain Involved?

- Clinical director
  - Monthly to yearly staffing decisions
  - Chain of command for running the OR
  - Some disputes involving other Departments
- Vice Chair for Research
  - Total amount of departmental funding
  - Number and funding of Research Residents

12

In What Sorts of Tasks Must the Chair Remain Involved?

- Section Heads
  - Rules for "specialty call"
  - Conflicts among sections
  - Head count in sections
- Program Directors
  - Reminding faculty and residents that the residency and fellowships ultimately are not governed by democratic rules
  - Helping PDs fend off external attacks on residency and fellowship programs
  - Budgets for residency program

13

Was The Delegation Appropriate?

- What are the results?
  - Did the project turn out well?
  - Did the project take an unexpected turn?
  - Did the project die in a hot mess?

14

Results Of A Project Can Be Perceived Differently

- What are the results?
  - Did the project turn out well?
  - Did the project take an unexpected turn?
  - Did the project die in a hot mess?

15

Was The Delegation Appropriate?

- What are the results?
  - Did the project turn out well?
  - Did the project take an unexpected turn?
  - Did the project die in a hot mess?
- Were you appropriately kept up to date?
  - Was the subordinate in your office every other day gossiping and seeking approval?
  - Were you blindsided with a barrage of questions from the Dean or another Department Chair?

16

JB's Delegation Misadventures #1

- Tried to recruit an investigator to fill an endowed professorship on my own
- No proper candidates responded to advertising
- After >year, formed search committee with strong group of "pals"
- Approached, interviewed several candidates
- Finally, search committee happened to be listening to a visiting professor
- Problem solved despite lack of delegation

17

JB's Delegation Misadventures #2

- I repeated Misadventure #1, with a worse outcome!

18

JB's Delegation Successes

- Selected a group of "coordinators" when the preceding Anesthesia Clinical Director retired from that position
- Gave responsibility for all ERAS activities to a world expert on ERAS (not a tough call)
- Gave responsibility for negotiating a successful contract for ICU coverage in a community site to two senior faculty (Pulm-CCM at VCU previously had failed)

19

Objectives

- To discuss how best to interact with Vice Chairs, Section Directors and fellow Department Chairs
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  - Positive vignettes
  - Negative vignettes
- To discuss effective cooperation
  - Positive vignettes
  - Negative vignettes

20

Benefits of Cooperation

- Acknowledges your mutual respect
- Improves communication & morale
- Builds teams, teamwork, engagement and leads to a collective sense of success
- Makes it easier to achieve goals important to multiple departments

21

Barriers to Cooperation

- "If you want it done right do it yourself"
- "It takes less time to do it myself"
- "They may screw it up"
- Lack of trust
  - Competition amongst departments
  - Silo mentality
  - Other chairs have widely differing agendas
- Chair selection criteria in Neurology, Psychiatry, Internal Medicine & Pediatrics is very different from that in Anesthesiology, ED, Radiology or Othopedic Surgery…

22

JB's Cooperation Adventures

- Worked with Chair of Radiology to put MR scanner in new Pediatric Ambulatory facility
- Health system facility "experts" say that there was "no need"
  - Pediatric general surgeons say "we like CT"
  - Experts: "MR will be installed in years to come"
- Facility "completed"
- 4 months after facility opens, hole blasted through exterior wall, rented crane, 20 mph wind, MR installed, exterior wall restored

23

JB's Cooperation Adventures

- Opioid management (PM&R, Neurosurgery) – success (but everything changed)
- OR Leadership Structure– spectacular success
  - (OR Medical Director, Consultant)
  - VP for Periop (OR Med Director)
- "Book Club" (Rad Onc, Path, Rad, Ortho, Psych, ED Vice) – ongoing (quiet) success
  - Constituency + interest group
  - Log rolling
  - Intel, "Black Ops"
  - Mental health

24

https://www.myinterestingfacts.com/wp-content/uploads/2015/10/Squid-Image.jpg (accessed 9.9.19)

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25

https://www.thespruceeats.com/kalamarakia-tiganita-small-fried-squid-1705223

VIRGINIA COMMONWEALTH UNIVERSITY SCHOOL OF MEDICINE

26

Objectives

- To discuss how best to interact with Vice Chairs, Section Directors and fellow Department Chairs
- To discuss effective delegation
  - Positive vignettes
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- To discuss effective cooperation
  - Positive vignettes
  - Negative vignettes

VIRGINIA COMMONWEALTH UNIVERSITY SCHOOL OF MEDICINE

27

Summary

- Appropriate delegation of tasks and authority is a good thing
  - Faculty development
  - Succession planning
  - Time management
- Cooperation with other chairs
  - Mental health
  - Getting things done
  - Protection

VIRGINIA COMMONWEALTH UNIVERSITY SCHOOL OF MEDICINE

28

Useful References

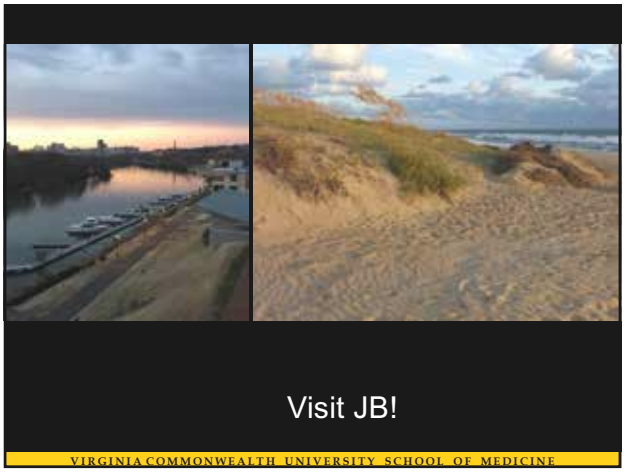
- Lin Grensing-Pophal. HR Daily Advisor. "**Delegation—How to Identify Tasks"** https://hrdailyadvisor.blr.com/2018/07/03/delegation-identify-tasks/ (accessed 2 Oct 2019)
- Lin Grensing-Pophal. HR Daily Advisor." **Delegation—Review and Adjust as Needed" https://hrdailyadvisor.blr.com/2018/07/06/delegation-review-adjust-needed/**

VIRGINIA COMMONWEALTH UNIVERSITY SCHOOL OF MEDICINE

29

Visit Richmond Virginia!

30


Visit JB!
VIRGINIA COMMONWEALTH UNIVERSITY SCHOOL OF MEDICINE

31

HANDOUT

Tips on Recruitment

Jill M. Mhyre, MD

11/08/2019
3:50pm - 4:10pm

Tips on Recruitment

Jill M Mhyre, MD
The Dola S Thompson Professor & Chair

UAMS

1

Objectives

- Define your vision for the department & institution
- Build an employee value proposition & strategy to sell it
- Identify individual needs that will make or break recruitment
- Tailor the recruitment experience to maximize a match

UAMS

2

Define your vision for the department & institution

- Vision: By 2029, UAMS will lead Arkansas to be the healthiest state in the region through synergies in education, clinical care, research and purposeful leadership

UAMS 2029 VISION

- The UAMS Department of Anesthesiology is poised to partner across the clinical and academic enterprise to help lead a transformation in health for the state

UAMS

3

The Employee Value Proposition

What your team members get

1. Location
2. Money
3. Time

https://www.brinknews.com/curating-compelling-employee-value-proposition/

UAMS

4

Three Primary Variables Drive Recruitment

1. Location
   - Family & Friends
   - Weather, activities, airport
2. Money
3. Time

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5

Time

1. Total hours
2. Autonomy
3. Time Off
4. Predictability
5. Flexibility

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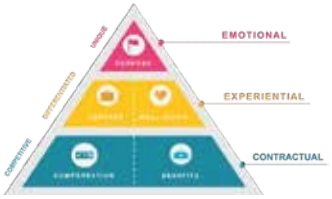
6

Intrinsic Motivation

- Autonomy
- Purpose
- Competence
- Relatedness



https://www.brinknews.com/curating-compelling-employee-value-proposition/

UAMS

7

Promote Employee Referrals

"Turn every employee into a recruiter"

- Best recruitment strategies are word of mouth
  - Faculty recruit through professional networks, social connections with private practices, social media
  - CRNAs recruit through social networks, social media
  - Budget to send department members to academic meetings
  - Surgeons recruit through professional networks

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8

Prioritize the Candidate Experience

Well designed recruitment experience shows that your organization cares about its people

Advertising → Initial Contact → Phone Interview → Visit Planning → Visit → Follow-up

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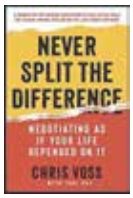
9

Listen

- What motivates the candidate?
- Who do we need to convince?
- What key variables will drive the decision?
- What is the bottom line? Is one defined?
- What are they NOT asking?



- Ask Directly:
  - "Is there anyone we could introduce you to, or anything in our community that would help you and your family to feel at home here?"

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10

Edmund Tori, DO

Master of Influence & Persuasion

MedStar Institute for Innovation

1. Manage your state
2. Assume the best
3. Make them comfortable
4. Remove objections early
5. Move people with what already moves them
6. Remark about the remarkables
7. Make it easy

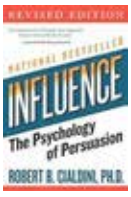
UAMS

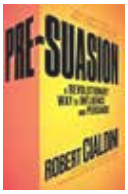
11

6 Universal Principles of Influence

Robert Cialdini

1. Reciprocity
2. Commitment/consistency
3. Social proof
4. Authority
5. Liking
6. Scarcity





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12

The Visit

- Showcase the community
  - Recruit the family, real estate tours, school tours
- Make them comfortable
  - Transportation, Lodging, Restaurant
- Highlight the professional opportunity match
  - Individual interviews to learn about the institution
  - Panel interview just before lunch

Follow up

- Timely communication with the candidate
- Negotiating for resources
  - Academic recruits
- Stay in touch with candidates who do not come
  - Academic network
  - Community network
  - Alumni network

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13

Attract & Cultivate Talent – Play the Long Game

- Focus on Education
  - Fellowships
  - Residency
  - Medical School
  - COM Recruitment & Selection
  - CON CRNA School

UAMS

14

HANDOUT

Retaining the Best (Faculty)

Michael H. Wall, MD, FCCM

11/08/2019
4:10pm - 4:30pm

Retaining the Best Faculty

Michael H Wall, MD, FCCM
JJ Buckley Professor and Chair
Department of Anesthesiology
University of Minnesota

1

Conflict of Interest

- None

2

Outline

- Mentorship vs sponsorship
- Find a passion
- Faculty Development
  - Time management
  - Leadership development
  - Coaching
  - Education

3

Mentorship vs Sponsorship

Mentorship
- Can be any level
- Support, feedback and advice
- Navigate politics
- Increase competence and self-worth
- Focus on personal and professional development

Sponsorship
- Senior with influence
- Exposure to senior leaders
- Assigned projects
- Protect from negative publicity
- Fight to get folks promoted

Leagueofwomeningovernment.org

4

Mentorship vs Sponsorship

- Mentors talk with you, sponsors talk about you
- Mentors give you perspective, sponsors give you opportunities
- Mentors advise, sponsors ACT

- Faculty need both!

5

Mentorship

- Traditional 1 to 1 mentorship
  - Assign 1 to 2 mentors per person
  - Meet monthly or quarterly
  - Need a system to monitor
  - Often logistically hard to do
- Group mentoring

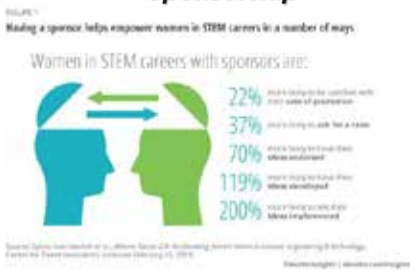
6

Mentorship

- Group mentoring
  - Been used in many organizations
  - Can be effective
  - Is more efficient
  - Usually assigned based on teams or interest
  - Can learn from mentors and mentees/peers

7

Sponsorship



8

Sponsorship- How to get one??

- Develop mentoring relationship(s)
- Have mentor(s) make introductions to more senior "sponsors"
- Lets the sponsor see you in action
- Ask for one!

Hess, Medical College of Georgia

9

Outline

- Mentorship vs sponsorship
- ***Find a passion***
- Faculty Development
  - Time management
  - Leadership development
  - Coaching
  - Education

10

Passion

- There is no passion to be found playing small - in settling for a life that is less than the one you are capable of living.
  - Nelson Mandela
- Enjoy the journey and try to get better every day. And don't lose the passion and the love for what you do.
  - Nadia Comaneci

11

Passion

- My personal opinion:
- *The key role of the mentor is to help folks find what they are really passionate about….*
- In alignment with goals of
  - University (i.e. President)
  - Medical School (i.e. Dean)
  - Department (Chair)

12

Passion

- Be specific and focus!
- Research
  - Basic, clinical, translational, education, outcomes, etc.
- Education
  - Simulation, UME, GME, etc.
- Administration
  - Department, Hospital, System, etc.

13

Passion

- Once you figure that out….
- Find sponsors ***and***
- Develop a strategic ***individual*** faculty development plan

14

Outline

- Mentorship vs sponsorship
- Find a passion
- Faculty Development
  - Time management
  - Leadership development
  - Coaching
  - Education

15

Faculty Development

- Faculty Development
  - Time management
  - Leadership development
  - Coaching
  - Education

16

National Center for Faculty Development and Diversity

- Free!
  - Many/most Universities are already members
- Weekly motivational email (the Monday Motivator)
- Access to the full NCFDD Core Curriculum
- Guest expert webinars
- Intensive multi-week courses facilitated by national experts
- Private discussion forum
- Monthly writing challenges
- Opportunity to connect with a writing accountability partner.

https://www.facultydiversity.org/

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NCFDD "Core Curriculum"

- Skill #1: Every Semester Needs a Plan
- Skill #2: Align Your Time with Your Priorities
- Skill #3: How to Develop a Daily Writing Practice
- Skill #4: Mastering Academic Time Management
- Skill #5: Moving from Resistance to Writing
- Skill #6: The Art of Saying "No"
- Skill #7: Cultivating Your Network of Mentors & Sponsors
- Skill #8: Overcoming Academic Perfectionism
- Skill #9: Engaging in Healthy Conflict
- Skill #10: Strategies for Dealing with Stress & Rejection

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18

Time Management

- NCFDD Faculty Success Program
  - *"learning the secrets to increasing your research productivity, getting control of your time, and living a full and healthy life"*
  - 94% improved writing productivity
  - 87% better work life balance (harmony)
  - 98% overall satisfaction
  - $4,400 per person

https://www.facultydiversity.org/

19

Leadership Development

- ASA Practice Management Conference
  - Discuss common challenges and solutions
  - Forefront of anesthesia practice management
  - Managed care, compliance, third-party payers, regulators and declining reimbursements
  - Current trends and obtain necessary tools to conduct a careful and comprehensive assessment of practice operations and financial management are essential to success
- $635

20

Leadership Development

- ASA Executive Physicians Leadership Program I
  - Northwestern Kellogg School of Management
    - Economic/political issues facing the American healthcare
    - Fundamental financial
    - Negotiation and craft and execute a plan for optimal solutions
    - Influence skills in a leadership context
    - Conflict resolution skills
    - Identify and articulate their own leadership values
    - Articulate their own organization's strategy and the impact of strategy choices on change management
  - $6500

21

Leadership Development

- ASA Executive Physicians Leadership Program II: Transformational skills development
  - Northwestern Kellogg School of Management
    - Values-based leadership
    - Health care economics and policy
    - Design thinking
    - Communicating change in organizations
    - Advanced negotiations and conflict resolution
  - $6800

22

Leadership Development

- LOTs of possibilities and programs
- Pick one
  - So team learns similar concepts, language and culture
- Use different ones
  - So teams learn variety of concepts etc.

23

Coaching

- An **executive coach** is a qualified professional
- Help with:
  - Gain self-awareness
  - Clarify goals
  - Achieve their development objectives
  - Unlock their potential
  - Act as a sounding board
- Great for new leaders

24

Coaching

- **Here are seven ways executive coaching benefits you as a leader:**
  - Heightened self-awareness.
  - Improved self-regulation.
  - Higher levels of empathy.
  - Boost in cognition at work.
  - Increased levels of motivation.
  - Better social skills.
  - Improved leadership abilities.

25

Coaching

- Most coaching relationships last 6-12 months
  - 360 evaluation
  - Standardized psychologic/leadership evaluations
  - Feedback
  - Homework
- $300-500/hour
  - Usually upfront costs, then one session a month or so

26

Passion & Education

Passion	Education
Administration	MHA
Administration/Business	MBA
Research	MPH
Research	Masters in Clinical Research
Education	Masters in Medical Education
??	etc.

27

How to Retain the Best—Invest!

- Mentorship program
  - One-on-one and group
- Find a passion!
- Sponsorship
- NCFDD-Core Curriculum
- Time management
- Leadership training
- Coaching
- Education

28

How to Retain the Best—Invest!

- ***"All growth depends upon activity. There is no development physically or intellectually without effort, and effort means work."***

  —Calvin Coolidge

29

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mhwall@umn.edu

30

HANDOUT

Tenured, but Tired?

Vesna Jevtovic-Todorovic, MD, PhD, MBA

11/08/2019
4:30pm - 4:50pm

Tenured, but Tired?

Vesna Jevtovic-Todorovic, MD, PhD, MBA
CU Medicine Endowed Professor of Anesthesiology and Pharmacology
Chair, Department of Anesthesiology
University of Colorado School of Medicine

University of Colorado Medicine

1

I have disclosed that I do not have a financial relationship or interest with any proprietary entity producing healthcare goods or services in conjunction with this conference.

Medicine

2

Academic Tenure

- ***Tenure*** is an indefinite academic appointment that can be terminated only for cause or under extraordinary circumstances (e.g. program discontinuation).
- ***Tenure*** is a means of defending the principle of academic freedom which holds that it is beneficial for society in the long run if scholars are free to hold and examine a variety of views.
- ***The recruitment and retention***
  (The American Association of University Professors, 1940)

Medicine

3

Pro Arguments

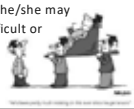
- The job security granted by tenure is necessary to recruit and retain talented individuals into professorships because in many fields private industry jobs pay significantly more.
- Tenure also protects teachers from being fired for personal, political or other non-work related reasons.
- Tenure prohibits school districts from firing experienced teachers to hire less experienced, less expensive teachers.
- Tenure protects teachers from being fired for teaching unpopular, controversial or otherwise challenged curricula.

Medicine

4

Con Arguments

- Tenure is not the only way to protect academic freedom – We have policies in place to protect the faculty.
- Modern tenure systems diminish academic freedom, forcing those seeking tenured positions to profess conformance.
- Economist Steven Levitt, 2007, who recommends the elimination of tenure in order to incentivize higher performance among tenured professors also points out that a pay increase may be required to compensate faculty members for the lost job security.
- Some U.S. states have considered legislations to remove tenure at public universities (Flaherty, 2017) – Missouri (for new hires from 2018); Iowa – (to eliminate all tenure even for ones who already have it); Wisconsin?
- Does it reward non-producing faculty? Once a professor is awarded tenure, he/she may begin putting reduced effort into their job, knowing that their removal is difficult or expensive to the institution (Flaherty, 2014).



Medicine

5

Productivity & Salary in Academia

Data from National Study of Postsecondary Faculty (n=17,635)

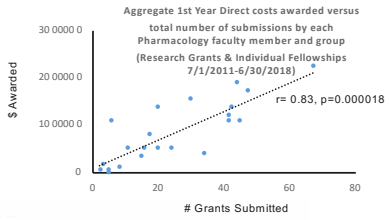
Kaskie, Gerontologist, 2017, Vol. 57, No. 5, 816-823.

An increasing need to raise student tuitions, endowments or request federal and state subsidies to offset rising salary and benefit payouts (Ginsberg, 2011). Filling the gap with the earnings of more productive faculty.

Medicine

6

Performance is Variable and Related to How Hard You Try…



Courtesy of Dr. Thorburn, Professor and Chair, Department of Pharmacology, UC Denver

Medicine

7

Institutional Approaches in the USA

- **Separation of Promotion from Tenure** - Reduction in new faculty being offered tenure-track positions (over the last two decades more than 70% faculty are in non-tenured positions - *Kezar, A. Changing faculty workforce models. New York: TIAA-CREF Institute, 2014*);
- The establishment of guaranteed base salaries for tenured faculty that are less than full amount;
- Tight control over the number of 'tenured lines' allocated to each Department by the University while providing protection/opportunity/feasibility for non-tenured faculty;
- Rapid expansion of adjunct positions (*Kezar, A. Changing faculty workforce models. New York: TIAA-CREF Institute, 2014);*
- How this shift in the faculty model impacts institutional missions to educate, create knowledge and serve has been of concern (Baldwin & Wawrzynski, 2011; Duranleau & McLaughlin, 2014).

Medicine

8

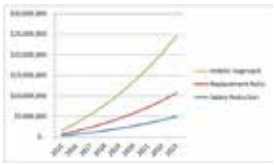
University of Colorado, SOM

Courtesy of Cheryl Welch and Dr. S. Lowenstein, Associate Dean of Faculty Affairs

Medicine

9

Possible Approaches to Fiscal Responsibility



Kaskie, Gerontologist, 2017, Vol. 57, No. 5, 816-823.

1) Making more explicit linkages between pay policies to permit salary reduction to the base and faculty productivity (e.g., obtaining research awards, expectations for maintaining clinical productivity and/or for maintaining strong teaching portfolio);
2) Engaging faculty and staff in comprehensive counseling regarding the next stage in their career;
3) Engaging faculty into a health and wellness programs (maintenance of high level of performance).

Medicine

10

Johns Hopkins Medicine – School of Medicine Task Force Summary Report to Dean Paul Rothman, MD

- Report as of November 2015
- Dr. Rothman convened the Task Force to address Tenured Faculty Support and Transition in the SOM;
- As the ranks of faculty past the age of 65 grow, there is increasing recognition at many universities that it is critically important to develop clear institutional strategies to assist faculty members in their transition;
- Specifically, Dean Rothman asked the Task Force to assess resources and programs available to assist and support tenured faculty during their transition.

Medicine

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Johns Hopkins Data

- Analysis of 2014 data from Johns Hopkins examining tenured late career faculty productivity finds a marked decrease in both clinical and research revenue compared to early and mid career faculty;
- The gap of 12 million dollars was reported between expenses for late career faculty salary and the revenue they generate;
- Based on current trends in retirement rates and the growing number of tenured late career faculty, the SOM cost to cover this revenue/expense gap was projected to grow to 18 million by 2018.

Medicine

12

National Strategies in the USA

- Annual review for tenured Professors which concentrates on rigorous post-tenure review (Wood, M. & Johnsrud, L. The Review of Higher Education, 28, 393–420, 2005) and long-term career planning with the Department Chair;
- Mentoring and career development programs, policies and resources that support the needs of faculty in the later stage of their careers;
- Well-publicized and attractive pathways for phased retirement that allow tenured faculty to reduce effort over 2-5 years while still retaining full benefits (at U. Penn called 'reduction in duties in anticipation of retirement');

Medicine

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National Strategies in the USA (Cont'd)

- A retirement incentive program available to tenured faculty who are not able to keep up with the required level of academic and/ or clinical productivity who elect to retire (Pencavel, 2004). However, since less then one out of eight eligible faculty would consider early retirement, it is not clear whether this approach would have any long term benefits (Kaskie et al., 2012).
- A post-retirement physical academic home ('post-retirement academy') at the level of the SOM and funded by the SOM. This approach requires substantial resources at the University level most commonly not available at Departmental level.

Medicine

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Conclusions

- The topic of tenure remains critical in academic institutions in the USA and the state legislators are repeatedly putting it on political agenda;
- The best approach will remain complex and multi-prong;
- The financial implications will remain important in our decision-making as the challenges of the rising costs of higher education continue to mount.
- Education of the chairs as to the resources available to the faculty and potential avenues for new duties/responsibilities.
- Follow the rules that apply to everyone.

Medicine

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HANDOUT

AACPD

ABA Update

David O. Warner, MD

ITE and Assessment Update

Robert Gaiser, MD

11/08/2019
8:00am - 8:20am

The American Board of Anesthesiology

2019 ABA UPDATE

Society of Academic Anesthesiology Associations

DAVID O. WARNER, M.D.
Secretary, ABA Board of Directors
Mayo Clinic
Rochester, MN

ROBERT R. GAISER, M.D.
Chair, Assessments Committee
University of Kentucky
Lexington, KY

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Brigham and Women's Hospital

Mark Keegan, M.B., B.Ch.
Mayo Clinic

2

PROGRAM DIRECTOR MEETINGS

3

NEW ABSENCE FROM TRAINING POLICY

Effective July 1, 2019

4

WHAT CHANGED?

OLD POLICY	NEW 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 policy will require lengthening total training time

ABSENCE FROM TRAINING POLICY UPDATES

- We've received 26 requests since the policy became effective on July 1 – most have been for family leave, but several have been for residents' medical leave
- We recognize the challenges the policy may pose; however, we believe it is in the best interest of our trainees and the patients they serve
- We welcome your feedback and will continue to monitor the impact of the policy on programs

6

RESEARCH INITIATIVES

Adding the BASIC Exam increased knowledge at the end of residency as measured by written post-graduation exams

Details on how we administer and score the oral exam

Participation in MOCA, including MOCA Minute, is associated with fewer license actions taken by state medical licensing boards against physicians

Noted prevalence of burnout, distress, and depression among anesthesiology residents over past seven years

Perceived institutional support and work-life balance impact well-being

FUTURE OSCE VALIDATION RESEARCH

- OSCE description manuscript
- OSCE first-year results
- Analysis of OSCE and SOE measurement constructs
- Impact of OSCE on training programs

8

ADDITIONAL CERTIFICATION PATHWAY

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

CONTENT OUTLINE UPDATES

- **Initial Certification Examinations Content Outline**
  - In 2021, the content outline will change to reduce duplication in regional anesthesia topics and to clarify descriptors for the In-Training Exam - Anesthesiology and the ADVANCED Exam
- **Objective Structured Clinical Exam Content Outline (APPLIED Exam)**
  - In 2020, the Interpretation of Monitors and Interpretation of Echocardiograms skills will be combined so all candidates will be tested in both areas

11

ASSESSMENT UPDATE: THREE RESPONSE OPTIONS

- In 2020, we're transitioning some of our MOCA Minute multiple-choice questions from four- to three-response options
  - Diplomates will receive MOCA Minute questions with both three- and four-response options
- Also in 2020, we'll pilot three-option questions with other assessments:
  - Pediatric Anesthesiology Exam, Critical Care Medicine Exam and In-Training Exams for Pediatrics and Critical Care Medicine
- We will consider transitioning other assessments to three-option questions based on the pilot results

12

FEES CHANGING FOR FIRST TIME SINCE 2012

Assessment	Increase	2020 Fee
ITE-Anesthesiology	$75	$175
ITE-Subspecialties	$75	$175
BASIC	$100	$875
ADVANCED/Part 1	$100	$875
APPLIED/Part 2	$300	$2,400
Subspecialties	$200	$1,800
MOCA	No Change	$210; $100 (1st certificate; each additional one)

2020 IN-TRAINING EXAMINATION DATES

Anesthesiology: Feb. 6-10

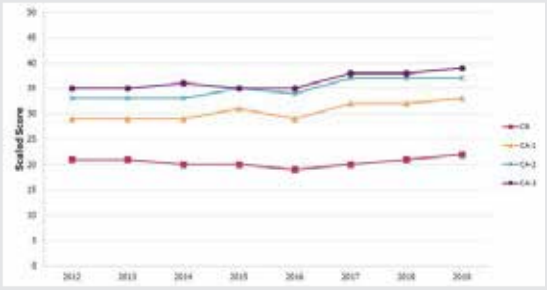
Pediatric Anesthesiology: Feb. 20-22

Pain Medicine: March 19-21

Critical Care Medicine: April 16-18

IN-TRAINING EXAM PERFORMANCE

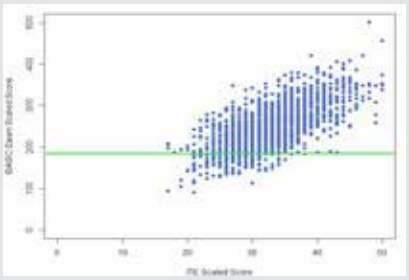
BY TRAINING LEVEL & EXAM YEAR



15

RELATION OF SCORES

2019 ITE TO 2019 JUNE BASIC EXAMINATION



The correlation between the 2019 ITE scaled scores and 2019 June BASIC Exam scaled Scores is 0.684, $p < 0.001$

16

RELATION OF SCORES

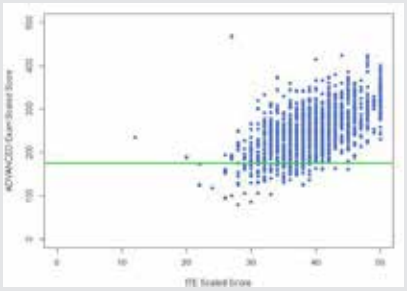
2019 ITE TO 2019 JUNE BASIC EXAM

Scaled Score	Percentile Rank in CA1	N	2019 June BASIC Scaled Score Mean (S.D.)	BASIC Pass Rate
≤25	≤7	145	194 (41)	54%
26-30	10-31	475	219 (37)	82%
31-35	38-64	625	247 (38)	95%
36-40	72-89	392	280 (38)	99%
41-45	91-98	145	313 (43)	100%
≥46	≥98	35	343 (46)	100%

17

RELATION OF SCORES

2019 ITE TO 2019 JULY ADVANCED EXAMINATION



The correlation between the 2019 ITE scaled scores and 2019 July ADVANCED Exam scaled Scores is 0.571, $p < 0.001$.

18

RELATION OF SCORES

2019 ITE TO 2019 JULY ADVANCED EXAM

Scaled Score	Percentile Rank in CA3	N	2019 July ADVANCED Scaled Score Mean (S.D.)	ADVANCED Pass Rate
≤25	≤1	5	168 (48)	40%
26-30	1-4	58	182 (55)	57%
31-35	6-22	302	219 (42)	87%
36-40	30-58	569	240 (43)	94%
41-45	65-87	431	264 (42)	99%
≥46	≥90	182	304 (46)	100%

19

2019 JUNE BASIC EXAM RESULTS

- Candidates were assigned to examine on Friday or Saturday
- Key validation eliminated thirteen items from two forms
- 89.7% of residents passed

N	Mean Scaled Score	Standard Deviation	Pass Rate	Reliability
1,825	249.4	51.6	89.7%	0.85

20

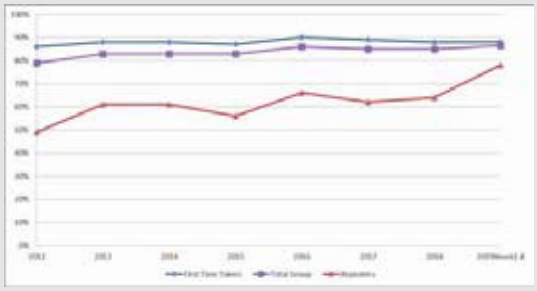
2019 JULY ADVANCED EXAM RESULTS

- Candidates were assigned to examine on Friday or Saturday
- Key validation eliminated six items from two forms
- 92.1% of candidates passed

N	Mean Scaled Score	Standard Deviation	Pass Rate	Reliability
1,643	246.9	53.4	92.1%	0.78

21

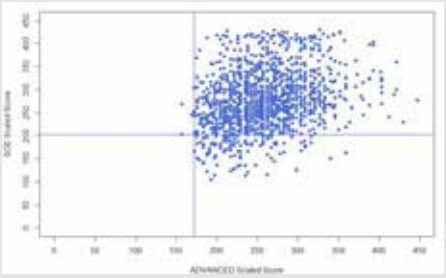
SOE/PART 2 EXAM SUCCESS RATES



22

RELATION OF SCORES

2019 SOE TO FIRST ATTEMPT ON 2018 JULY ADVANCED EXAM



The correlation between the 2019 SOE scaled scores and first attempt on 2018 JULY ADVANCED Exam scaled scores is 0.284, $p < 0.001$

23

2019 OSCE RESULTS: WEEKS 1-8

N	Mean Scaled Score	Standard Deviation	Pass Rate
1,582	253.4	38.8	94.6%

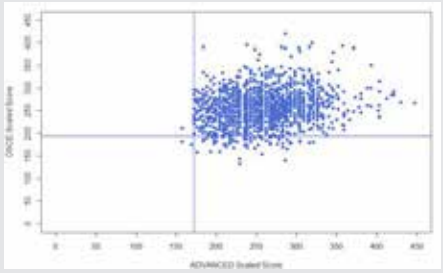
1,567 candidates took both SOE and OSCE

	OSCE: Fail	OSCE: Pass	Total
SOE: Fail	34 (2.2%)	142 (9.1%)	176 (11.2%)
SOE: Pass	58 (3.7%)	1,333 (85.1%)	1,391 (88.8%)
Total	92 (5.9%)	1,475 (94.1%)	1,567 (100%)

24

RELATION OF SCORES

2019 OSCE TO FIRST ATTEMPT ON 2018 JULY ADVANCED EXAM

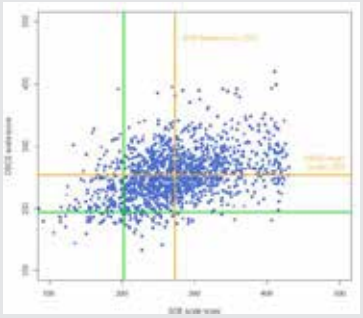


The correlation between the 2019 OSCE scaled scores and first attempt on 2018 JULY ADVANCED Exam scaled scores is 0.190, $p < 0.001$

25

RELATIONSHIP BETWEEN OSCE AND SOE SCORES

The correlation between the 2019 OSCE scaled scores and 2019 SOE scaled scores is 0.409, $p < 0.001$



ABA The American Board of Anesthesiology

QUESTIONS?

COMMUNICATIONS CENTER
Phone: (866) 999-7501
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MAIL CORRESPONDENCE
ABA Secretary
4208 Six Forks Rd, Suite 1500
Raleigh, NC 27609-5765

FOLLOW US

HANDOUT

AACPD

How I Implement the ABA Leave Policy

Mark A. Hagemeier, JD

11/08/2019
8:45am - 9:30am

How I Implement the ABA Leave Policy

Moderator: Charles A. Napolitano, MD, PhD

Mark A. Hagemeier, JD
David Stahl, MD
Kristina R. Sullivan, MD

8:45-9:30 AM

1

How I Implement the ABA Leave Policy

Overall Panel Objectives/ At the end of this presentation the audience will be able to:

- Discuss the implications of the ABA Leave Policy
- Acknowledge and employ various processes for its implementation within your program
- State the intent of FMLA and its application to the ABA Leave Policy
- Recognize the legal ramifications in rendering ABA Leave Policy decisions

2

Revised Policy 3.03

Without prior approval from the ABA, a resident may be absent from training up to a total of 60 working days (12 weeks) during the CA 1-3 years of training.

Attendance at scientific meetings, not to exceed five working days per year, shall be considered part of the training program and not count toward the absence calculation.

Residents should also comply with the policy of the institution and department in which that portion of the training is served for the duration of any absence during the clinical base year.

3

Revised Policy

The ABA will consider requests for up to 40 additional days (8 weeks) away from training (over and above the 60 working days). Such additional leave of absence time must be approved by the ABA as follows:

Any request for such leave must be received by the ABA within four weeks of the resident's resumption of the residency program.

The request shall be in writing from the program director, countersigned by the department chair (if that person is different than the program director), and the resident.

The request must include: (1) the reason for the absence training request (as an example, serious medical illness, parental or family leave that are covered under the Family and Medical Leave Act would be reasons acceptable to the ABA) and (2) documentation about how all clinical experiences and educational objectives will be met.

4

Revised Policy

Absences in excess of those described above will require lengthening of the total training time to compensate for the additional absences from training. The additional training days required will be equal to the total number of working days missed beyond (1) the 60 working days (without need for ABA approval); and (2) the additional 40 working days (approved by the ABA).

Residents who have their residency extended may sit for the Summer ADVANCED examination if they complete all requirements by Sept. 30 of the same year. They may sit for the Winter ADVANCED examination if they complete all requirements by March 30 of the same year.

A lengthy interruption in training may have a deleterious effect upon the resident's knowledge or clinical competence. Therefore, when there is an absence for a period more than six months, the ABA Credentials Committee shall determine the number of months of training the resident must complete subsequent to resumption of the residency program to satisfy the training required for admission to the ABA examination system.

5

Policy Guidelines

Qualifying Circumstances for Extended Leave (up to 40 additional day/eight weeks)

This policy is designed to align with circumstances covered by the Family and Medical Leave Act (FMLA), which allows for reasonable unpaid leave for certain family and medical reasons. These reasons may include:

- The birth and care of a newborn, adopted or foster child
- The care of an immediate family member (child, spouse or parent) with a serious health condition
- The resident's own serious health condition

6

Policy Guidelines

Health Conditions Deemed "Serious"
A serious illness is defined as an illness, injury, ailment, impairment or physical/mental condition that involves an overnight hospital or hospice stay or ongoing medical treatment by a healthcare provider. Ongoing or continuous treatment by a medical provider generally includes:

- An incapacitated state lasting longer than three consecutive days and/or subsequent treatment that involves a regime of continuing treatment beyond drinking fluids, bedrest, exercise or taking over-the-counter medicines.
- Any period of incapacity due to pregnancy or prenatal care
- Any period of incapacity that is permanent or long-term
- Any period of incapacity for treatment of chronic conditions, such as asthma, diabetes, epilepsy, etc.
- Any absence or period of incapacity resulting from multiple treatments, such as chemotherapy, radiation, dialysis or physical therapy

These conditions should keep the resident or an immediate family member from performing his/her job, attending school or doing other routine activities that would allow the resident to perform at his/her normal capacity.

7

Policy Guidelines

Conditions or Circumstances Not Covered by This Policy
Our Absence from Training Policy should not be applied to routine medical exams or checkups (e.g., physicals or dental exams), common colds, flu, earaches, stomach aches or other routine doctor visits or ailments. This leave may also not be used for jury duty, non-medical-related appointments, vacations or other routine life occurrences.

Conditions not considered serious for purposes of this policy include:

- The common cold, flu, earaches and other ailments mentioned above, unless complications arise
- Routine medical exams
- Conditions requiring over-the-counter medication, bedrest, drinking fluids, exercise and similar activities that can be applied without a visit to a healthcare provider
- Cosmetic treatments unless they require inpatient hospital care or complications arise

8

Policy Guidelines

Qualifying for Additional Time

- A letter of request from the residency program director must come within four weeks of the resident's resumption of training.
- Request letters must be in writing from the program director, and countersigned by the resident and department chair.
- Requests must include the reason for the leave, which should align with the reasons outlined in the guidelines with documentation about how clinical experience and educational objectives will be met.
- Requests must be approved/supported by the program prior to submission to the ABA. Programs have the discretion to decline resident requests.
- If the resident does not qualify for the additional absence from training that was previously taken, his/her residency training may be extended to compensate for the additional absence, per the policy.

