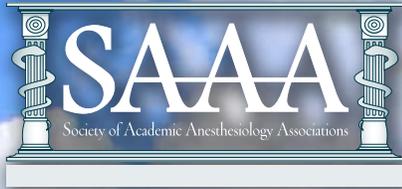


BALTIMORE



2015 Annual Meeting Syllabus

November 6-7, 2015

*Renaissance Baltimore Harborplace
Baltimore, MD*

Jointly provided by the American Society of Anesthesiologists (ASA) and Society of Academic Anesthesiology Associations (SAAA).



Program Information

Target Audience

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

About This Meeting

Topics for this meeting were selected by various methods. Suggestions for topics were derived from evaluations of the 2014 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.

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 Anesthesiology Associations. The American Society of Anesthesiologists is accredited by the ACCME to provide continuing medical education for physicians.

The American Society of Anesthesiologists designates this live activity for a maximum of *15 AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Commercial Support Acknowledgement

The CME activity is not supported by any educational grants.

Disclaimer

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

Disclosure Policy

The American Society of Anesthesiologists remains strongly committed to providing the best available evidence-based clinical information to participants of this educational activity and requires an open disclosure of any potential conflict of interest identified by our faculty members. It is not the intent of the American Society of Anesthesiologists to eliminate all situations of potential conflict of interest, but rather to enable those who are working with the American Society of Anesthesiologists to recognize situations that may be subject to question by others. All disclosed conflicts

of interest are reviewed by the educational activity course director/chair to ensure that such situations are properly evaluated and, if necessary, resolved. The American Society of Anesthesiologists educational standards pertaining to conflict of interest are intended to maintain the professional autonomy of the clinical experts inherent in promoting a balanced presentation of science. Through our review process, all American Society of Anesthesiologists CME activities are ensured of independent, objective, scientifically balanced presentations of information. Disclosure of any or no relationships will be made available for all educational activities.

Special Needs

The Society of Academic Anesthesiology Associations 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 SAAA at (414) 389-8619.

Cancellation Policy

Cancellation of a meeting registration must be submitted in writing and will be accepted up until October 9, 2015. You 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 SAAA office in Milwaukee, Wisconsin.

Overall Learning Objectives

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

- Discuss the perioperative surgical home (PSH).
- Translate current and future state of departmental and healthcare financing.
- Analyze future trends in anesthesiology manpower and training.
- Discuss the advantage and disadvantages of part-time faculty.
- Explain ACGME milestone assessment and remediation.

Faculty Disclosures

The American Society of Anesthesiologists remains strongly committed to providing the best available evidence-based clinical information to participants of this educational activity and requires an open disclosure of any potential conflict of interest identified by our faculty members. It is not the intent of the American Society of Anesthesiologists to eliminate all situations of potential conflict of interest, but rather to enable those who are working with

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the clinical experts inherent in promoting a balanced presentation of science. Through our review process, all American Society of Anesthesiologists CME activities are ensured of independent, objective, scientifically balanced presentations of information. Disclosure of any or no relationships will be made available for all educational activities.

Name	Commercial Interest	Nature of Relationship
Vivian Lee, M.D., Ph.D., M.B.A.	Merrimack	Equity position; Stock Options; Consulting Fees
Matthew D. McEvoy, M.D.	Edwards Life Sciences	Funded Research
	GE Foundation	Funded Research
Douglas C. Shook, M.D., FASE	Edwards Lifesciences	Honoraria
	St Jude Medical	Honoraria
Randolph H. Steadman, M.D., M.S.	UCLA Simulation Center	Salary
	Agency for Healthcare Research and Quality	Funded Research

All others, including editor, authors, reviewers and staff for the SAAA 2015 Annual Meeting reported they have no relationship(s) with commercial interest(s).

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Guidebook & Claiming CME Credit

Guidebook Mobile App

The SAAA 2015 Annual Meeting has gone mobile using Guidebook!

We strongly encourage you to download our mobile guide to enhance your experience at the SAAA 2015 Annual Meeting. You'll be able to plan your day with a personalized schedule and download all the meeting materials from your handheld device.

The app is compatible with iPhones, iPads, and Android devices. Windows Phone 7 and Blackberry users can access the same information via our mobile site at <https://guidebook.com/g/saaa2015>.

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

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guidebook



Directions for Claiming CME Credit

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

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

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

If you have not previously accessed the ASA Education Center, you will soon receive an e-mail from the ASA Education Center with log-in instructions.

2. Once you have logged on to the ASA Education Center homepage, click the tab that says "MY LEARNING" and select "MY ENROLLMENTS" to view the link to the SAAA 2015 Annual Meeting.

3. Select the link to access the course evaluation and claim credit.

4. To retrieve a username or password, enter your email address at: <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 Education Center at educationcenter@asahq.org.

Future Meetings: Save the Date!

All Events held at Swissôtel Chicago • Chicago, Illinois

2016 Annual
Meeting
November
11-12, 2016

2017 Annual
Meeting
November
3-4, 2017

2018 Annual
Meeting
November
2-3, 2018

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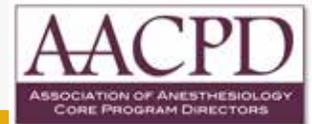
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Dolores B. Njoku, M.D.

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Charles W. Brock, M.D.

AAAC Concurrent Session



Friday, November 6

All AAAC presentations held in Baltimore A&B unless otherwise noted.

6:45 – 7:45am **AAAC Council Meeting** (*Executive Boardroom*)

7:00 – 8:00am **Continental Breakfast**

Morning Session

8:00 – 12:15pm **New Chair Session**
Moderator: Jeanine P. Wiener-Kronish, M.D.

8:00 – 8:05am **Introductions**

8:05 – 9:45am **Compensation Models**
Moderator: Kevin K. Tremper, Ph.D., M.D.

8:05 – 8:30am **Alabama Birmingham – Funds Flow Approach**
Keith A. (Tony) Jones, M.D.

8:30 – 8:55am **Mayo Clinic Approach**
Bradly J. Narr, M.D.

8:55 – 9:15am **Duke Approach**
Joseph P. Mathew, M.D., MHSc, M.B.A.

9:15 – 9:45am **Question & Answer**

9:45 – 10:10am **Break**

10:10 – 12:15pm **Morning Session Part 2**
Moderator: Lee A. Fleisher, M.D.

10:10 – 10:45am **Receiving Your Fair Share Through Bundled Payments or Funds Flow**
Lee A. Fleisher, M.D.

10:45 – 11:45am **What Deans Want in Chairs – What is Competency in Chairs and How to Get the Needed Skills**
Meghan M. Palmer, Ph.D.

11:45 – 12:15pm **Everything You Wanted to Ask Seasoned Anesthesia Chairs**
Moderator: Jeanine P. Wiener-Kronish, M.D.
Jane C.K. Fitch, M.D.
Lee A. Fleisher, M.D.
Jeffrey R. Kirsch, M.D.
Kevin K. Tremper, Ph.D., M.D.

Joint Session (All Groups)

12:15 – 1:30pm **Box Lunch** (*Maryland Ballroom CDF*)

12:30 – 1:30pm **Representation of Academic Anesthesiology** (*Maryland Ballroom CDF*)
Beverly K. Philip, M.D.

Afternoon Session

1:30 – 5:15pm **All Chair Session**
Moderator: Jeffrey R. Kirsch, M.D.

1:30 – 1:50pm **Perfect Storm (Finances and Statistics 2014)**
Charles W. Whitten, M.D.

1:50 – 2:00pm **Questions and Answers**

2:00 – 2:20pm **Compliance Update**
Judith Jurin Semo, PLLC

2:20 – 2:30pm **Questions & Answers**

2:30 – 5:15pm **Perioperative Surgical Home**
Moderator: Zeev N. Kain, M.D., M.B.A.

2:35 – 2:55pm **PSH - ASA's Goals and Concerns**
Daniel J. Cole, M.D.

2:55 – 3:05pm **Questions & Answers**

3:05 – 3:25pm **PSH – Successes and failures: What have we learned from the ASA Learning Collaborative?**
Zeev N. Kain, M.D., M.B.A.

3:25 – 3:30 pm **Questions & Answers**

3:30 – 3:50pm **Break**

3:50 – 4:10pm **Financial Viability of PSH for the Department**
Aman Mahajan, M.D., Ph.D.

4:10 – 4:20pm **Questions & Answers**

4:20 – 4:40pm **Branding Anesthesiology as the Practice of Perioperative Medicine**
Ronald G. Pearl, M.D., Ph.D.

4:40 – 4:45pm **Questions & Answers**

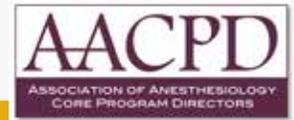
4:45 – 5:10pm **Realistic Mechanisms for Implementation of a PSH Curriculum Within the Context of Current RRC and ABA Rules**
James P. Rathmell, M.D.

5:10 – 5:15pm **Question & Answers**

5:15 – 5:30pm **AAAC Business Meeting**
Moderator: Jeffrey R. Kirsch, M.D.

5:30 – 7:30pm **SAAA Reception (All Groups)**
Held Off-Site at The Center Club – One Block from Renaissance

AACPD Concurrent Session



Friday, November 6

All AACPD presentations held in Maryland Ballroom B unless otherwise noted.

6:45 – 7:45am AACPD Council Meeting (*Gulford*)

7:00 – 8:00am Continental Breakfast

8:00 – 8:15am Welcome and Announcements
Joy L. Hawkins, M.D.

Morning Session

8:15 – 10:00am Perioperative Surgical Home
Moderator: Christopher E. Swide, M.D.

8:15 – 8:30am Defining the PSH - ASA's Goals and Concerns
Daniel J. Cole, M.D.

8:30 – 9:30am Panel: Three Programs' Approaches to Development and Implementation of a PSH Residency Curriculum
Matthew D. McEvoy, M.D.
Leslie C. Thomas, M.D.
Navid Alem, M.D.