9

Policy FAQs

What criteria should be used to determine which residents should get additional leave?
Programs should only approve additional leave time in cases of serious illness or the birth, adoption or fostering of a child, as described in the policy guidelines. The additional leave must be approved by both the program and the ABA.

What rationale should be used to deny the additional leave?
The ABA believes this policy serves the best interests of our residents, and in the long-term our patients and profession. However, programs have the discretion to decline resident requests. Please refer to the **guidelines** for additional assistance.

How should two residents requesting additional leave at the same time be handled? How does a program manage any perceived inequity?
Programs should use their discretion when reviewing leave requests. The ABA will not consider requests that are not previously approved by training programs. Programs can refer to the policy **guidelines** to confirm that the requests align with the qualifying conditions. Programs have the discretion to decline leave requests.

10

Policy FAQs

Does a resident have to use 60 working days of leave before being considered for approval for the additional 40 days?
No. The additional 40 days of leave is to be used for conditions covered by FMLA; not vacation, routine appointments or other absences unrelated to a serious health condition. The other 60 working days of leave may be apportioned according to individual program policies.

Can the additional 40 days of leave be approved before it is taken?
No. Requests for the additional leave must be made upon a resident's return to training (after the leave has been taken).

Can the request for approval of leave taken in the CA-1 or CA-2 years wait until the CA-3 year?
No. Requests for approval for the additional leave must be made within four weeks of resumption of training, regardless of when the leave is taken. If a resident's leave request is granted early on in training and then he or she is not meeting training standards near the end of training, the program has the discretion to extend training independent of the leave policy.

11

Policy FAQs

How do programs ensure that residents with eight weeks less training than their peers are prepared to practice independently?
We rely on the program directors to attest to residents' ability to practice independently. If a resident is not prepared to work independently, which is sometimes the case with or without missing any training, we would expect their training reports to reflect this and that the program would mandate additional training.

If a resident is managing a chronic illness or has a family member managing one, can he or she use the 40 additional days sporadically rather than in a single block of time?
Yes. Residents may use the additional 40 days over time rather than all at once, pending approval from the training program.

What if a resident requests the additional time off, but chooses to voluntarily extend his/her training?
If a resident felt he or she could benefit from making up the missed training, we would not discourage that. However, it would not be required. It is up to the program to determine if the resident has the clinical experience and expertise necessary to practice independently at the end of the training program and whether he/she could benefit from additional training.

12

Policy FAQs

Can the 40 days of additional leave be taken in the CB year of a four-year program?
No. This policy applies only to residents in their CA 1-3 years.

What happens if a program chooses not to comply with this policy?
The policy is meant to serve the best interest of residents and the patients they serve. Training programs may use their discretion when implementing this policy. There is no requirement that a program must implement this policy.

13

FMLA: Introduction

The Family and Medical Leave Act (FMLA) was passed in 1993 and revised January 16, 2009, and March 8, 2013, with some provisions retroactive to February 5, 2012.

Of all federal employment laws, the FMLA is one of the most popular and beneficial to employees. Most employees are aware of the basic requirements of the law, but they may not realize the law provides employers with various options on how to administer FMLA leave.

14

FMLA: Employers Covered

A covered employer is one of the following:

- Private-sector employer with 50 or more employees in 20 or more workweeks in the current or preceding calendar year, including a joint employer or successor in interest to a covered employer.
- Public agency, including a local, state or federal government agency, regardless of the number of workers it employs.
- Public or private elementary or secondary school, regardless of the number of workers it employs.

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FMLA: Employees Eligible for Leave

An eligible employee meets the following criteria:

- Works for a *covered* employer.
- Has worked for the employer for at least 12 months.
- Has at least *1,250 hours* of service for the employer during the 12-month period immediately preceding the leave.
- Works at a location where the employer has at least *50* employees within 75 miles.

16

FMLA: Basic Provisions

Qualifying reasons for FMLA leave:

1. For the birth of a child and to care for the newborn child.
2. For placement with the employee of a child for adoption or foster care.
3. To care for the employee's spouse, child or parent with a serious health condition.
4. Because of a serious health condition that makes the employee unable to perform the functions of the employee's job.
5. Because of any qualifying exigency arising out of the fact that the employee's spouse, child or parent is a military member on covered active duty (or has been notified of an impending call or order to covered active duty status).
6. To care for a covered service member with a serious injury or illness if the employee is the spouse, child, parent or next of kin of the covered service member.

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FMLA 12-month period:
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- A rolling 12-month period measured backward from the date an employee uses any FMLA leave.

18

FMLA: Basic Provisions

FMLA does *not* require paid leave.

The law allows employers to require employees to use any paid leave that they may have as part of their FMLA leave.

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FMLA: Basic Provisions

FMLA allows employers to require employees to submit certification of the need for FMLA leave.
Certification may be required for:

- An employee's serious health condition.
- A family member's serious health condition.
- The qualifying exigency for military family leave.
- The serious injury or illness of a covered service member for military family leave.

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The Americans with Disabilities Act (ADA) of 1990 was the first comprehensive civil rights law in this country that addressed the needs of people with disabilities. The law was amended by the ADA Amendments Act (ADAAA) of 2008. It applies to employers with 15 or more employees.

The ADA as amended prohibits discrimination in employment, public services and accommodations, and telecommunications. It also requires employers to make a reasonable accommodation to an applicant or employee if needed to perform the essential functions of a job.

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ADA: Covered Individuals

Employment discrimination is prohibited against qualified individuals with disabilities. Covered individuals include applicants for employment and employees.

Persons discriminated against because they have a known association or relationship with an individual with a disability also are protected.

A qualified individual with a disability is 1) an individual with a disability who satisfies the requisite skill, experience, education and other job-related requirements of the employment position such individual holds or desires, and 2) an individual who, with or without reasonable accommodation, can perform the essential functions of such position.

22

ADA: Covered Individuals

An individual is considered to have a disability if he or she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

The term **"substantially limits"** means:

An impairment is a disability if it substantially limits the ability of an individual to perform a major life activity as compared to most people in the general population. An impairment need not prevent, or significantly or severely restrict, the individual from performing a major life activity to be considered substantially limiting.

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Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

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Caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others, and working; and

The operation of a major bodily function, including functions of the immune system, special sense organs and skin; normal cell growth; and digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive functions. The operation of a major bodily function includes the operation of an individual organ within a body system.

25

ADA: Covered Individuals

Whether an impairment is substantially limiting is made *without regard* to "ameliorative effects" of mitigating measures.

Mitigating measures may include:

- Medication.
- Medical supplies, equipment or appliances.
- Low-vision devices (not including ordinary eyeglasses or contact lenses).
- Prosthetics.
- Hearing aids and other hearing devices.
- Mobility devices.
- Other types of medical assistance or therapy.

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28

ADA: Substance Abuse

Alcohol

A person who currently uses alcohol is not automatically denied protection simply because of alcohol use.

An alcoholic is a person with a disability under the ADA and may be entitled to consideration of accommodation, if he or she is qualified to perform the essential functions of a job.

However, an employer may discipline, discharge or deny employment to an alcoholic whose use of alcohol adversely affects job performance or conduct to the extent that he or she is not qualified.

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Drugs

A drug addict is protected as having a disability only if he or she *is receiving recovery treatment* and is not a current user.

Persons addicted to drugs, but who are no longer using drugs illegally and are receiving treatment for drug addiction or who have been rehabilitated successfully, are protected by the ADA from discrimination on the basis of past drug addiction.

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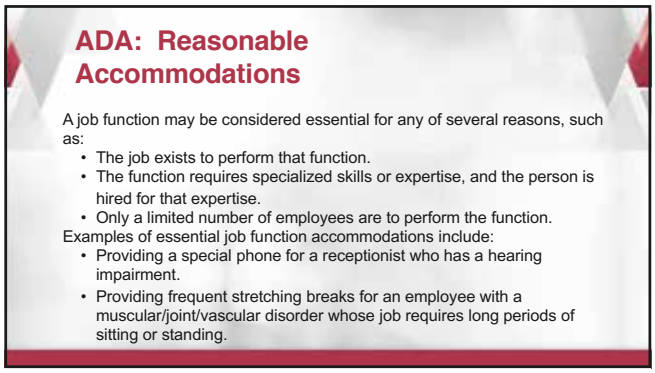
ADA: Reasonable Accommodations
Reasonable accommodation is any modification or adjustment to a job or the work environment that will enable the qualified individual with a disability to participate in the application process or to perform essential job functions (the fundamental duties of the job).
Reasonable accommodation also includes adjustments to ensure that a qualified individual with a disability has rights and privileges in employment equal to those of employees without disabilities.

31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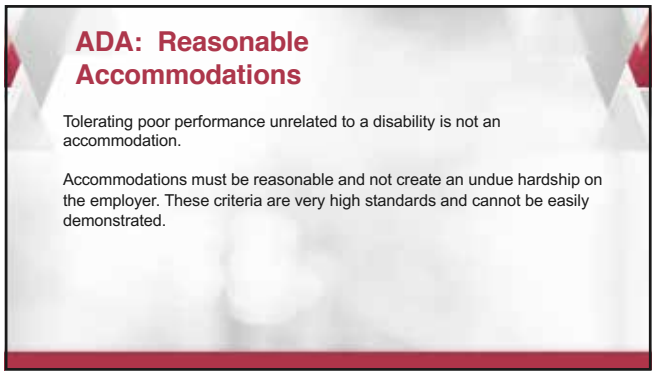
• Only a limited number of employees are to perform the function.
Examples of essential job function accommodations include:
• Providing a special phone for a receptionist who has a hearing impairment.
• Providing frequent stretching breaks for an employee with a muscular/joint/vascular disorder whose job requires long periods of sitting or standing.

32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Accommodations must be reasonable and not create an undue hardship on the employer. These criteria are very high standards and cannot be easily demonstrated.

33

HANDOUT

How I Implement the ABA Leave Policy

David Stahl, MD
Kristina R. Sullivan, MD

11/08/2019
8:45am - 9:30am

Implementation of the ABA Leave Policy

Kristina Sullivan, MD
University of California, San Francisco Department of Anesthesia and Perioperative Care
Residency Program Director and Associate Vice-Chair for Education
Sol Shnider Endowed Chair for Anesthesia Education

David Stahl, MD
The Ohio State University, Department of Anesthesiology
Assistant Clinical Professor
Residency Program Director

1

Disclosures

- We have no disclosures

2

Our Interpretation

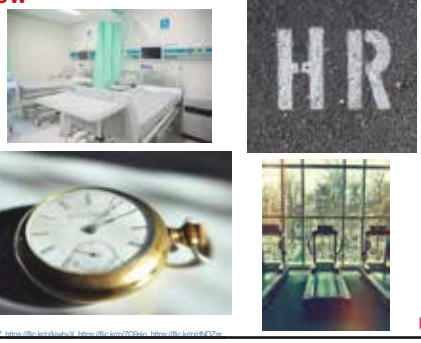
3

Guiding Principles

- All residents are held to the same baseline standard and must demonstrate sufficient competence to enter practice without direct supervision
- The milestone language helps to identify areas for improvement
- In general, the program will advocate for time away to be approved as long as the resident is on track to achieving the designated anesthesiology milestones

4

Overview



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Indications

FMLA / ADA

- Serious medical illness
- Birth, adoption, foster of child
- Health care of qualifying family member
- Exigency out immediate family member's active military duty

The Ohio State University Wexner Medical Center

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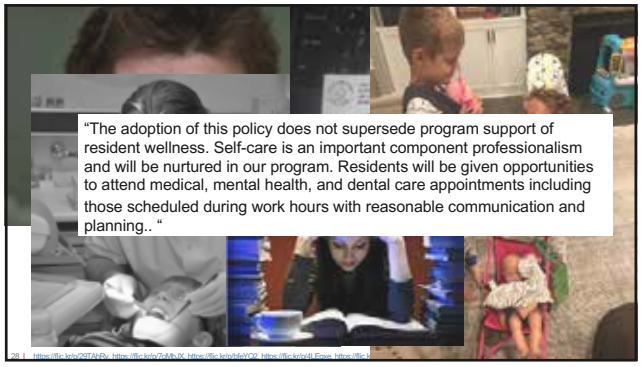

"The adoption of this policy does not supersede program support of resident wellness. Self-care is an important component professionalism and will be nurtured in our program. Residents will be given opportunities to attend medical, mental health, and dental care appointments including those scheduled during work hours with reasonable communication and planning.. "

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Human Resources

- How do your residents get paid when they are away?
  - Parental Leave?
  - Sick Leave
- A Union you say?

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Other Considerations

- Days missed including sick days, fellowship interviews, bereavement, personal leave or other cause will be tracked
- Above a threshold of 10 days (over 3 years), the total will be taken into consideration when the CCC determines the amount of days away granted
- Amount of call is considered and potentially required to be made up by the resident

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Human Resources

https://flic.kr/p/nDedGK

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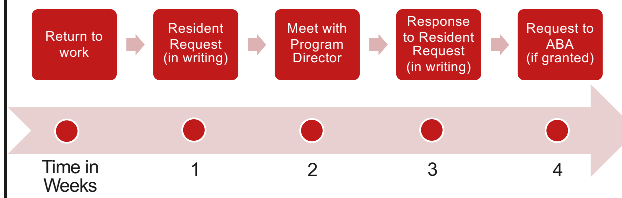
Timing



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Scheduled Resident Leave*

- A formal “additional days away request” is submitted prior to the leave by the resident to the CCC; advisor is informed
- A self-assessment study is submitted with the request:
  - ACGME Anesthesiology milestone progress
  - SMART goals to be utilized upon return
  - CCC will conduct a thorough review preferably before the resident begins the LOA

*emergent leaves do not require a formal submission prior to LOA; submission of self-assessment will occur upon return

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Factors used in CCC review

- Overall clinical performance compared to peers based on evaluations and assessments (multimodal)
- Rate of progression in achieving all ACGME Anesthesiology milestones
- Number of required clinical rotations completed (required rotations as defined in the ACGME Anesthesiology Program Requirements)
- Percent completion of required cases (index cases as defined in the ACGME Anesthesiology Program Requirements)
- Performance on ABA In-Training-Exam and BASIC exam

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Ensuring Adequate Training

- **Required Rotations**
- Case Counts
- Evaluations
- Examination Performance

The Ohio State University Wexner Medical Center

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Training

Eligibility for graduation to unsupervised clinical practice is determined by the Clinical Competency Committee after review of evaluations, feedback from clinical observation, milestone evaluations, event reporting, reviews of professionalism, completion of administrative tasks, and testing scores. Trainees approved by the ABA for additional time away from training must also successfully demonstrate that they meet these standards in order to successfully graduate according to their original training schedule. At the discretion of the program director, trainees who fail to meet those standards may require additional time in training in order to reach minimum competency and be required to extend their training despite ABA approval of additional days away from training.

The Ohio State University Wexner Medical Center

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Ongoing CCC Review

- If the resident falls below the target level expected by the program the CCC may judge that extension of training is necessary; the resident will be notified in writing of the decision to extend training; any NOC will likely lead to extension
- Our GME policies govern extensions of training and appeals processes that must be followed

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Special Tracks

- Research Track
- Critical Care Track

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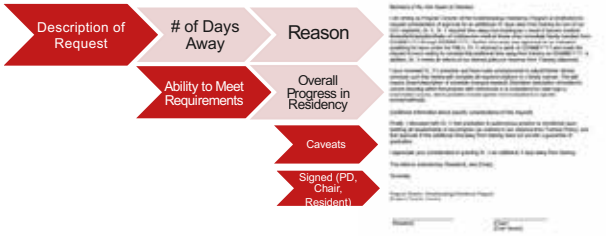
Example



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Examples

- UCSF Policy
- OSU Policy
- Example Letter

https://go.osu.edu/ucsfpolicy

https://go.osu.edu/timeawaypolicy

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Special Thanks

- California Society of Anesthesiologists for sponsoring an annual CSA Program Director's Meeting
- Wisdom and guidance of the California Program Directors
- OSU Program Coordinator: Sarah Robertson
- Our OSU Education Leadership, Clinical Competency Committee & Program Evaluation Committee

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Questions?

Thank You

Kristina.Sullivan@ucsf.edu
@krosesully

david.stahl@osumc.edu
@DoctorStahl

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References

- ABA Policy Book, http://www.theaba.org/ABOUT/Policies-BOI, accessed 09/01/2019.
- ABA Absence from Training Policy Guidelines, http://www.theaba.org/PDFs/BOI/Absence-from-Training-Policy-Guidelines, accessed 09/01/2019.
- ABA Absence from Training Policy FAQ, http://www.theaba.org/PDFs/BOI/Absence-from-Training-Policy-FAQs, accessed 09/01/2019.
- Internal Institutional FML Policies.

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HANDOUT

AACPD

RRC Update

Cheryl Gross, MA, CAE
Cynthia A. Wong, MD

11/08/2019
9:30am - 9:50am

ACGME Review Committee for Anesthesiology Update

Cynthia Wong, MD, Chair

1

Disclosure

- No disclosures to report

2

Session Objectives

- Introduce new Review Committee members
- Summarize specialty 2019 Annual Program Review
- RC and ACGME Updates and Projects
  - *Program Requirement Changes*
  - *Milestones 2.0*
  - *Program Director Guide to the Common Program Requirements*
  - *New Resident Survey*

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New Member - 2020

- Jill Mhyre, MD
- University of Arkansas for Medical Sciences
- Professor and Chair, Department of Anesthesiology

4

New Resident Member - 2020

- Johnny Jianing Wei, MD
- CA-1 Resident
- University of Kansas School of Medicine

5

The Stats

6

Trends in Core Anesthesiology Programs

Academic Year	# Approved Residents	# Core Programs
2018-2019	7,299	153
2017-2018	7,171	153
2016-2017	6,994	147
2015-2016	6,728	135
2014-2015	6,685	133
5-Year Trend	**↑ 9.2%**	**↑15.0%**

7

Core Anesthesiology Program Size

Number of Filled Positions	Number of Programs
0 Residents	2
1-24 Residents	43
25-49 Residents	52
50-74 Residents	34
74-99 Residents	15
100+ Residents	7

	Number of Positions
Range	0-111
Mode	31
Median	37
Mean	43

89.5% Fill

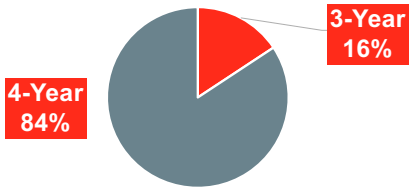
8

Subspecialty Programs – 2018-2019

Subspecialty	Number of Programs	Filled	Active Fellows
Adult Cardiothoracic	68	97.3%	153
Clinical Informatics	1	50.0%	1
Critical Care Medicine	62	78.5%	194
Regional Anesthesiology and Acute Pain Medicine	27	82.9%	63
Obstetric Anesthesiology	37	74.5%	46
Pain Medicine	103	92.3%	382
Pediatric Anesthesiology	60	84.6%	219

9

Fundamental Clinical Skills Year



10

Anesthesiology Review Committee Activities – 2018-2019

11

Annual Anesthesiology RC Activities

- **The Review Committee meets to review:**
  - Applications
  - Permanent Complement Increase Requests
  - Annual Data
    - *Programs with Citations*
    - *Programs with Annual Data Indicators*
  - 10-Year Site Visit Reports

12

Annual Anesthesiology RC Activities

- **The Review Committee meets to review:**
  - Applications
  - Permanent Complement Increase Requests
  - Annual Data
    - *Programs with Citations*
    - *Programs with Annual Data Indicators*
  - 10-Year Site Visit Reports

13

2018-2019 Annual Program Review

446 Programs Reviewed

- *425 Continued Accreditation*
- *3 CA with Warning*
- *17 Initial Accreditation*
- *1 Withhold*

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

14

Program Requirements

15

Pain Medicine Program Requirements

- **Multidisciplinary with Physical Medicine and Rehabilitation and Neurology**
- **Negotiation**

16

Pain Medicine Program Requirement Changes

- **To be eligible to apply for a program, sites only need to sponsor one residency in:**
  - *Anesthesiology, Physical Medicine and Rehabilitation, Child Neurology, or Neurology*

17

Pain Medicine Program Requirement Changes

- **There may be multiple Pain Medicine programs at a single institution**
  - *Must demonstrate commitment to multidisciplinary nature of the subspecialty with applicable faculty appointments*

18

CORE Requirements Proposed

- **Core Faculty Members**
  - Minimum of six core faculty members, not including program director

19

CORE Requirements Proposed

- **Coordinator Support**
  - *≤ 20 residents – 0.5 FTE*
  - *21-40 residents – 1.0 FTE*
  - *41-60 residents – 1.5 FTE*
  - *61-80 residents – 2.0 FTE*
  - *81-100 residents – 2.5 FTE*
  - *>100 residents – 3.0 FTE*

20

We HEARD You!

- **Proposed changes made to ensure consistency amongst Anesthesiology subspecialties**
- **Review and comment period open in late November**
- **Please review and let us know of concerns or recommended changes**

21

General Subspecialty Changes Proposed

- **Program director must devote at least 50% of time to subspecialty**
- **<5 fellows, 10% FTE non-clinical protected time**
- **5 or more fellows, 20% FTE non-clinical protected time**

22

General Subspecialty Changes Proposed

- **Program Director:**
  - *Current certification in Anesthesiology*
  - *Current certification in subspecialty, if available*
    - If not available, completion of fellowship or 3 years' service as a fellowship faculty member
  - *At least 3 years' post-fellowship service in subspecialty*

23

General Subspecialty Changes Proposed

- **Faculty**
  - *Varies by subspecialty*
- **3 core faculty members required**
  - *For programs with 4 or more fellows, there must be at least 1:1 core faculty-to-fellow ratio*

24

General Subspecialty Changes Proposed

- **Coordinator Support**
  - *At least 20 percent FTE for fellowships with a single fellow*
  - *For each fellow over one, must have additional 2% support for administrative time*

25

General Subspecialty Changes Proposed

- **Fellow Scholarly Activity**
  - *Must conduct or be substantially involved in scholarly project related to subspecialty suitable for publications*
  - *Disseminated through a variety of means, including publication and presentation at national or international meetings*
  - *Must have a faculty mentor overseeing the project*

26

Other Projects

27

Milestones 2.0

- **Initial meeting for core Anesthesiology held in Chicago – September 12-13, 2019**
  - *Anticipated 45-day Review and Comment period – late spring 2020*
- **Subspecialty revisions will follow**
  - *Will send self-nomination invitation to AASPD for dissemination*

28

Milestones 2.0

- **When your specialty Milestones are complete, a Supplemental Guide (SG) is available to aid your CCC**
  - *Available as a Word document so that your CCC can personalize it to your program*
  - *Creates a shared mental model about the what the levels mean and how they will be evaluated*

29

Other Projects

- **New Program Director Guide to the Common Program Requirements – coming soon!**
- **New Resident Survey launching in January to encompass new Common Program Requirements**

30

Four Steps to Resolving Citations

1. How did you engage residents and faculty to investigate the issue?
2. What IS the issue?
3. What actions will/have you implemented to correct the issue?
4. How will you monitor and sustain the improvement?

31

TIPS

- "Major Changes and Other Updates" can be used:
  - *To communicate with the Review Committee on progress toward Areas for Improvement concerns*
  - *To proactively indicate how the program is working to address annual concerns, such as Resident Survey, board pass rate, etc.*

32

Contact ACGME Staff – They want to help!

Cheryl Gross, MA, CAE, Executive Director
cgross@acgme.org ♦ 312-755-7417

Kerri Price, MLIS, Associate Executive Director
kprice@acgme.org ♦ 312-755-5023

Aimee Morales, Senior Accreditation Administrator
amorales@acgme.org ♦ 312-755-7419

33

34

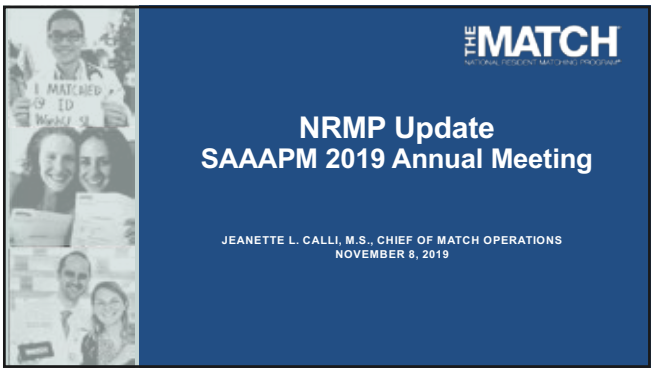
HANDOUT

AACPD

NRMP Update

Jeanette L. Calli, MS

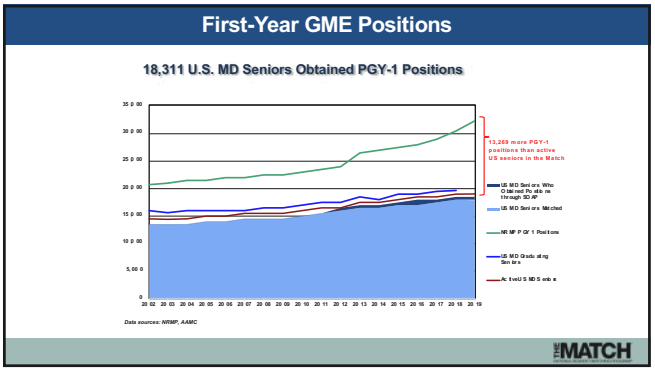
11/08/2019
10:30am - 10:45am


THE MATCH
NRMP Update
SAAAPM 2019 Annual Meeting
JEANETTE L. CALLI, M.S., CHIEF OF MATCH OPERATIONS
NOVEMBER 8, 2019

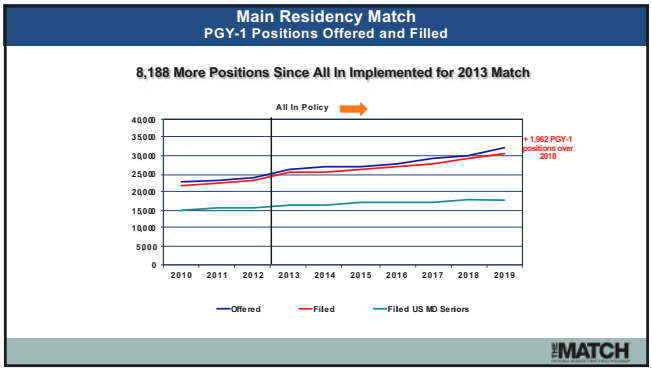
1


AGENDA
THE MATCH
NATIONAL RESIDENT MATCHING PROGRAM
Main Residency Match Trends
Supplemental Offer & Acceptance Program
New Policies for 2020 Match Season
Transition to Residency Conference

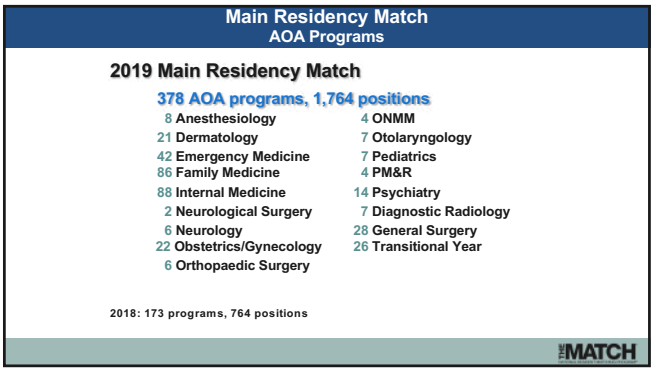
2


First-Year GME Positions
18,311 U.S. MD Seniors Obtained PGY-1 Positions
13,269 more PGY-1 positions than active US seniors in the Match
US MD Seniors Who Obtained Positions through SOAP
US MD Seniors Matched
NRMP PGY1 Positions
US MD Graduating Seniors
Actual US MD Seniors
Data sources: NRMP, AAMC
THE MATCH

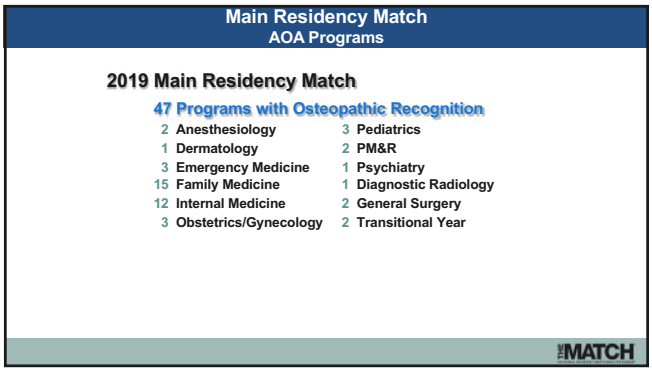
3


Main Residency Match
PGY-1 Positions Offered and Filled
8,188 More Positions Since All In Implemented for 2013 Match
All In Policy
+1,962 PGY-1 positions over 2018
40000
35000
30000
25000
20000
15000
10000
5000
0
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
Offered
Filled
Filled US MD Seniors
THE MATCH

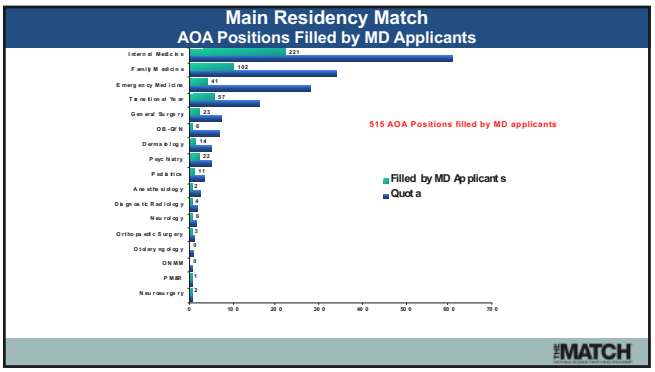
4


Main Residency Match
AOA Programs
2019 Main Residency Match
378 AOA programs, 1,764 positions
8 Anesthesiology
21 Dermatology
42 Emergency Medicine
86 Family Medicine
88 Internal Medicine
2 Neurological Surgery
6 Neurology
22 Obstetrics/Gynecology
6 Orthopaedic Surgery
4 ONMM
7 Otolaryngology
7 Pediatrics
4 PM&R
14 Psychiatry
7 Diagnostic Radiology
28 General Surgery
26 Transitional Year
2018: 173 programs, 764 positions
THE MATCH

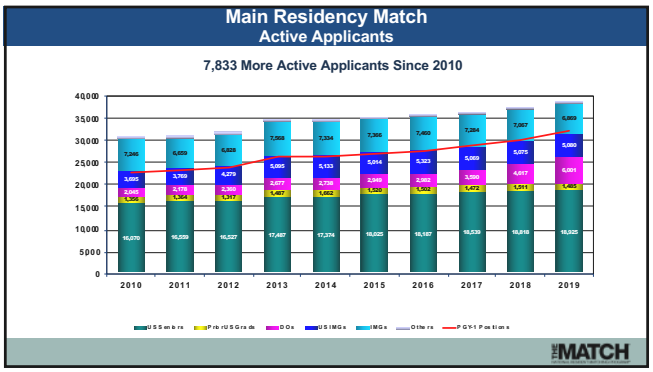
5


Main Residency Match
AOA Programs
2019 Main Residency Match
47 Programs with Osteopathic Recognition
2 Anesthesiology
1 Dermatology
3 Emergency Medicine
15 Family Medicine
12 Internal Medicine
3 Obstetrics/Gynecology
3 Pediatrics
2 PM&R
1 Psychiatry
1 Diagnostic Radiology
2 General Surgery
2 Transitional Year
THE MATCH

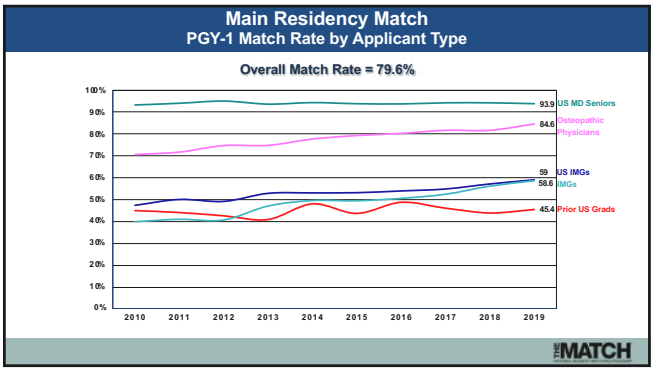
6


Main Residency Match
AOA Positions Filled by MD Applicants
Internal Medicine
Family Medicine
Emergency Medicine
Transitional Year
General Surgery
OB-GYN
Dermatology
Psychiatry
Pediatrics
Anesthesiology
Diagnostic Radiology
Neurology
Orthopaedic Surgery
Otolaryngology
ONMM
PM&R
Neurosurgery
221
102
41
57
23
6
14
22
11
2
1
1
1
1
1
1
2
515 AOA Positions filled by MD applicants
Filled by MD Applicants
Quota
THE MATCH

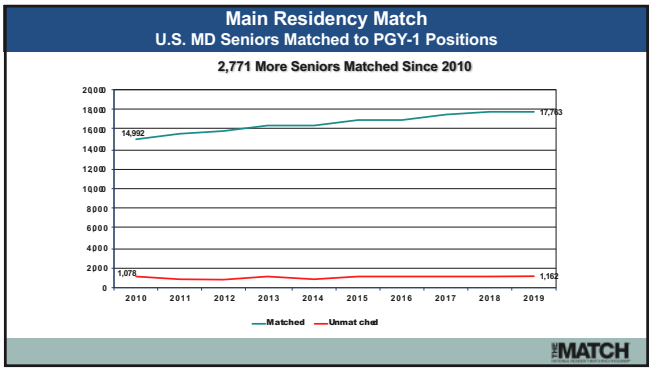
7


Main Residency Match
Active Applicants
7,833 More Active Applicants Since 2010
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
THE MATCH

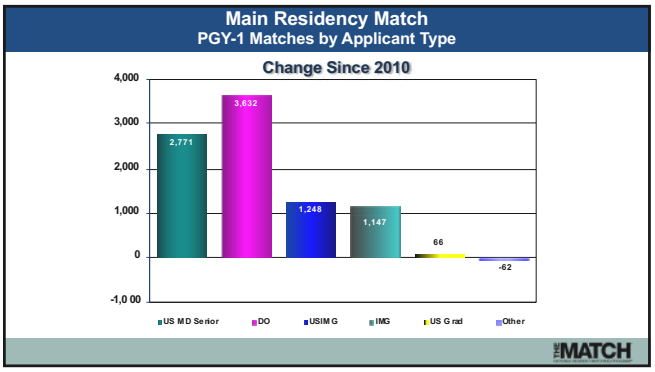
8


Main Residency Match
PGY-1 Match Rate by Applicant Type
Overall Match Rate = 79.6%
93.9
84.6
59
58.6
45.4
US MD Seniors
Osteopathic Physicians
US IMGs
IMGs
Prior US Grads
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
THE MATCH

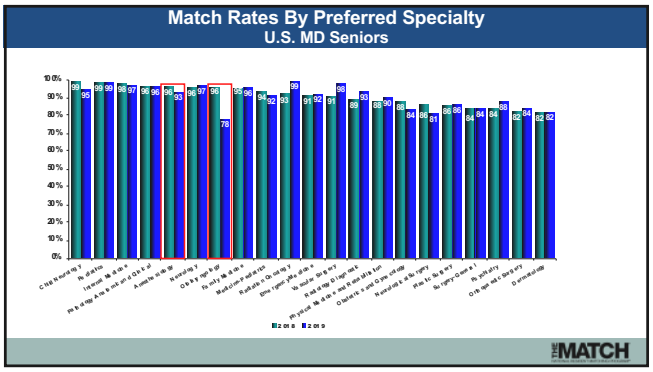
9


Main Residency Match
U.S. MD Seniors Matched to PGY-1 Positions
2,771 More Seniors Matched Since 2010
14,992
17,763
1,078
1,162
Matched
Unmatched
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
THE MATCH

10


Main Residency Match
PGY-1 Matches by Applicant Type
Change Since 2010
2,771
3,632
1,248
1,147
66
-62
US MD Senior
DO
USIMG
IMG
US Grad
Other
THE MATCH

11


Match Rates By Preferred Specialty
U.S. MD Seniors
2 0 1 9
2 0 1 8
THE MATCH

12

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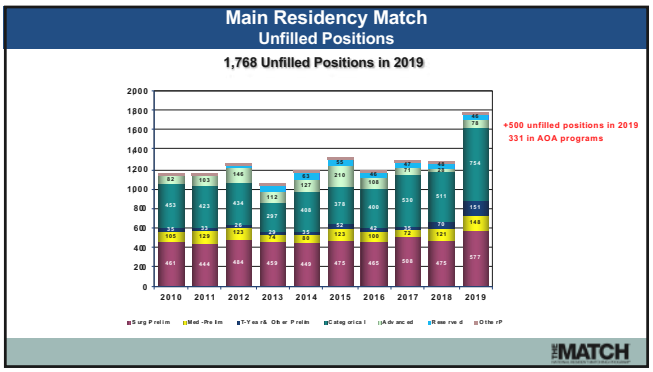

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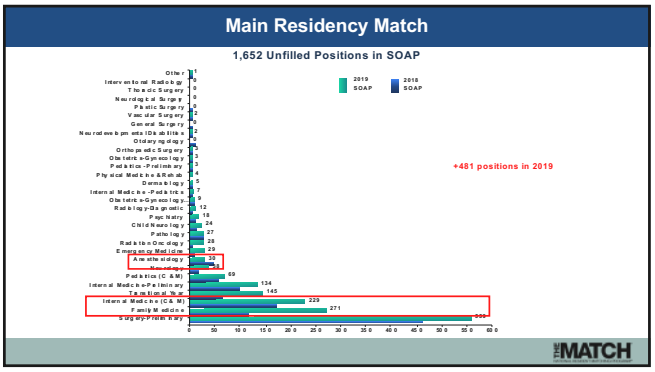

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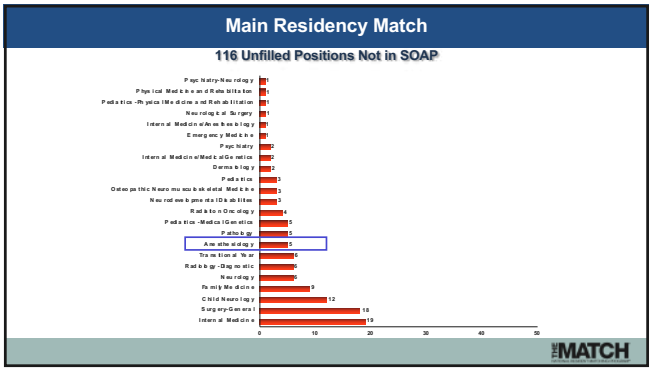

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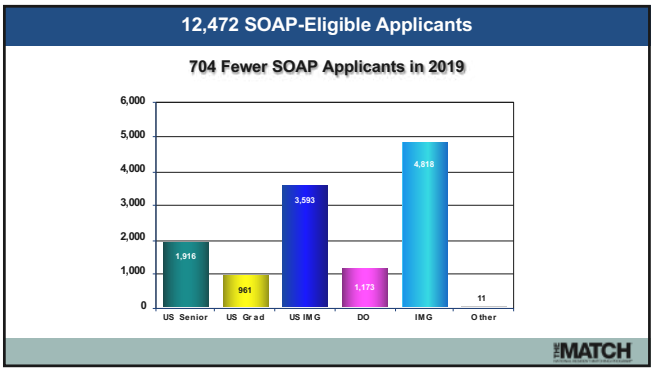

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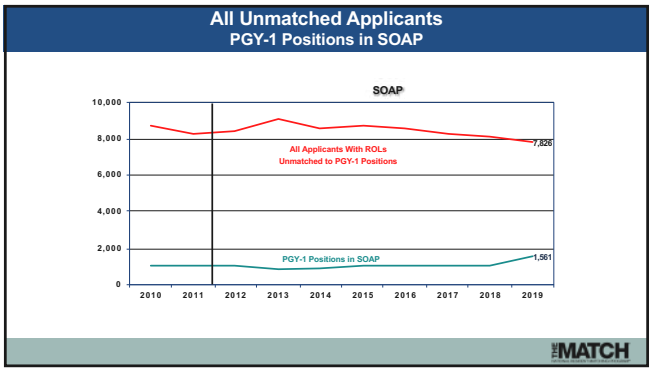

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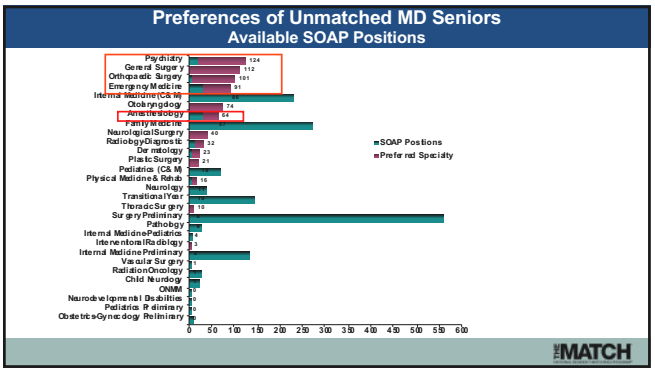

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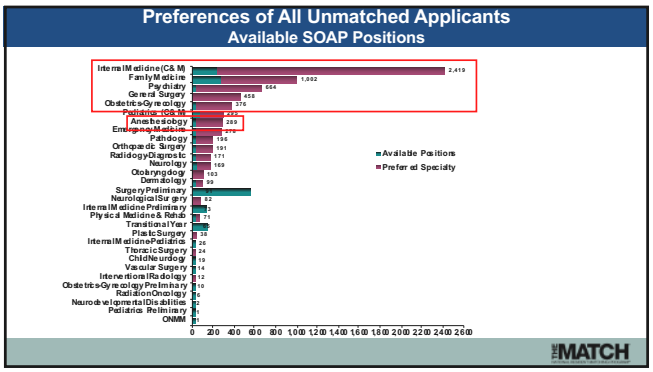

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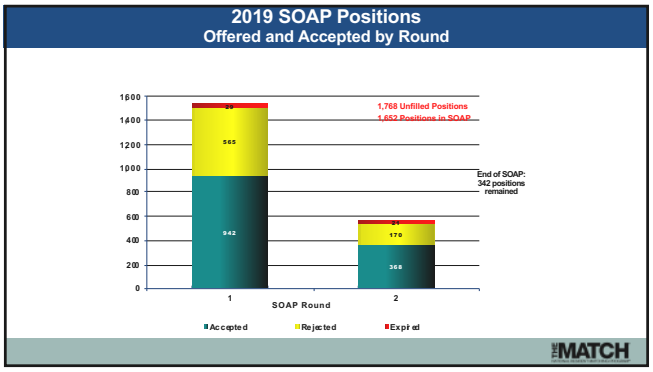

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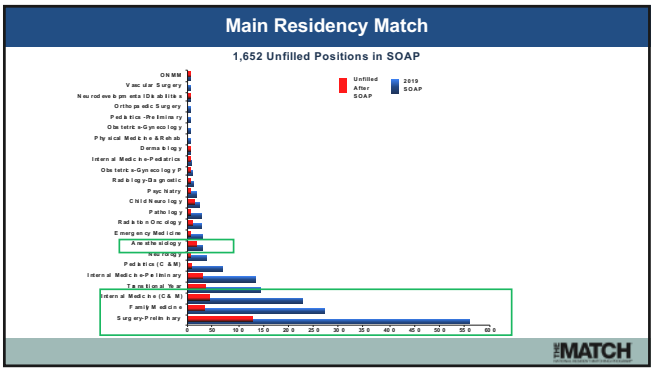
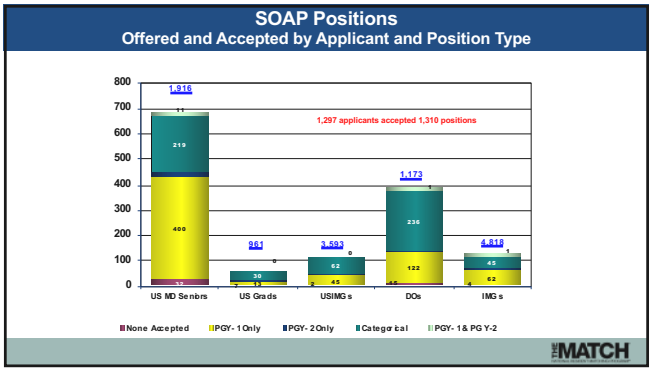
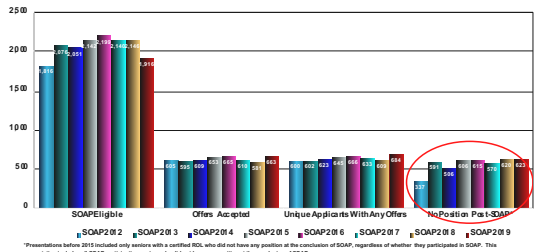


23



24

U.S. MD Seniors in SOAP 2012-2019



*Presentations before 2015 included only seniors with a certified ROL who did not have any position at the conclusion of SOAP, regardless of whether they participated in SOAP. This presentation includes all SOAP-participating seniors who did not have any position at the conclusion of SOAP.

THE MATCH

25

THE MATCH

New Policies for 2020 Match Season

26

New Polices for 2020 Match Season

Sponsored Applicants:

- Section 2.2.1: In addition to US allopathic medical school seniors, students enrolled in osteopathic medical schools accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation will be sponsored applicants.
  - Allopathic and osteopathic students must be offered positions only through the NRMP or another national matching plan
  - Only medical school officials can withdraw allopathic and osteopathic students from the Match, and only for pre-approved reasons.

Rank Order Lists:

- Section 4.6.1 and 4.6.2: Applicants and programs have the right to keep their rank order lists and SOAP preferences/preference lists confidential and not to share them with any other individual or entity.

THE MATCH

27

THE MATCH

Transition to Residency Conference

28

Transition to Residency Conference

THE MATCH

29

THE MATCH

Questions?

www.nrmp.org
support@nrmp.org
866-653-NRMP

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HANDOUT

AACPD

Lessons Learned Panel

Andrea Dutoit, MD

11/08/2019
11:00am - 12:00pm

Mistakes made, lessons learned

What they say they want isn't what they really want…

Dr. Andrea Dutoit, MD
University of Nebraska Medical Center

UNMC

1

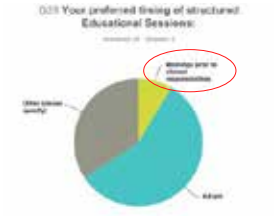
How do we improve the program?

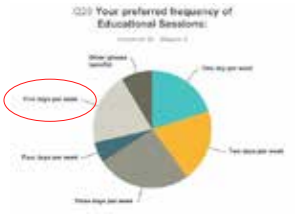
- Program usually sends out yearly in spring
- Questions vary each year:
  - Call hours and schedule
  - Didactics
  - Clinical duties
  - Other hot ACGME topics

2

Didactics in 2017 :

Daily AM lectures; faculty chooses presentation style
Timing 615-645 am
Case starts 730 am





Conclusion: Residents don't like our current timing/frequency… but there was more…

3

- Didactic timing/frequency comments:

I don't believe we need these structured lectures. We could use this time to study how we feel works best

Mornings prior to clinical responsibilities only because there is no way people would stay later than they needed if released from the OR to stay for lectures; however, lectures almost everyday of the week are redundant

Anytime NOT mornings/prior to clinical responsibilities

I do not feel that afternoon lectures would be a good system and would take away from clinical duties.

One "out of OR" experience per month, daily teaching in the ORs

Depends on how much time we could dedicate to this outside of the ORs.

Daytime protected 2-3 hour block

4

5

We can listen to these new types of learners…

- Got rid of daily morning lectures
- Strong preference noted for independent learning
  - Electronic based learning curriculum based on each rotation
    - Keywords
    - Cases of the Week/modules
    - https://www.unmc.edu/anesthesia/educationcontent/portal-home/general-anesthesia-topics/
- Wednesday mornings 1.5 hours dedicated to:
  - Mock orals
  - Simulation
  - Grand rounds
  - OSCE practice
- Increased unassigned non-clinical time pre-call

6

7

SURVEY

2018: What they had to say…

- Vast majority still studying way less than they thought they needed
- Technology
  - Tracking on line curriculum showed lower than expected participation
    - I think that the amount of material that needs to be covered to truly make the learning point the first and primary resource for data is massive.
- Program weaknesses
  - not having a structured didactic system in place, not all residents learn best with e-modules
  - Continuing to work on didactic structure.
  - Didactics, dedication to resident education.

8

And now I am the program director!

9

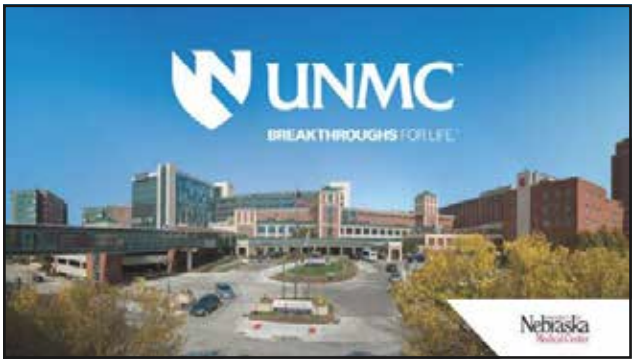
Back to the drawing board…

- Reviewed all recent surveys and changes made
- Lets add a time-specific, structured didactic back in but let's try to make it better… again…
  - Afternoons
    - Tuesday for Basic/CA1
    - Thursday for Advanced /CA2-3
  - Change up the format- 1.5 hrs split into…
    - Faculty lectures
    - Peer presentations of board topics
    - Mock oral peer practice
    - Resident Case presentations
    - Interactive/gamified board questions via kahoot

10

- Giving residents time doesn't mean the time will be spent the way its intended!
- What residents say they want isn't necessarily what they really want!
- There's no way to please everyone…

11



12

HANDOUT

AACPD

Lessons Learned Panel

Shelley George, MD

11/08/2019
11:00am - 12:00pm

Lessons Learned?

Post Traumatic Flashbacks from a former PD

1

- No Disclosures

2

Goals and Objectives

- What does it look and feel like when a hospital declares Bankruptcy?
- CMS Funding
- What Role did/does the ACGME play?
- Can you Plan for a Closure?/Catastrophe?

3

4

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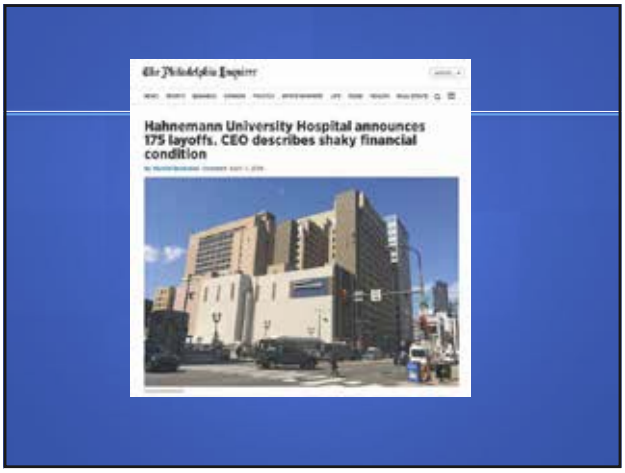
6



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9

A Look Back: Closures before us

Philadelphia

- Graduate Hospital
- Medical College of Pennsylvania

Safety Net Hospital

- St. Vincent's Hospital

10

GME

- During this time:
  - Confirmation that we were not over the CAP
  - DIO had not been notified of closure so continued with business as usual.
  - DIO discusses options with neighboring DIOs.
  - Believed there would have to be at least a 90 day notice as per requirements by the Pennsylvania Health Department

11

12

It's Official

- June 26, 2019 Hahnemann Announces the hospital will close in 60 days.

13

Chaos Unleashed

- Keep working and Interview!
- Residents: what are they going through?

14

15

PD Thinking

- How can I minimize disruption in the lives of my residents?
- How many slots for each PGY level are there in Philadelphia?
- Get them out as soon as possible.

16

Resident Thinking

- Can I get back home?
- What about my WEDDING? MY SCHEDULE? MY FELLOWSHIP?
- What about my family?
- What about my mortgage? Rent?
- It might be kind of nice to be in NYC!!!
- ECFMG's : Am I going to be deported

17

The Turmoil of the Resident

18

19

CMS $$$$

- The Business of GME
- Orphan Status:
- How Much and When

20

21

ACGME

- Notice of the closure
- Updated the DIO daily of new openings for every residency type in the country
- Allowed programs to increase the number of spots temporarily
- Allowed programs to have unequal distribution of PGY level if desired

22

ACGME

- Site Visits
  - After the news of impending bankruptcy
  - After the news of the residents not being released
- Communication with CMS for confirmation of Funding
- Legal Action
- Communication with DIO's nationwide after realization that residents and fellows with not go with 1/0.5 FTE

23

ACGME AND FUNDING

1. Programs cannot/do not give interviews until ACGME allows them to open positions.
2. Institutions are not allowed to offer positions until it is clear that funding will go with the resident.

24

Lessons Learned: Planning for the Unknown

- Do not think the institution thinks or cares about the residents
- Set up a consortium or meeting of the DIO's in proximity
- Keep residents continually apprised in order to decrease anxiety
- Know that CMS protects the resident funding following the resident to the next institution via CMS intermediaries
- PD to PD process
- Is there a real legally non discoverable reporting system to state a concern to the ACGME
- When an institution changes hands could there be a mandate for recommitment to the GME not every 5 years but annually?
- Should the CFO who signs the CMS cost report be accountable to the ACGME?
- Who should maintain the salary of the DIO?

25

26

HANDOUT

AACPD

Lessons Learned Panel

Timothy R. Long, MD

11/08/2019
11:00am - 12:00pm

HANDOUT

AACPD

Best Practices in Assessing Milestones

Debra Jean Szeluga, MD, PhD

11/08/2019
1:30pm - 1:40pm

Evaluation of Resident Performance

- Debb Szeluga, MD, PhD
- Associate Professor
- Vice Chair for Education
- University of Iowa

1

Educational Objectives

- Describe the milestone-driven evaluation system created at the University of Iowa
- Stimulate discussion

2

Challenges

- Limited options for tools
- Limited ability to customize exiting tools
  - Couldn't randomize questions
  - Couldn't avoid questions for skills that didn't apply
  - Required evaluator to assign a performance "score"
  - Evaluators generally assign high "scores"

3

Question Development

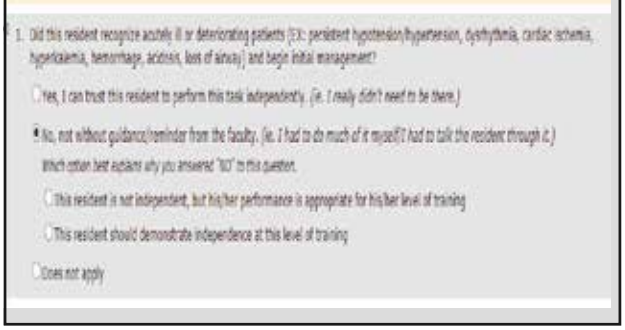
- Invited all faculty and residents to contribute questions and identify behaviors, skills, attributes
- Similar to EPAs
- Rotation-specific wording/examples
- Bank of 277+ questions

4

Question Generation and Rules

5

Faculty Evaluation



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Clinical Day

- Evaluation covers a clinical day
  - Combination of patients with different degrees of illness/case complexity
  - Mode/longest duration

7

Preliminary Milestone Level Determination

- Computer calculates *preliminary* Milestone level
  - Based on training level
  - At least 10 evaluations
- Positive and negative impact factors
- Competency Committee determines *final* Milestone level

8

Resident Evaluation Report

Dr. Anthony Tiger
CA-1 resident

211 evaluations completed with answers.

21 evaluations completed with insufficient contact.

Overall Comments (45) | show

9

Summary

- Shared the UI resident Milestone evaluation tool
- Described its generation
- Identified utility
- Hopefully, stimulated discussion
- THANK YOU

10

HANDOUT

AACPD

Best Practices in Assessing Milestones

Pedro P. Tanaka, MD, PhD, MACM

11/08/2019
1:40pm - 1:50pm

Milestone Learning Trajectories of Residents

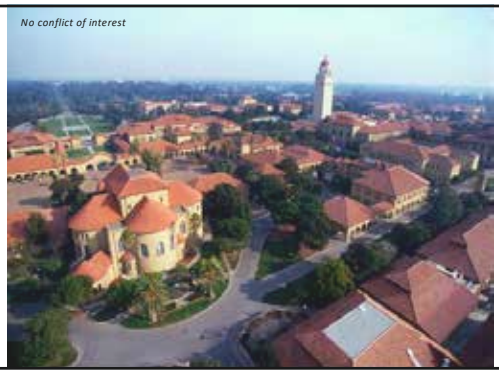
Pedro Tanaka, MD, PhD, MACM
Clinical Professor

STANFORD ANESTHESIA

Pedro Tanaka | ptanaka@stanford.edu

1

No conflict of interest



2

Outline

- Scope of the problem
  - Longitudinal milestones data
  - Incidence and determinants of straight line scoring

3

Longitudinal milestones data

Clinical competency committees report milestone data to the Accreditation Council for Graduate Medical Education (ACGME). The goals of this study were to measure the:

1) frequency of "straight-line scoring" (a resident receives the same milestone level score for all 25 anesthesiology sub-competencies);
2) proportion of residents that reach "Level 4" (defined as ready for unsupervised practice) for each sub-competency by the time of graduation; and
3) variability among programs or individual residents in baseline milestone level or rate of improvement.

Under review JEPM.

4

Methods

De-identified milestone ratings on a 10-point scale in each of the 25 sub-competencies submitted to the ACGME semi-annually from July 1, 2014 to June 30, 2017 were retrospectively analyzed for all graduating residents (n=69) from a convenience sample of five anesthesia residency programs. An overall milestone level for each of the six ACGME core competencies was calculated using scores from each of the sub-competencies within each core competency.

5

Frequency of straight-line scoring varies by institution

	Residency Program (number of residents)				
	A (n=13)	B (n=5)	C (n=11)	D (n=21)	E (n=17)
Straight line scoring whereby a resident receives the same milestone level score for all 25 anesthesiology sub-competencies	273/1950 (14%)	427/750 (57%)	148/1650 (9 %)	693/3150 (22%)	663/2550 (26%)

Evaluators often rate milestone competencies along one dimension

6

Not all residents achieved level 4 in all sub-competencies

	Residency Program (number of residents)				
	A (n=13)	B (n=5)	C (n=11)	D (n=21)	E (n=17)
Reached at least Level 4 or higher by the time of graduation in all 25 Anesthesiology sub-competencies	11/13 (86%)	5/5 (100%)	6/11 (55%)	20/21 (95%)	9/17 (53%)

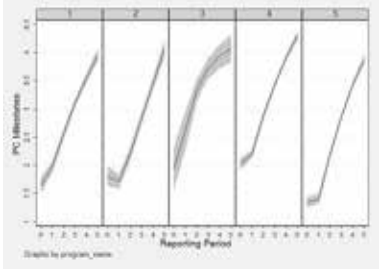
7

Distribution of Growth Trajectories by Sub-competency

Sub-competency	Group 1 (%) 2 scores above 4	Group 2 (%) 1 score 4 and one above 4	Group 3 (%) Reach Level 4 or higher in one instance	Group 4 (%) not reach Level 4 in any instance
Overall	4/67 (6)	11/67 (16.5)	43/67 (64)	9/67 (13.5)

8

Milestone learning growth trajectories as reported to the ACGME vary significantly across individual residents as well as by program.



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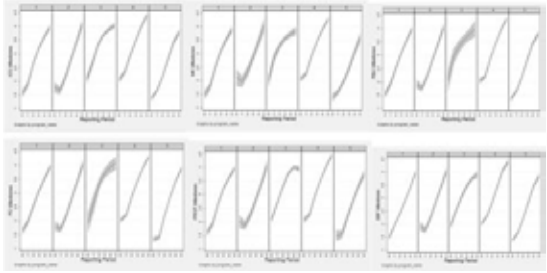
Mean Milestones Ratings for each of the six ACGME Core Competencies follow a pattern in each program



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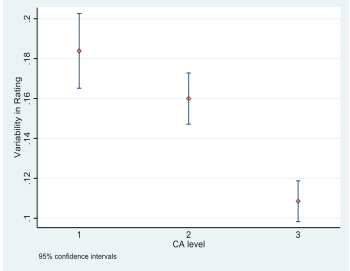
Incidence and determinants of straight line scoring

Resident Class	Number of observations	Proportion
CA1	638	44.98%
CA2	694	45.1%
CA3	697	56.95



Study in progress.

11

Incidence of SLS varies by rotation

Rotation	Number of observations	Proportion
ASC scheduler	25	48%
Abdomen	33	27%
Acute Pain	98	70%
Bariatrics	40	7%
CV ICU	105	40%
Cardiac	127	22%
Chronic Pain	58	64%
Echo	13	46%
ENT	66	79%
Liver	73	68%
MICU	140	18%
MSD	73	89%
Neuro Cranis	91	49%

12

Possible determinants

- Understanding of Milestones Terminology
- Data Collection/ Utilization
- Time commitment
- Bias
- Faculty Buy – In

13

Our approach

- Part of National EPA study
- Working with MedHub using an EPA evaluation form to upload to resident portfolio.
- Educating faculty during the process.

14

15

16

HANDOUT

AACPD

Best Practices in Assessing Milestones

Glenn E. Woodworth, MD

11/08/2019
1:50pm - 2:00pm

Practical Implementation of EPAs in US Anesthesiology Training

GLENN WOODWORTH MD, PROGRAM DIRECTOR, REGIONAL AND ACUTE PAIN FELLOWSHIP
Oregon Health & Science University

1

Anesthesia EPA Pilot Project Approach

- Learn from our international neighbors
- Formed US Committee
- Checked in with RRC
- Separate out Procedures
- Delphi process to define EPA titles and procedural skills

2

2

20 EPAs in the US Anesthesiology Pilot

Core Activity

- Preop Assessment
- Airway management
- Transfer of care
- PACU care

Case Based

- General OR Case
- OOR Case
- Labor analgesia
- C/S
- Pregnant Non OB surgery)
- Peds periop care
- Neonatal periop care
- Cardiac surgery
- Thoracic surgery
- Regional anesthesia case
- Chronic pain non OR
- Intracranial procedure
- Major trauma
- AAA
- Critical care non OR
- Acute Pain non OR

3

3

Procedural Badges

- Specific procedural skills
  - Arterial line
  - Central line
  - Single shot interscalene block
- Same method for assessment as Case-based EPAS
- Trainees "earn" entrustment

4

4

Entrustment Scale

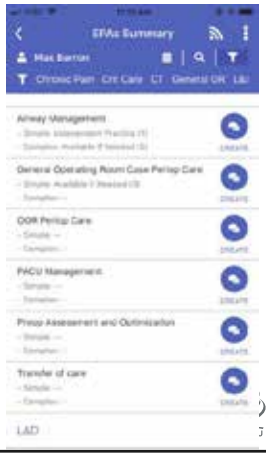
- I did it
- Direct supervision – constant supervision
- Indirect supervision – frequent consultation
- Reactive supervision – infrequent consultation
- Independent practice

5

5

Digital Portfolio

- Total number of assessments
- Current score for each EPA or Procedural Skill
- Based on most recent 5 scores



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6

Entering an Assessment

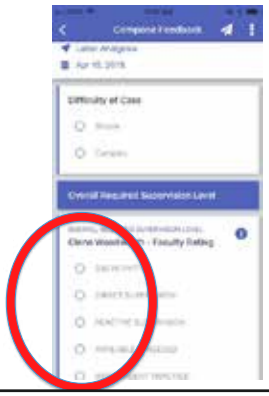
- **Only 3 things to fill out**
  - Difficulty
  - Score
  - Comments

7

7

Mark you level of Supervision

- Check the box



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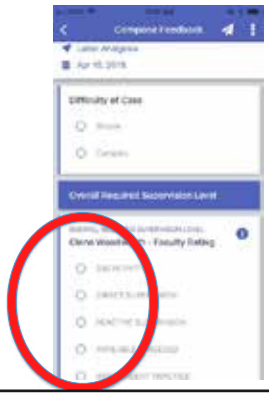
8

Mark your level of Supervision

- Check the box



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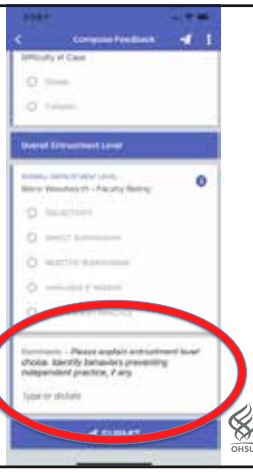
9

Enter Comments

- Type or dictate your comments
- Then submit



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10

CCC Reporting

- For each trainee view the current level vs graduation target

11

11

CCC Reporting

- Click to drill down on a particular EPA or Procedure to get a graphical view

12

12

Three Easy Steps

- Complexity
- Score
- Comments

13

13

Questions

14

HANDOUT

AACPD

Joint Panel with AAPAE: The Annual Program Evaluation: From Button Checking to Improving Your Program

Dawn Dillman, MD

11/08/2019
2:00pm - 3:30pm

HANDOUT

Joint Panel with AAPAE: The Annual Program Evaluation: From Button Checking to Improving Your Program

Gina B. Hendren, MD

11/08/2019
2:00pm - 3:30pm

HANDOUT

AACPD

Joint Panel with AAPAE: The Annual Program Evaluation: From Button Checking to Improving Your Program

Lara Zisblatt, EdD, MA, PMME

11/08/2019
2:00pm - 3:30pm

HANDOUT

AACPD

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

Timothy R. Long, MD
Michael Wiisanen, MD

11/08/2019
4:00pm - 5:00pm

Session Name: Current Session

Date Created: 11/8/2019 3:25:40 PM
Active Participants: 114 of 114
Average Score: 0.00%
Questions: 45

Results by Question

1. I have been in my PD role for: (Multiple Choice)

	Responses	
	Percent	**Count**
<1 year	17.05%	15
1-3 years	31.82%	28
3-5 years	15.91%	14
5-7 years	10.23%	9
7-10 years	10.23%	9
>10 years!	14.77%	13
Totals	**100%**	**88**

2. The new ABA absence policy is: (Multiple Choice)

	Responses	
	Percent	**Count**
Great	17.39%	16
OK, but could be improved	56.52%	52
A complete disaster	26.09%	24
Totals	**100%**	**92**

3. Have you established a program specific policy based on the new ABA absence policy? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	35.11%	33
No, but working on it	48.94%	46
No, wasn't planning on it	15.96%	15
Totals	**100%**	**94**

4. Should the ABA allow deferred decisions regarding the leave policy? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	83.16%	79
Yes, only when taken early in residency (CBY/CA-1 years)	10.53%	10
No	6.32%	6
Totals	**100%**	**95**

5. For residents that are granted additional leave, will you reduce their elective time? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	58.06%	54
No	7.53%	7
Maybe	34.41%	32
Totals	**100%**	**93**

6. For residents that take additional leave, they will need to make up at least some call (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	48.31%	43
No	51.69%	46
Totals	**100%**	**89**

7. In my program, residents fail the BASIC exam: (Multiple Choice)

	Responses	
	Percent	**Count**
Rarely	33.33%	30
Occasionally (1 resident per yr)	54.44%	49
Several residents per year	12.22%	11
Commonly	0%	0
Totals	**100%**	**90**

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

	Responses	
	Percent	**Count**
No	3.09%	3
Yes, after 1 failure	1.03%	1
Yes, after 2 failures	61.86%	60
Yes, after 3 failures	34.02%	33
Totals	**100%**	**97**

9. How do you choose your chiefs? (Multiple Choice)

	Responses	
	Percent	**Count**
Faculty vote	3.23%	3
Resident vote	7.53%	7
A & B	46.24%	43
PD decision	1.08%	1
PD decision with faculty and/or resident input	37.63%	35
Other	4.3%	4
Totals	**100%**	**93**

10. How do your residents sign-in to lecture? (Multiple Choice)

	Responses	
	Percent	**Count**
Hand-written sign-in sheet	56.7%	55
Electronic sign-in or Q-reader	35.05%	34
They don't, everyone just shows up	5.15%	5
They don't, lecture is optional and not tracked	3.09%	3
Totals	**100%**	**97**

11. How do you get your residents to attend lecture? (Multiple Choice)

	Responses	
	Percent	**Count**
Carrot (incentives)	11.7%	11
Stick (punishment)	27.66%	26
Neither, and we have a problem with attendance	23.4%	22
Neither, and we do NOT have a problem with attendance	37.23%	35
Totals	**100%**	**94**

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

	Responses	
	Percent	**Count**
Yes	72.16%	70
No	8.25%	8
Some residents learn about it, but informally	19.59%	19
Totals	**100%**	**97**

13. We have a grading system for residents that choose to give a presentation (e.g. grand rounds) as their academic project: (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, but only after we had a series of poor presentations	4.4%	4
Yes, it was put into place well ahead of time	14.29%	13
No	57.14%	52
N/A	24.18%	22
Totals	**100%**	**91**

14. How much non-OR, no-call time do your residents get (e.g. elective time)? (Multiple Choice)

	Responses	
	Percent	**Count**
None	36.56%	34
< 2 weeks	6.45%	6
2-4 weeks	21.51%	20
4-6 weeks	12.9%	12
>6 weeks	22.58%	21
Totals	**100%**	**93**

15. Do your residents change epidural bags and take out the catheter after labor? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, we believe it is a physician role	40.91%	36
Yes, only because it has been ingrained culturally	27.27%	24
No, nursing takes care of this	31.82%	28
Totals	**100%**	**88**

16. Does your department pay residents to work past a certain hour? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	30.11%	28
Yes, but it is/was a temporary fix for staffing	8.6%	8
No	61.29%	57
Totals	**100%**	**93**

17. How does your program account for resident interview days (Multiple Choice)

	Responses	
	Percent	**Count**
Taken out of ABA-approved vacation time	43.18%	38
Sick leave	10.23%	9
Off the books!!	46.59%	41
Totals	**100%**	**88**

18. Regarding resident inter-professional concerns: (Multiple Choice)

	Responses	
	Percent	**Count**
We don't have a great way to deal with it	64.77%	57
We have a great system, but it is institution specific	29.55%	26
We have a great system and could be used elsewhere and I would be willing to share!	5.68%	5
Totals	**100%**	**88**

19. How many 24-hr calls do your residents take monthly (averaged among CA1-3 classes)? (Multiple Choice)

	Responses	
	Percent	**Count**
None (we have strictly night float or late start calls)	16.48%	15
1-3	45.05%	41
4-6	38.46%	35
7-9	0%	0
>9	0%	0
Totals	**100%**	**91**

20. Are your trainees unionized? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, and I think it's great	8.89%	8
Yes, it's a nightmare!	10%	9
No	81.11%	73
Totals	**100%**	**90**

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

	Responses	
	Percent	**Count**
Yes	77.17%	71
No	21.74%	20
I didn't know there was a minimum	1.09%	1
Totals	**100%**	**92**

22. What is the closest coordinator FTE:resident ratio in your program? (Multiple Choice)

	Responses	
	Percent	**Count**
1:20	24.44%	22
1:30	30%	27
1:40	23.33%	21
1:50	5.56%	5
1:60	7.78%	7
<1:60	8.89%	8
Totals	**100%**	**90**

23. As PD, my interview days . . . (Multiple Choice)

	Responses	
	Percent	**Count**
Come out of my protected time	73.91%	68
Are in addition to my minimum protected time	26.09%	24
Totals	**100%**	**92**

24. Do you "blind" (hide) photos of ERAS applications while selecting candidates to interview? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes (program decision)	13.98%	13
Yes (GME decision)	12.9%	12
No	73.12%	68
Totals	**100%**	**93**

25. Have you implemented anything formal to help with diversity recruitment? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	54.44%	49
No	45.56%	41
Totals	**100%**	**90**

26. Who does ERAS screening? (Multiple Choice)

	Responses	
	Percent	**Count**
PD	25.56%	23
APD	5.56%	5
PD and APD	28.89%	26
Committee and the PD	36.67%	33
Committee without the PD	3.33%	3
Totals	**100%**	**90**

27. Who interviews prospective residents? (Multiple Choice)

	Responses	
	Percent	**Count**
A select group (PD, APD's, and hand-picked faculty/residents)	89.25%	83
Only PD and APD's	2.15%	2
All faculty	8.6%	8
Totals	**100%**	**93**

28. How many interviewers do your candidates meet with? (Multiple Choice)

	Responses	
	Percent	**Count**
2	8.42%	8
3	25.26%	24
4	37.89%	36
>4	28.42%	27
Totals	**100%**	**95**

29. How many candidates per position do you interview? (Multiple Choice)

	Responses	
	Percent	**Count**
Less than 5	2.17%	2
5-7	8.7%	8
8-10	27.17%	25
11-13	34.78%	32
14-16	18.48%	17
>16	8.7%	8
Totals	**100%**	**92**

30. We invite more applicants than we have interview spots for (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	52.69%	49
No	47.31%	44
Totals	**100%**	**93**

31. Do you allow "second looks" for applicants? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	67.82%	59
No, we have never been asked	9.2%	8
No, we have been asked but don't allow it	22.99%	20
Totals	**100%**	**87**

32. My GME allows me to rank applicants without full funding (i.e. go over cap) (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	27.06%	23
No	72.94%	62
Totals	**100%**	**85**

33. Does your department/program have a formal lactation policy? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	42.22%	38
No	48.89%	44
Not sure	8.89%	8
Totals	**100%**	**90**

34. Does your department/program have designated space for lactation? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, and it's adequate	78.89%	71
Yes, and it's not adequate	12.22%	11
No	8.89%	8
Totals	**100%**	**90**

35. How do you designate "core" faculty as requested by ACGME (Multiple Choice)

	Responses	
	Percent	**Count**
All faculty that work with residents are listed as core	25%	22
We hand-select those based on contributions	75%	66
We have a "merit" system where faculty can earn the designation	0%	0
Totals	**100%**	**88**

36. I had program aims written prior to the ADS update (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	33.72%	29
No	66.28%	57
Totals	**100%**	**86**

37. Our institution has resources to help with the ADS update (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	62.2%	51
No	37.8%	31
Totals	**100%**	**82**

38. The amount of time I spent on the ADS update this year was: (Multiple Choice)

	Responses	
	Percent	**Count**
<2 hrs	0%	0
2-4 hrs	5.81%	5
4-6 hrs	11.63%	10
6-8 hrs	11.63%	10
8 hrs or more	70.93%	61
Totals	**100%**	**86**

39. I'm thrilled that the "site director" for external rotations will complete our ACGME survey next year. (Multiple Choice)

	Responses	
	Percent	**Count**
Yes	5.95%	5
Indifferent	27.38%	23
No	20.24%	17
What??!!!	46.43%	39
Totals	**100%**	**84**

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

	Responses	
	Percent	**Count**
Yes	38.2%	34
No	7.87%	7
No, but we have regularly scheduled wellness activities	53.93%	48
Totals	**100%**	**89**

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

	Responses	
	Percent	**Count**
No	32.56%	28
Yes, only residents	4.65%	4
Yes, only faculty	5.81%	5
Yes, both residents and faculty	56.98%	49
Totals	**100%**	**86**

42. Do you have a formal diversity committee? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, departmentally	2.33%	2
Yes, institutionally	54.65%	47
A and B	15.12%	13
No	27.91%	24
Totals	**100%**	**86**

43. How much longer do you plan on being PD? (Multiple Choice)

	Responses	
	Percent	**Count**
<1 year	5.13%	4
1-3 years	34.62%	27
3-5 years	34.62%	27
5-7 years	12.82%	10
7-9 years	3.85%	3
≥ 10 years	8.97%	7
Totals	**100%**	**78**

44. How much longer do you plan on being PD? (Multiple Choice)

	Responses	
	Percent	**Count**
<1 year	4.88%	4
1-3 years	35.37%	29
3-5 years	32.93%	27
5-7 years	13.41%	11
7-9 years	3.66%	3
≥ 10 years	9.76%	8
Totals	**100%**	**82**

45. Regarding PD succession planning: (Multiple Choice)

	Responses	
	Percent	**Count**
Things are looking great	35%	28
We have some plans in place	43.75%	35
Things are looking bleak	21.25%	17
Totals	**100%**	**80**

HANDOUT

AASPD

How to Prepare for Your Self-Study Site Visit, and Other ACGME Pearls from the New RRC Chair

Cynthia A. Wong, MD

11/08/2019
8:05am - 8:25am

How to Prepare for Your Self-Study Site Visit and Other ACGME Pearls

Cynthia Wong, MD, Chair
ACGME Review Committee for Anesthesiology

1

Disclosure

- No disclosures to report

2

Session Objectives

- Expectations – Self-study and 10-Year Site Visit
- RC Updates and Projects
  - *Program Requirement Changes*
  - *Milestones 2.0*
- New Resident Survey
- Responding to Citations and Areas for Improvement

3

The Program Self-Study and 10-Year Accreditation Site Visit

4

NEW CPR - Self-Study

Common Program Requirements Updates starting July 1, 2019:

V.C.1.e) The annual review, including action plan, must:

V.C.1.e).(1) be distributed to and discussed with the members of the teaching faculty and the residents; and, (Core)

V.C.1.e).(2) be submitted to the DIO. (Core)

V.C.2. **The program must complete the Self-Study prior to its 10-Year Accreditation Site Visit.** (Core)

V.C.2.a) A summary of the Self-Study must be submitted to the DIO. (Core)

5

Self-Study

- What is the ACGME Self-Study?
  - *An objective, comprehensive evaluation of the residency or fellowship program, with the aim of improvement*
- 8 Steps to Conducting your Self-Study (ACGME Website)
- Complete the Self-Study Summary
- Upload the document into ADS by the last day of the month of the Self-Study date

6

24 Months (or more) after submitting…

7

10-Year Accreditation Site Visit

- 8 Steps to Prepare for the 10-Year Accreditation Site Visit (ACGME Website)
  - *Complete the Summary of Achievements*
  - *Complete the Self-Study Update (optional)*
  - *Prepare for a full accreditation site visit*
- **10-year site visit may take place 24 months or more after the self-study date listed in ADS.**

8

10-Year Accreditation Site Visit

- **Full accreditation site visit**
- **Approximately 90 days' notice**
- **Begins with a review of the Self-Study**
  - Self-Study is NOT used by the Review Committee for accreditation

9

10-Year Accreditation Site Visit

- **Each Program Requirement will be discussed, as applicable, with the DIO, program director, coordinator (usually for document review) faculty, and residents/fellows**
  - *15 or fewer residents/fellows – all will be interviewed*
  - *More than 15 residents/fellows – 15-20 peer-selected, representing all required years of education*
- **The site visitor will send an agenda for the day**

10

10-Year Accreditation Site Visit

- **Ensure PLAs are up-to-date**
- **Update block diagram and participating sites – ensure consistency and accuracy**
- **Update faculty roster and program director CV**
- **Update responses to citations as applicable**
- **Update "Major Changes and Other Updates"**

11

10-Year Accreditation Site Visit

- **Review Annual Program Evaluation**
  - *Resident/Faculty Surveys*
  - *Letters of Notification*
  - *Case log and patient experience data*
  - *Resident, program director, and faculty scholarly activity*

12

Other Resources

- Webinar, August 2, 2019: Maximizing the Value of the ACGME Self-Study Process for Your Program: No Need to be Afraid!
- Updated FAQs for site visits on the ACGME webpage, with more information about the Self-Study and 10-Year Site Visit
- NEW! Linda B. Andrews, MD, SVP, Field Activities (landrews@acgme.org)
- Andrea Chow, MA, Associate Director, Field Activities (achow@acgme.org)

13

Program Requirements

14

Pain Medicine Program Requirements

- Multidisciplinary with Physical Medicine and Rehabilitation and Neurology
- Negotiation

15

Pain Medicine Program Requirement Changes

- To be eligible to apply for a program, sites only need to sponsor one residency in:
  - *Anesthesiology, Physical Medicine and Rehabilitation, Child Neurology, or Neurology*

16

Pain Medicine Program Requirement Changes

- There may be multiple Pain Medicine programs at a single institution
  - *Must demonstrate commitment to multidisciplinary nature of the subspecialty with applicable faculty appointments*

17

CORE Requirements Proposed

- Review and comment period open late November 2019
- Core Faculty Members
  - Minimum of six core faculty members, not including program director

18

CORE Requirements Proposed

- **Coordinator Support**
  - ≤ 20 residents – 0.5 FTE
  - 21-40 residents – 1.0 FTE
  - 41-60 residents – 1.5 FTE
  - 61-80 residents – 2.0 FTE
  - 81-100 residents – 2.5 FTE
  - >100 residents – 3.0 FTE

19

Fellowship PR: We HEARD You!