9:30 – 10:00am Moderated Question & Answer

10:00 – 10:30am Break

10:30 – 12:00pm AACPD/AASPD Joint Session: Choosing the Right Resident/Fellow
Moderators: Karen J. Souter, M.B., B.S., FRCA & Jack S. Shanewise, M.D., FASE

10:30 – 11:00am Interviewing Tips
Mary Somers, M.S., NCC, BCC

11:00 – 11:20am Recruiting the Successful Resident: Examining Barriers, Pitfalls, Tips, and Trends Noted in the Literature
Russell K. McAllister, M.D.

11:20 – 11:40am Cognitive Simulation Training Use During Resident Applicant Interviews: Exploring A New Frontier Into Higher Order Thinking
Alan William Kulig, M.D.

11:40 – 12:00pm Moderated Question & Answer

Joint Session (All Groups)

12:00 – 1:30pm Box Lunch (*Maryland Ballroom CDF*)

12:30 – 1:30pm Representation of Academic Anesthesiology (*Maryland Ballroom CDF*)
Beverly K. Philip, M.D.

Afternoon Session

1:30 – 3:00pm Afternoon Session 1: Milestone Assessment & Remediation
Moderator: Timothy R. Long, M.D.

1:30 – 1:50pm Those Hard-to-Assess Milestones
Catherine M. Kuhn, M.D.

1:50 – 2:10pm Mapping Milestones to EPAs
Susan D. Wolfsthal, M.D.

2:10 – 2:30pm Remediation of the "Problem" Resident via GME
Harendra Arora, M.B., B.S.

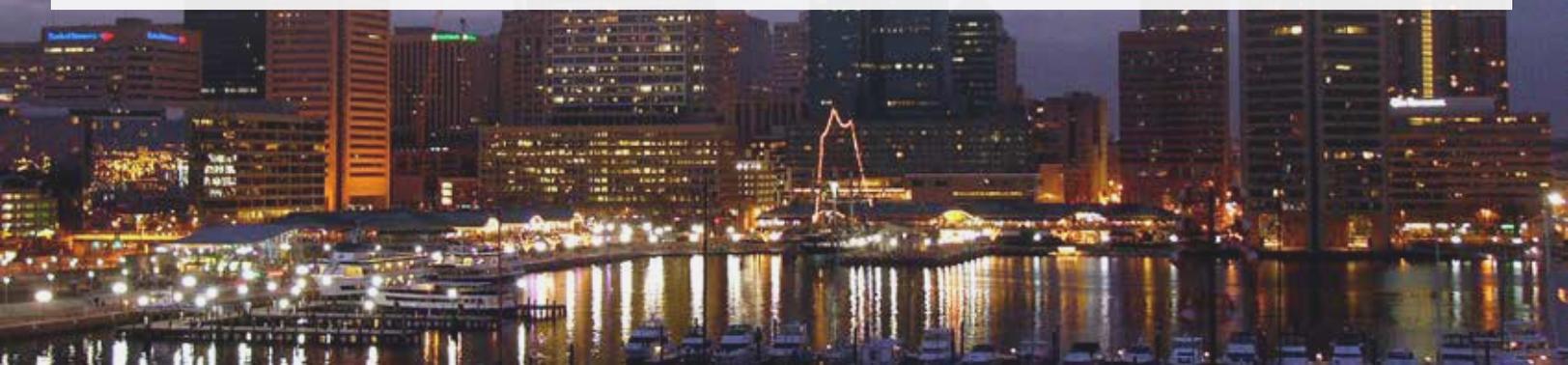
2:30 – 3:00pm Moderated Question & Answer

3:00 – 3:30pm Break

3:30 – 5:00pm Everything You Always Wanted to Know – Version 2.0
Paul W. Kranner, M.D.
Amy Murray, M.D.

5:00 – 6:00pm AACPD Business Meeting
Moderator: Joy L. Hawkins, M.D.

5:30 – 7:30pm SAAA Reception (All Groups)
Held Off-Site at The Center Club – One Block from Renaissance



Friday, November 6

All AASPD presentations held in Maryland Ballroom AE unless otherwise noted.

7:00 – 8:00am Continental Breakfast

8:00 – 8:15am Welcome and Announcements
Jack S. Shanewise, M.D., FASE

Morning Session

8:15 – 10:00am Panel: **Subspecialty Milestones: What Have We Learned?**
Moderator: Jack S. Shanewise, M.D., FASE

8:15 – 8:40am Core Program Experience with Milestones
Robert R. Gaiser, M.D., M.S.Ed.

8:40 – 9:05am Crunching Milestones Data for your CCC
Elizabeth H. Ellinas, M.D.

9:05 – 9:30am Common Milestones for All the Subspecialties
Mark Stafford-Smith, M.D., CM, CRCP(C), FASE

9:30 – 10:00am Moderated Question & Answer

10:00 – 10:30am Break

10:30 – 12:00pm AACPD/AASPD Joint Session: **Choosing the Right Resident/Fellow**
Moderators: Karen J. Souter, M.B., B.S., FRCA & Jack S. Shanewise, M.D., FASE

10:30 – 11:00am Interviewing Tips
Mary Somers, M.S., NCC, BCC

11:00 – 11:20am Recruiting the Successful Resident: Examining Barriers, Pitfalls, Tips, and Trends Noted in the Literature
Russell K. McAllister, M.D.

11:20 – 11:40am Cognitive Simulation Training Use During Resident Applicant Interviews: Exploring A New Frontier Into Higher Order Thinking
Alan William Kulig, M.D.

11:40 – 12:00pm Moderated Question & Answer

Joint Session (All Groups)

12:00 – 1:30pm Box Lunch (Maryland Ballroom CDF)

12:30 – 1:30pm Representation of Academic Anesthesiology (Maryland Ballroom CDF)
Beverly K. Philip, M.D.

Afternoon Session

1:30 – 3:00pm Mastering the Match
Moderator: Charles W. Brock, M.D.

1:30 – 1:50pm The Military and the Match
Darian C. Rice, M.D., Ph.D.

1:50 – 2:10pm NRMP Match Experience & Tips, Concerns and Data from Pediatrics
Susan R. Staudt, M.D., M.S.Ed.

2:10 – 2:30pm San Francisco Match Experience & Tips
Douglas C. Shook, M.D., FASE

2:30 – 3:00pm Moderated Question & Answer

3:00 – 3:30pm Break

3:30 – 5:00pm Subspecialty Breakout Sessions

- Adult Cardiothoracic (Federal Hill)
- Critical Care Medicine (Guilford)
- Obstetric (Mt. Washington)
- Pain Medicine (Maryland Ballroom AE)
- Pediatric (Homeland)

5:00 – 5:30pm AASPD Business Meeting
Moderator: Jack S. Shanewise, M.D., FASE

5:30 – 6:30pm AASPD Council Meeting (Executive Boardroom)

5:30 – 7:30pm SAAA Reception (All Groups)
Held Off-Site at The Center Club – One Block from Renaissance

Saturday, November 7 All SAAA presentations held in Maryland Ballroom ABE unless otherwise noted.

7:00 - 9:00am RRC Consultations

7:00 – 8:00am Continental Breakfast

8:00 – 11:20am Annual Updates
Moderator: Jane C.K. Fitch, M.D.

8:00 – 8:20am MOCA 2.0
Daniel J. Cole, M.D.

8:20 – 8:30am Question & Answer

8:30 – 8:50am SAAA Director to ASA Update
Zeev N. Kain, M.D., M.B.A.

8:50 – 9:00am Question & Answer

9:00 – 9:10am What's in a Name? Renaming our Specialty for the Future
Zeev N. Kain, M.D., M.B.A.

9:10 – 9:20am Question & Answer

9:20 – 9:40 am RRC Update
Robert R. Gaiser, M.D., M.S.Ed.

9:40 – 9:50am Question & Answer

9:50 – 10:20am Break

10:20 – 10:40am ABA Update
James P. Rathmell, M.D.

10:40 – 10:50am Question & Answer

10:50 – 11:10am ITE Update
David O. Warner, M.D.

11:10 – 11:20am Question & Answer

11:20 – 11:50am MOCA: To Participate or Not to Participate – That is the Question
Participate: Deborah J. Culley, M.D.
Not Participate: Randolph H. Steadman, M.D., M.S.

11:50 – 12:00pm Question & Answer

12:00 – 1:30pm Box Lunch (Maryland Ballroom CDF)

12:30 – 1:30pm Data, Transparency & Engagement: Forces for Transformation in Academic Medicine (Maryland Ballroom CDF)
Vivian Lee, M.D., Ph.D., M.B.A.

1:30 – 5:00pm Afternoon Session

Moderator: Peter Rock, M.D., M.B.A., FCCM

1:30 – 1:50pm Whether, How and Why Departments Should/Shouldn't Make Accommodations for its Members with Learning Disabilities
Michael G. Fitzsimons, M.D., FCCP

1:50 – 2:00pm Question & Answer

2:00 – 2:20pm Strategies to Prevent Burnout of Leaders in Academic Medicine
Mark Hyman Rapaport, M.D.

2:20 – 2:30pm Question & Answer

2:30 – 2:50pm Approaches To Transform A Disruptive Physician Into A Productive Member Of Your Faculty
Mohammed M. Minhaj, M.D., M.B.A.

2:50 – 3:00pm Question & Answer

3:00 – 3:30pm Break

3:30 – 4:00pm Full Time, Part Time and Glide Time: Flexible employment schedules for anesthesiologists are preferred over traditional employment models. A Pro/Con debate.
Pro: Jeffrey R. Kirsch, M.D.
Con: David A. Zvara, M.D.

4:00 – 4:20pm GME "101"
Lori K. Mihalich-Levin, J.D.

4:20 – 4:30pm Question & Answer

4:30 – 4:50pm IOM Report and Physician Workforce Projections
Tannaz Rasouli

4:50 – 5:00pm Question & Answer

5:00 – 5:30pm SAAA Business Meeting
Moderator: Jeffrey R. Kirsch, M.D.



Compensation Models: Alabama Birmingham – Funds Flow Approach

Keith A. (Tony) Jones, M.D.

November 6, 2015
8:05AM – 8:30AM

UAB THE UNIVERSITY OF ALABAMA AT BIRMINGHAM

Faculty Compensation Models: A Key Driver of Culture

Keith A. (Tony) Jones, M.D.
Alfred Habeeb Professor and Chair



UAB SCHOOL OF MEDICINE
Department of Anesthesiology and Perioperative Medicine

Conflicts of Interest

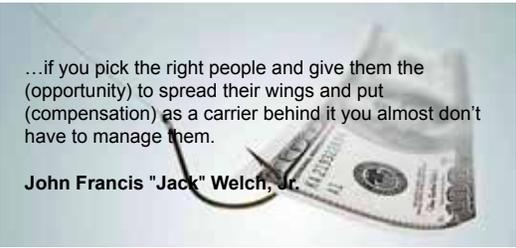
No Conflicts

UAB SCHOOL OF MEDICINE
Department of Anesthesiology and Perioperative Medicine

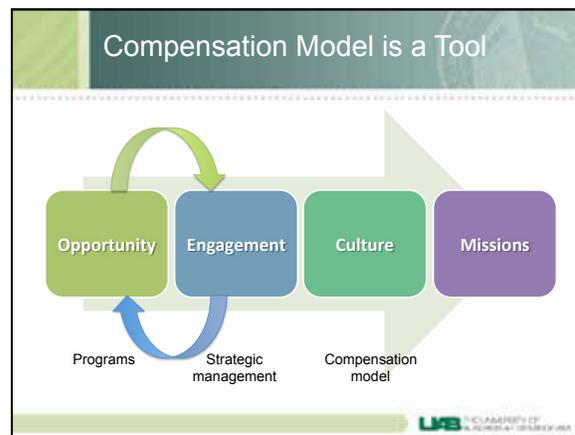
Mission, Opportunity and Compensation

...if you pick the right people and give them the (opportunity) to spread their wings and put (compensation) as a carrier behind it you almost don't have to manage them.

John Francis "Jack" Welch, Jr.



UAB SCHOOL OF MEDICINE
Department of Anesthesiology and Perioperative Medicine



What do Faculty Value?

- Money
- Opportunity
- Academic advancement

UAB SCHOOL OF MEDICINE
Department of Anesthesiology and Perioperative Medicine

Objectives: If you've seen one, you've seen one

- Describe two Department programs designed to promote *opportunity and engagement*
- Describe the Department compensation model and its alignment with UAB Medicine

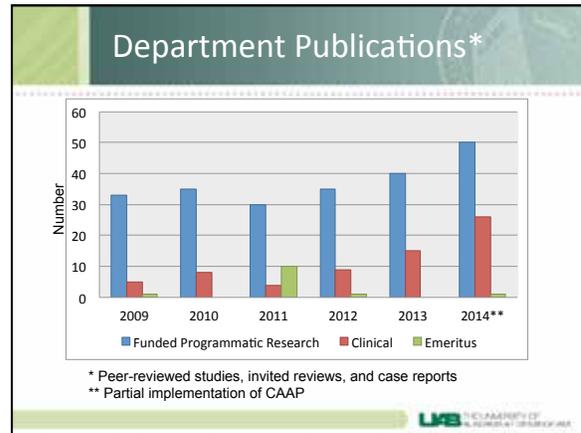
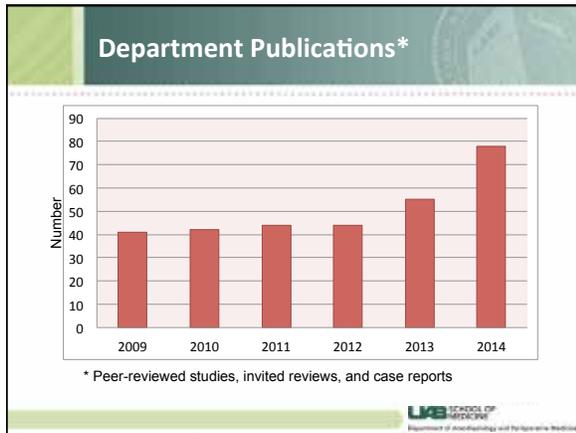
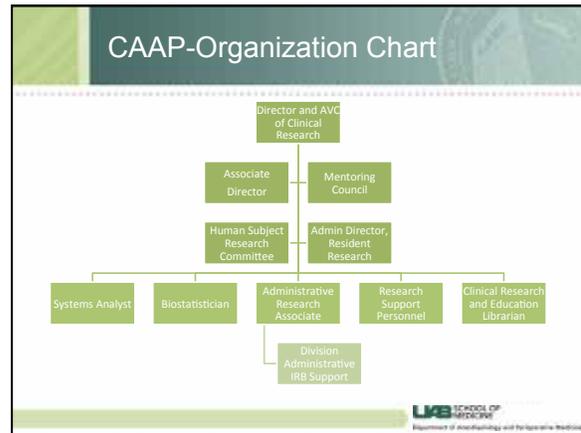
UAB SCHOOL OF MEDICINE
Department of Anesthesiology and Perioperative Medicine



- ### Strategic Initiative: Programmatic Research
- Large-scale, program-oriented research
 - Neuroscience and Pain Medicine
 - Organ Injury and Transplantation
 - Requirement of sustainability via extramural grants and contracts

- ### Strategic Initiative: Clinician Academic Achievement
- Investigator-initiated research
 - No requirement of sustainability by extramural grants
 - Will require the development of a support structure that provides clinicians with *transparency and accountability*
 - Non-clinical time
 - Mentorship (study design)
 - Direct project funding support
 - Indirect support
 - Informatics and database support
 - Biostatistics
 - IRB regulatory and administrative support
 - Technician support





Leadership Education and Development (LEAD) Program

- Provides physicians the opportunity to obtain advanced skills in research and leadership through enhanced educational tracks
 - **Innovative Research Tracks** provide training and experience in research, scientific writing, and presentation skills
 - **Innovative Leadership Tracks** provide opportunities to obtain Master's degrees, certificates, and added qualifications in a variety of subject areas

Available Tracks

- Research Tracks for Residents
 - **Resident Mentored Research Experience Track (RMRET)**
 - **Resident Academic Career Development (RACD)**
- Leadership Tracks for Residents and Faculty
 - Master's Degrees: MS in Health Care Administration, MS in Health Care Informatics
 - Certificates: Business Administration, Health Care Management, and others
 - Quality Improvement and Patient Safety (ABMQ)

Department Support

- Non-clinical time as needed
- 50% tuition/fees



The LEAD Fund

- The LEAD Program is supported by the LEAD Fund, a philanthropic initiative of the department
- Generous gifts from alumni, faculty and friends help support the costs of tuition, travel and supplies
- Gifts are matched 1:1 by the department



LEAD Program Participation

Category	Count
Faculty	<ul style="list-style-type: none"> • Master's (3) • Informatics (0) • Certificate/Board (3) • Business (3) • Quality (12)
Trainees	<ul style="list-style-type: none"> • Master's (5) • Informatics (1) • Certificate/Board (7) • Business (2) • Quality (7) • Research (5) • RACD (5) • RMRET (28)
Staff	<ul style="list-style-type: none"> • Master's (1) • Informatics (0) • Certificate/Board (0) • Business (0) • Quality (3)

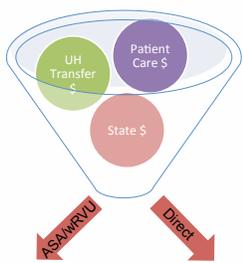


Institution to Faculty Alignment

- UAB Medicine: • Institution (UH, SOM, HSF) Funds Flow
- Department: • Department At-Risk Compensation
• Chair At-Risk Compensation
- Faculty: • Faculty At-Risk Compensation Model



Funds Flow



Department (10% ARC) Expenses (100%)



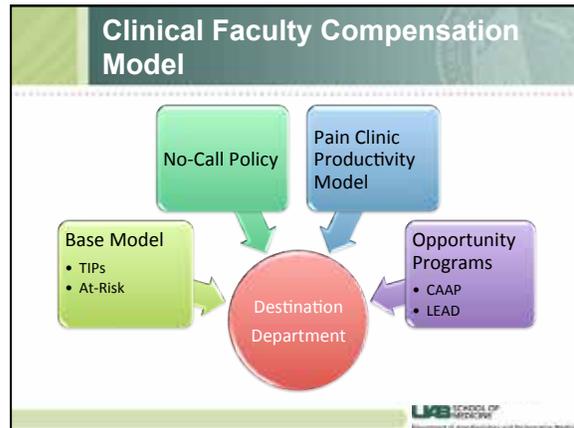
Institution Pillar Goals

Engagement	Quality	Finance	Advancement
Inpatient Patient Experience	Clinical Effectiveness (Readmissions and Core Measure Performance)	Financial Health of UAB Medicine	Accelerate basic and translational science leadership
Ambulatory Clinic Patient Experience			Ensure professional readiness of future scientific leaders
Employee Engagement	Mortality (O:E)	Documentation of the Patient's Condition	
Faculty Engagement	ICU and Medicine-Surgery Diversion	Research and Development Portfolio	
Trainee Experience	Access to Ambulatory Clinics		
	Professional Readiness of Future Physician Leaders		



Department At-Risk Revenue (10%)

Pt. Satisfaction	Quality	Finance	Advancement
CGCAPS	Mortality	Procedure Volume	Trainee Grant Support
HCAPS	CLABSI	On-Time Starts	Increase NIH Grants
	Beta Blocker Admin	Block Release Time	
	PROMPTS/ERAS	Unit of Service Cost	
		Documentation Score	
		Arrived Appointments	
		Bump Rate (≤ 30 days)	
		≤ 14 day appointment	