- **Proposed changes made to ensure consistency amongst Anesthesiology subspecialties**
- **Review and comment period open late November 2019**
- **Please review and let us know of concerns or recommended changes**

20

General Subspecialty Changes Proposed

- **Program director must devote at least 50% of time to subspecialty**
- **<5 fellows, 10% FTE non-clinical protected time**
- **5 or more fellows, 20% FTE non-clinical protected time**

21

General Subspecialty Changes Proposed

- **Program Director:**
  - *Current certification in Anesthesiology*
  - *Current certification in subspecialty, if available*
    - If not available, completion of fellowship or 3 years' service as a fellowship faculty member
  - *At least 3 years' post-fellowship service in subspecialty*

22

General Subspecialty Changes Proposed

- **Faculty**
  - *Varies by subspecialty*
- **3 core faculty members required**
  - *For programs with 4 or more fellows, there must be at least 1:1 core faculty-to-fellow ratio*

23

General Subspecialty Changes Proposed

- **Coordinator Support**
  - *At least 20 percent FTE for fellowships with a single fellow*
  - *For each fellow over one, must have additional 2% support for administrative time*

24

General Subspecialty Changes Proposed

- **Fellow Scholarly Activity**
  - *Must conduct or be substantially involved in scholarly project related to subspecialty suitable for publications*
  - *Disseminated through a variety of means, including publication and presentation at national or international meetings*
  - *Must have a faculty mentor overseeing the project*

25

Other Projects

26

Milestones 2.0

- **Initial meeting for core Anesthesiology held in Chicago – September 12-13, 2019**
  - *Anticipated 45-day Review and Comment period – late spring 2020*
- **Subspecialty revisions will follow**
  - *Will send self-nomination invitation to AASPD for dissemination*

27

Milestones 2.0

- **When your specialty Milestones are complete, a Supplemental Guide (SG) is available to aid your CCC**
  - *Available as a Word document so that your CCC can personalize it to your program*
  - *Creates a shared mental model about the what the levels mean and how they will be evaluated*

28

Other Projects

- **New Program Director Guide to the Common Program Requirements – coming soon!**
- **New Resident Survey launching in January to encompass new Common Program Requirements**

29

Four Steps to Resolving Citations

1. **How did you engage residents and faculty to investigate the issue?**
2. **What IS the issue?**
3. **What actions will/have you implemented to correct the issue?**
4. **How will you monitor and sustain the improvement?**

30

TIPS

- **"Major Changes and Other Updates" can be used:**
  - *To communicate with the Review Committee on progress toward Areas for Improvement concerns*
  - *To proactively indicate how the program is working to address annual concerns, such as Resident Survey, board pass rate, etc.*

31

Contact ACGME Staff – They want to help!

Cheryl Gross, MA, CAE, Executive Director
cgross@acgme.org ♦ 312-755-7417

Kerri Price, MLIS, Associate Executive Director
kprice@acgme.org ♦ 312-755-5023

Aimee Morales, Senior Accreditation Administrator
amorales@acgme.org ♦ 312-755-7419

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HANDOUT

Scholarly Activity and a Teaching Portfolio: Is Anyone Focusing on Developing the PDs, and What About Your Educators?

Andrew J. Patterson, MD, PhD

11/08/2019
8:25am - 8:45am

Scholarly Activity and Teaching Portfolio: Is Anyone Focusing on Developing Program Directors, and What about Your Educators?

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

Objectives

1. At the conclusion of this presentation, attendees will be able to describe the ACGME expectations for scholarship and teaching for Anesthesiology program directors and faculty.
2. At the conclusion of this presentation, attendees will be able to describe the paradox that because many academic institutions require higher standards for promotion than the ACGME expects for scholarship and teaching, the ACGME may be placing non-academic training programs at an advantage over training programs at academic institutions.

Disclosures

Andrew J. Patterson, M.D., Ph.D. was a member of the Accreditation Council for Graduate Medical Education (ACGME) Review Committee (RC) for Anesthesiology from 2013-2019. Beginning in January 2020, he will serve as the American Board of Anesthesiology's ad hoc representative to the ACGME RC. He is currently Professor and Chair of the Department of Anesthesiology at Emory University. He is a former Fellowship Program Director for Anesthesiology Critical Care Medicine at Stanford University.

Is anyone focusing on scholarly activity for program directors and faculty? Yes, the ACGME is focusing on their scholarly activity. The ACGME expects institutions to have program directors and faculty who participate in scholarly activities as follows:

IV.D.2.a) Among their scholarly activities, program faculty as a group (including the program director) must demonstrate accomplishments in at least 3 of the following domains[1]:

- Research in basic science, education, translational science, patient care, or population health
- Peer-reviewed grants
- Quality improvement and patient safety initiatives
- Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports
- Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
- Contribution to professional committees, educational organizations, or editorial boards
- Innovations in education

The ACGME also expects program directors and faculty to participate in the dissemination of scholarship in the following ways:

IV.D.2.b).(1) Dissemination of Scholarship. Program faculty (and the program director) should participate in[1]:

- Grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or service as a journal reviewer, journal editorial board member, or editor

Is anyone focusing on teaching for program directors and faculty? Yes, the ACGME is focusing on teaching for program directors and faculty. The ACGME expects institutions to have program directors and faculty who participate in teaching as follows:

Faculty members (including the program director) must[1]:

II.B.2. c) Demonstrate a strong interest in the education of residents
d) Devote sufficient time to the education program to fulfill their supervisory and teaching responsibilities
e) Administer and maintain an educational environment conducive to educating residents
f) Regularly participate in organized clinical discussions, rounds, journal clubs, and conferences
g) Pursue faculty development designed to enhance skills at least annually
- reported for the program faculty in aggregate
- may include lectures, workshops, be individual or group activities
- may focus on education
- may include quality improvement/patient safety activities that improve patient care and allow faculty to serve as role models for trainees
- may include activities that foster the well-being of the faculty
- may focus on patient care and be based on a faculty member's practice-based learning and improvement efforts

Core faculty must[1]:

II.B.4 Have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents.

The Reality: The scholarly activity and teaching requirements established by the ACGME are not in synch with the expectations for promotion at many academic institutions.

The Reality: Program directors and faculty who focus on the ACGME expectations may not get promoted.

The Reality: Programs may have outstanding educators and teachers who do not rise in the academic ranks while individuals who do rise in the academic ranks might not have the time to become good educators.

The Reality: The divisions that may develop within the faculty ranks could have an adverse impact on department culture at many institutions.

The Reality: The ACGME may be placing non-academic training programs at an advantage over training programs at academic institutions.

References

[1] Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Anesthesiology. Effective: July 1, 2019. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/040_Anesthesiology_2019.pdf?ver=2019-06-17-094411-477

HANDOUT

Pro-Con Debate: Fellowship Applications Should Not Request Test Scores (ITE, USMLE, etc.) - Pro

Amy Miller Juve, EdD, MEd

11/08/2019
9:00am - 9:30am

Standardized tests as screening tools: Who we lose

Amy Miller Juve EdD, Associate Professor
Oregon Health & Science University

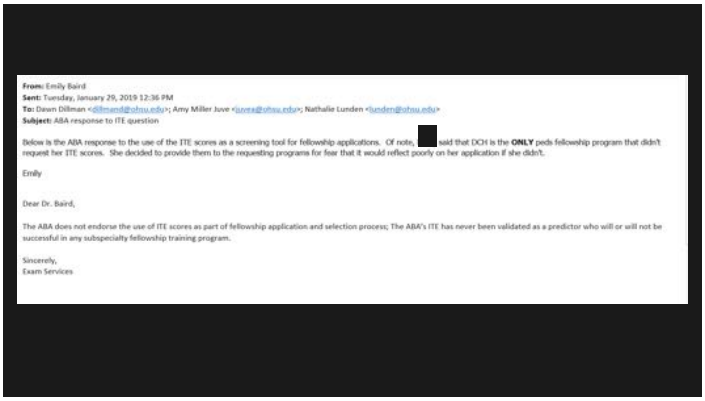
No disclosures

Objective:

Articulate the potential impact of using standardized test scores as a screening tool for fellowship applicants

ABA

The issue has been brought to our attention in the last several years during our meetings with the core program directors. We have told all our program directors – core and subspecialty – that the ITE is intended only as a measure of the resident's increasing command of the anesthesiology residency curriculum over the 4-year period of residency training and its use as an appropriate marker of likely future success in fellowship training has never been validated; therefore, ITE scores should never be part of the fellowship admissions decision making process. But clearly, the practice continues.



From: Emily Baird
Sent: Tuesday, January 29, 2019 12:36 PM
To: Dawn Dillman <[redacted]>; Amy Miller Juve <[redacted]>; Nathalie Lunden <[redacted]>
Subject: ABA response to ITE question

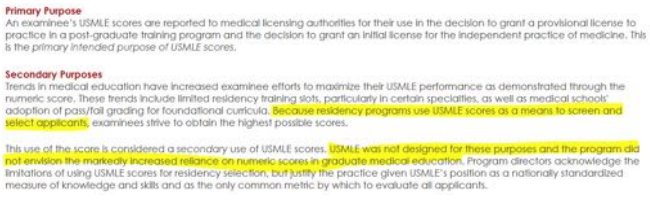
Below is the ABA response to the use of the ITE scores as a screening tool for fellowship applications. Of note, [redacted] said that DCH is the **ONLY** peds fellowship program that didn't request her ITE scores. She decided to provide them to the requesting programs for fear that it would reflect poorly on her application if she didn't.

Emily

Dear Dr. Baird,

The ABA does not endorse the use of ITE scores as part of fellowship application and selection process; The ABA's ITE has never been validated as a predictor who will or will not be successful in any subspecialty fellowship training program.

Sincerely,
Exam Services



Primary Purpose
An examinee's USMLE scores are reported to medical licensing authorities for their use in the decision to grant a provisional license to practice in a post-graduate training program and the decision to grant an initial license for the independent practice of medicine. This is the primary intended purpose of USMLE scores.

Secondary Purposes
Trends in medical education have increased examinee efforts to maximize their USMLE performance as demonstrated through the numeric score. These trends include limited residency training slots, particularly in certain specialties, as well as medical schools' adoption of pass/fail grading for foundational curricula. Because residency programs use USMLE scores as a means to screen and select applicants, examinees strive to obtain the highest possible scores.

This use of the score is considered a secondary use of USMLE scores. USMLE was not designed for these purposes and the program did not envision the markedly increased reliance on numeric scores in graduate medical education. Program directors acknowledge the limitations of using USMLE scores for residency selection, but justify the practice given USMLE's position as a nationally standardized measure of knowledge and skills and as the only common metric by which to evaluate all applicants.

Unintended Consequences

- Significant difference in mean scores between URM and non-URM (ABA Part 1) (Kim et al, 2012)
- Females, underrepresented minorities, applicants over the age of 30 (USMLE Step 1) (Fernandez et al, 2019)
- ITE transitions to a high stake exam = focus on "passing an exam"

JAMA Internal Medicine | Original Investigation

Comparison of Hospital Mortality and Readmission Rates for Medicare Patients Treated by Male vs Female Physicians

Yusuke Tsugawa, MD, MPH, PhD; Anupam B. Jena, MD, PhD; Jose F. Figueroa, MD, MPH; E. John Orav, PhD; Daniel M. Blumenthal, MD, MBA; Ashish K. Jha, MD, MPH

Patients treated by female internists have lower mortality and readmissions compared with those cared for by male internists.

GETTY IMAGES

Journal of Racial and Ethnic Health Disparities

October 2019, Volume 6, Issue 5, pp 1011 - 1020 | Cite as

The Impact of Patient-Provider Race/Ethnicity Concordance on Provider Visits: Updated Evidence from the Medical Expenditure Panel Survey

Authors | Authors and affiliations

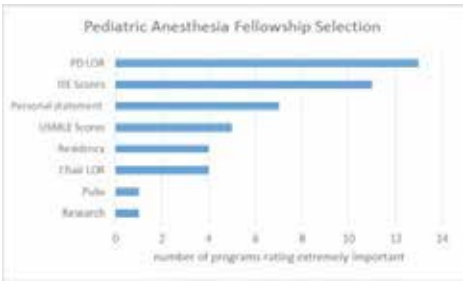
Alyson Ma, Allison Sanchez, Mindy Ma

There is an association between race/ethnicity concordance and the likelihood of patients visiting their provider. Study results demonstrate that racial disparities in health care utilization may be partially explained by race/ethnicity concordance.

Not surprising….

Standardized test scores best predict other standardized test scores

(vs. clinical performance)



In-training examinations are predictive of written board exam scores

BUT

The oral exam was developed to measure attributes that cannot be assessed by written exam

Interesting….

- Correlation between resident ranking and subsequent performance is low/poor (in training) or unrelated (in practice)
- Commonly used ranking criteria does not accurately predict poor performers
- Resident personality type correlates with faculty assessment of performance (vs USMLE) and high competency
- Clinical skills (determined by a program director assessment) were associated with higher odds of becoming board certified in anesthesiology
- Program director ratings of graduating residents' clinical competence were also related to board certification rates in internal medicine

Our future learners…

- Are enrolled in schools where standardized exams are not a part of, or are deemphasized, in the selection process
- Are advocating for a level playing field free from bias
- Will be in medical school at a time when the USMLE is P/NP (InCUS)

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HANDOUT

AASPD

Pro-Con Debate: Fellowship Applications Should Not Request Test Scores (ITE, USMLE, etc.) - Con

John B. Eck, MD

11/08/2019
9:00am - 9:30am

FELLOWSHIP APPLICATIONS SHOULD NOT REQUEST TEST SCORES-CON

JOHN ECK, MD

Disclosure: I have no actual or potential conflict of interest in relation to this presentation.

Learning objectives of this presentation:

1. Describe the core elements of the anesthesiology fellowship application
2. Review the challenges of overcoming the subjectivity inherent in applications
3. Identify relevant examinations that may be included in fellowship applications
4. Illustrate the advantages of utilizing objective data such as exam scores in assessing applicants to fellowship

Over the course of many years of preparation and training, physicians are required to take multiple standardized tests designed to objectively measure knowledge or aptitude. Beginning in high school, this might include Advanced Placement (AP) exams or college entrance exams like the ACT Exam or SAT (Scholastic Aptitude Test). In preparation for medical education, the large majority of schools require the Medical College Admissions Test (MCAT). In medical school, the United States Medical Licensing Examination (USMLE) or Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) are taken in several parts as an assessment of an individual's ability to demonstrate fundamental knowledge of medicine and are needed to qualify physicians for medical licensure in the United States. During residency training, most specialties utilize standardized exams to assess progress in knowledge acquisition within the specialty. For anesthesiology, this includes a yearly in-training exam administered by the American Board of Anesthesiology (ABA) or other available exams such as the Anesthesia Knowledge Test (AKT), administered by the Inter-Hospital Study Group for Anesthesia Education (IHSGAE).

Each of these exams is designed for a specific purpose. For example, the MCAT is designed specifically to qualify for entrance to medical school and the USMLE or COMLEX exams are intended as standardized requirements for licensure. As physicians progress in their training, examinations are not necessarily designed as a specific measure of aptitude or qualification for future endeavors (e.g. fellowship). For instance, the ABA in-training exam is designed to assess whether a resident is progressing satisfactorily in anesthesiology training and is on-track to achieve board certification. It may not specifically predict success in fellowship training, although this is not well-studied to date.

For a variety of reasons, residency training has overall become increasingly competitive as the number of post graduate positions has failed to keep pace with the growing number of medical school graduates over the years. The number of applications that each student submits for residency has grown over time in this environment, often overwhelming residency training programs. At the same time, many medical schools have moved to pass-fail grading systems and do not rank their students, leaving very little objective information to assess residency applicants. As there are no exams specifically designed to

assess aptitude for each specific specialty, residency program directors have been increasingly utilizing the licensure exams (USMLE or COMLEX) as one of the only available objective measures to evaluate applicants. Screening of applications by setting a threshold score is often utilized as programs may receive 10-100 times the number of applications than they have positions. This reliance on licensure exams for determination of future post graduate training has led to an emphasis on standardized exam preparation by students (and in some cases, medical schools), perhaps to the detriment of their overall medical education.

Fellowship training is not immune to the phenomenon or reliance on standardized exam scores for assessment of applicants. Program directors in competitive subspecialties (including anesthesia fellowships) may receive many hundreds of applications for a small number of positions. Although fair-minded, residency program directors and faculty referees may seek to promote their trainees through recommendation letters rather than providing objective assessments. Standardized applications with open ended personal statements may prove unsatisfactory to fellowship directors who are seeking to distinguish applicants from one another. As such, fellowship programs face the daunting task of screening applications in the setting of very little objective data. Perhaps it should be no surprise that similar to residency programs, fellowships may tend to over-utilize exam scores in their assessment of applicants to their programs.

The reliance on exam scores for assessment has come under recent scrutiny and changes in the structure of exams has been proposed as a way to minimize the reliance on these exams for purposes other than those intended. The Association of American Medical Colleges (AAMC) recently convened a working group of stakeholders to look at the issue and has proposed further work that is still pending.

One question is, is there any value in reviewing standardized exam scores other than for screening applications? Although there is virtually no data for fellowship training, performance on the USMLE has been shown to correlate with specialty board exam results for core residencies in pediatrics, emergency medicine, pathology and neurosurgery. Since many subspecialties (including several within anesthesiology) have board certification exams that follow fellowship training, program directors may find a history of success on exams to be a useful piece of information, especially because the Accreditation Council for Graduate Medical Education (ACGME) has set absolute minimum board passage rates for fellowships as a way to assess the quality of those training programs. Some evidence also exists that higher scores on in-training exams during residency correlate with success in achieving subsequent board certification in that specialty, including anesthesiology.

That success on standardized exams in the past is a predictor of success on subsequent standardized exams should come as a surprise to no one. People who retain knowledge and are good at taking tests will probably maintain that ability. The unanswered question is, what difference does it make? Does doing well on tests make anyone a better doctor? Not entirely, although fundamental knowledge is important and if nothing else, exams are a motivation to learn. There is some evidence that outcomes in patient care may be improved when patients are cared for by physicians with higher licensing exam scores, although more study is needed to validate this notion.

Ultimately, there is a fundamental lack of objective data available to fellowship program directors in selecting applicants. There is no definitive “entrance exam” or aptitude test for fellowship training like the SAT or MCAT for college or medical school, respectively. As such, training programs rely on

surrogate exams that, although not intended to be used as screening tools for entrance into training programs, do provide a means of assessing knowledge and perhaps function as a predictor of success on subsequent board certification exams. Does that approach necessarily exclude applicants who would otherwise be excellent subspecialists but who are simply not very good at taking tests? Without more study, this is a difficult question to answer. Program directors must use their discretion and utilize all the information available to them, not simply test scores. This is likely what most programs do anyway. Test scores are simply one element among many that might be used to assess applicants.

Eliminating a program's access to test scores because they are being used for purposes other than that intended misses the big picture. This approach doesn't give credit to program directors who are generally fair-minded and are doing their best to find trainees who are a good fit for their programs. Fundamentally, it's important to recognize that all applicants are not identical, just as all programs are not the same. In deciding on the appropriate fit between an applicant and a program, more data is always better than less. Any objective data, used appropriately in context (and in combination with the available subjective data), makes any application more complete and should therefore not be excluded.

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HANDOUT

AASPD

Beyond Scores: Qualities of a Successful Candidate

Douglas C. Shook, MD, FASE

11/08/2019
9:30am - 9:50am

HANDOUT

AASPD

Session Breakout 1: How to Develop a Teaching Portfolio

Jennifer E. Dominguez, MD, MHS
Erin K. Hennessey, MD
Ankeet D. Udani, MD, MSEd

11/08/2019
10:30am - 11:30am
11:30am - 12:30pm

HANDOUT

AASPD

Session Breakout 2: How to Be an Effective Mentor / Mentee

Ellen Y. Choi, MD
Shanna Sykes Hill, MD

11/08/2019
10:30am - 11:30am
11:30am - 12:30pm

Weill Cornell Medicine

UChicago Medicine

Mentoring

Giving and Receiving

Shanna Hill, MD
Ellen Choi, MD

Disclosures

- **Ellen Choi declares no relevant financial conflicts of interest.**
- **Shanna Hill declares no relevant financial conflicts of interest.**

What is the definition of mentorship?

Mentorship is a professional, working alliance in which individuals work together over time to support the personal and professional growth, development and success of the relational partners through the provision of career and psychosocial support.

-National Academies Report on Mentoring
www.nap.edu/MentorshipinSTEMM

What is a mentor?

Mentor:

- **Is invested in long term success.**
- **Engages in frequent regular communication (time investment).**
- **Helps mentee to produce high quality work and stay on the path to success.**

Vs.

Role Model - provides inspiration and represents a goal that can be aspired to, but may not know or interact with you.

Coach - helps improve performance in one domain or with a specific issue over a shorter time frame.

Sponsor - uses their sphere of influence to aid a mentee.

Connector - uses their extensive network and personal connections to link you to the right mentor, coach, sponsor, partner.

Benefits of mentoring

Mentee Benefits	Mentor Benefits
Personal growth and development	Personal growth and development as a Teacher-Mentor
Networking	Developing a personal network
Enhance productivity	Enhance productivity
Career advancement and promotion	Promotion
Career satisfaction	Career satisfaction
Career commitment	Establish legacy

Adapted from Detsky AS, et al.[2] Ludwig S & Stein R[3]

Preparing to be mentored: What is your area of interest?

Administration & Leadership
- Division leadership
- Department leadership
- Hospital leadership
- Department and Hospital committees

Clinical Care
- Care teams
- Niche expert
- New initiatives

Education
- Course director
- Simulation guru
- Program leadership

Research
- Basic research
- Clinical research
- Outcomes research

Preparing to be mentored: Develop your plan

- **Perform a needs assessment- what do you need? What can this mentor provide?**
- **Develop a written plan for career goals**
- **Define your time deadlines and goals**
- **Define your barriers: Need to develop resources and support.**

Keeping in mind:

- Continue to meet expectations of Department and Hospital
- Talks and publishing are necessary for promotion

Preparing to be mentored: Goals and Timeline

- **What are my professional goals?**
  - **Short term: this year**
  - **Intermediate:1-5 years**
  - **Long term: >5 years**
- **Don't forget your personal goals!**
  - **Family/interpersonal**
  - **Financial**
  - **Physical health**

Preparing to be mentored: What are my strengths and challenges?

- **Personal qualities:**
  - **Personality traits: introvert? Outgoing?**
  - **Work habits: procrastinator? Where are you able to concentrate best? Do you need hard deadlines?**
  - **Organizational, technical, writing abilities?**
  - **Networking skills- not an inherent skill!**
- **Department support?**
- **Institutional resources? Other outside resources?**

What are some traits of a good mentor?

- **Approachable**
- **Empathetic to the mentee**
- **Open minded: can respect mentee's personality and goals**
- **Patient: everyone works at a different pace.**
  - **There will be mistakes made!**
- **Honest/forthright: can communicate honest feedback about mentee's work, their progress, their career**
- **Can serve as a role model**
- **Has expertise in your area of interest**

 **Do a background check!**

What does a good mentor do?

- **Has the time and is willing!**
- **Regular communication**
- **Career development**
- **Champion/sponsor- interested in long term success**
- **Coach- helps to guide mentee to produce high quality work**
- **Confidant- keeps confidentiality**
- **Counselor- helps to manage issues**

Avoid "The One" mentality!

Team mentoring offers more! Why?

- **More people = more perspectives**
- **More mentors = manageable mentoring load**
- **Safety net in todays more mobile working world**

Who should be on your mentoring team?

Should include:
- Multiple perspectives
- Varied experiences
- Expand your network

Look for mentors:
- In your field- clinical or research
- OUTSIDE your field or industry
- Peer mentoring! Both senior AND junior to you

Where can I meet a mentor?

- **Introduce yourself at meetings**
- **Current faculty and also *departed* faculty!**
- **Conferences- go to networking events**
- **Lectures- stay after, approach the speaker**
- **Attend poster sessions**
- **Join a committee**

Where to Find Internal Mentors

- **Division, department, institution**
- **Committees- colleagues who you don't normally interact with but share some similar interests/goals or have an interesting skill set**
- **Other clinical departments or other affiliated non-clinical departments:**
  - **Epidemiology, public health, biostatistics**
  - **Other clinical disciplines**
- **Institutional mentoring programs***

Where to Find External Mentors

- **National or regional committees or task forces**
- **Special interest groups or sections**
- **National research networks**
- **National mentoring programs**
- **Social media**
- **Invite/organize for guest speakers at your institution**
- **Give a talk**

How to approach a mentor

- **How can I approach a potential mentor?**
  - **Starter sentences**
  - **Elevator pitch**
- **Good habits**
  - **Walk with business cards**
  - **Collect business cards**
  - **Note where you met them, one thing about them, one thing you talked about**
  - **Send a follow-up email within 5 days**

What if they say no?

Networking for Introverted Scientists: The Approach

Google **it! So many tips out there for people like us!**

nature **career column by Dr. Ruth Gotian PhD (2019) gives this advice for strategy in approaching mentors:**

1. **BEFORE YOU GO: Identify a core group of people who are likely to be there that you would like to meet**
2. **AT THE EVENT:**
   1. **Introduce yourself to every possible person in your core group. Make yourself memorable by establishing a connection!**
   2. **Ensure they know what specialty/industry you are in. What are you doing and where do you aim to be?**
   3. **Make sure they know how to get a hold of you before you walk away.**
3. **AFTER THE EVENT: follow up on meaningful interactions with an email**

Networking for Introverted Scientists: Survival

She also gives this advice for managing stress:

1. **Arrive Early**
2. **Arrive with a colleague or friend**
3. **Have a strategy for giving yourself a break midway**
4. **Have starter and closer sentences ready**

***Also consider stacking in your favor by introducing yourself to people prior to the event or introducing yourself by email, creating a more familiar and less daunting setting.**

What are the jobs of the mentee?

- **Be respectful of your mentor's time**
- **Have a plan**
- **Communicate effectively**
- **Take action on feedback**
- **Run through doors opened for you**

This is not something to approach lightly.

Your best effort should go into this relationship.

Be respectful of your mentor's time

- **Use your time wisely!**
- **Communicate regularly and frequently:**
  - **Schedule regular interactions: in person, virtual, email**
  - **Send an email prior to meeting with topics so mentor can be prepared**
  - **Remind your mentor where you left off last time**
  - **Plan for your meeting- set an agenda with specific talking points**
  - **Provide updates**
- **Bring your plan, thoughts, and concerns/ solutions to the table.**
- **Ask for feedback in small bites:**
  i.e. submit sections of a paper for review rather than an entire paper.
- **Listen actively!**

Planning and Communicating

- **Reach out regularly, get yourself on the calendar**
- **Meetings vs. emails**
  - **Prepare for meetings, formulate questions.**
  - **Keep emails succinct. Avoid lengthy emails.**
  - **Ask quick answer emails (yes/no). Avoid vague questions.**
  - **Preferred contact in case of urgent matter**
- **Goals and aspirations: be the driver!**
  - **What re your needs?**
  - **What are your goals?**
  - **Learning when to say no**
- **Communicate re developing barriers:**
  - **Gaps in resources or support**
  - **Close the loop**
- **Reach out for reasons other than needing something**
  - **Send updates**
  - **Don't forget to say thank you!**

Running the meeting: Topics?

Progress towards goals since last update:

– Include feedback from other sources (journals etc)

– Include discussion of barriers and problem solving

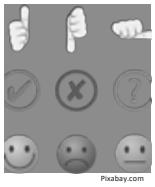
New projects:

– Should you or shouldn't you?

Career advice:

– Directions, satisfaction

– Additional training, applications



Feedback from mentor:

– How are you doing with your progress?

– Are things working in mentor relationship or would a modification be helpful?

– Be open to feedback!

What should you expect from your mentor?

- **Has knowledge/ willing to share knowledge**
- **Available**
- **Clear with expectations**
- **Supportive**
- **Able to provide good feedback/guidance**
- **Political wisdom and connectedness**
- **Will be your advocate (passive vs. active)**
- **Trustworthy, honest**
- **Follows through**
- **Respectful**
- **Willingness to communicate opportunities**
- **Matures in relationship**

What are the jobs of a mentor?

- Support
- Challenge
- Establish expectations
- Assess mentee's abilities
- Assess mentee's needs
- Know who you are mentoring (generational, cultural, professional)
- Take a work/experience history
- Establish the rules of engagement and what you can provide

What you should expect from your mentee

- Organized
- Demonstrates initiative
- Follow through
- Respectful
- Articulates needs
- Takes responsibility for arranging meetings
- Responsible
- Efficient
- Able to learn (return on investment)
- Matures in relationship

Rules of Mindful Mentoring

- Give credit where it is due
- Activities assigned to mentee should be beneficial to the mentee
- Encourage your mentee to branch out and connect with others
- Keep things moving
- Be honest in your feedback, even if it's difficult.
- Be available

Chopra, et al. The Mentoring Guide . Michigan Publishing.

Day One Mentorship Meeting

- Setting: Private, focused
- Mentor welcomes mentee
- Describe time frame and tasks for the day
- Describe own career path and interests
- Elicit mentee's past experience and interests
- Discuss ground rules
  - How often to meet, who initiates contact
  - What is covered in meetings vs other communications
  - Discuss your expectations of mentee
- Discuss your role
  - Facilitation, feedback, and evaluation
- Discuss mentorship goals
  - In general (long term) and for this session (short term)
- Review time line

Evaluating the mentorship

- Do you have mentoring chemistry?
- Beware your own implicit bias!
- Do I trust this person?
- Do your background check!
- Consider a "trial run"
- Give them a "test"

When things go wrong: scenarios for discussion

Scenario 1: Mentee lacks commitment

A new junior faculty member in your department comes to you seeking advice. He seems to be struggling to fulfill his various clinical, teaching, and scholarly duties. You have observed him closely, and think that he has a poor work ethic and lacks commitment. You think he will not succeed unless he starts working much harder. What course of action would you take?

Scenario 2: Management, not mentorship

You are a newly arrived junior faculty member, working in a field that is similar to that of your assigned mentor. Your mentor is excited and strongly recommends that you embark on projects he has thought up, which would consume almost all of your non-clinical time. You do not think you would be able to adequately perform your other duties if you followed his direction. How do you handle this situation?

Scenario 3: Mismatch between mentor and mentee

You are a program director and find it difficult to interact with your fellow due to personality differences and seem to clash over insignificant items. You are not sure if this is a communication issue, so you try to change your communication style, which does not improve the situation. Issues that you think are important do not seem to be appreciated by the fellow. What would be your approach to resolving this?

Scenario 4: Dealing with conflicting advice

You are mentoring a junior faculty member, who has been advised by another faculty member in the department to start writing and submitting grants. You think that it is too early, and that the mentee should collect more preliminary data and establish herself at the institution by prioritizing her clinical and didactic responsibilities. How do you handle the situation? What would you do if you were the mentee?

Scenario 5: Providing inadequate direction

You overhear a fellow complaining to a resident that you are distant and he never sees you. How do you respond?

How to manage these challenges?