- ### Base Compensation Model
- Goal: ≥75th of the AAMC (all sources)
 - No differential for programmatic research track
 - Base salary determined by
 - Academic rank (290K, 315K, 320K)
 - Fellowship training (10K)
 - Leadership stipends (12-60K)
 - Call compensation
 - Stipend for pager call (\$300 M-Th, \$400 Fr-Su)
 - \$150 per hour after 1700 hours and weekends

- ### Teaching Incentive Points (TIPs)
- Purpose: to recognize the investment of time and expertise by faculty in the didactic teaching requirements of the Department
 - Points are awarded only for scheduled didactic teaching activities directed towards all clinical trainees at UAB
 - Awards for teaching excellence
 - Awards for mentorship excellence

- ### Clinical Faculty ARC: Participation
- All clinical faculty are required to participate
 - Less than full time faculty
 - Faculty > or = to 0.60 FTE must participate fully
 - Faculty < 0.60 FTE must participate 50% of requirements

Faculty At-Risk Compensation

<p>Clinical Professionalism</p> <ul style="list-style-type: none"> • \$500 per record) • Monthly • ABX (100%) • Temp (100%) • Documentation Compliance (100%) • Attestations • E-signatures 	<p>Education Professionalism</p> <ul style="list-style-type: none"> • 2.5% of base salary • Annually • TIPs (≥5) • Evaluations (≥ 75%) 	<p>Academic Professionalism</p> <ul style="list-style-type: none"> • 2.5% of base salary • Annually • Quality Conference Attendance (50%)
---	---	---

No-Call Policy

- Intended to accommodate faculty who have needs to eliminate their call requirement
- All or none
- Reasons for not participating in call must be compelling and approved by the Chair
- 30% reduction in base salary
- Subject to the current and anticipated department needs



Pain Clinic Productivity Incentive Plan

Clinic Eligibility Metrics

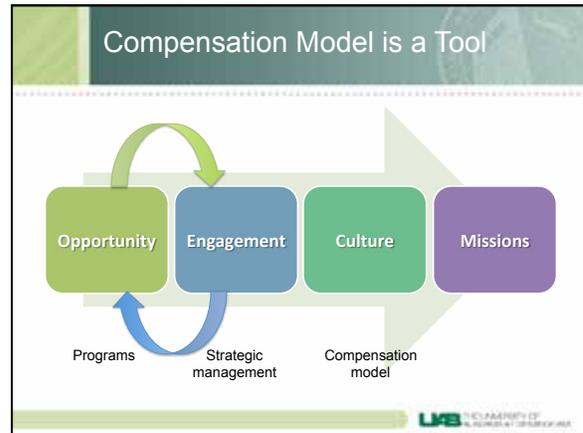
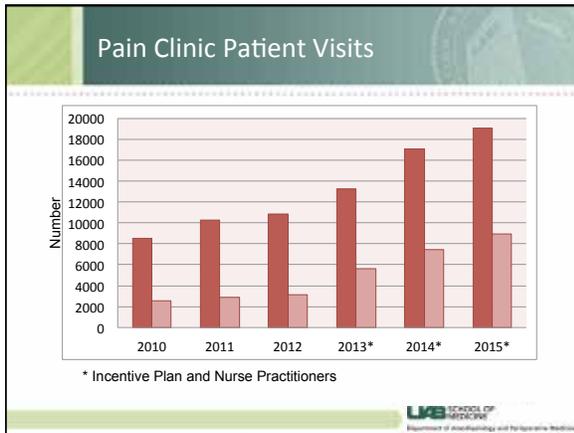
- Aggregate *clinic* wRVU Threshold ≥ 29/day/FTE
- Teaching Evaluation ≥ 8
- Documentation Compliance Varies semi-annually

Individual Eligibility Metrics

- Teaching Evaluation ≥ 8
- Documentation Compliance Varies semi-annually
- wRVU Threshold Determined based on base compensation

Payment Plan

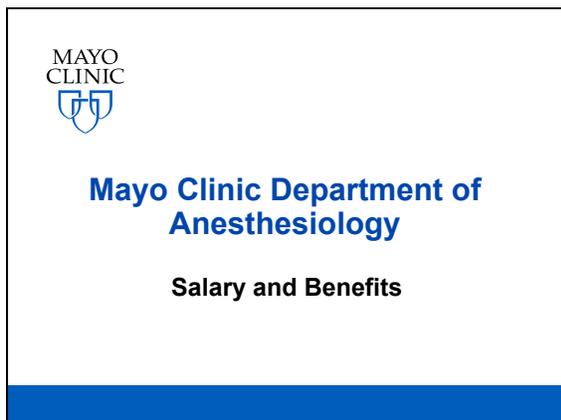
- 50% of wRVUs > *individual* wRVU threshold
- Typical payout of \$10,000 per quarter/FTE

Compensation Models: Mayo Clinic Approach

Bradly J. Narr, M.D.

November 6, 2015
8:30AM - 8:55AM



Mayo Clinic

- No contracts for professional staff
- Salary Model
 - 5 steps with yearly step increase to target
 - No difference between subspecialties
 - No difference for academic rank
 - No money for call
 - Funded researchers supported by Mayo Clinic Research Committee to target clinical salary
 - Clinical Time Variation (currency)

Mayo Clinic Scholar

- Fellowship or Research training
 - ½ of the starting first year staff salary
 - Staff vacation benefit
 - Staff CME / Presentation travel benefit
 - Pay-back with reduced step increases first 3 years on staff
 - Pay back provisions if you leave Mayo



**If you are not getting bigger
you are getting smaller.**

Alan D. Sessler M.D. (1985)

Physician Salary Calculator

Our tool is available in online and physical, slide-rule versions. Choose the tool that best fits your information needs. Try out our online tool now. To request a complimentary copy of the slide rule version, call 800.272.2707.

PROVIDER "CONTRIBUTION TO OPERATIONS" PERCENTAGE CALCULATOR

Provider Specialty: **Providers in Jackson & Coker Database: 31,145**
Providers Listed in United States: 38,557

ANNUAL Avg. Compensation for Full-Time Provider		HOURLY Avg. Compensation for Full-Time Provider	
National Average Compensation:	\$355,413	National Average Compensation:	\$171
Average Benefits:	\$71,083	Average Benefits:	\$34
Total Average Compensation:	\$426,495	Total Average Compensation:	\$205
National Average Gross Revenue per Provider:	\$1,352,120	National Average Gross Revenue per Provider:	\$650
Full-Time Provider Contribution:	217%	Full-Time Provider Contribution:	217%
		Locum Tenens Provider Contribution:	164%

Referral Practice Allergies

Allergy	Type	Reaction	EMR Site
Other (2 allergies)			
(Free Text) BOBCATS	Other	Other; Can't breathe, Lungs itch	Mayo Clinic Rochester
(Free Text) MOUNTAIN LIONS	Other	Unknown; Can't breathe, Lungs itch	Mayo Clinic Rochester



Mayo Clinic

Consolidated Statements of Activities
Years Ended December 31, 2014 and 2013 (in Millions)

	2014			2013		
	Unrestricted	Temporarily Restricted	Permanently Restricted	Unrestricted	Temporarily Restricted	Permanently Restricted
Revenue, gains and other support:						
Net medical service revenue (Note 2)	\$ 8,105.8	-	-	\$ 8,188.8	\$ 7,801.1	-
Grants and contracts	375.2	-	-	375.2	374.9	-
Investment return allocated to current activities (Note 4)	156.3	18.6	-	173.9	148.2	28.7
Contributions payable for current activities	36.4	142.7	-	178.1	48.2	142.3
Pharmaceutical	335.7	-	-	131.2	113.3	-
Other (Notes 3 and 16)	736.7	-	-	734.7	630.5	-
Net assets received from restrictions (Note 12)	476	(175.80)	-	484	(158.5)	-
Total revenue, gains and other support	9,193.1	(157.2)	-	9,368.8	8,926.7	271.0
Expenses (Note 12):						
Salaries and benefits	5,871.5	-	-	5,871.5	5,582.2	-
Supplies and services	2,285.4	-	-	2,285.4	2,138.8	-
Facilities	885.1	-	-	885.1	849.0	-
Finance and investment	80.3	-	-	80.3	80.1	-
Total expenses	9,022.3	-	-	9,022.3	8,650.1	-
Income (loss) from current activities	170.8	(157.2)	-	346.5	276.6	271.0
Noncurrent and other items:						
Contributions not available for current activities, net	(17.2)	4.8	183.9	97.5	(19.4)	25.8
Unrealized investment return, net (Note 4)	173.8	35.8	-	209.7	208.9	174.2
Income for expense (Note 7)	(24.2)	-	-	(24.2)	(22.1)	-
Restructuring and other	(8.3)	(7.4)	18.7	(1.8)	3.2	-
Total noncurrent and other items	124.1	36.2	202.6	161.2	190.5	370.0
Income in net assets before other changes in net assets	294.9	(121.0)	202.6	507.7	467.1	641.0
Person and other contributions:						
Investment adjustments (Note 12)	(1,588.3)	-	(1,588.3)	(1,703.2)	-	(1,703.2)
Income (decrease) in net assets	(1,293.4)	72.8	134.4	(1,195.5)	236.7	147.8
Net assets at beginning of year	6,414.6	1,298.3	888.9	7,601.8	2,428.8	1,013.3
Net assets at end of year	5,121.2	1,371.1	1,023.3	6,406.3	2,665.5	1,161.1

See Notes to Consolidated Financial Statements.

Compensation Models: Duke Approach

Joseph P. Mathew, M.D., MHSc,
M.B.A.

November 6, 2015
8:55AM - 9:15AM



Compensation Models: The Duke Approach

Joseph P. Mathew, MD, MHSc, MBA

*Jerry Reves Professor of Anesthesiology
Chairman, Department of Anesthesiology
Duke University Medical Center*

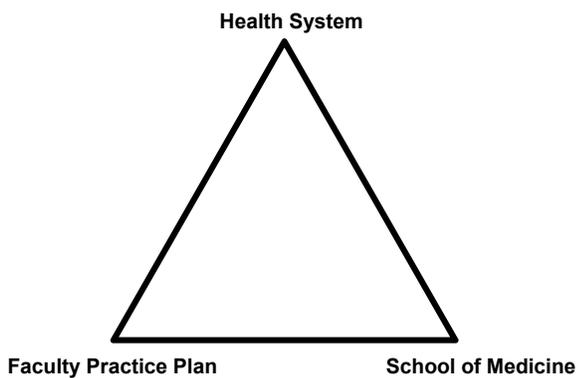
ORIGINS

- Financial loss
- Compensation not linked to productivity
- Change culture
- MGMA salary median



Image courtesy of Barnes Denning
(blog.barnesdenning.com)

ORGANIZATIONAL STRUCTURE



COMP STRUCTURE

- **Clinical effort**
 - 10 hour time-based units, called clinical day equivalents (CDE)
- **Academic effort**
 - Base pay
 - Incentives, using a tiered point-based system to reward productivity
- **Gain sharing**
 - Clinical work based on charges, CDEs and call
 - Academic work

BASE COMPENSATION

- Progresses with rank (and tenure)
- Prorated between University and PDC effort
- “Citizenship” expected as part of base compensation



BASE COMPENSATION

- **Base Training Compensation**
 - Additional \$\$\$ for fellowship, PhD, double Boards
- **Personal Career Advancement (PCA)**
 - Based on projected and recent academic productivity
 - Distributions based on tiered point system
 - Education, Research, Admin, Mentoring
 - Projected yearly with monthly holdbacks

BASE COMPENSATION

Combined Base = Base + Base Training + PCA

DEFINITIONS

- **PDC**
 - Private Diagnostic Clinic (Faculty Practice Plan)
- **CDE**
 - Clinical Day Equivalent
 - 10 hour commitment to clinical activity
- **PCA**
 - Personal Career Advancement
 - Academic productivity

STRUCTURE

- **Clinical**
 - Escalating \$/CDE associated with years of service
 - In-house call = CDE + bonus value
 - Home call = 0.1 CDE
- **Research**
 - Defined for each fiscal year with expected salary recovery
- **Educational**
 - Directed educational time
- **Administrative**
 - Baseline time + incentives based on performance metrics

SALARY RECOVERY

- **Quarterly Clinical Recovery**
 - 10% of expected CDE dollars
 - Meet expected CDEs
 - Availability
 - $\geq 90\%$ billing compliance
- **Annual Academic Recovery**
 - 10% of projected PCA
- **Annual Research Salary Recovery**
 - 50% recovery threshold
 - 20-33% returned based on tiers



GAIN SHARING

- 70% of PDC profit
- **Clinical**
 - Charges x CDEs – 24%
 - CDEs – 32%
 - Call Hours – 8%
 - Division chief discretion – 8%
 - Chair discretion – 8%
- **Academic**
 - PCA – 20%



Image courtesy of Mediation Solutions (mediation.ppcf.com)

SUMMARY

- “x” type monthly pay
 - 74% of total comp
- “y” type hold-back and true-up
 - 7% of total comp
- “z” type bonuses for individual performance
 - 19% of total comp
 - 1-2% for group performance



EXTERNAL REVIEW

- **Does not sufficiently incentivize one more case at the end of the day**
- **Complicated**
- **Limited linkage to quality measures**
- **No linkage to patient satisfaction**

- **You get what you pay for!**

Receiving Your Fair Share Through Bundled Payments or Funds Flow

Lee A. Fleisher, M.D.

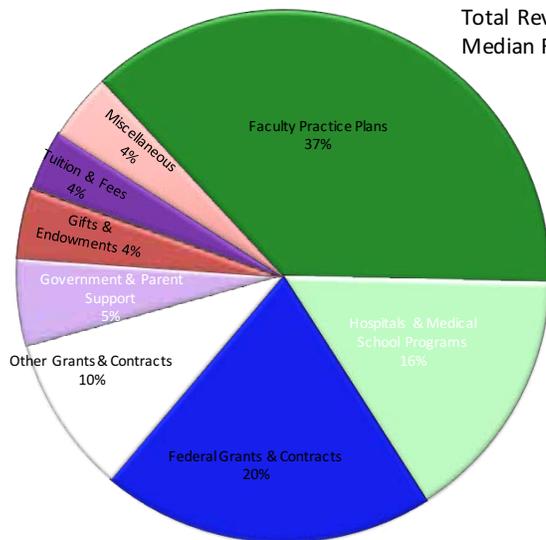
November 6, 2015
10:10AM - 10:45AM

Receiving your fair share through Bundled Payments or Funds Flow

Lee A. Fleisher, M.D.
Robert D. Dripps Professor and Chair
Department of Anesthesiology and Critical Care
Professor of Medicine
Perelman School of Medicine
University of Pennsylvania
Lee.fleisher@uphs.upenn.edu

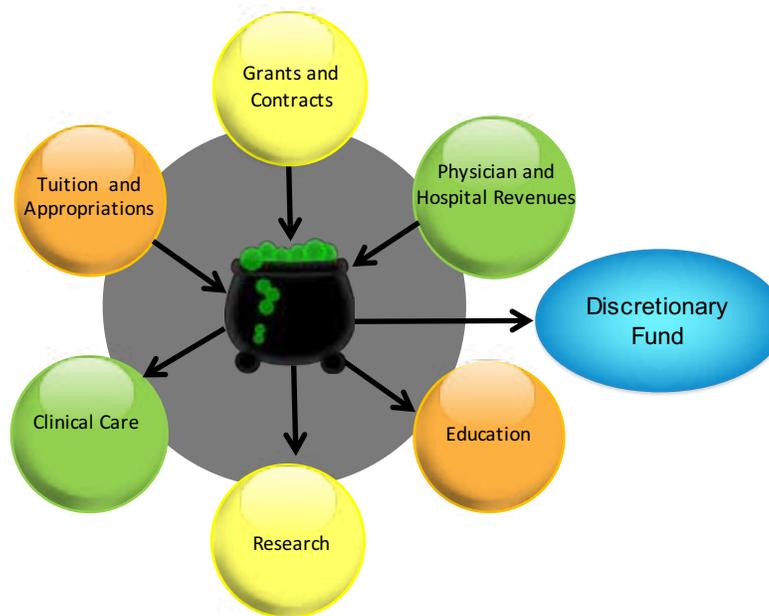
Medical School Revenue by Source
126 Fully Accredited Medical Schools, FY2011

Total Revenue: \$93B
Median Revenue: \$526M



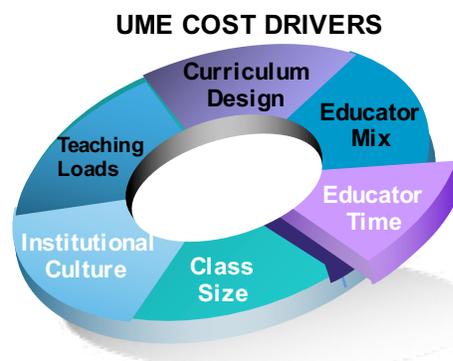
Source: LCME Part I-A Annual Financial Questionnaire, FY2011

The Cauldron



We Lack Good Data on Cost

- Cost estimates vary widely by methodology—no basis for comparison
- Accurate assessment of faculty effort is key—and difficult to achieve
- Outcome measures are limited—for UME and GME



"The cost of medical education has been an issue of public concern for nearly 100 years."

*Robert Jones & David Korn
On the cost of educating a medical student.
Acad Med 72:200, 1997*

Why healthcare is local

- Anesthesia units paid by private insurers at large multiple of Medicare rates
- Actual multiple varies greatly by geographic area and payer
- Payer mix has an exaggerated effect on total revenue compared to other specialties



relationship between revenue and work has great variability between AMCs

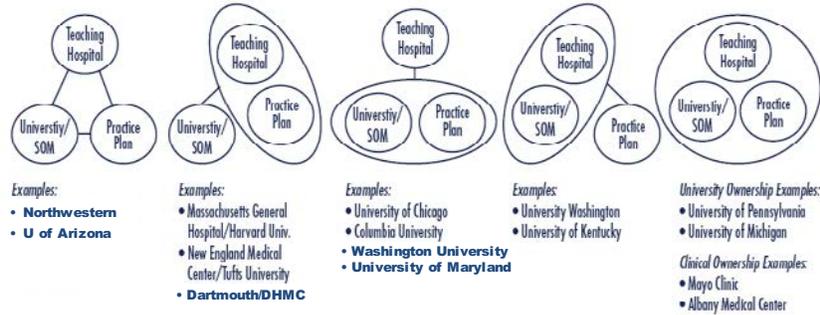
Funds Flow Defined

Funds Flow is more than simply the exchange of money for services rendered. It is one of the major vehicles by which academic medical centers, schools of medicine and faculty practice plans *align their strategies, define expectations and support one another.*

Funds Flow Framework and Scope

There are a number of common funds flow models- regardless of the AMC Organization Structure. However, understanding each unique situation is critical