- **Set goals and stay aligned.**
- **Set boundaries and expectations**
- **Establish regular communication, plan time in advance.**
- **Consider supplementing with communication methods other than in-person meetings**
- **Be empathetic**
- **Establish a mentorship TEAM**

Conclusions:

- **Mentees:**
  - **You need more than one type of mentor in your network- build a team!**
  - **Mentoring is a two way street.**
    - **Choose wisely. Then be a good mentee!**
    - **Needs alignment of expectations with both sides understanding roles and responsibilities**
  - **Learning how to be a good mentee is a learned skill that takes practice. There will be mistakes!**
  - **Balance good citizenship and "selfish" career development**
- **Mentors:**
  - **Establish expectations and know who you are mentoring.**
- **Mentorship comes with multiple challenges, but these can be overcome by setting expectations and effective communication.**
- **Mentorship is reciprocal and collaborative- pay it forward!**

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HANDOUT

AASPD

Session Breakout 3: Tracking Graduates & Reaching Out to Alumni

Lynn R. Kohan, MD
Edward R. Mariano, MD, MAS

11/08/2019
10:30am - 11:30am
11:30am - 12:30pm

HANDOUT

Session Breakout 4: Teaching the Business of Medicine and Practice Management

M. Concetta Lupa, MD
Rene Przkora, MD, PhD

11/08/2019
10:30am - 11:30am
11:30am - 12:30pm

Breakout 4: Teaching the Business of Medicine and Practice Management

Rene Przkora, MD, PhD and M. Concetta Lupa, MD

Friday, November 8, 2019 (Combined notes from both sessions)

Questions to ponder:

1) **What is the business of medicine? What role do we play in it?**
    - **Bundled vs fee for service, payor mix, facility vs provider fees**
    - **Regional difference (type of procedure, anesthetic), provider type differences**
    - **Roles-**
        - **Individuals- responsible billing and practices to our dept and institution.**
        - **To Patients – underinformed about insurance coverage, don't want to impose unnecessary charges, as PDs- service vs educational obligations (the way they play into the system can't be ignored).**
        - **Trainees - Responsibility to teach this to our trainees.**
    - **Distinction vs private vs academic practice, fellows looking to get into pp.**
    - **How do we guide to differences between pp vs hospital based vs academic etc**
    - **Understanding contracts, RVUs**
    - **How to seek employment effectively**
    - **Costs/ lean methodology/efficiency**

2) **What practice management principles are important to understand? To teach?**
    - **Pros and cons of pp vs academic**
    - **Pain management- specific challenges with billing/coding/prior auth**
    - **Timing of discussing billing/coding- introductory lecture? Later in year?**
    - **Hands on experiential teaching (esp in pain management)**
    - **Value we assign to medication in the OR (cost) and equipment**
    - **Understanding reimbursement/economics to patient and institution**
    - **May depend on specialty**
    - **Intraop billing, ASA units, procedural units, RVUs**
    - **How do folks get introduced to leadership/management principles-**
    - **Most fellows see a lot of management even without a specific curricula (observation), communication overlays this as well**

3) **How can we best teach these principles to our fellows in just one year?**
    - **Experientially**
    - **Standardized teaching with follow-up – example- basics of billing and coding, then reinforce later**
    - **Sponsored outside courses**
    - **ASA practice management**
    - **Online modules**
    - **As a group we can create lectures, workshops.**
    - **Fellowships can combine resources to use within the same institution**

- **Relying on subspecialty societies- professional dev courses, having fellows attend these**
- **Peer to peer review (Insurance)- have fellows attend/be involved**
- **Interaction with clinical manager (pain) routine basis, so they know how clinic is run**

4) **Who is best to teach these principles?**
   - **Finding someone in your practice who has worked in different settings who knows about contracts**
   - **People with personal interest in personal finance, etc**
   - **Maybe someone is already in your group who knows these things well**
   - **Lawyers in community who specialize in Dr stuff**
   - **White coat investor website**
   - **Resources for fellows- buy them books on personal investment**
   - **Online resources, blogs**

5) **What are the barriers to teaching the business of medicine and practice management in a fellowship curriculum?**
   - **Many of us came into our jobs without much business background**
   - **There are only so many things you can do with your time**
   - **It's not really our primary interest!**
   - **Executive leadership integration maybe not the same in anesthesiology**
   - **Predicting the future – and having experts to find easily who understand these concerns and can teach it**
   - **Not just one person- probably the hierarchy of hospital- people in charge of contract negotiations with insurance companies, devices, etc.**
   - **Finding people in your own department (those who have been in PP, or who have MBAs)**
   - **Utilizing outside resources, such as those in finance etc.**
   - **Codes, RVUs change- hard to keep up.**
   - **Geographic dependent**
   - **Limited amount of time to give lectures.**
   - **Business principles are not tested so they don't get favor with time**
   - **Faculty with appropriate training are scarce**
   - **Low baseline knowledge in this area for most of our learners**
   - **Financial support to teach these business principles (Six sigma)**
   - **ASA Practice Management conference, but costs $$$**

6) **How does the size of the fellowship play a role in curriculum development?**
   - **The smaller the fellowship size, maybe smaller faculty size, equals less resources.**

- **As size of fellowship gets bigger, there may more resources for curriculum/faculty development, however, fellows may have more competing clinical obligations**
- **Strategies: piggybacking off other divisions in your dept, shared lectures, finding the common curriculum**

<u>Things we can do/other thoughts:</u>
Shared curriculum within the department, common principles

- **How much is covered in core residency?**
- **Low lying fruit vs harder to reach**
- **Lectures/online? Outsourcing curriculum**
- **Get fellows more involved in existing committees, business operation meetings**
- **Involving fellows in discussions about our own practice habits/billing (Share RVU information)**
- **Share comments (from patient) with fellows so they see how surveys can influence**
- **Look for preexisting online curricula**
- **Create a shared resource/location online for anesthesia specific curriucula**
- **Televideo sessions with neighboring institutions (Or just doing it in person together if geography allows**
- **Alumni lectures about private practice**
- **Cost lectures – laminated paper with cost of all drugs, placed in OR- helps start conversation**
- **Have clinic manager or business person in group come give a lecture**
- **Integrated fellow lecture series**

<u>Places to put common information:</u>

- **Toolbox, meded portal, podcasts, webinars**

<u>Which topics to address:</u>

- **Strategy, contracts, business, cost**
- **Medicare/Medicaid**
- **Billing**
- **OR efficiency**

Resources:

https://www.acog.org/About-ACOG/ACOG-Departments/CREOG/CREOG-Search/BUSINESS-OF-MEDICINE-TEACHING-MANUAL?IsMobileSet=false

https://www.mededportal.org/publication/1649/

https://www.medscape.com/academy/business

https://www.asahq.org/education-and-career/leadership-development?&ct=ad0fe84e3e1f276a9044553b3ddc6b2cd969d1fbf1f1d36bb0e717c52c50a735011a0d5beff4659d342314623439c829cba8c4e8c7db7aa65f4a6e050941eef8

HANDOUT

AASPD

Updates from the Subspecialties: Adult Cardiothoracic

Douglas C. Shook, MD, FASE

11/08/2019
1:30pm – 2:15pm

HANDOUT

AASPD

Updates from the Subspecialties: Critical Care Medicine

Nicholas Sadovnikoff, MD, FCCM, HEC-C

11/08/2019
1:30pm – 2:15pm

AASPD SUBSPECIALTY UPDATE: CRITICAL CARE

Nicholas Sadovnikoff, MD, FCCM
Brigham and Women's Hospital
Boston, MA

November 8, 2019
Chicago

1

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)
- 2014 SOCCA Changed sponsorship from ASA to IARS, moving annual meeting from October to May

2

Match Process

- SF Match since 2014 (6 match cycles)
- Common Application Service: new as of 2017 cycle
- Standardized LOR: not using
- Exceptions to the Match: unchanged

3

Numbers

	2014	2015	2016	2017	2018	2019
APPLICANT DATA						
Applicant registrations	196	189	194	203	187	171
# Applicant Rank Lists Submitted	147	148	153	157	156	144
Matched Total	127	137	149	150	151	139
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  - 'Couples match' (2)
  - Active military service (1)
  - Outside US at time of application (0)
  - Not eligible for ABA certification (0)
- Applicants remaining in match pool 77, down from 99 in 2018, down from 115 in 2017

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Issues with the ACCM Match

- Exception Process

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Positions matched	127	137	149	150	151	139
Exceptions (%)	31(24)	36(26)	56(38)	41(27)	57(38)	67(48)

  - Process
  - Fairness
  - Transparency
- Programs holding positions out of match/"irregularities"
- Timing – Feb 28 start date for exceptions in 2019

7

2019-2020 Match Timeline

	Date
Applicant Registration Began	November 4, 2019
Exceptions Agreements Begin	April 1, 2020
Rank List Submission Deadline	May 19, 2020
Results Released to Programs	May 26, 2020
Results Released to Applicants	May 26, 2020
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Fellowship Training Begins	July/August 2021

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Program Director Meetings

- SOCCA/IARS sponsored
  - Executive support/guidance from Vivian Abalama
  - Attendance excellent last several meetings
- Future meetings
  - SCCM: Orlando, Monday Feb 17, 2020
  - SOCCA/IARS: San Francisco, Friday May 15, 2020
  - SAAAPM/AASPD: Chicago, Friday November 6, 2020

9

Other Updates

- Improved Fellowship Section in SOCCA Website
  - Enhanced listings/photos
  - Links to Program Websites
  - Links to SF Match
- Recruitment to SOCCA
  - Automatic free resident through fellowship membership upon matching
  - Outreach to lapsed members
- Annual Board Review Course
  - To be taught by recent graduates
  - Day before SOCCA annual meeting to enhance fellow attendance
- Enhanced pathway for dual ACCM/ACTA applicants
  - Greater transparency from either specialty's application process

10

HANDOUT

AASPD

Updates from the Subspecialties: Obstetric

Jennifer E. Dominguez, MD, MHS

11/08/2019
1:30pm – 2:15pm

OBSTETRIC ANESTHESIA FELLOWSHIP UPDATE

Jennifer E. Dominguez, MD, MHS
Assistant Professor
Program Director, Duke Obstetric Anesthesiology Fellowship Program
Department of Anesthesiology, Duke University School of Medicine
November 8, 2019

1

OBSTETRIC ANESTHESIA FELLOWSHIP UPDATE

- 90% of programs have committed to a match through SF Match
- 90% of positions will be in the match
- Exceptions will be honored.
- Contract with *Society of Obstetric Anesthesia and Perinatology* being finalized
- Programs will receive an e-mail with instructions to register for SF Match once available

- **Cost to program:**
  - Year 1: Entry fee + match cost = **$325 per program**
  - Subsequent Years: **$150 per program per year**
- **Cost to Applicant:**
  - **$50 one time fee**
- **Timeline:**
  - November 15, 2020: Applicants can begin registering with SF match
  - Rank list deadline: June 16, 2020 (anticipated)
  - Match Day: June 23, 2020

2

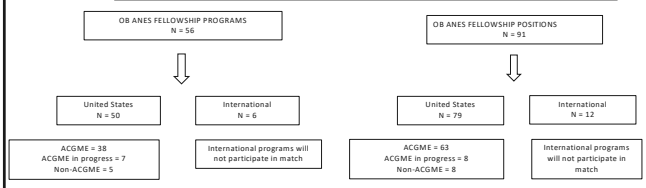
OBSTETRIC ANESTHESIA FELLOWSHIP UPDATE

SF MATCH EXCEPTIONS:

1. Applicants who are in **active military service** at the time of application.
2. **Internal candidates**, i.e. applicants who are currently in the anesthesiology residency program at the same institution as the OB Anesthesia fellowship.
3. **Dual fellowships**: Applicants who are making a commitment to come to the institution of the OB anesthesia fellowship for more than one year.
4. **International/Not ABA eligible:** Applicants who are enrolled in an anesthesiology residency outside the USA at the time of the application, and/or who are not eligible for ABA certification due to non-US training.
5. Applicants whose **spouse or partner is applying for a GME-approved post graduate training program** in a medical specialty in the same region as the OB Anesthesia fellowship.

3

OBSTETRIC ANESTHESIA FELLOWSHIP UPDATE



45/50 US programs in match (90%)

71/79 US positions in match (90%)

4

OBSTETRIC ANESTHESIA FELLOWSHIP UPDATE

BENEFITS?

- Transparent, fair, and valid application process
- Ability to track applicant volume & unfilled positions over time to assess trends.
- Larger applicant volume
- Remove pressure from applicants to make quick, uninformed decisions
- Increased visibility for programs to applicants

CHALLENGES?

- Cost to programs
- Cost to applicants
- Keeping programs committed to process even in years when doesn't serve their interests.

5

HANDOUT

Updates from the Subspecialties: Pain Medicine

Magdalena Anitescu, MD, PhD

11/08/2019
1:30pm – 2:15pm

THE UNIVERSITY OF CHICAGO MEDICINE

Updates on Pain Medicine 2019

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

1

Pain Medicine Programs

- Total for 2020 appointments: 107, 3 withdrawn programs
- Participating (certified) in match: 104, 97% participation
- Filled: 101 (97%), Unfilled: 3 (3%)

2

Pain Medicine Positions

- Total for 2020 appointments: 367 positions
- Filled: 361 (98%), unfilled 6 (2%)

3

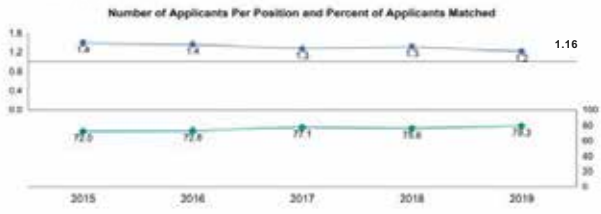
Applicants

- Applicants for 2020 appointment: 426
- Matched: 361 (85%)
- Not matched: 65 (15%)

4

Positions and applicants

- Stable from 2018:
  - 1.3 applicants per position



5

The applicants

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

6

What's new in the Pain World

Future of our fellows

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

8

Pain Medicine Fellowship-2019 Program Requirements

- Several minor issues (qualitative vs quantitative)
- One major issue: **Eliminate the one fellowship per institution requirement.**
- Letters from ASA, ASRA, AAPM, AAASPD, APPD emphasizing
  - The multidisciplinary aspects of the pain medicine fellowship
  - Collaboration between specialties
  - Use all institutional resources based on common planning and not competition

9

June 2019

- Open commentaries session at ACGME
- 6 PD, 5 presenting testimony
  - 1 Neuro
  - 1 Psychiatry
  - 2 PMR
  - 3 Anesthesia
- **Decision was to eliminate the requirement.-LOST**
- Next steps- institutions

10

CONCLUSIONS

- Consistent, high competitive fellowship 20% applicants not matching
- Steady state of the match, now the 7th year.
- Advantages/Disadvantages

• Applicants:	• Program directors	• Programs
– Apply/interview widely, costly	– Many applications/Time consuming	– Potential more
– Time away from work	– No objective data	– Quality of Education
– Extracurricular activities to serve the application best possible	– Short Time of the interview	– Institutional resources

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

11

THANK YOU FOR LISTENING!

12

HANDOUT

AASPD

Updates from the Subspecialties: Pediatric Anesthesiology

Franklyn P. Cladis, MD

11/08/2019
1:30pm – 2:15pm

HANDOUT

AASPD

Updates from the Subspecialties: Regional Anesthesiology and Acute Pain Medicine

Edward R. Mariano, MD, MAS

11/08/2019
1:30pm – 2:15pm

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

@EMARIANOMD

@EMARIANOMD

Disclosures

- None

@EMARIANOMD

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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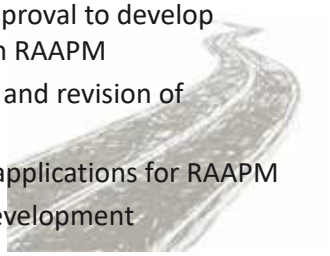
Road to Accreditation

- 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



@EMARIANOMD

The road to accreditation for fellowship training in regional anesthesiology and acute pain medicine

Edward R. Mariano* and Richard W. Rosenquist†

Purpose of review
The purpose of this review is to provide the background and rationale for pursuing accreditation of regional anesthesiology and acute pain medicine (RAAPM) fellowships, explain specific steps and challenges in the process, and forecast the future of fellowship training.

Recent findings
In 2016, the first fellowship program in RAAPM was able to apply for accreditation from the Accreditation Council for Graduate Medical Education (ACGME). The establishment of this newly accredited subspecialty fellowship and the announcement of the first accredited programs represented a tremendous achievement in anesthesiology training and medical education in general and was the culmination of nearly 4 years of dedicated effort.

Summary
Programs with initial ACGME accreditation are on a 2-year term and will be reviewed to evaluate adherence to the program requirements and the quality of fellowship training. Deficiencies identified will need to be resolved or face loss of accreditation. However, a program's maintenance of accreditation represents a commitment to its fellows to provide a training experience that can be held as a benchmark for all programs.

Keywords
accreditation, acute pain medicine, anesthesiology, fellowship, regional anesthesiology

@EMARIANOMD

The road to accreditation for fellowship training in regional anesthesiology and acute pain medicine

Edward R. Mariano* and Richard W. Rosenquist†

KEY POINTS

- The process of accrediting fellowship programs in regional anesthesiology and acute pain medicine was initiated in 2013 with a letter to the Chief Executive Officer of the Accreditation Council for Graduate Medical Education.
- The review of the proposal and development of program requirements preceded the eventual opening of the application period and took approximately 3.5 years.
- Nine fellowship programs in regional anesthesiology and acute pain medicine were accredited in the first round with a total of 12 in the first year.
- Accredited programs will be reviewed regularly to evaluate adherence to the program requirements and the quality of fellowship training, and deficiencies identified will need to be resolved or face loss of accreditation.
- A program's maintaining accreditation represents a commitment to its fellows to provide a training experience that can be held as a benchmark for all programs.

Table 1. The first nine ACGME-Accredited Regional Anesthesiology and Acute Pain Medicine Fellowship Programs

Programs
Stanford University
Cedars-Sinai Medical Center
University of California, San Francisco
Massachusetts General Hospital
Brigham and Women's Hospital
Montefiore Medical Center/Albert Einstein College of Medicine
Icahn School of Medicine at Mount Sinai/St. Luke's-Roosevelt Hospital
Duke University Hospital
Vanderbilt University Medical Center

ACGME, Accreditation Council for Graduate Medical Education.

@EMARIANOMD

Today (2019)

- 84 RAAPM fellowships in US and Canada (+9 from 2018)
- 200+ positions available in the US and Canada

https://www.asra.com/fellowship-directory?showType=1

@EMARIANOMD

1st Site Visits 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

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ACGME-Approved Programs (31)

+9 from November 2018

- Stanford
- Cedars-Sinai
- UCSF
- UCLA-Harbor
- Mayo Clinic (FL)
- Northwestern
- Univ Iowa
- Johns Hopkins
- Mass General
- Brigham & Womens
- Mayo Clinic (MN)
- Dartmouth
- Mt. Sinai SLR
- Columbia
- Cornell
- Mt. Sinai
- Duke
- Univ Cincinnati
- Univ Pittsburgh
- Vanderbilt
- Virginia Mason
- Univ Nebraska
- Montefiore
- Natl Cap Consortium
- Ochsner Clinic
- Ohio State
- OHSU
- Penn State
- UC Davis
- UIC Chicago
- Yale

Continued accreditation achieved in 2019 shown in red.

@EMARIANOMD

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
  - Knowledge/Practice Sharing
  - ACGME Accreditation
  - Common Application (Dr. Brian Allen)

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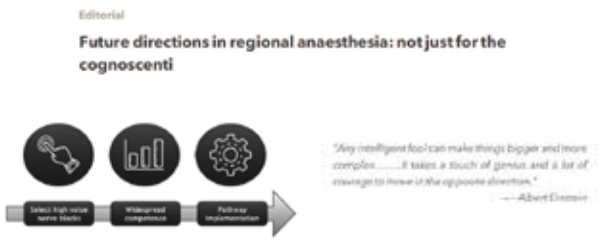
Time to Redefine What is Basic?



Turbitt, Mariano, El-Boghdadly. Anaesthesia 2019 epub

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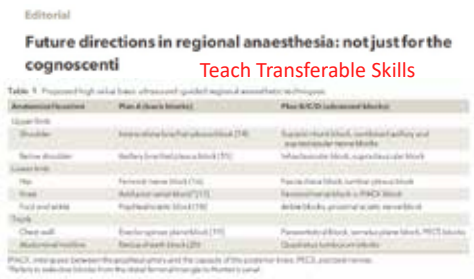

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HANDOUT

AASPD

Subspecialty Breakout Session: Adult Cardiothoracic

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ACCM Program Directors' Meeting

SAAAPM/AASPD
November 8, 2019
Nick Sadovnikoff

1

Agenda

- Welcome/Introductions
  - 2019 match review
  - Timeline for 2020 match
  - Most recent match statistics
  - Exception Process Review and updates
- Future Meeting Dates
- Updates
  - ABA – Brenda Fahy
  - Dual fellowship applications task force – Kevin Thornton
  - Communications – Kevin Hatton
  - SCCM FoTE educational study – Nibras Bughrara
  - SOCCA Fellowship webpage
  - Fellow delegates to ASA Committee Critical Care

2

Agenda

- Old Business
  - CAS/ Standardized Letter
  - Critical Care Ultrasound
  - Membership Committee
  - SOCCA Interchange
  - ACGME language for protected time for PDs
  - Pediatric Requirement/Name of our specialty at ACGME
- Floor open for miscellaneous ideas/debate

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  - Not eligible for ABA certification (0)
- Applicants remaining in match pool 77, down from 99 in 2018, down from 115 in 2017

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ACCM vs ACTA

ACCM
- 62 programs
- 218 positions
- 171 registrations

ACTA
- 67 programs
- 223 positions
- 355 registrations

9

2019-2020 Match Timeline

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11

SOCCA Twitter Handle

@SOCCA_CritCare

Communications update (?)

12

SOCCA BOD Update 5/17/19

- BOD amended the bylaws to expand the board from 13 to 15 members
- PD Chair allotted a non-voting position on the board
- Proposal to coalesce the committees/task forces
  - Membership
  - Education (could/should include U/S?)
  - Communications
  - Research
- Approved free memberships for ACCM fellowship applicants – this constitutes 183 new members as of 5/15

13

SOCCA Fellowship Webpage

- Upgrades in place
  - ? 3 Programs missing
  - Link to website (some have already)
  - PD Headshots (25/59)
  - # of positions
  - Offer 2 year slots?
  - Accept EM applicants?
  - Be sure to check the information for your program and update as needed

14

Old Business

- CAS/ Standardized Letter
  - ? One from PD, one from ICU
- Critical Care Ultrasound
  - First exam January 2019
- Board Review Course
- SOCCA Interchange
- ACGME language for protected time for PDs
  - Persistent silence from ACGME/RRC

15

RRC response re: protected time

The Review Committee for Anesthesiology has begun its preliminary discussions on the focused revisions to the subspecialty program requirements, and expects to finalize the revisions at its September 2019 meeting. Program Director protected time will definitely be part of the proposed revisions, and the Review Committee is working to ensure consistency between all subspecialties. 6/4/2019

16

THANKS!

Thank you all for your participation in the group and your dedication to the promotion and advancement of our subspecialty.

17

HANDOUT

AASPD

Subspecialty Breakout Session: Obstetric

Jennifer E. Dominguez, MD, MHS

11/08/2019
2:45pm - 5:30pm

AASPD OB Anesthesia Subspecialty Breakout Session

Jennifer E. Dominguez, MD, MHS
Michaela Farber, MD

November 8, 2019

1

Agenda

- 2:45 - 3:00 PM: Introductions and Overview
- 3:00 – 3:30 PM: Discuss transition to SF Match
- 3:30 - 3:45 PM: Dr. Glenn Woodworth re: Entrustable Professional Activities
- 3:45 – 4:00 PM: Break
- 4:00 PM – 5:15 PM: Curriculum development/brainstorming
- 5:15 - 5:30 PM: Wrap up/next steps

2

OBSTETRIC ANESTHESIA FELLOWSHIP UPDATE

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1. Applicants who are in **active military service** at the time of application.

2. **Internal candidates**, i.e. applicants who are currently in the anesthesiology residency program at the same institution as the OB Anesthesia fellowship.

3. **Dual fellowships**: Applicants who are making a commitment to come to the institution of the OB anesthesia fellowship for more than one year.

4. **International/Not ABA eligible:** Applicants who are enrolled in an anesthesiology residency outside the USA at the time of the application, and/or who are not eligible for ABA certification due to non-US training.

5. Applicants whose **spouse or partner is applying for a GME-approved post graduate training program** in a medical specialty in the same region as the OB Anesthesia fellowship.

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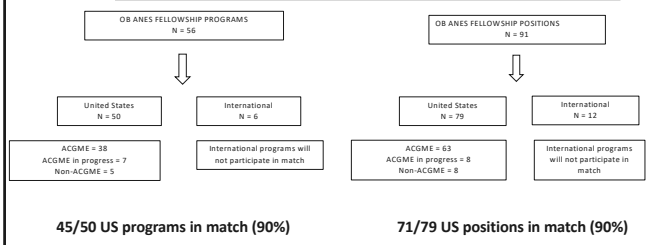
OBSTETRIC ANESTHESIA FELLOWSHIP UPDATE



45/50 US programs in match (90%)

71/79 US positions in match (90%)

5

OBSTETRIC ANESTHESIA FELLOWSHIP UPDATE

BENEFITS?

- Transparent, fair, and valid application process
- Ability to track applicant volume & unfilled positions over time to assess trends.
- Larger applicant volume
- Remove pressure from applicants to make quick, uninformed decisions
- Increased visibility for programs to applicants

CHALLENGES?

- Cost to programs
- Cost to applicants
- Keeping programs committed to process even in years when doesn't serve their interests.

6

HANDOUT

AASPD

Subspecialty Breakout Session: Pain Medicine

Magdalena Anitescu, MD, PhD
Scott Brancolini, MD, MPH
Rene Przkora, MD, PhD

11/08/2019
2:45pm - 5:30pm

THE ASSOCIATION OF PAIN PROGRAM DIRECTORS
ADVANCING EDUCATION IN MULTIDISCIPLINARY PAIN MEDICINE

SAAPM 2019 Meeting
Breakout Session Pain Medicine

SCOTT BRANCOLINI, MD, MPH - MODERATOR
ASSOCIATE PROFESSOR, UPMC
PRESIDENT, APPD

RENE PRZKORA, MD, PHD - MODERATOR
ASSOCIATE PROFESSOR, UNIVERSITY OF FLORIDA
VICE-PRESIDENT, APPD

11.8.19

1

FINANCIAL DISCLOSURES

- DR. BRANCOLINI – NONE
- DR. PRZKORA – see separate slide
- DR. ANITESCU – will send

2

LEARNING OBJECTIVES

- Review ACGME Pain Medicine Fellowship Program Requirements
  - Updates regarding more than one pain fellowship per program
- Review 2019 Match data
- Update - Practice and Business Management Curriculum Development – Rene Przkora, MD, PhD
- Pain Medicine Journal – Magda Anitescu, MD, PhD
- APPD Elections

3

ACGME Pain Medicine Program Changes – I.B.1.b

- **I.B.1.b)** There must be an institutional policy governing the educational resources committed to pain medicine that ensures cooperation of all the involved disciplines. There must be only one ACGME accredited pain medicine program within a Sponsoring Institution, and a single multidisciplinary fellowship committee to regularly review the program's resources and its attainment of its stated goals and objectives. (Core) [Moved from I.B.4.]

4

ACGME Pain Medicine Program Changes – I.B.1.b

- Now permitted to have >1 pain fellowship per institution.
- Must be an institutional policy and multidisciplinary review committee
- Each institution must decide if there are enough resources
- New pain medicine programs must submit their own application to see if resources are adequate
- Any volunteers to help draft a sample policy ?

5

Accreditation Council for Graduate Medical Education

June 14, 2019

Dear Colleagues,

Earlier this week, the ACGME Board of Directors approved a major revision of the Program Requirements for Graduate Medical Education in Pain Medicine, with a July 1, 2019 effective date. The Requirements are available under the "Future Effective Date" heading on the Program Requirements pages of the Anesthesiology, Neurology, and Physical Medicine and Rehabilitation sections of the ACGME website. The ACGME thanks all who participated in the public comment process and/or the ACGME Committee on Requirements open forum.

The new Requirements continue to emphasize a multidisciplinary approach to pain medicine. Programs must adequately demonstrate their commitment to the multidisciplinary nature of the specialty with applicable faculty member appointments. A multidisciplinary program in pain medicine must be conducted in an institution and/or participating sites that sponsor(s) ACGME-accredited residencies in at least one of the following specialties: anesthesiology; physical medicine and rehabilitation; and child neurology or neurology. This will allow Sponsoring Institutions with a single program the flexibility to develop a pain medicine fellowship if they meet the multidisciplinary faculty requirements.

Secondly, there may be more than one ACGME-accredited Pain Medicine program overseen by a Sponsoring Institution. There must be an institutional policy governing the educational resources committed to pain medicine that ensures cooperation of all the involved disciplines as well as a multidisciplinary fellowship committee in place to regularly review the resources and attainment of stated goals and objectives of all of the institution's Pain Medicine programs. This requirement allows each institution to decide if it can demonstrate that resources are adequate for more than one pain program, and new pain medicine programs will be required to submit an application demonstrating sufficient resources are in place to support the program.

Accreditation Council for Graduate Medical Education
401 North Michigan Avenue
Suite 2000
Chicago, Illinois 60611
T: 312.755.5000
F: 312.755.7498
www.acgme.org

6

ACGME Program Directors Feedback

- Position statements not in favor of > 1 pain fellowship per institution
  - ASRA
  - ASIPP
  - AAPM
  - ASA
  - AASPD
  - APPD
  - Individual programs

7

Testimony Given: June 7th, 2019 – ACGME Headquarters

- Dr. Anitescu
- Dr. Przkora
- Dr. Barad
- Dr. Wahezi
- Dr. Brancolini
- Dr. Rathmell
- Dr. Pingree
- Dr. Issa

8

Pain Medicine Applicants' Residency Specialties
Appointment Years 2015-2017

	2015		2016		2017	
Residency Specialty	All Applicants	Matched Applicants	All Applicants	Matched Applicants	All Applicants	Matched Applicants
Anesthesiology	308 (78%)	230 (80%)	302 (76%)	229 (80%)	292 (74%)	231 (89%)
Emergency Medicine					3	<3
Family Medicine	4	<3	<3	<3		
Internal Medicine	<3		<3		<3	
Neurology	13	6	16	11	15	10
Child Neurology					<3	<3
Pediatrics	<3					
PM&R	65 (16%)	47 (16%)	88 (22%)	58 (20%)	83 (21%)	61 (23%)
Psychiatry	<3		7	3	4	<3
Radiology - Diagnostic	<3		<3	<3		
Internal Medicine/Psychiatry	<3	<3				
Pediatrics/Anesthesiology					<3	<3
Pediatrics/PM&R	<3	<3				
Diagnostic Radiology/Nuclear Medicine/Nuclear Radiology					<3	<3
Total	**397**	**286**	**416**	**303**	**401**	**309**
Percent unmatched		**28%**		**27%**		**23%**

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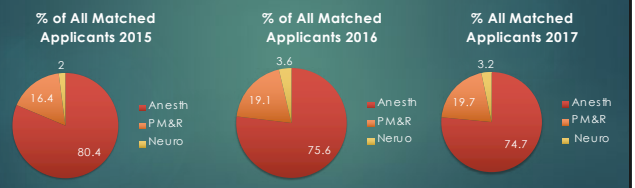
Pain Medicine NRMP Data: % of matched fellows by specialty



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MATCH DATA for 2020-2021 AY

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NRMP Match Data Comparison Data Fellowship Class 2019-2020 & 2020-2021

2019-2020

Program Statistics	Number	%
Enrolled Programs	104	
Withdrawn Programs	1	
Certified Programs	103	
Programs Filled	95	92.2%
Programs Unfilled	8	7.8%
Certified Positions	359	
Positions Filled	345	96.1%
Positions Unfilled	14	3.9%

2020-2021

Program Statistics	Number	%
Enrolled Programs	107	
Withdrawn Programs	3	
Certified Programs	104	
Programs Filled	99	95.2%
Programs Unfilled	6	1.6%
Certified Positions	367	
Positions Filled	361	98.4%
Positions Unfilled	6	1.6%

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NRMP Match Data: Fellowship Class 2020-21

Applicant Statistics	Number	%
Matched Applicants	361	
U.S. Foreign	35	9.7%
MD Graduate	248	68.7%
Foreign	15	4.2%
DO Graduate	60	16.6%
Canadian	3	0.8%
Applicants Preferring this Specialty*	426	
Matched to this Specialty	361	84.7&
Matched to a Different Specialty	0	0.0%
Did not Match to any Program	65	15.3%

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Practice and Business Management Curriculum Development - Upate

Rene Przkora
MD PhD
Professor and Chief of Pain Medicine
Director Multidisciplinary Pain Medicine Fellowship
Department of Anesthesiology
College of Medicine
University of Florida
Gainesville, Florida

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Disclosures

- Pain Medicine Division Chief and Pain Medicine Fellowship Director, University of Florida, Gainesville, FL
- Board Member, Florida Society of Interventional Pain Physicians
- Committee Member: ASA, ASRA and ASIPP
- NIH funding
- Educational Grants from Boston Scientific, Abbott and Medtronic
- Industry Grants from Abbott and Boston Scientific

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Topics

- Background
- Curriculum Development
- Implementation

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Background

- Practice and business management are key components to a successful practice.
- Our impression is that many fellowships rely on residency training to provide exposure to business education and the training during the fellowship year is scant.

17

Background

- Data:

Pain Physician. 2018 Jan;21(1):E43-E48.

Do Pain Medicine Fellowship Programs Provide Education in Practice Management? A Survey of Pain Medicine Fellowship Programs.

Przkora R, Antony A, McNeil A, Brenner GJ, Mesrobian J, Rosenquist R, Abouleish AE.

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Background

- Przkora et al.:

The majority of pain medicine fellows receive some practice management training, mainly on billing documentation and preauthorization processes, while most do not receive business education (e.g., human resources, contracts, accounting/financial reports). More than 70% of fellows reported that they receive more business education from industry than from their fellowships, a result that may raise concerns about the independence of our future physicians from the industry. Our findings support the need for enhanced and structured business education during pain fellowship.

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Curriculum Development

- Joint effort of the APPD and Glenn Woodworth from the *Anesthesia Toolbox*.
- Materials will count as peer-reviewed via the *Anesthesia Toolbox*.

20

Curriculum Development

1. Practice Management			
	A.	Documentation and Coding (E&M) and Compliance	Lecture
	B.	Coverage Policies – (Pre-)Authorization Process and Appeal Process	Lecture
	C.	Center Advisor Committees (CAC)	Podcast
	D.	Scheduling, cancellations and no-shows	Podcast
	E.	CPT/RUC process	Lecture/Online Module
	F.	HCPCS and ASC versus In-office Coding and Billing Charges/Revenue	Lecture/Online Module
	G.	Monthly Financial Reports	PBLD
	H.	Work-Related Value Units (WRVU)	Lecture/Online Module
	I.	Midlevel Supervision (PA/NP) & midlevel insurance reimbursement (incident-to billing etc)	Lecture
	J.	The Difficult Patient	Podcast
	K.	Preauthorization – medications, care and procedures	Lecture
2. Business Management			
	A.	Contracting with Payors	Podcast
	B.	Contracting with Employees - Human Resources – Employment Law	Lecture
	C.	HIPAA	Lecture/Online Module
	D.	Stark Laws/Anti-Kickback Laws/False Claims Act	Lecture/Online Module
	E.	Billing/collection	Lecture
	F.	Business Development	PBLD
	G.	Office rental and renovation – lease and purchase	Podcast
3. Personal Job Management			
	A. Contract evaluation		PBLD
	B. Contract attorneys		Podcast
	C. Non-competes clauses		Podcast
	D. Payment models		Lecture/Online Module
	E. Independent practice versus large single specialty or multispecialty group practice		Podcast
	F. Starting your own practice		Podcast
	G. Red flags in job evaluation		PBLD
	H. Hospital privileging		Podcast
	I. Licenses, DEA, State and Federal Laws		Lecture/Online Module
	J. Negotiation		Podcast
	K. Personal financial management (insurance, investment, retirement)		Lecture
	L. Marketing and practice growth (principles, development, practical points)		Lecture

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Implementation

- Emailed out to the APPD members to sign up.
- Distribute to other interested Faculty.

➡ Please sign up!

22

Contact

- Email:
  Rene Przkora
  rprzkora@anest.ufl.edu
  przkora@yahoo.com

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Pain Medicine Journal
New opportunity for residents and fellows

Magda Anitescu MD, PhD
Professor of Anesthesia and Critical Care
University of Chicago
On behalf of Dr Michael Hooten and Kayode Williams

24

Context

- Multiple Presentations at multiple meetings (ASRA, NANS, AAPM, ASA, etc) regarding novel, innovative case reports or techniques
- Limited time commitment of residents and fellows
- Many interesting ideas lost due to lack of publication

25

Solution: Pain Medicine Journal residents and fellows Forum

Quick turn around approximately 2 weeks
Limited number of editors all on same page
Ensures disseminations of ideas and promotes innovation

26

What is it

- 1500 words (8-10 pages) with max 8-10 references
- Written by residents/fellows actively in training
- Board level questions with answers
- Topics
  - Case reports, case series
  - Innovative use of technology in clinical settings
  - Innovative solution to difficult clinical problems
  - Observations from pilot studies
  - etc

27

Formatting

- Brief introduction or background
- Brief description if the clinical case of challenging clinical scenario
- Brief method section and a separate brief results section
- Brief discussions of key findings and potential clinical implications
- 2-3 board level questions and answers (5 answers with explanations)
- 1 table OR 1 figure
- One author should be staff member from trainee program

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Send us your manuscripts!

- Thanks
- Questions?

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APPD Website

https://appdhq.org/

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APPD Leadership Elections – Congratulations!

- President: Rene Przkora, MD, PhD, University of Florida
- Vice President: Magda Anitescu, MD, PhD, University of Chicago
- Secretary/Treasurer: Sayed Wahezi, MD, Montefiore Medical Center
- Board Members:
  - 1. Lynn Kohan, MD, University of Virginia
  - 2. Boris Spektor, MD, Emory
  - 3. Susan Moeschler, MD, Mayo Clinic, Rochester, MD
  - 4. open
- Past President: Scott Brancolini, MD, MPH, University of Pittsburgh Medical Center

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Future Topics to Discuss?

- Contact us!

THANK YOU

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THANK YOUs!

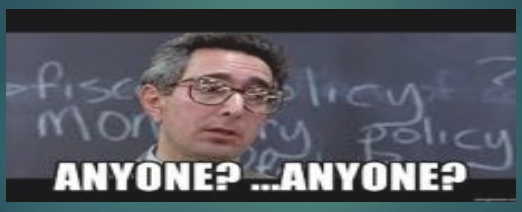
- To a generation of MACKEYS:
  - Ian Mackey, our programmer/website builder
  - New duties to be handled by AAPM
- And of course, Sean Mackey, MD, PhD, exiting board member, Stanford
  - Without whom much of our organization would not exist!
  - Thank you!
- Mark Bicket, MD, PhD, Johns Hopkins – thank you for your tenure on our APPD board.
- Sarah Bilissis, for everything!

33

WAIT…I have a topic

34

Who is on the track for a promotion?



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How about a post meeting:

- Get together
- Email / CV trade
- Happy hour!