Figure 1
AMC Organizational Structures

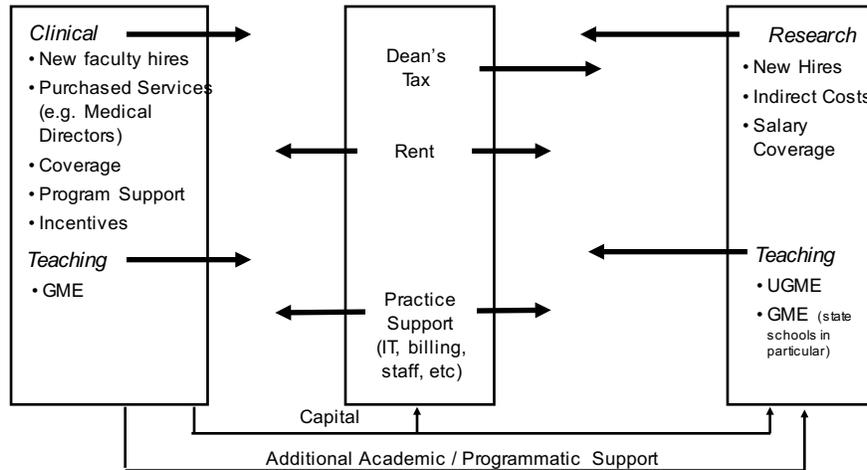


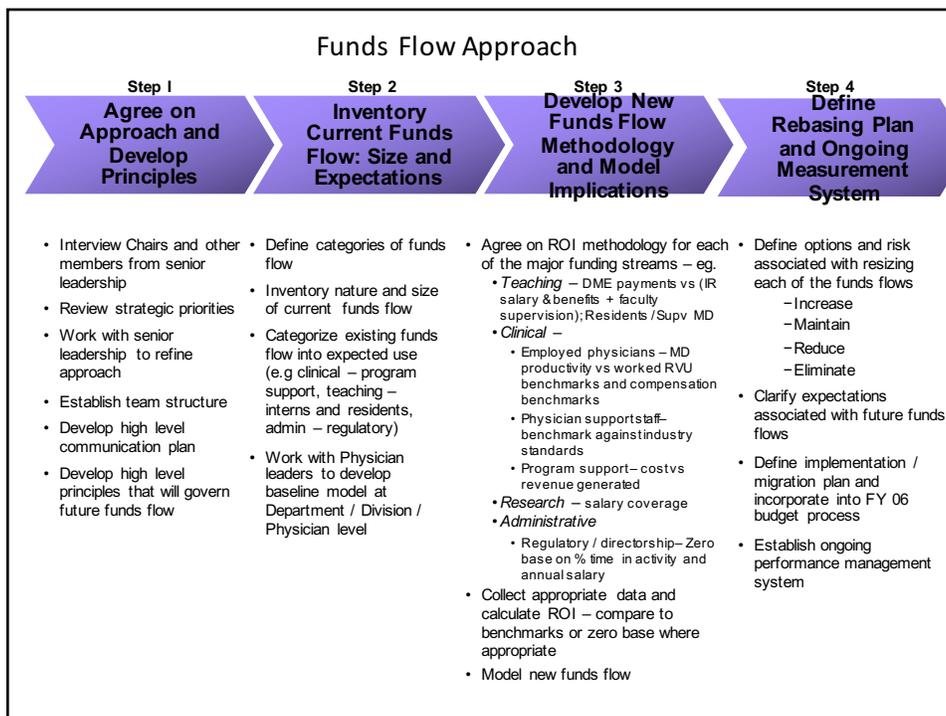
Source: Considering Alternative Organization Models for Academic Medical Centers, Levine, Academic Clinical Practice, Summer 2002, Vol. 14, No. 2

Funds Flow Framework and Scope

Hospital (s) Clinical Department / Faculty Practice School of Medicine

1. Treat Patients 2. Teach 3. Conduct Research 4. Provide Admin Support





Defining Various Funds Flow Methodologies: Teaching

- Faculty Supervision
 - **GME:** Support for faculty time spent supervising interns and residents, based on ratio of faculty to residents (1:6 in cognitive departments, 1:10 in procedural departments)
 - Based on average departmental faculty salaries (capped) and appropriate ratio of faculty to residents
 - **UGME:** Time spent by faculty in supporting medical student activities. Support based on teaching RVUs
- Administrative support to achieve ACGME standards/ requirements
 - 5-tiered system based on total # of residents/faculty and ACGME standards

Defining Various Funds Flow Methodologies: Research

- Academic development funds to support new faculty research
 - Support guarantee based on projected start-up and support costs for a 3-5 year period, using ROI approach
- Indirect cost sharing
 - Support for research administration and overhead expenses borne within the departments
 - Clinical departments will receive percentage of indirect cost revenues, based on home department of PI
- Salary coverage incentive payments
 - Provided to departments that meet research salary coverage targets, on a sliding scale
 - Coverage to help support scholarly time associated with research activities and salaries that are above the NIH cap
 - % of faculty salary up to NIH cap (% varies by faculty appointment)

Defining Various Funds Flow Methodologies: Clinical

- Purchased services:
 - Compensation for a clearly defined role which has a job description & specific performance measures, e.g., 25% of Chair salary, benefits, malpractice; 15% for Medical Director of ICUs
- New Hires:
 - Support for new physicians entering the marketplace and establishing their practice. Three-year guarantee provides incentive to outperform budgeted figures
- Programmatic Support:
 - Provide sufficient support so that the clinical mission is breakeven if department is clinically productive (65th percentile in UHC benchmarking) and is operationally productive (department infrastructure). Departments need to explain what is driving their losses (e.g. payor mix, malpractice, hospital mission, etc.)
- Incentives:
 - Provide to departments / services to support a specific outcome, e.g. new margin or improved patient satisfaction

Funds Flow – Broader Implications – Clinical Productivity

- Issue: Hospital leadership wants to ensure that monies being distributed on the clinical mission are for productive departments / faculty
- Solution: Clinical Chairs and Faculty Practice agree on a clinical productivity standard that will be measured at least annually
 - There are a number of different clinical productivity tools to consider though the UHC database is often used because:
 - Large dataset of *academic* practices
 - Frequent updates (quarterly vs annually)
 - Ability to choose percentile comparison
 - Clinical Chairs and faculty practice must also agree on a standard (e.g. 50th, 65th, 75th)
 - Tie funds flow to the department at large vs an individual faculty
 - Communicate CFTE expectations annually and share current performance at least quarterly

Lessons Learned

Lessons Learned

- Leadership – School, Faculty Practice Plan and Hospital – need to agree on objectives upfront and strategic importance
- Continue to remember that Funds Flow is as much about the external environment as it is about internal distribution of money
- Engage Clinical Chairs as soon as possible and communicate frequently
- Agree on Scope upfront – broader is generally better
- Be prepared to address a number of related issues including faculty productivity & comp, overhead, P&Ls by Mission, etc
- Data needs to be transparent – within the department, within the practice plan, between the entities
- Keep it simple
- Create incentives so that performance above expectations can be rewarded
- Aligning expectations may not be seen so favorably by all
- Make new agreements multi-year

Underlying Principles

- | | |
|--|--|
| Align with Penn Medicine Strategic Plan | <ul style="list-style-type: none"> • Promote partnership based on a shared commitment to vision, mission and values • Comply with all regulations |
| Fair and Transparent | <ul style="list-style-type: none"> • Foster open dialogue and full disclosure of all relevant information • Rely on data and fact-based information in making decisions <ul style="list-style-type: none"> – Realize data informs decision making but cannot replace it • Utilize consistent categories, practices and policies • Future funds flow will include clear articulation of the specific purpose of the funds, quantitative and / or qualitative performance expectations, as well as duration of support |
| Match Revenue with Expenses | <ul style="list-style-type: none"> • Be based upon a rational, value-based model, matching services and benefits to financial arrangements |
| Provide Appropriate Incentives | <ul style="list-style-type: none"> • Appropriate incentives (upside and downside) will be put in place to encourage <ul style="list-style-type: none"> – <i>Achieving</i> system growth objectives and goals; – <i>Exceeding</i> system growth objectives and goals • Expectations for individual faculty productivity must be tied to compensation and communicated at least annually • Funds flow should provide some opportunity for gain sharing related to future margin growth |
| Measure and Monitor Over Time | <ul style="list-style-type: none"> • Establish clear measures of performance for ongoing monitoring |

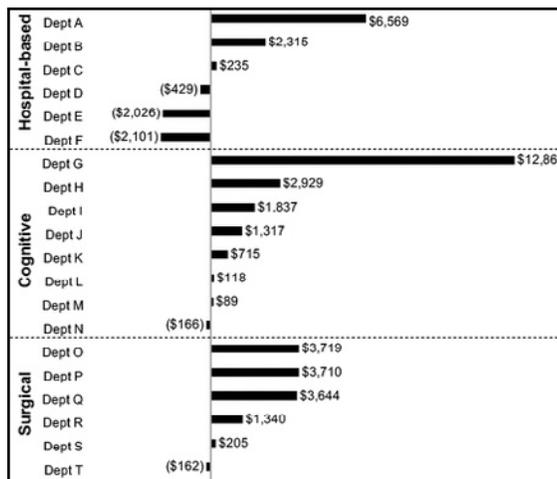
Clinical Model: Incentives

Incentives

- ▣ Incentives will be provided to departments / services to support a specific outcome – for example new margin or improved patient satisfaction
- ▣ Not all departments will receive an incentive payment. Incentives will generally be targeted to areas of strategic importance and / or ability to significantly contribute to the System's program growth targets
- ▣ Incentives should have some risk on both upside and downside – e.g. if Dept does not achieve a certain threshold than some portion of their programmatic support would be reduced. If however, the threshold is achieved and more, the department should get more than just the identified programmatic support

Aligning Academic and Clinical Missions Through an Integrated Funds-Flow Allocation Process.
Kennedy, David; Johnston, Elizabeth; Arnold, Ethan

Academic Medicine. 82(12):1172-1177, December 2007.
DOI: 10.1097/ACM.0b013e318159e1b8



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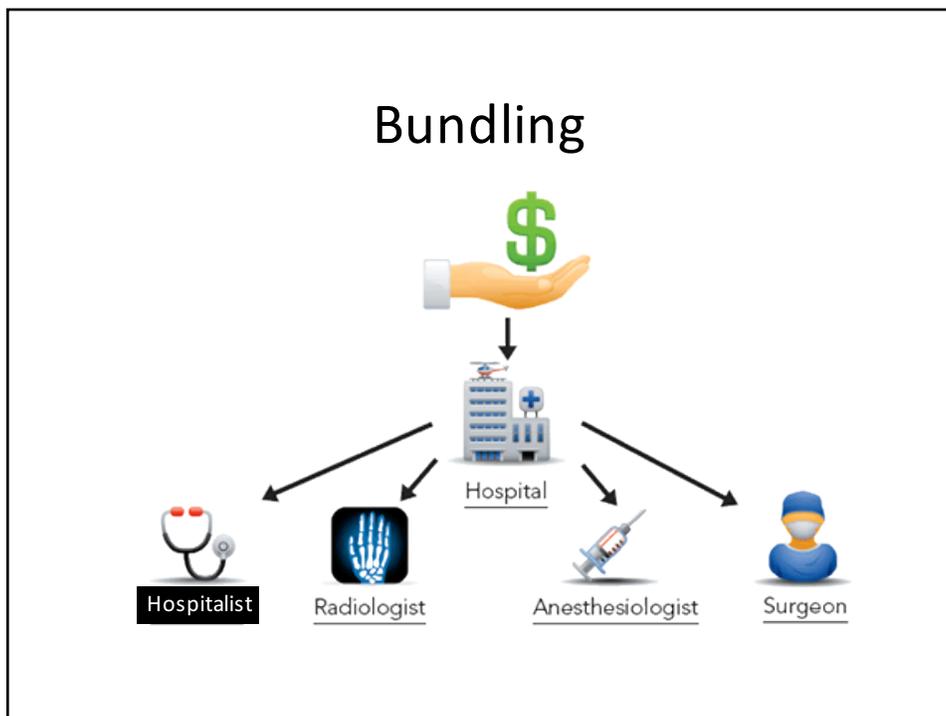
The NEW ENGLAND JOURNAL of MEDICINE

2018. Perhaps even more important, our target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018. Alternative payment

Perspective

Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care

Sylvia M. Burwell



**DEPARTMENT OF HEALTH AND
HUMAN SERVICES**

**Centers for Medicare & Medicaid
Services**

42 CFR Part 510

[CMS-5516-P]

RIN 0938-AS64

**Medicare Program; Comprehensive
Care for Joint Replacement Payment
Model for Acute Care Hospitals
Furnishing Lower Extremity Joint
Replacement Services**

AGENCY: Centers for Medicare &
Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

Piece of Pie



■ THE OPEN MIND

The Perioperative Surgical Home as a Future Perioperative Practice Model

Zeev N. Kain, MD, MBA,* Shermeen Vakharia, MD, MBA,* Leslie Garson, MD,* Scott Engwall, MD, MBA,*
Ran Schwarzkopf, MD,† Ranjan Gupta, MD,† and Maxime Cannesson, MD, PhD*

we have made in patient safety.²⁰ Surgeons are typically not interested in the medical management of their patients and are currently not involved in their preoperative optimization. It is our opinion that while hospitalists are interested in getting involved in the management of the PSH, they lack the fundamental understanding of perioperative physiology that results from the surgical experience and thus are not ideally positioned to deliver optimal postoperative care.

Disrupt relationships



The American College of Surgeons (ACS) has a long-standing expectation that its members will safeguard their patients' care throughout the course of surgical treatment. The ACS *Statements on Principles* state, "The surgeon is responsible for the patient's safety throughout the preoperative, operative, and postoperative period, including the responsibility for eliminating wrong-site, wrong-procedure, and wrong-patient surgery."

The College and other stakeholders are now developing recommendations on how best to ensure that patients receive safe, high-quality surgical care. Some of you may be familiar with the perioperative surgical home (PSH), which the American Society of Anesthesiologists (ASA) has proposed. The ASA has brought forth the PSH as a model of delivering health care throughout the patient's entire surgical care experience – from decision making through recovery.

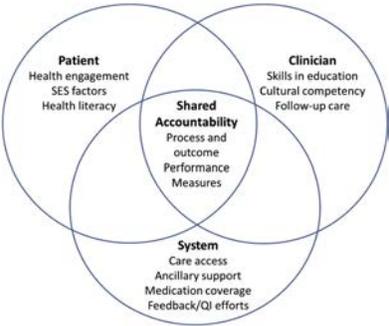
Under the PSH paradigm, the patient's care would be coordinated by a director of perioperative services. The ASA suggests that a physician is best suited to this role. Application of this concept must be compatible with the surgeon's sense of responsibility for overseeing all aspects of surgical patient care, although surgeons welcome collaborative efforts to ready patients for an operation with the anesthesiologist acting as partner. The leaders of the ACS and the ASA have been discussing perioperative care, and the ACS will continue to work with the ASA to ensure that all of the surgical patient's needs are properly met.



Bundled Payment Programs



What is shared accountability?



Surgery Quality Measures: Outcome

Quality Measure	HIQRP	HVBP	HRRP	HACRP
SSI: Procedure specific surgical site infection outcome measure (NQF #0753)	X	X		X
PSI 4: Death among surgical inpatients with serious, treatable complications (NQF #0351)	X			
PSI 90: Patient safety for selected indicators (composite) (NQF #0531)	X	X		X
CABG 30-Day Mortality: Hospital 30-day all-cause, risk-standardized mortality rate following coronary artery bypass graft surgery	X			
CABG 30-Day Readmission: Hospital 30-day all-cause, unplanned, risk-standardized readmission rate following coronary artery bypass graft surgery	X		X	
Elective THA/TKA 30-Day Readmission: Hospital 30-day all-cause, unplanned, risk-standardized readmission rate following elective primary total hip arthroplasty and/or total knee arthroplasty (NQF #1551)	X		X	
Elective THA/TKA Complications: Hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty (NQF #1550)	X	X		
All-Cause Unplanned Readmission: Hospital-Wide All-Cause Unplanned Readmission (NQF #1789)	X			

A couple of options



How do we divvy up the pie?

- Traditional FFS
- Fixed payment
- Lower fixed payment and share in any profit margin
 - Should the anesthesiologist be allowed to share in potential reward?
 - Does the anesthesiologist want to assume any risk?



What Deans Want in Chairs – What is Competency in Chairs and How to Get the Needed Skills

Meghan M. Palmer, Ph.D.

November 6, 2015
10:45AM – 11:45AM

What Deans Want in Chairs: What is Competency in Chairs and How to Get the Needed Skills

Megan M. Palmer, PhD

Disclosure: The speaker has no disclosures.

Learning Objectives: As a result of attending this session, participants will be able to 1) identify a list of common skills/attributes needed in order to be an effective chair, 2) articulate the competencies in which they perceive they have strength as well as those competencies that may need further development, and 3) consult selected resources to assist in their leadership development.

Summary: Today, academic department chairs are expected to be competent in multiple aspects of the enterprise of academic medical centers, which includes but is not limited to securing funding, reducing costs, recruiting and managing a diverse faculty and staff, developing innovative educational practice, strategic and business planning, conflict management, and negotiation skills. As a result, department chairs have tremendous influence in academic health centers, yet data indicate that they are often underprepared to take on these important leadership roles due to a lack of understanding of the skills need to be a successful chair as well as limited or no training in leadership. Further, even after starting in their new roles, chairs often receive little training or feedback, and may struggle to transition smoothly into their new leadership role.

In an effort to support department chairs, the Indiana University School of Medicine Office of Faculty Affairs and Professional Development reviewed relevant literature from the last 15 years in both academic medicine and higher education as whole that examined the attributes of successful department chairs and other academic leaders. This review included research studies as well as general perspectives and firsthand commentaries about the roles and responsibilities of these leaders. To arrive at a set of leadership competencies for department chairs, we discussed the crosscutting themes from the literature. Once we established our initial set of themes, we evaluated the extent to which these attributes matched those of our most effective department chairs and sought feedback from institutional leaders.

The six competencies, presented in Table 1, were ultimately informed by both a review of relevant literature and our experiences as faculty development professionals who are involved in both the recruitment and development of chairs and other academic leaders. These competencies now form the basis for our department chair recruitment, development, and feedback process. Table 1 lists the competencies we identified as well as a subset of skills associated with each competency, and some of the literature that inspired us to include the competency in our model.

Table 1. Leadership competencies developed by the Indiana University School of Medicine used to recruit, develop, and give feedback to chairs

Leadership Competencies	Example of Included Skills
Leadership and team development	Engages in succession planning Creates leadership opportunities for others Serves as a mentor and/or sponsor Sets tone of equitable and supportive climate for all
Performance and talent management	Encourages faculty development Effectively recruits and supports faculty and learners Provides ongoing feedback Empowers others
Vision and strategic planning	Establishes shared vision Inspires others toward a common goal Encourages innovation Fiscally responsible
Emotional intelligence	Is self-reflective Serves as a role model Open to views of others Committed to enhancing diversity
Communication skills	Articulates a vision Negotiates for resources and support Actively listens Engages others in decision making
Commitment to the tripartite mission	Insists that department advance all three missions Integrates department goals with stakeholder goals Advances community of scholars across mission areas Can meet the needs of a changing environment

It should be noted that rather than focus on a very specific skill (e.g., managing a budget), we developed broader categories and then worked to define the subset of skills associated with each competency.

Strategically attending to the way that chairs are selected, developed, and given feedback has tremendous potential to increase the success of chairs and, in turn, to constructively shape the culture of AHCs. Further, with the knowledge of the competencies needed to be effective chairs themselves can take action to develop their skills as a means to thrive in their leadership role.

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Additional Resources:

- Association of American Medical Colleges – [National Leadership Development Programs List](#)
- Wiley - [The Department Chair](#)

Suggested Reading:

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Perfect Storm (Finances and Statistics 2014)

Charles W. Whitten, M.D.

November 6, 2015
1:30PM - 2:00PM

UT SOUTHWESTERN MEDICAL CENTER

**Perfect Storm Part II:
Is a Tsunami Brewing?**

Charles W. Whitten, M.D.
Professor and Chairman
Margaret Milam McDermott Distinguished Chair
in Anesthesiology and Pain Management
Department of Anesthesiology and Pain Management
UT Southwestern Medical Center
5323 Harry Hines Boulevard
Dallas, Texas 75390-9068
Office phone: 214-648-5413
Fax: 214-648-5461
charles.whitten@utsouthwestern.edu



**Conflict of Interest +
Why am I qualified to do this??**

- I have no conflicts except:
 - I have a long standing interest in the economics of academic anesthesia practice dating back to collaborations which began with Amr Abouleish and others in the late 1990's.
 - We continue to perform collaborative research utilizing national databases.
- At UTSW we have recently undergone over \$2 billion of health care construction on Harry Hines Blvd. in Dallas, TX. Our hours of operation/sites of service have increased by almost 50% in the last year. Case volume in 2014 was greater than 140,000 Anesthetics.