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HANDOUT

AASPD

Subspecialty Breakout Session: Pediatric Anesthesiology

Franklyn P. Cladis, MD

11/08/2019
2:45pm - 5:30pm

HANDOUT

AASPD

Subspecialty Breakout Session: Regional Anesthesiology and Acute Pain Medicine

Jeff Gadsden, MD, FRCPC, FANZCA
Christina L. Jeng, MD, FASA

11/08/2019
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. Preparing for site visits in 2019
2. Standardized Program Director evaluations?
3. Discussion

HANDOUT

Overview of EPAs, Workplace-Based Assessment

Glenn E. Woodworth, MD

11/08/2019
10:30am - 11:00am

Entrustable Professional Activities (EPAs)

GLENN WOODWORTH MD, PROGRAM DIRECTOR, REGIONAL AND ACUTE PAIN FELLOWSHIP
Oregon Health & Science University

1

Disclosures

- The speaker has no disclosures

2

2

Learning Objectives

Upon Completion of this activity, participants will be able to:

- Describe the advantages and disadvantages of workplace-based assessments
- Define Entrustable Professional Activity (EPA) as a type of workplace-based assessment
- Compare and contrast different entrustment scales
- Compare and contrast EPAs and Milestones
- Describe the role of EPAs as a part of an overall competency assessment program

3

3

Traditional Assessment

- May not assess competencies important for clinical care
- May not translate to performance in clinical care

4

4

Workplace-based Assessment: Advantages

- Construct validity – meaningful and relevant
- In the wild
- Meaningful to faculty as well

5

5

Entrustable Professional Activities (EPAs)

- Type of workplace-based assessment
- Provide a holistic view of the trainee
- Align scoring with natural judgments about supervision

6

6

Multiple Entrustment Scales

Author					
ten Cate	Not allowed to practice EPA	Allowed to practice under direct, proactive supervision	Allowed to practice EPA only under reactive, on-demand supervision	Allow to practice unsupervised	Allowed to supervise others
Ottawa	I had to do it	I had to talk them through it	I had to prompt them from time to time	I need to be there just in case	I did not need to be there

7

7

Problems with Entrustment Scales

ten Cate	Not allowed to practice EPA	Allowed to practice under direct, proactive supervision	Allowed to practice EPA only under reactive, on-demand supervision	Allow to practice unsupervised	Allowed to supervise others

- Ends of the scale are not as meaningful
- May need greater discrimination in the middle levels

8

8

Modification of Entrustment Scales

2) Allowed to practice EPA only under proactive, direct supervision

a) As a coactivity with supervisor

b) With supervisor in room ready to step in

3) Allowed to practice EPA only under reactive/on-demand supervision

a) With supervisor immediately available, all findings checked

b) With supervisor immediately available, key findings checked

c) With supervisor distantly available, findings reviewed

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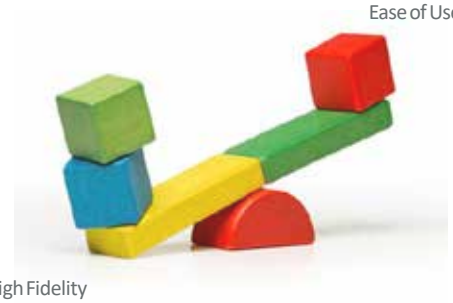
Simplicity vs Fidelity

Ease of Use



High Fidelity

10

10

Workplace-based Assessment: Disadvantages

- Not standardized
- Reliability affected by multiple factors
  - Trainee competence
  - Other attributes of the trainee
  - Patient/Case factors
  - Context
  - Attributes of the supervisor

11

11

EPA vs Milestones

- How are EPAs different from competencies or milestones?
  - EPAs are one type of assessment
  - EPAs are a unit of work
  - Encompass multiple competencies
- EPAs inform milestones

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EPAs Do Not Replace Milestones

- EPAs are one form of competency assessment
- One assessment tool cannot assess all competencies

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Questions

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HANDOUT

Anesthesia EPA Process

Glenn E. Woodworth, MD

11/08/2019
11:00am - 11:30am

Practical Implementation of EPAs in US Anesthesiology Training

GLENN WOODWORTH MD, PROGRAM DIRECTOR, REGIONAL AND ACUTE PAIN FELLOWSHIP
Oregon Health & Science University

1

Disclosures

- The speaker has no disclosures

2

2

Learning Objectives

Upon Completion of this activity, participants will be able to:

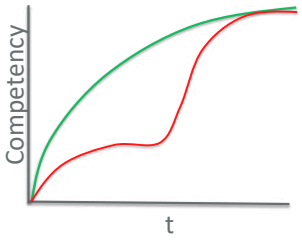
- Describe the current status of EPA use in UME and GME
- Identify implementation of EPAs in international anesthesiology training
- Define the structure of Entrustable Professional Activities (EPAs)
- Describe the process used to develop EPAs for a pilot project in US Anesthesiology training
- Describe the practical implementation of EPS in a pilot project including data collection via a mobile APP and reporting

3

3

What We Know: Assessment

- Competency assessment is important for resident evaluation (CCC)
- Timely assessment and meaningful feedback is critical for learning



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4

What We Know: Faculty Assessments

Faculty dislike filling out assessments

- Burdensome
- Don't think they are meaningful
- Infrequent, not timely, not meaningful

5

What We Know: Problems with Assessments

- Lack of valid and reliable tools
- Assessments are subject to bias
- Require training
- Assessment subject to context
  - Patient factors
  - Resident factors

6

We are Here to Help

- Training
- Decrease burden of submitting (get more data)
- Make assessments meaningful
- Stimulate timely and meaningful feedback

7

Project Goals

- Define EPAs for US Anesthesiology training
- Do not reinvent the wheel
- Provide off-the shelf tools
- Minimalist approach to assessment
- Pilot test an implementation

8

8

Simplicity vs Fidelity

Ease of Use

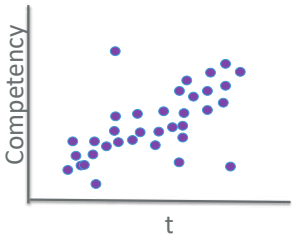
Utility

9

9

Big Data

- Lots of data can wash out many factors that bias or affect scoring
- The assessment system better be easy to use



ten Cate O. Nuts and bolts of entrustable professional activities. J Grad Med Educ. 2013;591):157-8

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10

Anesthesia EPA Pilot Project Approach

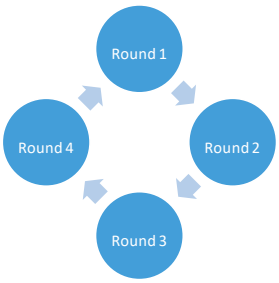
- Learn from our international neighbors
- Formed US Committee
- Checked in with RRC
- Separate out Procedures
- Delphi process to define EPA titles and procedural skills

11

11

Delphi Process

- 110 EPA titles
- Goal: Narrow the list
- Iterative approach to reach consensus



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12

20 EPAs in the US Anesthesiology Pilot

Core Activity

- Preop Assessment
- Airway management
- Transfer of care
- PACU care

Case Based

- General OR Case
- OOR Case
- Labor analgesia
- C/S
- Pregnant Non OB surgery)
- Peds periop care
- Neonatal periop care
- Cardiac surgery
- Thoracic surgery
- Regional anesthesia case
- Chronic pain non OR
- Intracranial procedure
- Major trauma
- AAA
- Critical care non OR
- Acute Pain non OR

13

13

EPA Structure

- EPA Title
- General description of the EPA
- Key Features
- Assessment plan

14

14

Mapping EPAs to milestones

- Each EPA is mapped to the milestones
- Achieving each level of entrustment also achieves milestones

List of Subcompetencies and Milestones (check all that apply to each level of entrustment)	Did Activity Supervisor did the acitvity	Direct Supervision constant or near constant supervision, requires physcial presence	Reactive Supervision Supervisor directed trainee from time to time, trainee often requires consultation	Available if Needed Supervisor was available just in case, reactive supervision that is infrequent	Independent Practice Trainee ready for independent practice
Patient Care 1: Pre_anesthetic patient evaluation, assessment and preparation					
Performs general histories and physical examinations			x	x	x
Identifies clinical issues relevant to anesthetic care with direct supervision		x	x	x	x
Identifies the elements and process of informed consent			x	x	x

15

15

Procedural Badges

- Specific procedural skills
  - Arterial line
  - Central line
  - Single shot interscalene block
- Same method for assessment as Case-based EPAS
- Trainees "earn" entrustment

16

16

Entrustment Scale

- I did it
- Direct supervision – constant supervision
- Reactive supervision – frequent consultation
- Available if Needed– infrequent consultation
- Independent practice

17

17

Supervision is Different than Trust

- But we can't allow trainees to perform independently!
- Score the level of trust in what the trainee could do

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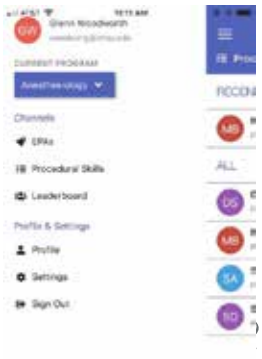
Pilot EPA assessment approach

- Digital portfolio
  - EPAs
  - Procedural badges
- Easy to use APP (minimal clicks)



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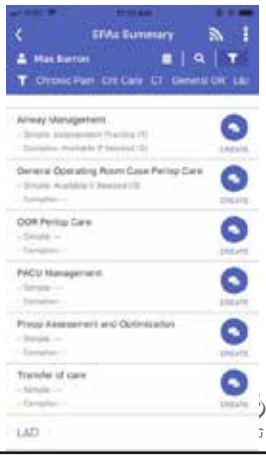
Digital Portfolio

- Total number of assessments
- Current score for each EPA or Procedural Skill
- Based on most recent 5 scores



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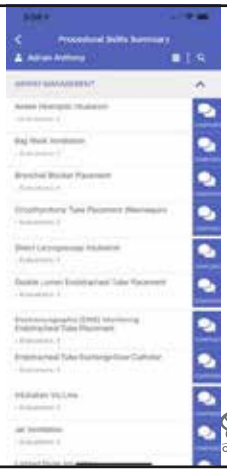
Faculty Version

- Only Total number of assessments visible
- Pros and Cons to this approach



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21

Entering an Assessment

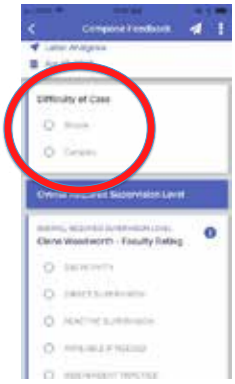
- **Only 3 things to fill out**
  - Difficulty
  - Score
  - Comments

22

22

What Makes Something Complex

- Patient comorbidities
- Complexity of EPA
- Emergency
- Complications



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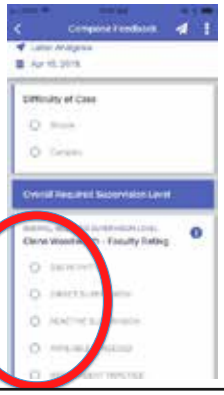
Mark your level of Supervision

- Check the box



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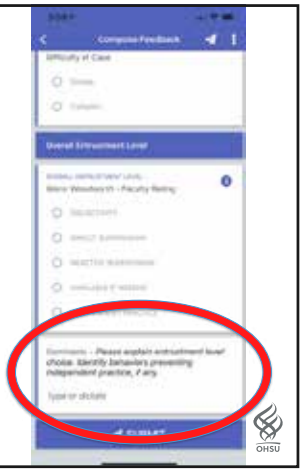
Enter Comments

- Type or dictate your comments
- Then submit



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25

Three Easy Steps

- Complexity
- Score
- Comments

26

26

Don't Forget about Feedback

- Why did you score the EPA the way you did?
- Identify gaps in trainee performance
- Talk about a learning plan

27

27

CCC Reporting

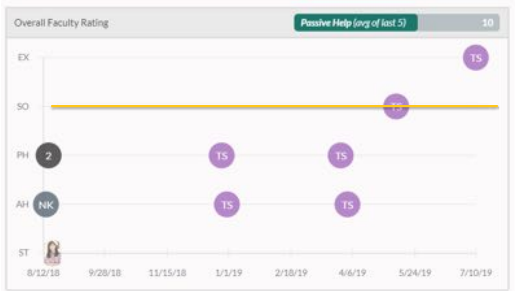
For each trainee view the current level vs graduation target

28

28

CCC Reporting

- Click to drill down on a particular EPA or Procedure to get a graphical view



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Pilot Project Goals

- Score every case or procedure – get in the habit!!!!!
- Provide feedback to the trainee

30

30

Future Directions

- Modify the system based on feedback
- Compare rate and quality of feedback prior to and after implementation of the APP
- Assess the utility of the EPA data to the CCC

31

31

Questions

32

HANDOUT

Implementation of EPAs @ Program Level

Sally Ann Mitchell, EdD, MMSc

11/08/2019
11:30am - 12:00pm

IMPLEMENTATION OF EPAS @ PROGRAM LEVEL

SALLY ANN MITCHELL, EDD, MMSC

Summary
Entrustable professional activities (EPAs) have been defined and incorporated into undergraduate medical education (UME) and graduate medical education (GME) as a framework for operationalizing competency-based assessment of students and trainees across a multitude of institutions and specialties. The EPA data collection instrument is a customized software program available via desktop, laptop, and smartphone/tablet application (APP). Anesthesiologist faculty record the level of complexity, supervision, and entrustment for 20 EPAs as performed by resident trainees during daily clinical practice. The implementation of the concept of EPAs and the APP at the program level are the focus of this presentation. The APP, myTIPreport, is accessible for demonstration at https://mytipreport.org/ As the presenter of this session, I have no disclosures. I have no commercial nor financial relationship with the APP or affiliates.

A consortium of 21 GME academic anesthesiology faculty from 17 institutions/programs used the Delphi method to develop 20 EPAs germane to the practice of anesthesia, which were subsequently mapped to the ACGME anesthesiology residency core program Milestones. Design, development, and long-term findings are beyond the scope of this presentation. Thus, the learning objectives of this presentation focus on implementation and early findings at the program level for Indiana University School of Medicine:

- Describe Keller's ARCS model of motivational instructional design (attention, relevance, confidence, satisfaction)
- Apply ARCS model to implementation of EPAs
- List outcomes of instruction for ARCS (effort, performance, consequences, satisfaction) and instruments used to measure these constructs
- Understand challenges, barriers, and successes of the implementation process - early findings.

John Keller is the developer and founder of the ARCS Model of Motivation. This educational model is based on four key learning process elements which inspire and sustain learners' motivation: attention, relevance, confidence, and satisfaction (ARCS). Details of implementation strategies, materials, and outcomes are presented in the Power Point slide deck. The conclusion addresses a few challenges and successes experienced at IUSM; barriers are considered challenges which have yet to be overcome in the short time given for the pilot study.

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November 8, 2019

Implementation of EPAs @ Program Level

Sally Ann Mitchell, EdD, MMSc
Assistant Professor of Clinical Anesthesia
Vice Chair of Education
Indiana University School of Medicine | Department of Anesthesia

1

Disclosures

None – financial or otherwise

2

Learning Objectives

Describe Keller's ARCS model of motivational instructional design

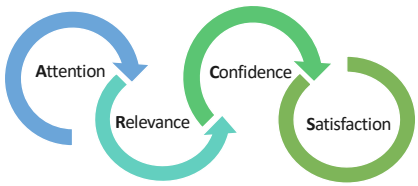
Apply ARCS model to implementation of EPAs

List outcomes of instruction for ARCS and instruments used to measure these constructs

Understand challenges, barriers, and successes of the implementation process - early findings

3

Keller's ARCS model of motivational instructional design



Apply ARCS model to implementation of EPAs

4

ATTENTION

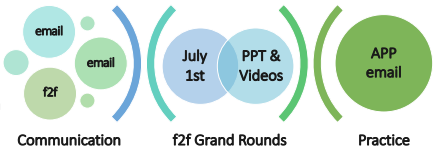
- Methods for grabbing the learners' attention include

Perceptual arousal

Inquiry arousal

Humor

Active participation



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RELEVANCE

- Use concrete examples with which learners are familiar

Experience

Needs Matching

Present Worth

Future Usefulness

6

RELEVANCE

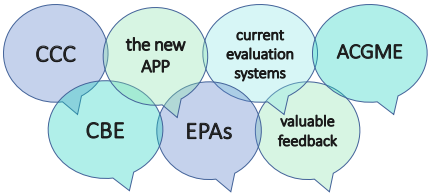
- Use concrete examples with which learners are familiar

Experience

Needs Matching

Present Worth

Future Usefulness



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CONFIDENCE

- Help students understand opportunities for success

Provide objectives and prerequisites

Give learners control

Provide feedback

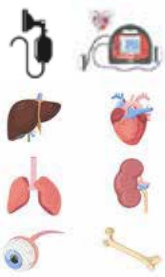
8

SATISFACTION

- Learning must be rewarding or satisfying

Intrinsic reinforcement + Extrinsic rewards = ROI

Provide immediate application opportunities



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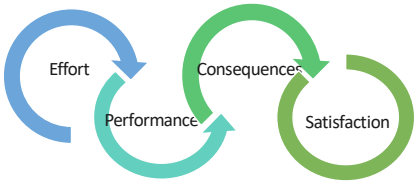
Outcomes of instruction with ARCS



Instruments used to measure these constructs

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Effort

myTIPreport

Faculty = 100; 73; 56

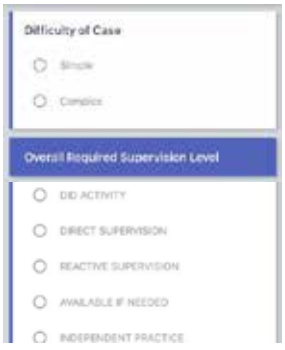
Residents = 78; 76

11

Performance

myTIPreport

Faculty rating of resident



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Performance

myTIPreport

CA2 resident

13

Performance

myTIPreport

CA3 resident

14

Consequences = accountability vs reward

None for pilot phase – educational research only

8 of 78 residents = 0 entries

23 of 78 < 5 entries

Average entries = 8

15

Satisfaction

US/UX – electronic survey questionnaires – rollout, midway, end pilot

Conversations – well received, but . . .

Evidence of use

CCC utility – TBD – need more data

16

Understand the implementation process

CHALLENGES	BARRIERS	SUCCESSES
large program	dispersed orientation	4 sessions in 2 weeks
	faculty FTE	super-users
5 clinical sites	access to OR	3 out of 5
IT firewalls	connectivity	not yet Duo ?!
survey fatigue	no accountability	self-initiated

17

Questions ? ? ?

mitchsaa@iu.edu

18

HANDOUT

Troika Consulting Activity

Amy Miller Juve, EdD, MEd

11/08/2019
1:00pm - 1:50pm

Troika Consult Exercise

You can help people gain insight on issues they face and unleash local wisdom for addressing them. In quick round robin "consultations," individuals ask for help and get advice immediately from two others. Peer-to-peer coaching helps with discovering everyday solutions, revealing patterns, and refining prototypes. This is a simple and effective way to extend coaching support for individuals beyond formal reporting relationships.

Five Structural Elements

1. Structuring Invitation
   - Invite the group to explore the questions "What is your challenge?" and "What kind of help do you need?"
2. How Space Is Arranged and Materials Needed
   - Any number of small groups of 3 chairs, knee-to-knee seating preferred. No table!
3. How Participation Is Distributed
   - In each round, one participant is the "client," the others are "consultants"
   - Everyone has an equal opportunity to receive and give coaching
4. How Groups Are Configured
   - Groups of 3
   - People with diverse backgrounds and perspectives are most helpful
5. Sequence of Steps and Time Allocation
   - Invite participants to reflect on the consulting question (the challenge and the help needed) they plan to ask when they are the clients. 1 min.
   - Groups have first client share his or her question. 1-2 min.
   - Consultants ask the client clarifying questions. 1-2 min.
   - Client turns around with his or her back facing the consultants
   - Together, the consultants generate ideas, suggestions, coaching advice. 4-5 min.
   - Client turns around and shares what was most valuable about the experience. 1-2 min.
   - Groups switch to next person and repeat steps.

Tips and Traps

- Invite participants to form groups with mixed roles/functions
- Suggest that participants critique themselves when they fall into traps (e.g., like jumping to conclusions)
- Have the participants try to notice the pattern of support offered. The ideal is to respectfully provoke by telling the client "what you see that you think they do not see"
- Tell participants to take risks while maintaining empathy
- If the first-round yields coaching that is not good enough, do a second round
- Beware that two rounds of 10 minutes per client is more effective than one round of 20 minutes per client.
- Keep the spaces safe: if you share anything, do it judiciously
- Questions that spark self-understanding or self-correction may be more powerful than advice about what to do
- Tell clients to try and stay focused on self-reflection by asking, "What is happening here? How am I experiencing what is happening?"
- Make Troika Consulting routine in meetings and conferences

Ken Steinberg 2019

Troika Consult Exercise

Brief Summary of Steps and Schedule

1. Form groups of three
2. 10 minutes per person
3. Spend 1 – 2 minutes sharing your question
4. Spend 1 – 2 min having the consultants ask you clarifying questions
5. Spend 4 – 5 minutes receiving feedback and advice from your consultants
6. Spend 1 – 2 minutes sharing what you heard and what was most valuable
7. Switch to the next person

Adapted from (last accessed 9.8.2019):
http://www.liberatingstructures.com/8-troika-consulting/

Ken Steinberg 2019

Troika Consult:

Unleashing local wisdom to address current problems or issues

1

Objectives

- Participate in peer-to-peer coaching
- Refine your skills in asking for help
- Improve your listening and consulting skills

2

Steps (10 minutes/concern)

- Identify a problem/challenge
- Get into groups of 3 (people you do not already know)
- Identify a "client" and 2 "consultants" for each of the 3 rounds
- Client shares challenge/problem (1-2 minutes)
- Consultants ask clarifying questions (1-2 minutes)
- Client turns around
- Consultants discuss solutions and coaching advice (4-5 minutes)
- Client turns around and shares what was most valuable

3

HANDOUT

Data Visualization

Ashley Grantham, PhD
Faye Haggar, EdD

11/09/2019
8:00am - 9:00am

Data visualization

Ashley Grantham, PhD
Faye Haggar, EdD

1

Learning objectives

- Define data visualization
- Describe the ways people transform data into visual representation
- Identify opportunities for application of data visualization in GME
- Craft visual presentations of data for effective communication

2

What is data visualization?

- "The graphical representation of information and data"
- "An accessible way to see and understand trends, outliers, and patterns in data"

(Tableau, 2019)

3

How do you communicate training program trends with your program director?

With faculty members?

With trainees?

4

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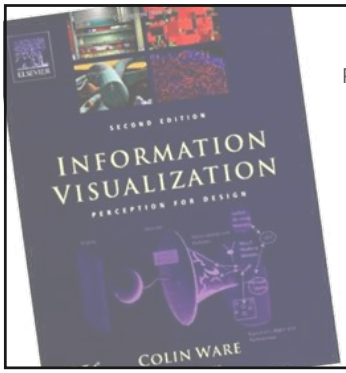

Preattentive visual properties

- Color
- Form
- Movement
- Spatial Positioning

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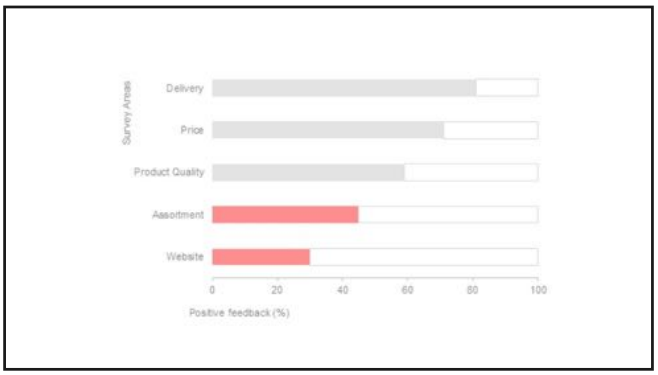

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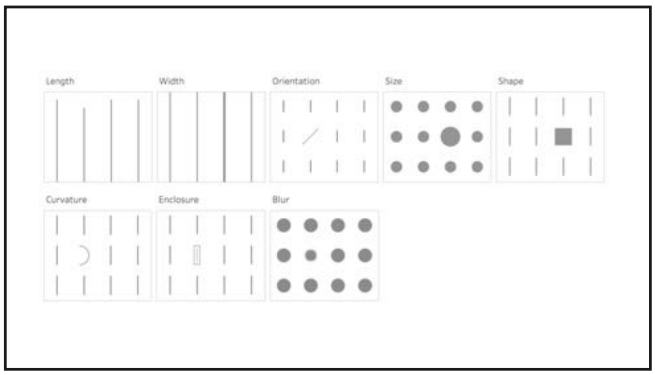

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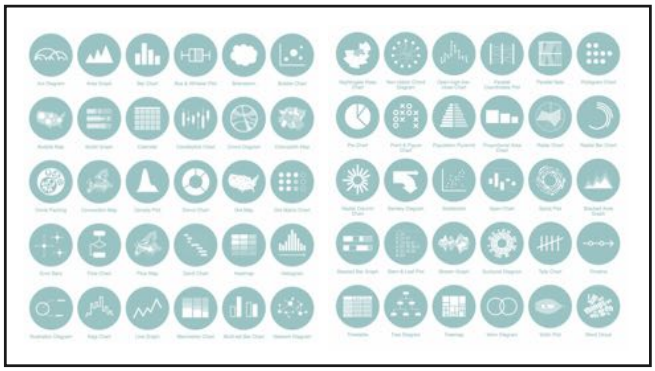
How many chart types can you name?

9



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11

Create a visualization

Year	6pm	6:30pm	7pm	7:30pm	8pm	Total (8:15pm)
2019	22	160	386	612	759	822
2018	13	148	336	523	667	747
2017	0	106	197	321	436	454
2016	33	152	233	303	371	391
2015	0	147	310	542	653	673
2014	0	172	367	619	816	869

12

Benefits of technology in data visualization

- Enables efficient analysis of large amounts of data
- Facilitates easy manipulation of data
- Can allow for "real time" updates

13

How could you use data visualization in your role in your program?

14

Duke dashboard

- Tableau dashboard
- Partnership between education leadership and departmental IT

15

Duke dashboard variables

- Test scores
- Clinical metrics including:
  - Anesthesia technique performed
  - Trainee OR hours
  - PACU LOS
  - ASA class

16

Future applications

- Communicating trends
  - Program
  - Individual learning outcomes
    - Evaluation scores
    - Test scores
- Creating posters and presentations

17

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HANDOUT

ASA Update

Mary Dale Peterson, MD, FASA, MSHCA, FACHE

11/09/2019
8:00am - 8:45am

ASA and SAAAPM: Partnering for a Better Future

Mary Dale Peterson, M.D., MSHCA, FACHE, FASA
ASA President
November 11, 2019

American Society of Anesthesiologists

asahq.org

1

Disclosures and Objectives

- Nothing to disclose
- Objectives: Participants will learn
  - How ASA is working with our 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

2

Special Thank You to SAAAPM Leadership

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Cynthia A. Wong, M.D.
University of Iowa Carver College of Medicine

4

Today's Discussion

- ASA: Who We Are and how we are working with SAAAPM
- Membership Update
- Advocacy & Awareness Update
- Key ASA Initiatives and Programs
- Q & A

5

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. Educational Resources
3. Health Systems Leadership
4. Member Growth & Experience
5. Quality & Practice Advancement
6. Scientific Discovery

6

We are ASA: Subspecialty Partner and Advocate

7

Enhanced Focus on Academic Community/Research Activities

ANESTHESIOLOGY 2019

- ASA worked extensively to address the academic community concerns with the annual meeting.
- In Orlando there was a dedicated research track, including 30+ academic and research educational sessions and events – sessions led by AUA, FAER, IARS and *Anesthesiology.*
- Research Central was home to featured abstracts that highlighted the best science in the specialty.
- A Research Lounge was available in partnership with ASA, AUA, IARS and FAER.
- Revised Affiliated Subspecialty Society Kiosks were in ASA's Resource Center where subspecialty leadership discussed research and society activities.
- The "SEA/ASA Distinguished Educator in Anesthesiology Award" was launched.

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Enhanced Focus on Academic Community/Research Activities

Key Challenges and Opportunities facing academic anesthesiology.

- Insufficient funding for research.
- Lack of recognition of, and appreciation for, the expertise within the specialty and its contributions to medicine as a whole and national public health.
- Insufficient academic institutional support for research and the development of physician scientists.
- Difficulty of sustaining a culture of inquiry and problem-solving in a specialty constrained by financial imperatives.
- Preserving the future of the specialty.
- Advancing anesthesiology practice, including developing new drugs.

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Enhanced Focus on Academic Community/Research Activities

Anesthesia Research Collaborative (ARC) - ASA, FAER, IARS

Major Themes

1) Communicating the value of anesthesia research to influence institutions, policy makers, NIH, and other external funders
2) Strengthening the research environment- what makes a good environment? How can we replicate successful environments?
3) Engaging stakeholders- identify areas where there is agreement on where research is needed that aligns with our specialty's strengths.

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Enhanced Focus on Academic Community/Research Activities

- 2020 annual meeting keynote will be Francis Collins, M.D., Ph.D., director, National Institutes of Health.
- ASA also has the Committee on Academic Anesthesiology, and Committee on Research supporting scientific research in addition to the ASA Academic Caucus.
- Foundation for Anesthesia Education and Research funding from ASA at $2million per year

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Membership Update

American Society of Anesthesiologists

asahq.org

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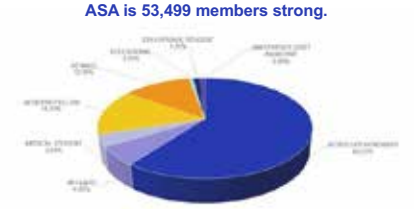
ASA Member Distribution

ASA is 53,499 members strong.



*91.16% of SAAAPM members are ASA members. Thank you!

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Advocacy & Awareness

American Society of Anesthesiologists

asahq.org

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"Nurse Anesthesiologist"

- ASA strongly opposed to term "nurse anesthesiologist."
  - Inappropriate, misleading and confusing to patients.
- Working with targeted states (New Hampshire and Florida)
- Strenghthening truth and advertising laws, e.g., Texas.
- Secured stronger AMA policy

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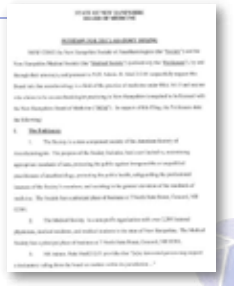
"Nurse Anesthesiologist"

- NH Petition for Declaratory Ruling
  - Requested by NHSA and NHMA
  - "…anyone who claims to be an anesthesiologist…is required to be licensed with the New Hampshire Board of Medicine."
  - "Anyone practicing anesthesiology in New Hampshire without a license from the BoM is potentially subject to liability under RSA 329:24 (unlawful practice)."



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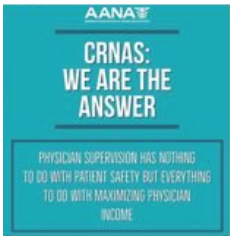
Anesthesiologists vs. Nurse Anesthetists



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2019 Agenda – Economic Strategic Planning Initiative

- ASA Economic Strategic Planning Initiative
  - All economic issues impacting the sustainability of private and academic practices
    - Medicare Payments
      - "33% Problem"
      - MACRA – MIPS and APMs
      - Medicare Advantage
    - Care Delivery Models
    - Medicare for All Implications

CMS

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2019 Agenda – NIH Research

RALLY FOR MEDICAL RESEARCH

- "…7th anniversary of the 'Rally for Medical Research Hill Day' THE BEST ONE YET."
- "…we have now seen four straight years of significant funding increases for the NIH."

Justine Summers, M.D., ASA Resident Scholar, at the Sept. '19 rally (left); and with Senior GOP House Appropriations Committee member, Rep. Tom Cole (OK) (right)

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2019 Agenda – Brain Health Initiative

- Stress of surgery and effects of anesthesia place older patients at risk for delirium and post-operative cognitive disorders.
- Complications results in billions of dollars in costs.
- NIH with NIA, are supporting efforts to address cognitive or brain function.

Lee Fleisher, M.D., Chair, ASA Brain Health Initiative

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2019 Agenda – Pediatric Dental Sedation

Joint Statement on Pediatric Dental Sedation

Joint Statement from the American Society of Anesthesiologists, the Society for Pediatric Anesthesia, the American Society of Dentist Anesthesiologists, and the Society for Pediatric Sedation Regarding the Use of Deep Sedation/General Anesthesia for Pediatric Dental Procedures Using the Single-Provider/Operator Model

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Single Operator Model (AAAOMS) vs. AAPD Model

- Dentist or oral surgeon would have to simultaneously manage the airway, draw up and/or administer rescue medications, recognize and run the code and manage CPR.
- Dental Assistants are not trained or qualified or licensed to draw up or administer medications and cannot perform airway rescue maneuvers.
- AAPD *Guideline on Use of Anesthesia Providers in the Administration of Office-Based Deep Sedation/General Anesthesia to the Pediatric Dental Patient* changed to state that deep sedation or general anesthesia requires licensed anesthesia providers separate from the operating dentist (2018).

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2019 Agenda – Drug Shortages

- Drug shortages have exploded
  - Production disruptions
  - Foreign manufacturers are reluctant to ramp up production
  - New generics take a long time to get FDA approval
- 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

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ASA Leadership on Drug Shortages

- 2018 Drug Shortages Summit (Sept. 2018)
  - "Drug shortages as a Matter of National Security: Improving the Resilience of the Nation's Healthcare Critical Infrastructure."
  - ASA, AHA, ASHP, DoD, FDA and other key stakeholders.
  - 19 Recommendations for Congress and FDA.
- 2019 National Defense Authorization Act (NADA)
  - Amendment in House version of NADA. Pending on House-Senate Conference.
  - Study of DoD Drug Supply Systems for Application to Civilians (Rep. Raja Krishnamoorthi (D-IL).
- Senator Susan Collins (R-ME) Draft Drug Shortage Legislation
  - Focus: Enhanced FDA and Manufacturer Coordination.
  - ASA staff working with Senator's staff.

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Get Involved in ASA's Efforts

- Provide data to ASA Drug Shortage Registry
  - On asahq.org
  - Data shared with other registries, Congress and the FDA Drug Shortage Office

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2019 Agenda – Resident Physician Debt Relief

- ASA endorsed: H.R. 1554, the "Resident Education Deferred Interest Act" (REDI Act), "Babin Legislation"
- Allows borrowers to qualify for interest-free deferment on their loans while serving in a medical internship or residency program.
- Payments halted during residency through deferment or forbearance processes.
- Loans continue to accrue interest that accumulates to the overall loan balance.

Chad Greene, M.D., (March 2019 Resident Scholar), and Rep. Brian Babin, DDS (R-TX)

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Trump Executive Order on Medicare

Sec. 5. Enabling Providers to Spend More Time with Patients. Within 1 year of the date of this order, the Secretary shall propose reforms to the Medicare program to enable providers to spend more time with patients by:

(a) proposing a regulation that would eliminate burdensome regulatory billing requirements, conditions of participation, supervision requirements, benefit definitions, and all other licensure requirements of the Medicare program that are more stringent than applicable Federal or State laws require and that limit professionals from practicing at the top of their profession;

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Surprise Medical Bills

- ASA Principles
  - Ban surprise medical bills. Patients responsible only for in-network cost sharing.
  - Appropriate payments to providers (prefer no benchmark).
  - Appeals/Arbitration/Independent dispute resolution system to resolve disputes between physicians and insurance companies, including fair arbiter criteria.
  - Enforceable network standards as an essential part of fixing this problem.
  - Looks to successful states (NY, TX) for solutions.
  - With ACEP led a coalition of medical specialty societies to support Ruiz Roe Bill, currently at approximately 100 co-sponsors.

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Scientific & Clinical Information

American Society of Anesthesiologists

asahq.org

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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

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Other Clinical Resources

Among the top 10 most-used ASA member resources:

- ASA Monitor
- Standards, Guidelines, Statements and Practice Parameters
- Online CME courses
- Live meetings
- Coming soon: Clinical Decision Support Tools

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ASA's Research Resources

- Center for Anesthesia Workforce Studies (CAWS)
  - Four national datasets to estimate supply
  - Resource center: Trends in supply, compensation and education
  - Anesthesia-related physician group practices
  - Oversight by the AH CAWR[1]
- Peer-reviewed articles
  - Anesthesia opt-out policy (4)
  - Physician group concentration
  - Billing modifier QZ
  - Perioperative Surgical Home
  - Anesthesia Care Team
- ASA 2018 ANESTHESIA ALMANAC

[1]ASA established the Ad Hoc Committee on Anesthesia Workforce Research (AH CAWR) in Jan 2018 to identify, prioritize and review workforce-related projects undertaken by ASA's CAWS.

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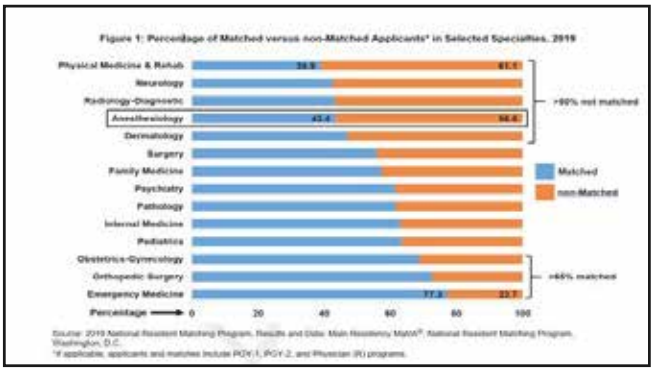

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Professional & Career Resources

American Society of Anesthesiologists

asahq.org

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Professional & Career Resources

- ASA is ramping up its portfolio of benefits, products and services to help you reach your professional and 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 on ASAHQ.org

Anesthesiology Career Center

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Q & A
Thank you!
American Society of
Anesthesiologists
asahq.org

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HANDOUT

Why Communication Matters and Why it Fails

Amy Lu, MD, MPH

11/09/2019
9:00am - 9:20am

Stanford HEALTH CARE
STANFORD MEDICINE

Why Communication Matters and Why It Fails

Amy Lu, MD, MPH

Stanford MEDICINE

1

The single biggest problem in communication is the illusion that it has taken place…

George Bernard Shaw

Stanford MEDICINE

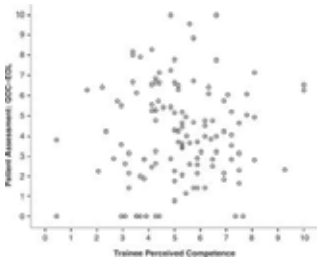
2

"Of course I'm listening to your expression of spiritual suffering. Don't you see me making eye contact, striking an open posture, leaning towards you and nodding empathetically?"

Stanford MEDICINE

3

Physician Self-Assessment vs. Patient Assessment of Communication Quality



Dickson, et al., *J Pall Med*. 2012

Stanford MEDICINE

4

The Most Common Procedure

- What is the average number of patient encounters in a physician's career?
  - > 200,000 in a lifetime
- Less training, practice, and feedback than other procedures

Stanford MEDICINE

5

Overview

- **Why communication matters: What does the evidence show?**
- **What are the types of communication failure?**
- **What are effective communication tools?**

Stanford MEDICINE

6

Why communication matters: What does the evidence show?

Research shows better communication skills lead to **Better Outcomes…**

For patients and patient safety
For clinicians and teams
For hospital quality metrics

7

Better Outcomes for Patients

- **Diabetes**[1]
  - Patients whose providers have high empathy scores have significantly lower A1C ($p < 0.001$).
- **Pain Management**[2,3]
  - Enhanced patient-provider communication can reduce pain symptoms and leads to less symptom distress.
- **Adherence to Medications** [4]
  - Communication styles that enhance trust and communication are positively associated with medication adherence ($p < 0.01$).
- **Satisfaction With Care**[5]
  - Providers who use relationship-centered communication models have higher patient satisfaction scores ($p < 0.02$).

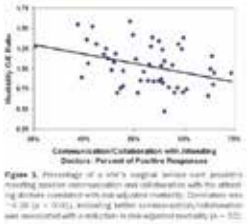
6. Kelley et al., PLoS One, 2014

1. Hojat et al, Acad Med 2013
2. Mistiaen et al, 2016
3. Howick et al., 2018
4. Young et al., 2017
5. Boissy A, J Gen Intern Med, 2016
6. Kelley, PLoS One, 2014

8

Better outcomes for patients in the perioperative period

- **Reduced perioperative morbidity**[1]
  - Better communication and collaboration on surgical teams correlated with improved NSQIP risk-adjusted patient morbidity
- **OR team communication and patient outcomes**[2]
  - Patients were observed to have an increased odds of complications or death when intraoperative information sharing was low



Davenport et al, 2007

1. Davenport DL, J Am Coll Surg, 2007
2. Mazzocco K, Am J Surg, 2009

9

9

Better Outcomes for Physicians and Teams

- **Burnout**[1]
  - Physicians who use relationship-centered communication experience less burnout ($p < 0.001$).
- **Wellbeing**[2]
  - Physicians who practice mindful communication demonstrate higher wellbeing (empathy, mood, mindfulness) and attitudes towards patient care ($p < 0.001$).
- **Workplace Satisfaction**[3]
  - Clinicians who use relationship-centered interviewing techniques report greater personal accomplishment, team cohesion, & workplace satisfaction.
- **Medical Malpractice**[4]
  - A supportive, trusting relationship between the provider and the patient reduces the chance of being sued.

1. Boissy A, J Gen Intern Med, 2016
2. Krasner MS, JAMA, 2009
3. Pollak KI, Patient Educ Couns, 2015
4. Hickson GB, Clin Obstet Gynecol, 2008

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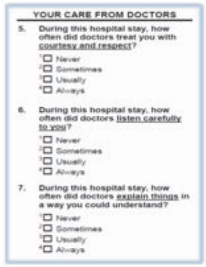
Better for Quality Outcomes and Institutions



- **Improved patient experience**[1]
  - Cleveland Clinic found providers using relationship-centered communication had significantly higher HCAHPS and CGCAHPS scores ($p<0.03$).
- **Reduced readmission rates**[2]
  - Effective physician communication with patients and care teams contribute significantly to postoperative readmission rates.
- **Reduced costs**[3]
  - Patient-centered communication is associated with fewer diagnostic testing expenditures.

1. Boissy A, J Gen Intern Med, 2016
2. Acher AW, J Am Coll Surg, 2015
3. Epstein RM, Ann Fam Med, 2005

11

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Better Outcomes for Patient Safety: CRICO benchmarking report

- CRICO analyzed 23,658 medical malpractice claims and lawsuits filed between 2009 and 2013 in which patients experienced some degree of harm
- 30% of these cases (N=7149) involved failures in communication with $1.7 billion total losses incurred
- 37% of all high-severity injury cases (N=8445) involved a communication failure
- 26% of malpractice claims related to surgery involved one or more communication errors

Source: Malpractice Risks in Communication Failures: Annual Benchmarking Report, Controlled Risk Insurance Company, 2015

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What are the types of communication failure?

- Lingard *et al*[1]. (421 communication failure events over a period of 3 months) characterized lapses in communication:
  - **Occasion failure**: timing of an exchange was requested or provided too late to be useful
  - **Content failure**: in which information was missing or inaccurate
  - **Purpose failure**: issues not resolved
  - **Audience failure**: key individuals excluded
  - **Arriaga's study: Systems failure**
- 36% of communication failures resulted in perceptible effects on system processes including ineptitude, tension between teams, wastage of resources, delays, inconvenience to patients, and procedural errors

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What are the types of communication failure?

- Lingard *et al*. (421 communication failure events over a period of 3 months) characterized lapses in communication into these reasons:
  - **Occasion failure**: timing of an exchange was requested or provided too late to be useful
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- 36% of communication failures resulted in perceptible effects on system processes including ineptitude, tension between teams, wastage of resources, delays, inconvenience to patients, and procedural errors
- Additional studies by Halverson and Hu to validate the

15

Communication failure: Lack of Psychological Safety

What is psychological safety?

"Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes.

A shared sense of psychological safety is a critical input to an effective learning system."

-Amy Edmondson
Psychological Safety and Learning Behavior in Work Teams.
Administrative Science Quarterly, 1999

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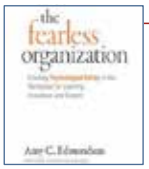
Creating Psychological Safety

The Leader's Tool Kit for Building Psychological Safety

	Setting the Stage	Inviting Participation	Responding Productively
Leadership Tasks:	**Frame the Work** • Set expectations about failure, uncertainty, and interdependence to clarify the need for voice • Framing is ongoing process **Emphasize Purpose** • Identify what's at stake, why it matters, and for whom it matters	**Demonstrate Situational Humility** • Acknowledge gaps • Be inclusive **Practice Inquiry** • Ask good questions • Model interior listening **Set Up Structures and Processes** • Create forums for input • Provide guidelines for discussion	**Express Appreciation** • Listen • Acknowledge and thank **Destigmatize Failure** • Look forward • Offer help • Discuss, consider, and brainstorm next steps **Punish Clear Boundary Violations**
To Accomplish:	Shared expectations and meaning	Confidence that voice is welcome	Orientation toward continuous learning



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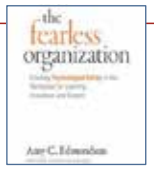
Psychological Safety and Accountability



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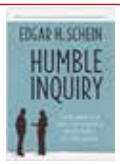
Communication, culture, and appreciative inquiry

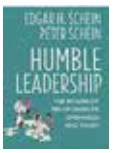
❖**Humble Inquiry: The gentle art of asking instead of telling**

- Humble Inquiry is about asking questions to which you do not already know the answer, of building a relationship based on curiosity and interest in the other person.
- Appreciative inquiry is essential to collaboration, culture, change and leadership.

❖**Humble Leadership: The power of relationships, openness and trust**

- Traditional forms of leadership based on static hierarchies is outdated and ineffective.
- In complex organizations, leadership needs to be more personal to insure open trusting communication that allows for collaborative problem-solving and innovation.





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Teaching and promoting perioperative communication: Simulation, checklists, and manuals

Conley and Gawande showed type of leadership and implementation effort affected success rate of checklist adoption and sustainability[1]

- Team-based approaches with engaged leadership was most successful approach
- Intraoperative team behaviors that improve communication
  - Briefings, information sharing, inquiry, vigilance

1. Conley DM, J Am Coll Surg, 2011

20

Framework for Communication: Teamwork and TeamSTEPPS

- **TeamSTEPPS Communication tools**
  - **Situation–Background–Assessment–Recommendation (SBAR)**
  - **Call-out**
  - **Check-back (Read-back)**
  - **Handoff**

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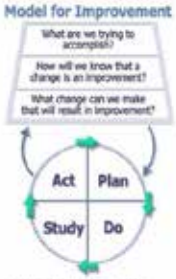
Framework for Safe, Reliable, and Effective Care

22

Framework for Safe, Reliable, and Effective Care



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Ferrari F1 Teamwork

24

Summary

- Communication impacts many arenas of medicine and healthcare
- Communication failures have many causes
- Methods to improve communication include team-based approaches, improving culture and psychological safety, and the quality of these implementation efforts affect their uptake

25

Teamwork and Communication

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HANDOUT

Giving and Receiving Feedback: Creating a Culture to Foster Feedback While Maintaining a Safe Work and Learning Environment

Keith Baker, MD, PhD

11/09/2019
9:20am - 9:40am

Giving and Receiving Feedback

Creating a culture to foster feedback
while maintaining a safe work and learning environment

SAAAPM
November 9, 2019
Swissôtel - Chicago, IL

Keith Baker, MD PhD
Vice Chair for Education
Dept. of Anesthesia, Critical Care and Pain Medicine
Massachusetts General Hospital
Boston, MA USA

1

1

I have **no disclosures** to make & **no conflicts** of interest to reveal

Caveats:
- I will **leave out much** material germane to feedback
- I will **simplify** the results of studies

2

2

Objectives:

Attendees will be able to describe:

1. What it means to have a "learning orientation"
2. How a learning orientation affects the feedback process
3. Broad educational effects of a learning oriented culture

3

3

The Foundation:
A culture based on a **learning orientation**

4

4

We ALL face Challenges

For example, I might…

- get a poor evaluation
- make a medication error
- not know the answer
- get a low test score
- miss the diagnosis
- fail at a procedure
- not get a promotion
- receive some critical feedback

etc…

5

5

When *you* encounter a challenge what is ***your goal?***

Master the Challenge
"Learning Goal"
"Growth Mindset"
"Learning Orientation"

Demonstrate ability
"Validation Goal"
"Performance Goal"
"Performance Orientation"

6

6

Learning Goal Orientation

The active striving toward development and growth in competence

- Implicit belief that ability is **malleable**
- Focuses on ***effort*** and ***strategy*** *as cause of success and failure*
- If a task needs hard work, then apply effort and strategy
- ***Success*** is defined by ***improvement and learning***

7

Performance Goal Orientation

Seeking to validate one's ability, gain favorable judgments of one's attributes and avoid negative judgments of one's self

- Implicit belief that ability is ***fixed***
- Focuses on ***ability*** as cause of success & failure
- If a task needs hard work, then assume low ***ability*** *-> quit*
- ***Success*** is defined as ***doing better than others***

8

What brings satisfaction?

Learning Oriented individuals would say:

I felt very satisfied when:

… I learned something new
… I saw improvement in my work → **Temporal comparison**
… I was totally involved in something I was doing
… I worked hard
… I worked on a challenging task or assignment

Validation Oriented individuals would say :

I felt very satisfied when:

… I got a higher grade than the others → **Social comparison**
… I received recognition or prestige
… I was the only one in class who knew the answer
… all the tasks and assignments were easy

Perrot et al. Adv. Health Sci. Ed. **6,** 193 (2001)

9

People with both goal orientations want to perform well!

The difference lies in **the goals** people have when confronted with challenging learning activities.

Learning/Growth/Mastery: They like to grow, learn and increase their abilities

Performance/Validation: They want to validate and demonstrate their abilities (hence the term "performance", think 'Broadway')

10

2 Concrete examples of what this "looks like":

Let's go to organic chemistry class…

Let's see how a resident responds to a difficult epidural placement…

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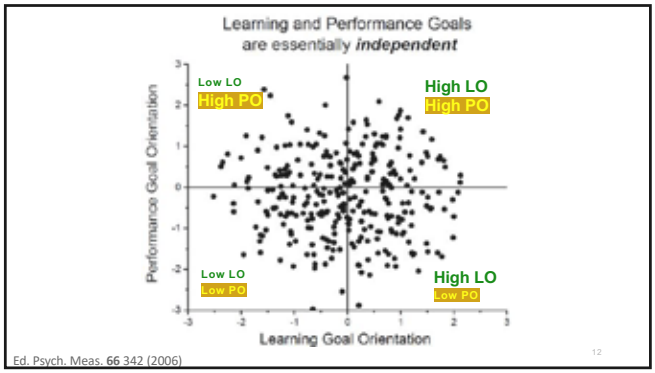

Ed. Psych. Meas. **66** 342 (2006)

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12

A person's Learning Orientation can be increased

Acutely

Nussbaum et al. Pers. Soc. Psychol. Bull **34**, 599 (2008)

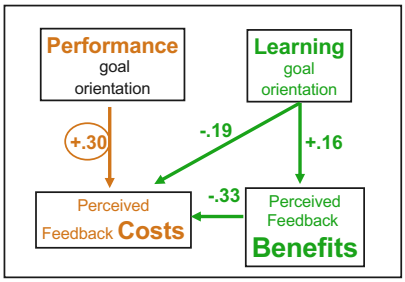
&

Chronically

Heslin et al. J. App. Psych. **90** 842 (2005)

13

Residents find **feedback** more **risky or 'costly'** if they have a **performance goal orientation**



Teunissen et al. Acad Med **84**, 910 (2009)

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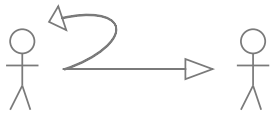
14

A **Learning orientation** usually **harmonizes** with feedback

A **Validation orientation** usually **conflicts** with feedback.

15

Feedback-Seeking



Gong et al. J. Management **43** 1234 (2017), China, MBA, workplace

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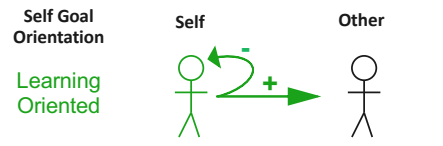
Feedback-Seeking Tendencies



Gong et al. J. Management **43** 1234 (2017), China, MBA, workplace

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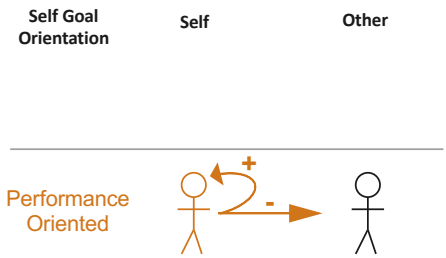
17

Feedback-Seeking Tendencies



Gong et al. J. Management **43** 1234 (2017), China, MBA, workplace

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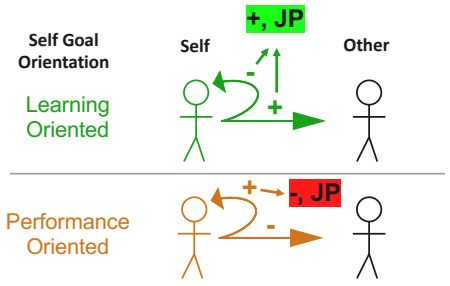
18

Feedback-Seeking Tendencies



Gong et al. J. Management **43** 1234 (2017), China, MBA, workplace

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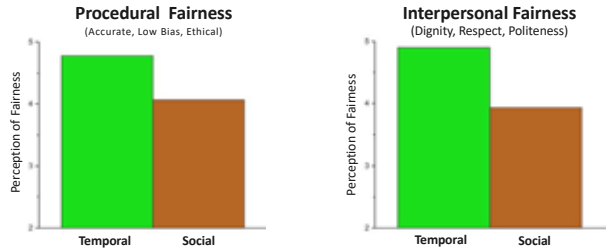
19

Perceptions of fairness are higher when performance evaluations are **relative to the self (temporal)** vs. relative to others (social)



Chun et al. Organ. Behav. Hum. Decis. Process. **145** 1 (2018) Neg valence, N = 400, p = 0.001

20

20

"It's ok....not everyone can be good at math"

Instructors who endorsed an entity theory (Performance Orientation) were more likely to diagnose a student as having low math ability based on a single test score (65%) and were more likely to **comfort** the student for their low ability and use teaching strategies that caused disengagement.

In response to **comfort feedback**:

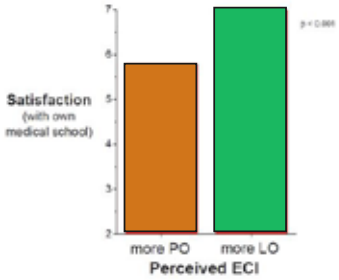
Students felt less supported, less encouraged, less motivated and expected to do worse in the course – even when the professor expressed support for the student and complimented their other strengths.

Rattan et al. J. Exp. Soc. Psych. **48** 731 (2012), college and STEM PhD TAs

21

21

Medical Student's Views of their School's **Educational Climate** Influences their **Satisfaction with their Medical School**



Krupat et al. Acad. Med. **92** 1757 (2017)

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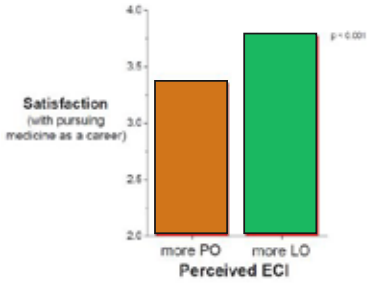
Medical Student's Views of their School's **Educational Climate** Influences their **Satisfaction with Medicine as a Career Choice**



Krupat et al. Acad. Med. **92** 1757 (2017)

23

23

Individuals with a **Learning Orientation** have lower levels of burnout

Dahlin et al. Med Teach. **29** 43 (2007)
Nerstad et al. Scand J Psychol. **59** 661 (2018)
Tuominen-Soini et al. Learning and Instruction **18** 251 (2008)

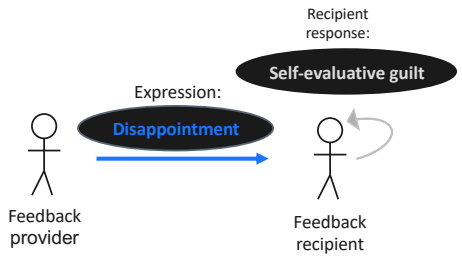
Individuals have less burnout when their leaders have a **Learning Orientation**

Sijbom et al. J. Pers. **87** 702 (2019)
Pensgaard et al. J. Sports Sci. **18** 191 (2000)

24

24

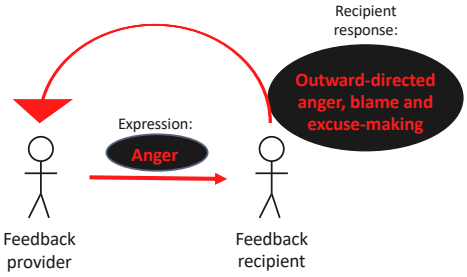
Negative emotions in feedback:
*Expressing **Disappointment***



Johnson and Connelly. Hum. Rel. **67** 1265 (2014)

25

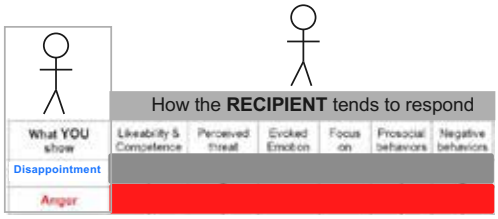
Negative emotions in feedback:
*Expressing **Anger***



Johnson and Connelly. Hum. Rel. **67** 1265 (2014)

26

Negative emotions in feedback:



Johnson and Connelly. Hum. Rel. **67** 1265 (2014)

27

Thanks for your attention

khbaker@partners.org

28

28

HANDOUT

The Millennial Challenge

Teresa A. Mulaikal, MD

11/09/2019
9:40am - 10:00am

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The Millennial Learner

Teresa A. Mulaikal, MD
Residency Program Director
Department of Anesthesiology
Division of Cardiothoracic & Critical Care Medicine

1

Objectives

- Define "Millennial Generation"
- Understand the millennial mindset to better engage and lead our organizations
- How do we safely & effectively communicate with millennials?

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Who are the Millennials? 1980-1996

Traditionalists 1900-1945	Baby Boomers 1946-1964	Generation X 1965-1979	Millennials 1980-1996	Generation Z 1997-early 2000s

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3

Why do they matter?

- In the United States, 73 million millennials born 1980-1996
  - America's largest generation
- To improve our organizational cultures, we need to understand their frames and values

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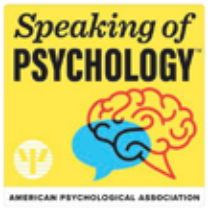
Gallup 2016 How Millennials Want to Work and Live

4

How do they think?

- Positive Self-View
  - Cultural shift to "Individualism"
  - "Generation Me"
  - "Living my best life"
- More tolerant
  - Support same sex marriage
  - Egalitarian view of gender roles



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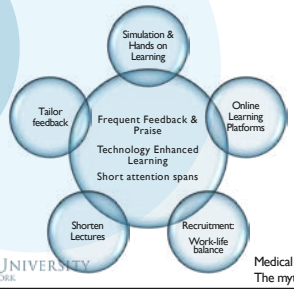
Unlocking the Psychology of Millennials Episode 26

5

Generation Theory for Millennial Learners



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Medical Education 2019; Generational "othering": The myth of the Millennial learner"

6

The Myth of the Millennial Learner

- Generational stereotypes ignore the diversity of individuals within a group
- Socially constructed myth that reflects popular culture not science
- Educators adopt "unconscious bias" in interactions with trainees

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In the City of New York

Generational "othering": The myth of the Millennial learner. *Medical Education*. 2019; 00: 1-6.

7

Thinking about yesterday, how much did you do each of the following? "A lot"

Topic	Millennials	Other Generation
Send / read email message	47%	34%
Send/ read a text message	69%	26%
Make/ receive a phone call using cell phone	48%	34%
Make/ receive a phone call using home land line	5%	11%
Use Twitter, including posting or reading tweets	11%	1%
Post or read messages on Facebook, Instagram, or some other social media site	35%	14%

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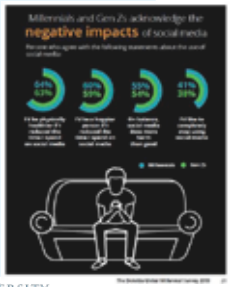
Gallup 2016 How Millennials Want to Work and Live

8

Social Media: Friend or Foe?



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Deloitte Global Millennial Survey 2019

9

Implications for Medicine?

- Health Insurance Portability & Accountability Act (HIPAA)
- Professionalism
- Respect

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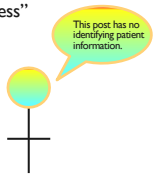
10

Hypothetical Scenario

- An enthusiastic anesthesiology resident is providing care for a patient undergoing an orthotopic heart transplantation. He posts a picture of the donor organ on Facebook.

"Amazing gift, so lucky to be a part of this process"



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11

Hypothetical Scenario

- A resident describes a delirious patient on a WhatsApp group chat. Her peers respond with the following messages.

These patients make it so easy!
#dead haha B52
LMAO lol

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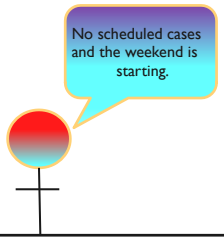
12

Hypothetical Scenario

- Resident on Friday night home call leaves the hospital after his case. It is 11pm and he decides to meet friends at a local bar. He posts pictures of his night on Instagram.

#anesthesialife

#homecall



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13

Group Chats

- WhatsApp, can promote solidarity within a residency class

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14

Instagram & Twitter for Recruitment

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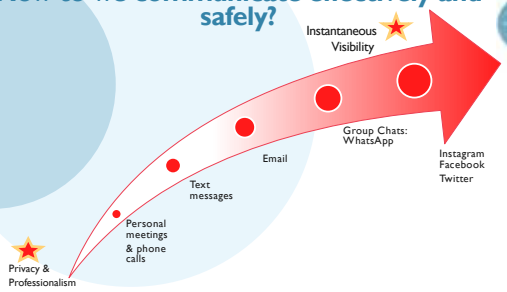
15

How to we communicate effectively and safely?



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16

Tips for Navigating Social Media with Trainees

- Leverage the benefits instantaneous communication and the solidarity it can create
- Educate residents on the importance of HIPAA
- Emphasize respect and integrity
- Collaborate with GME and Compliance Officers
  - Transparency

Constant *Supportive* Communication

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17

References

- "Unlocking the Psychology of Millennials" Speaking Psychology Episode 26, 2015 American Psychological Association.
- Gallup "How Millennials Want to Work and Live" 2016 Survey https://www.gallup.com/workplace
- Deloitte Millennial Survey 2019 "Societal discord and technological transformation create a generation disrupted." https://www2.deloitte.com/global/en/pages/about-deloitte/articles/millennialsurvey.html
- Buckingham M and Goodall A. "The Feedback Fallacy" *Harvard Business Review* March-April 2019.
- Jauregui J, Watsjold B, Welsh L et al. Generational "othering": The myth of the Millennial learner. Medical Education. 2019; 00:1-6.

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18

HANDOUT

Influencing through Communication Styles

Janet M. Shlaes, PhD, MBA, MA

11/09/2019
10:50am - 11:30am

Influencing and Communication

Janet Shlaes, PhD
November 9, 2019

1

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The program content and structure for this presentation were conceived and designed by the presentation facilitator. Your facilitator has disclosed that there is no actual or potential conflict of interest in regard to this program. The planners, editors, faculty and reviewers of this activity have no relevant financial relationships to disclose. This program was created without any commercial support.

2

Learning Objectives

1. Describe key elements of effective communication
2. Identify four main communication styles
3. Employ communication style flexing to influence communication outcomes

3

Agenda

Communication Exemplars → Communication Essentials → Influencing Essentials → Communication & Influencing Orientations → Application

4

Communication Exemplars

5

Essential Communication Qualities

- Clarity
- Credibility
- Authority
- Authenticity

6

Communication Styles: What's your "default" style?

RUSH

Rush System for Health | 10/30/19 7

7

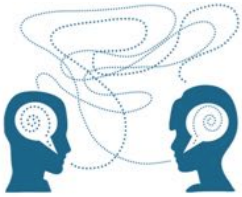
Communication, Influence and Outcomes

RUSH

Rush System for Health | 10/30/19 8

8

Communication Barriers



- Opposing Styles
- Timing
- Differing Agendas
- False Assumptions
- Stress and Fear
- Internal Focus
- External Distractions
- Cultural Expectations

RUSH

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9

Communication Strategies

- Know yourself
- Know your audience
- Know what you want to say
- Know why you want to say it
- Organize your thoughts
- Be direct, specific and clear
- Monitor non-verbal feedback
- Be positive and respectful

RUSH

Rush System for Health | 10/30/19 10

10

Style Flexing in Action: In Pairs

- Think about a time when you had to deliver challenging feedback about a "problem behavior" to a colleague/trainee who has a different default communication style from your style.
- Let your partner know which of the four basic communication styles to embody (your colleague's/trainee's style) and then facilitate a brief feedback conversation with your partner.
- After your brief feedback conversation, your partner will then report back to you their understanding of the "problem behavior."

RUSH

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11

Questions?

RUSH

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12

RUSH | Leadership and Learning Academy

Communication / Influencing Orientations

Goal Oriented	Vision Oriented
• Focus on details, data and driving results • Fast paced thinking and movement • Direct, brief, self-confident and forceful communication style • Action oriented • Motivated by success • Often experienced as impatient	• Creative "out of the box" thinking • Comfortable taking strategic risks • Collaborative focus • Charming, enthusiastic, friendly and optimistic communication style • Can be impulsive in action • Often lacking in follow-through
Task Oriented	**People Oriented**
• Rules, compliance and process focused • Analytical • Focused on "doing things right" • Values objectivity, reliability, accuracy and precision • Tendency to be quiet and reserved • Often focuses on micro-details	• Focus on building relationships, harmony and pleasing others • Values providing support and being perceived as reliable • Viewed by others as calm, patient, humble and an empathic listener • Can often be overly accommodating • Likes stability and can resist change

HANDOUT

Practical Leadership Skills: Negotiation

Laureen L. Hill, MD, MBA

11/09/2019
12:20pm - 1:00pm

PRACTICAL LEADERSHIP SKILLS: Negotiation

Laureen L. Hill, MD, MBA

Objectives:

- Describe the role of negotiation in effective leadership
- Identify key principles to achieve a successful negotiated agreement
- Apply negotiating principles to real-world cases

Good leaders are effective negotiators

Conventional wisdom would suggest good leadership includes vision, charisma and confidence

But, authority has its limits and in some cases you may have to resolve conflict with parties where you have no authority

Need to persuade people to follow your lead: appeal to their interests, communicate effectively and sell your vision; negotiation is less about competition and more about communicating

Negotiation skills = communication skills

Build a bigger pie

Effective negotiation is about making the pie bigger; this is referred to “integrative” negotiation; “Distributive” negotiation on the other hand is “I win, you lose”

Conflict is inherent - it is not negotiation if both parties want the same thing, but that needn’t be hostile

Avoid staking out positions

Focus on *interests*. You can gain more in integrative negotiation by asking lots of questions—ones that are likely to help you understand your negotiating partner’s needs and challenges – this is your source of power at the negotiating table

Avoid asking “yes or no” questions and leading questions, such as “Don’t you think that’s a great idea?” Instead, craft neutral questions that encourage detailed responses, such as “Can you tell me about the challenges you’re facing this quarter?”

Prepare, prepare, prepare

In both integrative negotiation and distributive (adversarial) bargaining, your best source of power is your ability and willingness to walk away and take another deal. Before arriving at the bargaining table, wise negotiators spend significant time identifying their best alternative to a negotiated agreement (BATNA) and taking steps to improve it.

Questions for you to prepare: What do you aspire to? What would you be content with? What could you live with?

If you act as if you're prepared to walk away from a deal unless you achieve your desired goal, your bargaining partner will be far more incentivized to meet your requirements or make serious problem-solving efforts to create enough value so that both of you get what you want.

Don't be afraid to rehearse out loud ahead of time!

It's never about the money

Before negotiating any deal, take a look at the way in which you "value" money and understand if it is a means to another end. Is it status you're seeking? Security? Education opportunity? Promotion? A meaningful break from work that affords you time for other pursuits?

Ask your negotiation partner what they value, prefer, need, fear, prioritize, or desire. Often what is on the table is not entirely consistent or clear

No one appreciates free

Negotiators are not particularly happy when they get what they think they want. They're happier when their bargaining partner says "no" a couple of times before they say "yes" because they are more afraid of leaving money on the table than they are about getting what they think they want, ie: if someone asks for a 5% raise and the boss says "yes" without hesitation, they generally suffer from buyer's remorse, thinking if they'd asked for 7% or maybe even 10%, they may have received it

Don't be afraid to ask

Some studies show that 20 percent of women in the workplace have never negotiated their compensation agreements; Women simply don't ask for higher salaries, compared to men.

It's important to ask for more than you actually want - negotiators call that number an "anchor" because it sets one end of the bargaining range and moves your negotiation counterpart in its direction throughout the course of the bargaining session.

You don't have to prove something that justifies what you want; all you have to do is say it.
Social science research confirms that appearances are reality. In one experiment, students were asked to cut in line at a local retailer. One group was told to give no reason, one a nonsensical reason, and one a good reason.

Here are the compliance rates:

- No reason: 40%
- A good reason: 98%
- A nonsensical reason: 97%

Conversely, never assume everything you hear is true. The bolder, the louder, the more emotional a statement might be, the more likely that statement is either a bullying tactic or a sign of insecurity

Build relationship

Do not leave or take too much on/from the table

Always think about how what you say and do can help establish a long-term business/professional relationship. A long-term relationship not only makes negotiating easier the next time, it also makes your business world a better place.

HANDOUT

Gossip or Fake News

Abiona V. Berkeley, MD, JD

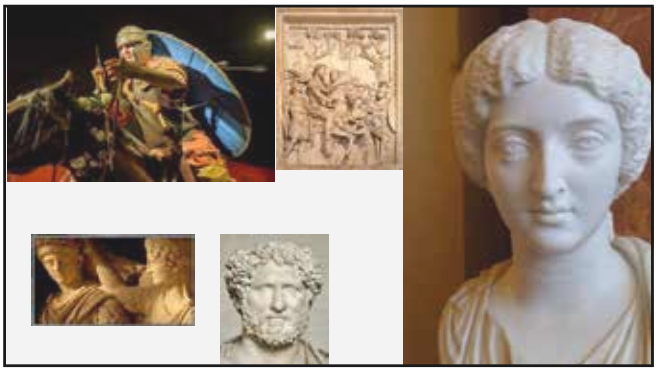
11/09/2019
1:15pm - 1:35pm


GOSSIP AND FAKE NEWS
Abiona V. Berkeley, MD, JD
Associate Professor of Clinical Anesthesiology
Director, Temple Anesthesiology Department Residency Program

1


Roman Empire
175 AD

2



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ROMAN EMPIRE
180 AD

4

5


Is Singapore's "fake news" law curbing free speech
Spy equipment embedded in 2000 rupee
Lisbon earthquake of 1755
Pizzagate
Facebook
Bernardino da Feltre
Spanish-American war
WhatsApp
Benjamin Franklin, American Indians and King George III
Google
Twitter
Increased violence against Muslims in Myanmar
Government conspiracy tied to yellow fever vaccine in Brazil
Witch hunters
Obama injured in White House explosion

6

NO FINANCIAL OR OTHER DISCLOSURES

7

OBJECTIVES

1. Review the use of gossip and fake news throughout history.
2. Examine the factors motivating gossip within the organizational structure.
3. Analyze the impact of social media on gossip and fake news.
4. Investigate the potential use of mathematical models in steering us to "truth."

8

WHY AND HOW DO PEOPLE GOSSIP

Eckhaus, E. & Ben-Hador, B. (2018). To Gossip or Not to Gossip: Reactions to a Perceived Request to Gossip - A Qualitative Study. Trames, 22, 273-288.

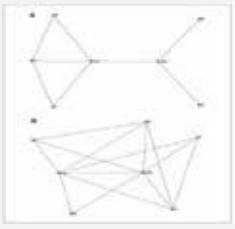
- Gossip is about creating community and defining social norms.
- Gossip may have a negative association which is not truly deserved.
- Eckhaus, et al study:
  - College juniors asked friends and family to describe a 3rd party to another friend.
  - Positive traits used in 3168 texts vs 1054 negative traits.
  - Only 1.5% used physical or appearance based traits and most of those were positive.

9

WHAT ARE THE SOCIAL CONSTRUCTS NEEDED FOR INFORMATION TO FLOW

Grosser, T, Lopez-Kidwell, V. & Labianca, G. (2010). A Social Network Analysis of Positive and Negative Gossip in Organizational Life. Group & Org Manage, (35(2), 177-212.

- Triad of gossiper, listener and target.
- Socialability, shared experiences and privacy.
- Negative gossip signifies a strong bond.
- Neither positive nor negative information flows easily between acquaintances.
- Ellickson, et at look at cattle ranchers.
  - Federal and state laws don't matter where "neighborliness" is prized.
- Positive information may be used to benefit gossiper.

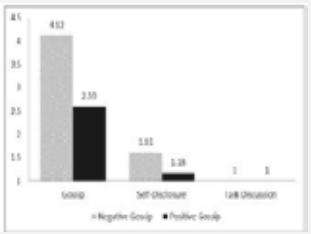


10

WHO DO WE WANT TO EXCHANGE INFORMATION ABOUT AND WHY

Melwani, Shimul, "A Little Bird Told Me So…: the Emotional, Attributional, Relational And Team-Level Outcomes of Engaging in Gossip" (2012) Publicly Accessible Penn Dissertations. 548

- In 2007, McAndrew and Garcia asked college students looked at 12 gossip scenarios with positive and negative information.
  - More interested in persons of our same gender and age.
  - More interested in rivals and protective of friends.
  - More likely to share negative information about rivals or superiors.
  - Positive information about rivals not interesting.
- Melwani, looking at the emotional benefits of gossip found negative gossip improves mood more than positive information does.

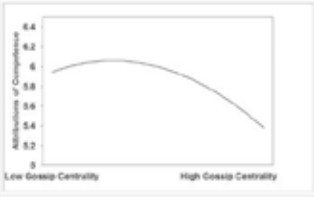


11

GOSSIP AS A GUIDE TO PERFORMANCE

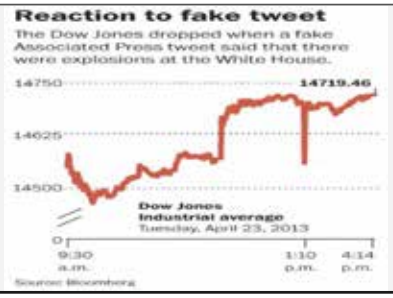
Melwani, Shimul, "A Little Bird Told Me So…: the Emotional, Attributional, Relational And Team-Level Outcomes of Engaging in Gossip" (2012) Publicly Accessible Penn Dissertations. 548.

- Used to define punishment and rewards.
- Kniffin et al, found rowing team members increase gossip when one member bucks the norms.
- Knez et al, looked at a multinational airline and their bonus structure.
- Almost requisite at the highest levels for flow of communication.
- The Pinto.
- Managers consider gossipers low performers.



12

THE RAPID SPREAD OF INFORMATION HAS HUGE POLITICAL, SOCIAL AND ECONOMIC RAMIFICATIONS



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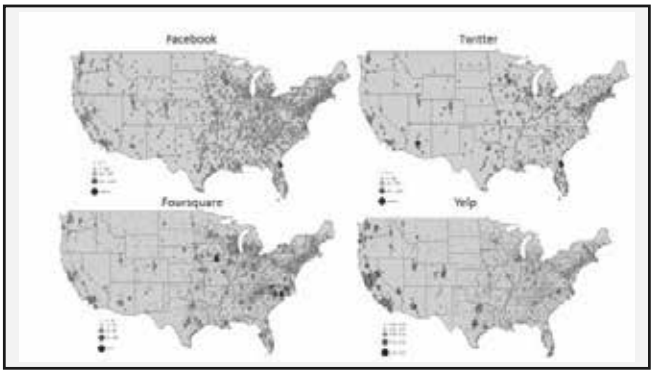
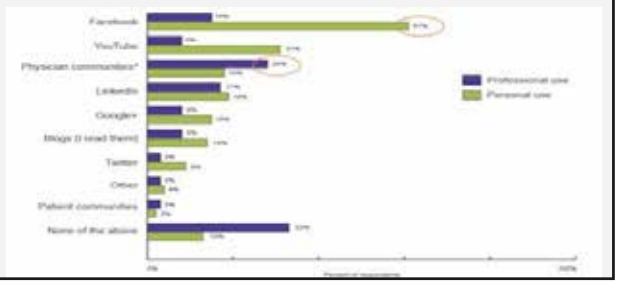


14

PROFESSIONAL AND PERSONAL SOCIAL MEDIA USAGE BY INDIVIDUAL PHYSICIANS

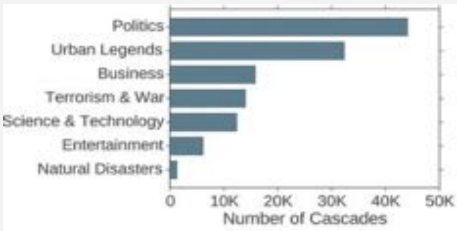
MODAHL, M., TOMPSETT, L., MOORHEAD, T. (2011). DOCTORS, PATIENTS & SOCIAL MEDIA. HTTP://WWW.QUANTIAMD.COM/Q-QCP/SOCIAL_MEDIA.PDF.



15

MOST FREQUENTLY TWEETED INFORMATION BETWEEN 2006-2017

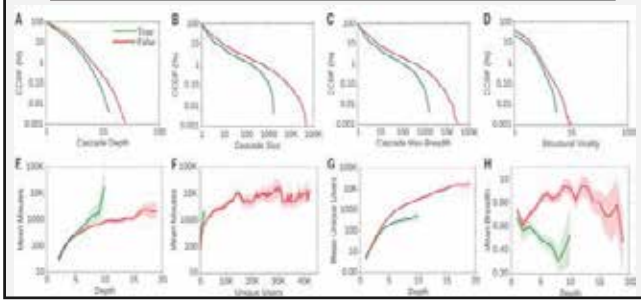
Vosoughi, S, Roy, D & Aral, S. The spread of true and false news online. (2018). Science, 359(6380),1146-1151.



16

COMPARISON OF THE SPREAD OF TRUE AND FALSE INFORMATION ON TWITTER BETWEEN 2006-2017

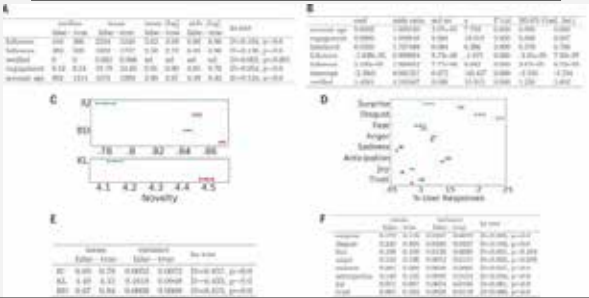
Vosoughi, S, Roy, D & Aral, S. The spread of true and false news online. (2018). Science, 359(6380),1146-1151.



17

FALSE INFORMATION IS MORE NOVEL THAN TRUTH

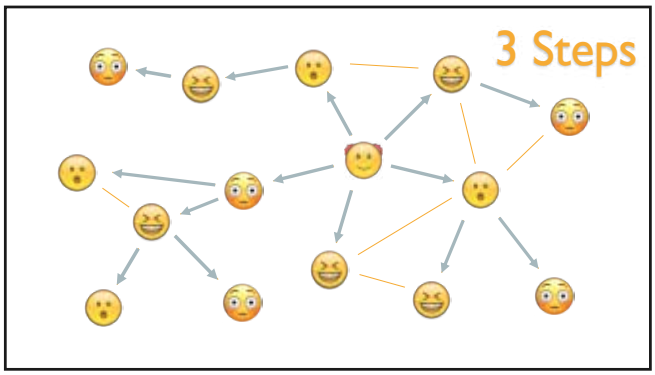
Vosoughi, S, Roy, D & Aral, S. The spread of true and false news online. (2018). Science, 359(6380),1146-1151.



18

MATHEMATICAL MODEL TO DECREASE SOCIAL MEDIA PROPAGATION OF FAKE NEWS

19



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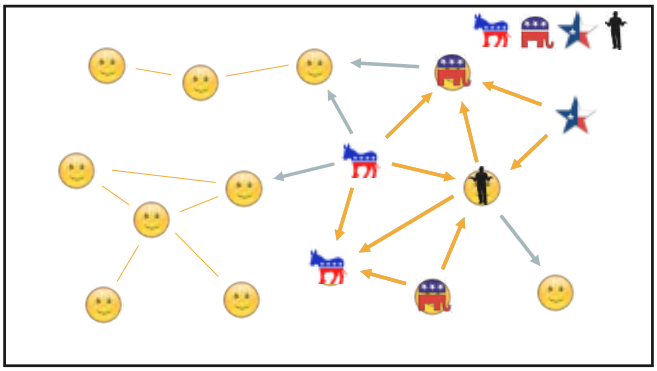

21

THE BOTTOM LINE

- Managers cannot afford to underestimate the significance of gossip.
- Respond in a timely manner to any negative information.
- The gossipers are not necessarily your low performers they may be counteracting information on your behalf.
- The answer to the ultimate question of life, the universe, and everything:
  - $pdl(\{k1,k2,\cdots,ki+1) = 1-f(d,\{k1,...,ki+1\},i+1)$,
  - may indeed be 42.

22

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HANDOUT

The Difficult Colleague

Mohammed M. Minhaj, MD, MBA, FASA

11/09/2019
1:35pm - 1:55pm

Medical Professionalism: Dealing with the "Difficult" Colleague

Mohammed M. Minhaj, MD, MBA, FASA, FACHE
Vice-Chair for Finance & Operations
Associate Chair for Faculty Development
Department of Anesthesia & Critical Care
Vice-President, Medical Staff Organization
University of Chicago Medicine

Disclosures

- Raydiant Oximetry (will not be part of this presentation)

Learning Objectives

- Describe the impact disruptive providers and unprofessional behavior have on health care systems
- Identify predictive factors for unprofessional behavior
- Describe methods to modify unprofessional behaviors

Why Professionalism?

October 25, 2018

Rovenstine Lecture: Professionalism requires a lifetime commitment

David Chestnut, M.D., presented 'On the Road to Professionalism' on Monday.

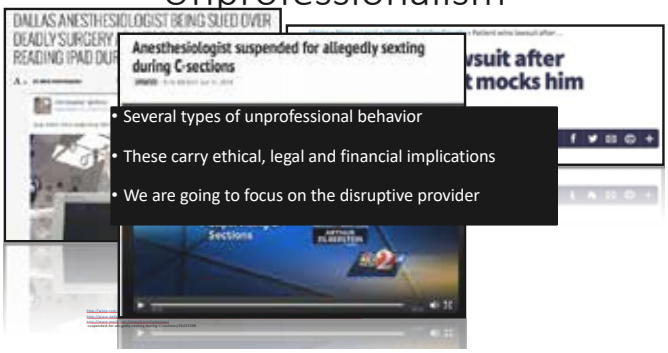
In a soul-searching Emery A. Rovenstine Memorial Lecture on Monday, David Chestnut, M.D., examined the key attributes of professionalism and his own journey on the road to professionalism in anesthesiology.

"Each of us helps shape the culture of professionalism in our practice environment. Professionalism is not something that we learn once. None of us is perfectly professional at all times in all circumstances. Professionalism is both a commitment and a competency that we practice over a lifetime," said Dr. Chestnut, Professor of Anesthesiology and Chief of Obstetric Anesthesiology at Vanderbilt University, Nashville.

The key attributes of professionalism in anesthesiology include humility, leadership, self-awareness, kindness, altruism, attention to personal well-being, responsibility

Professionalism = Organizational Culture

Unprofessionalism

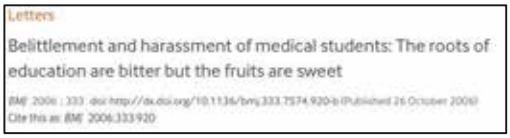


Outline

- What is Disruptive Behavior?
- The Impact of Disruptive Behavior
- Dealing with the Disruptive Provider

How Common is Disruptive Behavior?

- 1-5% of individuals in organizations may be considered disruptive, 6-18% in medicine
- What is now considered disruptive was once **lauded** in medicine

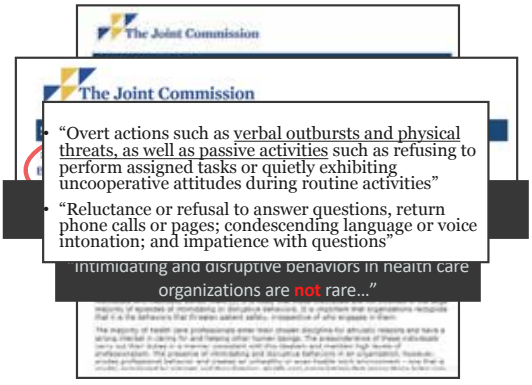

Letters

Belittlement and harassment of medical students: The roots of education are bitter but the fruits are sweet

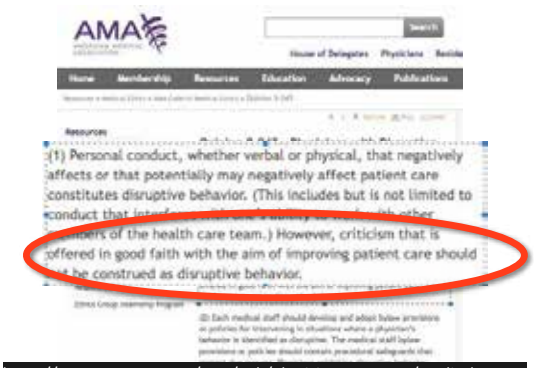
BMJ 2006 ; 333 doi http://dx.doi.org/10.1136/bmj.333.7574.920-b (Published 26 October 2006)
Cite this as: BMJ 2006;333:920

What is Disruptive Behavior?

"You ask me if I have a God complex… Let me tell you something: I **AM** God."



Disruptive behavior is a root cause of communication breakdowns

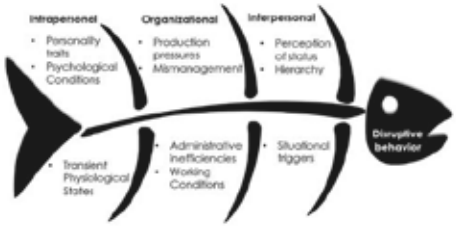


https://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9045.page

What is Disruptive Behavior?

Raising Voice/Yelling
Berating
Throwing instruments
Physical Abuse
Passive Aggressive Behaviors too!

Disruptive behaviour in the perioperative setting: a contemporary review

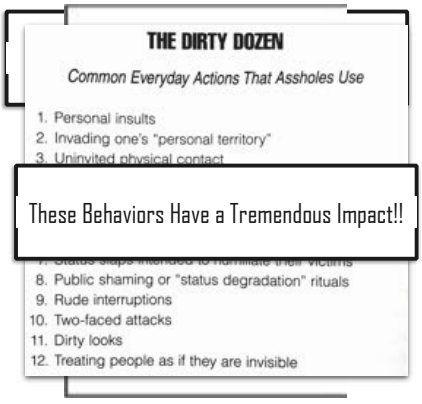


Can J Anesth/J Can Anesth (2017) 64:128–140

What is Disruptive Behavior?

Disruptive Behavior = Workplace Bullying

Disruptive Behavior <u>Destroys</u> Organizational Culture



Outline

- What is Disruptive Behavior?
- The Impact of Disruptive Behavior
- Dealing with the Disruptive Provider

EDUCATION

Impact and Implications of Disruptive Behavior in the Perioperative Arena

Alan H Rosenstein, MD, MBA, Michelle O'Daniel, MHA, MSG

- Study Design:
  - 25 question customized survey
  - Distributed in large urban academic medical center
  - Each member of OR team represented (244 completed survey total)
  - Results analyzed and compared to national research database

J Am Coll Surg 2006;203:96–105.

How Common is Disruptive Behavior?

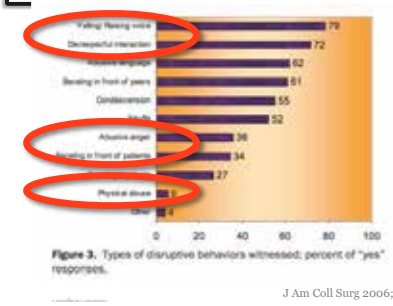
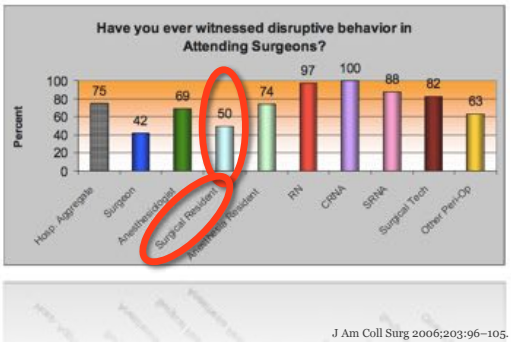
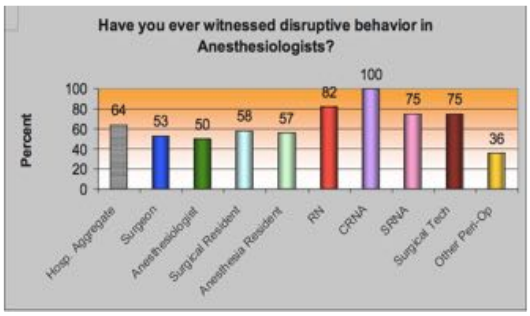


Figure 3. Types of disruptive behaviors witnessed: percent of "yes" responses.

J Am Coll Surg 2006;203:96–105.



J Am Coll Surg 2006;203:96–105.



J Am Coll Surg 2006;203:96–105.

EDUCATION

Impact and Implications of Disruptive Behavior in the Perioperative Arena

Alan H Rosenstein, MD, MBA, Michelle O'Daniel, MHA, MSG

- Conclusions:
  - Disruptive behaviors are extremely common in the perioperative setting
  - Significant **negative** **impact on *team dynamics***
  - Significant **negative** **impact on *communication flow* among the team**

J Am Coll Surg 2006;203:96–105.

PATIENT SAFETY SERIES

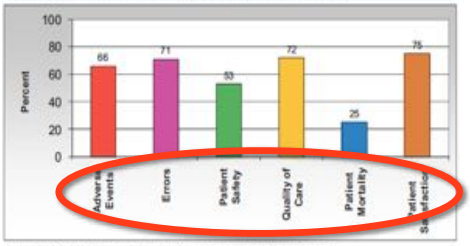
Managing disruptive behaviors in the health care setting: focus on obstetrics services

Alan H. Rosenstein, MD, MBA

- Survey to nurses, physicians and administrators
- A similar incidence of nurse and physician disruptive behavior
- Physician behavior more direct, overt and directed to nurses
- Nurse behavior more passive-aggressive; directed to nurses

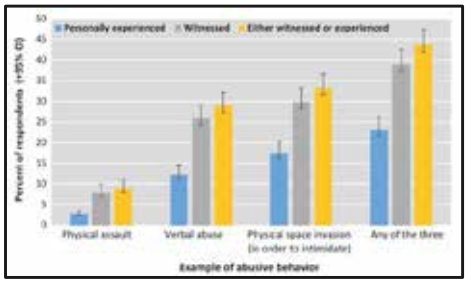
MARCH 2011 American Journal of Obstetrics & Gynecology

FIGURE 2
Linkage of disruptive behavior to undesirable clinical outcomes that occur "sometimes," "frequently," and "constantly"



Rosenstein. Managing disruptive behaviors in obstetrics services. Am J Obstet Gynecol 2011.

Abusive behaviour in Canadian and US operating rooms
Comportements abusifs dans les salles d'opération canadiennes et américaines

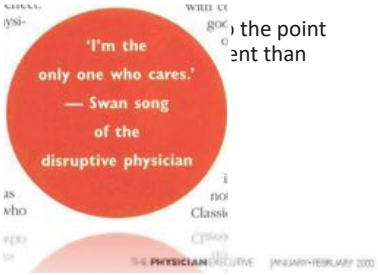


How do Others See the Disruptive Provider?

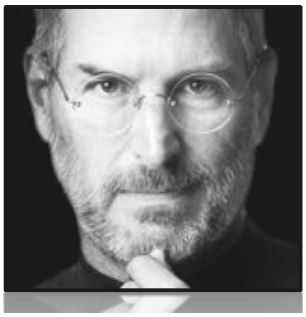
- Arrogant
- Entitled
- Bully
- Morale Killer

How do the Disruptive Providers See Themselves?

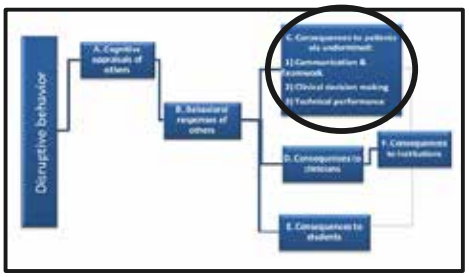
Usually ve the point of believin ent than others.



Why are individuals disruptive?



Disruptive behaviour in the perioperative setting: a contemporary review



Can J Anesth/J Can Anesth (2007) 54:12 pp 1-46

The Impact of Disruptive Behavior

- 12 % of staff members leave hospitals because of disruptive behavior
- 70% of 840 physicians reported witnessing disruptive behavior at least monthly. 10% reported seeing it daily.
- 7% of medication errors may be attributed to dysfunctional behavior
- Estimated cost of $1,000,000/year for a 400 bed hospital

Disruptive Physician Behavior, ACPE Report 2011

The Impact of Disruptive Behavior

- Physician disruptive behavior decreases nurse satisfaction and retention (Am J Nurs 2002;102:26-34)
- Negative effects on patient outcomes (Am J Nurs 2005;105:54-64)
- Reduces morale amongst other workers if behavior does not change--? Punishment (Academic Radiology vol 20;9 2013)
- Decreases respect for physicians and changes career paths for students (J Am Coll Surg 2006;203:96–105.)

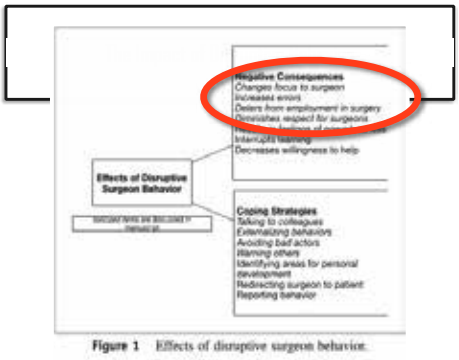
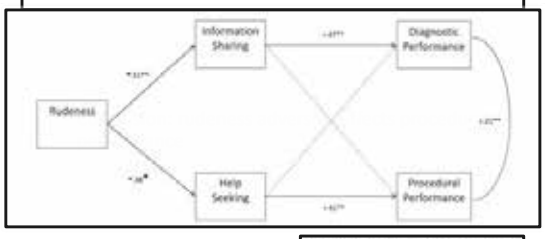


Figure 1 Effects of disruptive surgeon behavior.

The Impact of Rudeness on Medical Team Performance: A Randomized Trial

Arash Riskin, MD, MHP[1], Amir Erez, PhD[2], Trevor A. Foulk, BBA[2], Amir Kugelman, MD[3], Ayala Gover, MD[3], Irit Shorla, RN, BA[3], Kinneret S. Riskin[4], Peter A. Bamberger, PhD[5]



PEDIATRICS Volume 136, number 3, September 2015

The Impact of Rudeness on Medical Team Performance: A Randomized Trial

- Adversely affects procedural and diagnostic performance
- Greater impact than sleep deprivation

PEDIATRICS Volume 136, number 3, September 2015

What about the impact on Medical Students?

Experiences of belittlement and harassment and their correlates among medical students in the United States: longitudinal survey

Erica Frank, Jennifer S Carrera, Terry Stratton, Janet Bickel, Lois Margaret Nora

BMJ. doi: 10.1136/bmj.38924.722007.7C (published 8 September 2006)

Experiences of belittlement and harassment and their correlates among medical students in the United States: longitudinal survey

Erica Frank, Jennifer S Carrera, Terry Stratton, Janet Bickel, Lois Margaret Nora

What this study adds

Most medical students in the United States report having been harassed or belittled during their training

Poor mental health and low career satisfaction are significantly associated with being harassed or belittled

BMJ. doi: 10.1136/bmj.38924.722007.7C (published 8 September 2006)

What about the impact on Medical Students?

Lessons Learned From Comics Produced by Medical Students

Art of Darkness

JAMA December 8, 2015 Volume 314, Number 22

Demand AAMC and ACGME Take Action to Prevent Medical Student and Resident Suicides

The fact is [illegible] medicine with our mental health on par with or better than our peers. **Medical training can be dehumanizing. Fear-based teaching methods often prevail. Public humiliation, bullying, and sleep deprivation are commonplace.** Those who seek help often risk punishment and loss of their careers. Mental health is stigmatized within the medical profession to the detriment of all.

It comes to caring for us. **Please sign this petition to urge the AAMC and ACGME to track medical student and physician suicides, to enact policy requiring medical training programs to take concrete actions to combat the culture of abuse, and to offer routine and confidential on-the-job psychological support to all medical students and physicians.**

http://www.thepetitionsite.com/869/066/029/demand-aamc-and-acgme-put-an-end-to-medical-student-and-resident-suicide/

Outline

- What is Disruptive Behavior?
- The Impact of Disruptive Behavior
- Dealing with the Disruptive Provider

Professionalism in Anesthesiology

"What Is It?" or "I Know It When I See It"

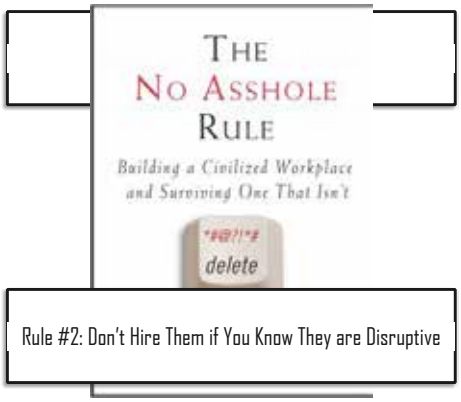
Editor's Note: This is the fourth in a four-part editorial series on the topic of excellence in anesthesia, which includes how it is designed, how it is measured, and how interventions to improve it might be assessed.

James C. Eisenach, M.D., Editor-in-Chief

Rule #1: Create and Model the Culture you Expect

- "Arrogance and pride are self-destructive."
- "Key attributes of professionalism include:
  - Humility
  - Leadership
  - Self-awareness
  - Kindness
  - Altruism…"

David Gheatrut, M.D., presented 'On the Road to Professionalism' on Monday.



THE NO ASSHOLE RULE

Building a Civilized Workplace and Surviving One That Isn't

#@!# delete

Rule #2: Don't Hire Them if You Know They are Disruptive

The Past can Predict the Future

THE NEW ENGLAND JOURNAL OF MEDICINE

SPECIAL ARTICLE

Disciplinary Action by Medical Boards and Prior Behavior in Medical School

Papadakis MA, Teherani A, Banach M, et al. Disciplinary Action by Medical Boards and Prior Behavior in Medical School. N Engl J Med 2005; 353:2673-2682

Physician Behavior

AN INTERVIEW TOOL TO PREDICT DISRUPTIVE PHYSICIAN BEHAVIOR

Edward A. Sandy, II, MD, MBA, Richard H. Beigi, MD, MSc, Clifford Cohel, DSW, and Kenneth C. Nash, MD, MBM

Sutton Model of Dealing with Disruptive Employees

- Say the rule, write it down and act on it
- Power breeds nastiness—don't promote them!
- Disruptive providers will hire other disruptive providers
- Get rid of them fast or keep 1-2?
  - Treat them as incompetent
- Model and teach **constructive** confrontation

Physician Leadership J 2014; 1:36–39.

Managing the Disruptive Provider- A Theoretical Model

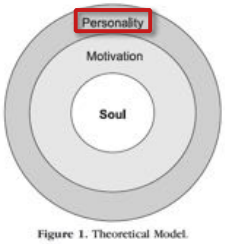
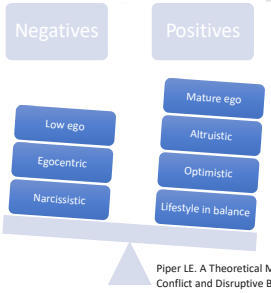


Figure 1. Theoretical Model.

Piper LE. A Theoretical Model to Address Organizational Human Conflict and Disruptive Behavior in Health Care Organizations

Managing the Disruptive Provider— A Theoretical Model: Personality Attributes



Piper LE. A Theoretical Model to Address Organizational Human Conflict and Disruptive Behavior in Health Care Organizations

Managing the Disruptive Provider—A Theoretical Model

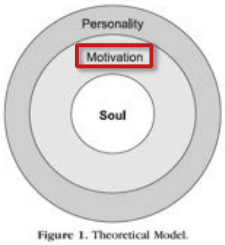
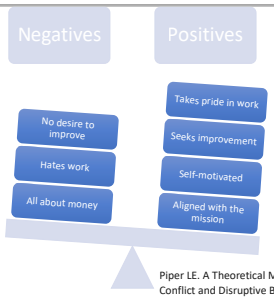


Figure 1. Theoretical Model.

Piper LE. A Theoretical Model to Address Organizational Human Conflict and Disruptive Behavior in Health Care Organizations

Managing the Disruptive Provider— A Theoretical Model: Motivation Attributes



Piper LE. A Theoretical Model to Address Organizational Human Conflict and Disruptive Behavior in Health Care Organizations

Managing the Disruptive Provider—A Theoretical Model

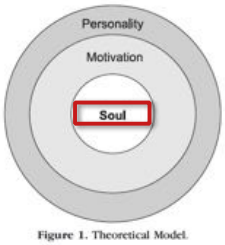
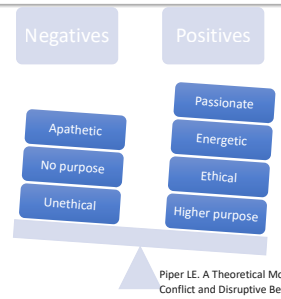


Figure 1. Theoretical Model.

Piper LE. A Theoretical Model to Address Organizational Human Conflict and Disruptive Behavior in Health Care Organizations

Managing the Disruptive Provider— A Theoretical Model: Soul Attributes



Piper LE. A Theoretical Model to Address Organizational Human Conflict and Disruptive Behavior in Health Care Organizations

Managing the Disruptive Provider—A Theoretical Model

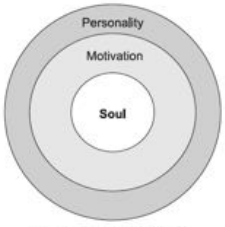


Figure 1. Theoretical Model.

Piper LE. A Theoretical Model to Address Organizational Human Conflict and Disruptive Behavior in Health Care Organizations

Managing the Disruptive Provider—A Theoretical Model

- Confront employees with conflict issues and apply the model to educate their understanding of their conflict behavior
- Renew leadership commitment to understand and address conflict in the workplace
- Provide inservice to leadership on organizational conflict dynamics
- Hire people with positive characteristics in soul, motivation, and personality
- **Let go of those with negative characteristics in these areas**

Managing the Disruptive Provider

- Have a clear policy on disruptive behavior (Joint Commission requirement)
- Mechanism for individuals to file anonymous complaints
- Collegial Intervention
- Formal Investigation
- Meeting with the Provider
  - Don't let the provider set the agenda
  - Document the meeting
  - Focus on behavior not personality or its cause
  - Do not send mixed messages

Disruptive behaviour in the perioperative setting: a contemporary review

Table 3 Guidelines for civil behaviour

John Hopkins Rules of Civility that are applicable to the operating room[112]	The Ontario Medical Association's fundamentals of civility[113]
• Acknowledge others: their presence, worth and effort	• Respect others and yourself
• Respect others' opinions, time, space (physical & emotional)	• Be aware
• Speak kindly	• Communicate effectively
• Respectfully assert yourself	• Take good care of yourself
• Don't blame	• Be responsible
• Keep it down	

Can J Anesth/J Can Anesth (2017) 64:128–140

Our

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- Inter

M

- Peer interv
  - Pick the
- Keep risk m
- Employee A
  - Neurops
  - Disrupti
- **DOCUMEN**

Managing the Disruptive Provider—Additional Resources

- Professional Renewal Center, Lawrence KS
- Vanderbilt Comprehensive Assessment Program for Professional
- LifeWings: http://www.saferpatients.com/services/disruptive-behavior/

Managing the Disruptive Provider: Are There Potential Repercussions?

- Multiple lawsuits have upheld disruptive behavior as a legitimate reason to revoke or refuse renewal of staff privileges
- Federal Healthcare Quality Improvement Act of 1986
  - Courts defer to hospitals peer review process
  - Supported by the AMA
- ADA—'The disabilities act forbids discriminating because of physical or mental disability **BUT** the law does not require affirmative action for the mentally ill, nor are employers expected to tolerate drug abuse, disruptive behavior, or violence.'

Let go of those with negative characteristics


The New York Times

SMALL-BUSINESS GUIDE

The Long Odds of Reforming an Employee Who Is a 'Destructive Hero'

Oct. 29, 2014

1980s--celebrated

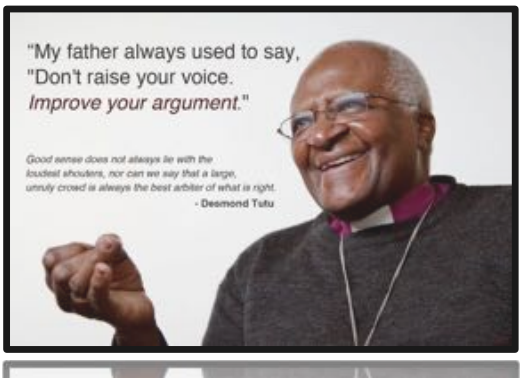
Tennis Podcast: ATP hands Nick Kyrgios a suspended ban – but why did it take so long? 2019

Outline

- What is Disruptive Behavior?
- The Impact of Disruptive Behavior
- Dealing with the Disruptive Provider

Summary

- Disruptive behavior can adversely impact patient care and safety
- Disruptive behavior also has financial, social, and morale implications—it **destroys** culture
- Creating a culture of 'zero tolerance' is not only an admirable goal, but a Joint Commission requirement
- Model **'constructive confrontation'**
- Modifying behaviors with disruptive providers can be difficult but not impossible that requires a multifaceted approach
- Intervene early, outsource as appropriate, and if behaviors cannot be modified **move on**



HANDOUT

Managing Conflict

Jonathan Hastie, MD

11/09/2019
1:55pm - 2:15pm

Managing Conflict

SAAAPM in Chicago, Illinois

JONATHAN HASTIE, MD
November 9, 2019

No disclosures

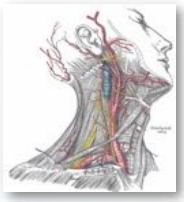
1

Objectives

- Define conflict in the healthcare setting.
- Apply two self-regulation approaches
  - Owning emotions
  - Metacognition
- Describe five conflict management styles.

2

Case 1: The Carotid Endarterectomy



01 68 year old man presents for right carotid endarterectomy.
- History of TIA
- Baseline BP 132/70

02 Preinduction arterial line
BP maintained with SBP 130, MAP 85
EEG placed with good baseline signals

03 Neurosurgeon enters room.
"What are you trying to do? Kill my patient?"

3

Definition & Impact

Managing In

Managing Out

4

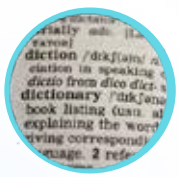
Definition & Impact

Managing In

Managing Out

5

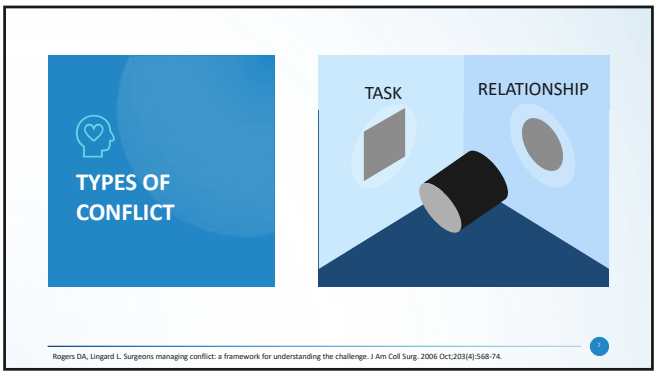
Definition of Healthcare Conflict



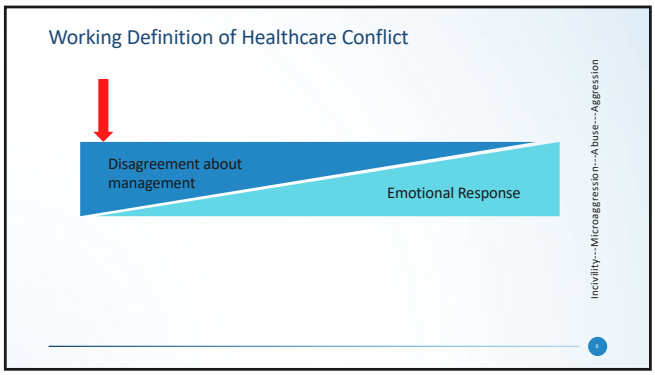
Conflict: a dispute, disagreement, or difference of opinion related to the management of a patient involving more than one individual and requiring some decision or action.

Back AL, Arnold RM. Dealing with conflict in caring for the seriously ill: "it was just out of the question". JAMA. 2005 Mar 16;293(11):1374-81.

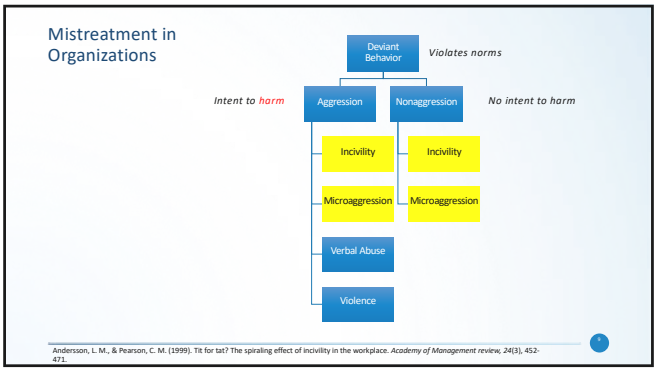
6


TYPES OF CONFLICT
TASK
RELATIONSHIP
Rogers DA, Lingard L. Surgeons managing conflict: a framework for understanding the challenge. J Am Coll Surg. 2006 Oct;203(4):568-74.

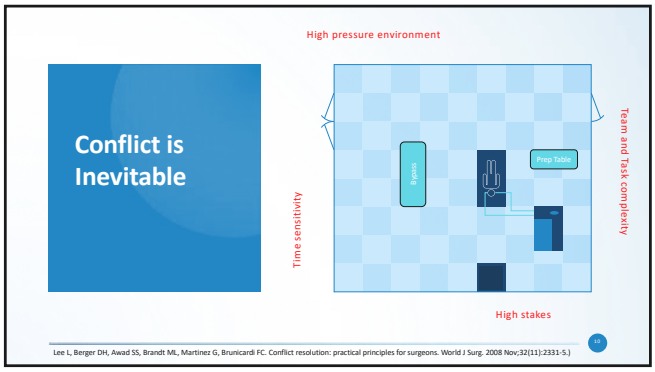
7


Working Definition of Healthcare Conflict
Disagreement about management
Emotional Response
Incivility---Microaggression---Abuse---Aggression

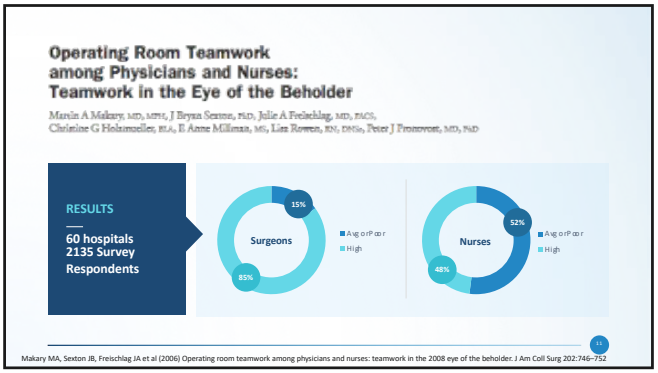
8


Mistreatment in Organizations
Deviant Behavior
Violates norms
Intent to harm
No intent to harm
Aggression
Nonaggression
Incivility
Incivility
Microaggression
Microaggression
Verbal Abuse
Violence
Andersson, L. M., & Pearson, C. M. (1999). Tit for tat? The spiraling effect of incivility in the workplace. Academy of Management review, 24(3), 452-471.

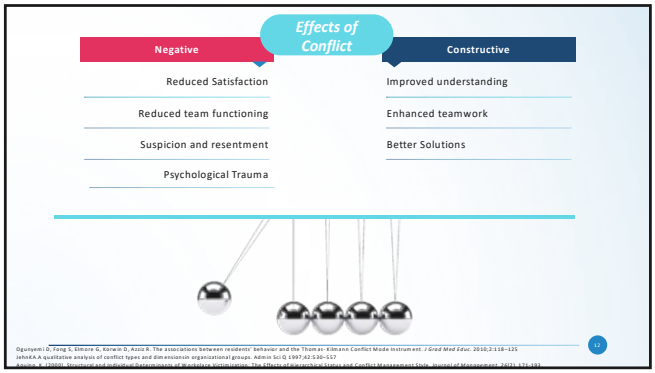
9


High pressure environment
Conflict is Inevitable
Time sensitivity
Team and Task complexity
High stakes
Lee L, Berger DH, Awad SS, Brandt ML, Martinez G, Brunicardi FC. Conflict resolution: practical principles for surgeons. World J Surg. 2008 Nov;32(11):2331-5.)

10


Operating Room Teamwork among Physicians and Nurses: Teamwork in the Eye of the Beholder
RESULTS
60 hospitals
2135 Survey Respondents
Surgeons
15%
85%
Nurses
52%
48%
Makary MA, Sexton JB, Freischlag JA et al (2006) Operating room teamwork among physicians and nurses: teamwork in the 2008 eye of the beholder. J Am Coll Surg 202:746–752

11


Effects of Conflict
Negative
Reduced Satisfaction
Reduced team functioning
Suspicion and resentment
Psychological Trauma
Constructive
Improved understanding
Enhanced teamwork
Better Solutions

12

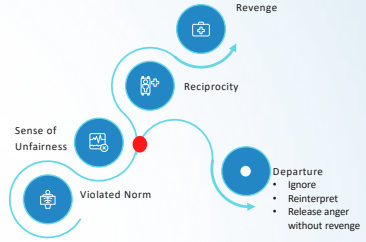
Constructive Conflict: Deliberate Hypotension

- Discern commitment to interests
- Find compromise
- Discover a third way

- Maintain credibility

13

Tipping Point: Incivility to Aggression



Tipping point: Threat to identity

14

Case 1: The Carotid Endarterectomy

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15

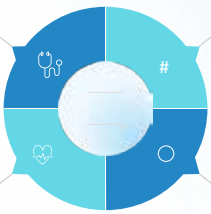

Definition & Impact


Managing In


Managing Out

16

Beliefs about Self



Well education, excellent training

Intelligent, make thoughtful decisions

Treat others with respect

Committed to my patient's care

17

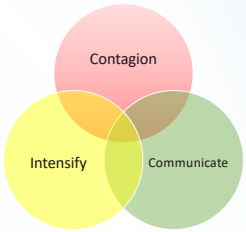
Threats to Identity

Professional Identity
- Ability
- Authority
- Authenticity

Personhood
- Gender
- Ethnicity
- Age
- Sexual Orientation

18

Purposes of Emotion



19

Emotional Intelligence

Goleman, D. (1998). Working With Emotional Intelligence. New York, NY. Bantum Books.

20

Emotional ~~Intelligence~~ Competence

Goleman, D. (1998). Working With Emotional Intelligence. New York, NY. Bantum Books.

21

Thinking Error: Owning Emotions

- He *is* intimidating

versus

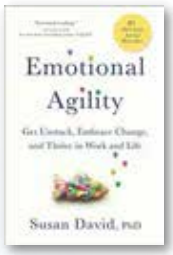
I *feel* intimidated

Henschel, Tom, narrator. "Thinking Errors." *The Look and Sound of Leadership*, Essential Communications, Oct 14, 2014. https://essentialcomm.com/podcast/thinking-errors/

Image credit http://www.dailynews.lk/2017/11/30/features/136023/david-and-goliath%E2%80%99s-dynamics-success

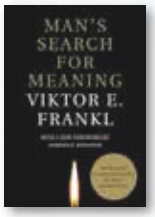
22

Metacognition: Acknowledge & Label Feelings



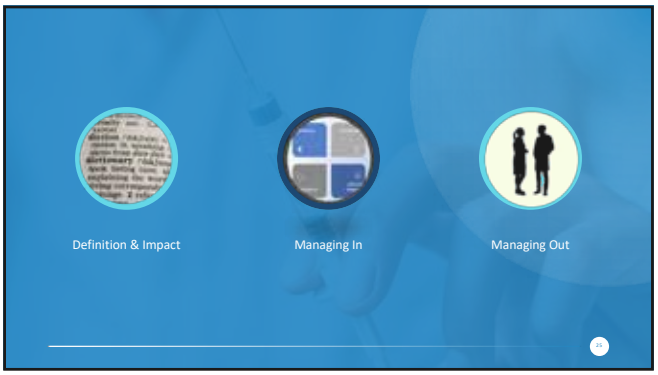
- Create separation
- Reframe
  - "He is so wrong, it's making me mad"
  - "I'm having the thought he is wrong, and I'm feeling anger."
- Thoughts and emotions are transient sources of data that may or may not be helpful.

23



"Between stimulus and response there is a space.
In that space is our power to choose our response.
In our response lies our growth and our freedom."

24



25

Case 2: The Disappearing ICU Bed

01 68-year old-Latina woman in CCU, treated for decompensated heart failure
- Brought to operating room for portacath placement

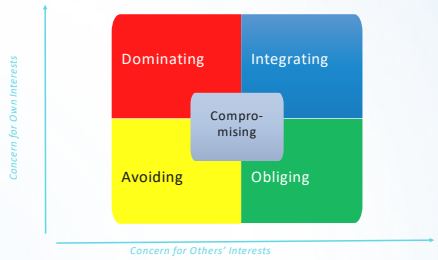
02 Anesthesia team called CCU to give report at end of the procedure.
"No bed. A wealthy hospital donor admitted, this was the most private bed."

03 Anesthesia attending investigates in CCU.
"If this patient's last name weren't Rodriguez, you wouldn't have taken her bed!"*

* Name changed

26

Conflict Management Styles



Rahim & Magner, 1995; van de Vliert & Kabanoff, 1990

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Conflict Management Styles in Anesthesiology Residents

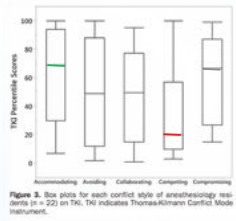

Figure 3. Box plots for each conflict style of anesthesiology residents (n = 22) on TKI. TKI indicates Thomas-Kilmann Conflict Mode Instrument.

Highest
- Accommodating (69th percentile)
- Compromising (67th percentile)

Lowest
- Competing (Dominating) (20th percentile)

Vasilopoulos T, Giordano CR, Hagan JD, Fahy BG. Understanding Conflict Management Styles in Anesthesiology Residents. Anesth Analg. 2018 May 17.

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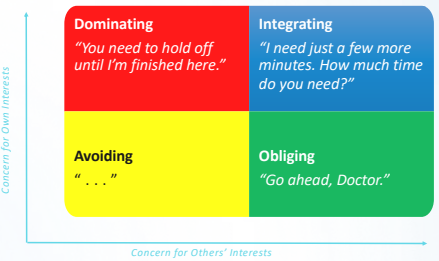
Illustration: Interrupted by Surgeon during Interview



Rahim & Magner, 1995; van de Vliert & Kabanoff, 1990

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Nontechnical Skills for Anesthesiologists

- TASK MANAGEMENT
  - Planning & Prioritizing
  - Maintaining Standards
  - Identifying & Using Resources
- SITUATION AWARENESS
  - Gathering information
  - Recognizing & Understanding
  - Anticipating
- TEAMWORK
  - Coordinating
  - Exchanging information
  - Considering others
  - Supporting others
- DECISION-MAKING
  - Identifying Options
  - Balancing Risks
  - Selecting options
  - Evaluating

Adapted from Fletcher G, et al. Br J Anaesth. 2003 May;90(5):580-8.

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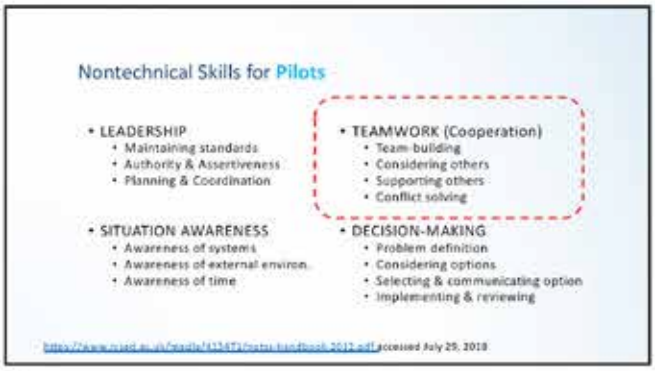

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Practical Tips for Managing Conflict
Know your style...and be flexible.
Identity: Embrace your beliefs and values.
Check your emotions.
Embrace leadership qualities.
Humor and charm can work in your favor.

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