**William P. Clements, Jr.
University Hospital
December 6, 2014**



**Parkland Memorial Hospital
August 20, 2015**



**Perfect Storm Overview:
Part I**

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

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

The Etiology of Perfect Storm Part I

**Match Day
1994**



Dealing with Generational Issues in Academic Medicine

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

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

Size of Residency Training Programs

- In 2014, 1,611 Senior Residents graduated (**35% women**). A total of 5,931 Anesthesiology Residents are enrolled in 133 Core Residency Programs.

Residency Production: Confounding Factors

- In 2014, we know that the following pursued ACGME fellowships:

Number of Programs	N=	Positions Filled	% Women
Critical Care Medicine	55	142	34%
Pain Medicine	97	326	19%
Pediatrics	51	200	62%
Cardiac	60	167	23%
OB	27	26	73%

Understanding Clinical Productivity for Anesthesiology Departments

- 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

Clinical Productivity by Facility Type

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

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

Author: E. Alkandak, MD, MSc, et al. Anesthesiology 2003;96:802-12

Productivity measurements based on “net operating charges (NOC)” and “net revenue” are used to evaluate the ability to generate income. The ability to generate income is a key factor in the financial success of an organization. The ability to generate income is a key factor in the financial success of an organization. The ability to generate income is a key factor in the financial success of an organization.

Understanding Anesthesia Clinical Productivity and Survey Results

Utilize the following:

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

Benchmarks by Facility Type, SAAA 2013

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

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

Dealing with Generational Issues in Academic Medicine

Benchmarks by Facility Type, SAAA 2013

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

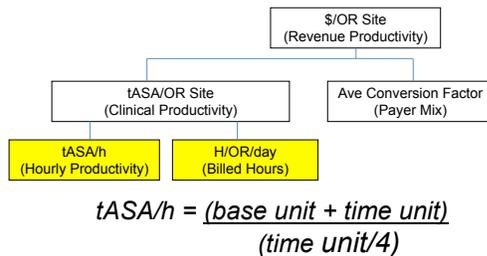
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Sites	21.0	26.0	4.0	31.4	18.0	14.5
tASA/OR	11,215	11,632	8,912	11,982	10,839	10,630
H/OR/d						
tASA/h						
Base/case						
H/case						
Staffing Ratio						

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Anesthesia Clinical Productivity



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

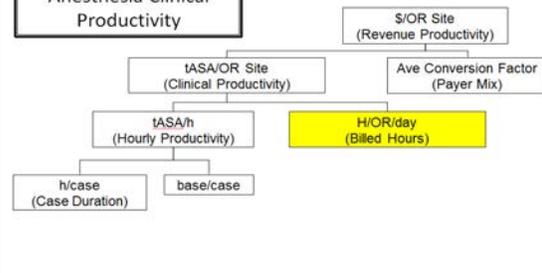
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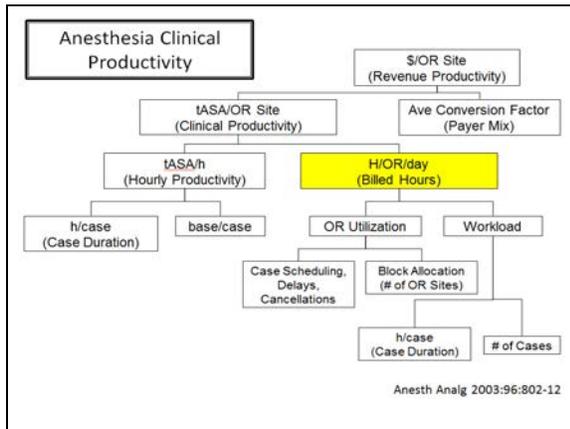
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Anesthesia Clinical Productivity



Anesth Analg 2003;96:802-12

Dealing with Generational Issues in Academic Medicine



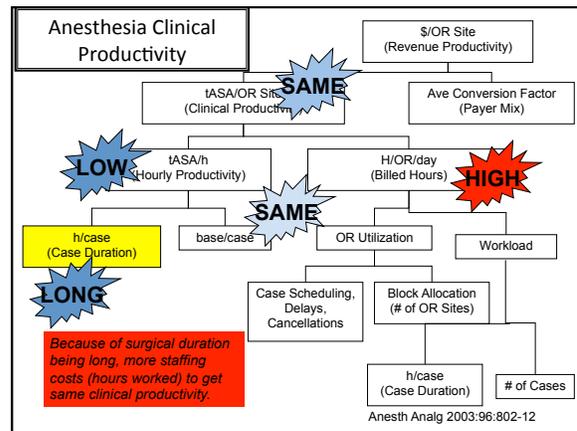
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H/OR/d	6.5	6.9	4.3	7.3	6.0	6.0
tASA/h	6.7	6.7	7.4	6.5	7.3	7.1
Base/case	5.8	6.0	4.5	6.2	5.8	5.4
H/case	2.2	2.3	1.2	2.5	1.7	1.6
Staffing Ratio						

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

How to use the benchmark data?

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



Benchmarks by Facility Type, SAAA 2013

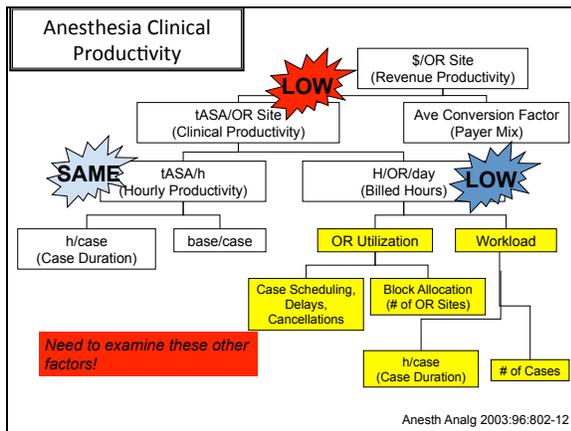
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H/case	2.2	2.3	1.2	2.5	1.7	1.6
Staffing Ratio						

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

How to use the benchmark data?

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

Dealing with Generational Issues in Academic Medicine



Other Findings

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

Benchmarks by Facility Type, SAAA 2013

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	All Groups (n=143)	All non ASC (n=111)	ASC (n=32)	AMC/ Indigent* (n=80)	Children (n=11)	Community (n=20)
Sites	21.0	26.0	4.0	31.4	18.0	14.5
tASA/OR	11,215	11,632	8,912	11,982	10,839	10,630
H/OR/d	6.5	6.9	4.3	7.3	6.0	6.0
tASA/h	6.7	6.7	7.4	6.5	7.3	7.1
Base/case	5.8	6.0	4.5	6.2	5.8	5.4
H/case	2.2	2.3	1.2	2.5	1.7	1.6
Staffing Ratio	1.8	1.7	2.8	1.8	1.7	1.8

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

Benchmarks 2013

MEDIAN VALUES (50%)	Facility Type					Type of Surgical Staff		
	All Groups (n=143)	All non ASC (n=111)	ASC (n=32)	AMC/ Indigent* (n=80)	Children (n=11)	Community (n=20)	Academic Only (n=57)	Mixed/ Private Practice** (n=54)
Sites	21.0	26.0	4.0	31.4	18.0	14.5	29.0	25.0
FTE	12.0	15.0	2.0	17.0	13.0	6.0	16.0	13.0
Staffing Ratio	1.8	1.7	2.8	1.8	1.7	1.8	1.8	1.7
tASA/case	14.3	15.6	9.1	16.6	12.5	12.3	16.6	14.1
Base/case	5.8	6.0	4.5	6.2	5.8	5.4	6.2	5.8
H/case	2.2	2.3	1.2	2.5	1.7	1.6	2.5	2.1
tASA/h	6.7	6.7	7.4	6.5	7.3	7.1	6.5	6.8
Case/OR/d	3.1	3.0	3.6	3.0	3.5	3.2	2.9	3.3
tASA/OR/d	11,215	11,632	8,912	11,982	10,839	10,630	12,023	11,445
H/OR/d	6.5	6.9	4.3	7.3	6.0	6.0	7.2	6.8

SAAA YEARLY SURVEY 2014

2014 Average Department

	Mean	+/- SD	Median
Surgical Anesthesiologist FTE's	48.3	31.9	41
Pain	4.0	2.85	3.6
ICU	3.6	4.6	2
Residents			
CA-1	14.0	7.1	13
CA-2	13.8	6.9	14
CA-3	13.8	7.54	13
CA-4	9.8	11.6 (Max 61)	6
Per ACGME Average sized Program - CAs 1,2 & 3 - 44.3			
Internship			
CA-0	8.9	6.7	8
Interns in home Dept.	10.7	5.8	10

Dealing with Generational Issues in Academic Medicine

Clinical Coverage

	Mean	+/- SD	Median
How many OR's does your Department cover each day?			
Sunday	4.1	3.68	4
Monday	40.7	26.5	38
Tuesday	41	26.5	39
Wednesday	40.8	26.5	38
Thursday	40.9	26.5	38
Friday	40.6	26.1	38
Saturday	4.8	4.2	4
How many Non-OR/Off Site locations does your Department cover each day?			
Sunday	0.8	1.2	0
Monday	10.9	10.4	8
Tuesday	10.8	10.4	8
Wednesday	11	10.4	8
Thursday	10.9	10.4	8
Friday	10.9	10.5	8
Saturday	0.9	1.3	0
How many OB deliveries with anesthesia involvement does your Department have each year?	2,908	2,157 (maximum 13,485)	2,409

Clinical Coverage

	Mean	+/- SD	Median
How many faculty do you have on each of these services per day on average, Monday thru Friday in the daytime.			
OB	1.5	1.06	1
ICU	1.6	1.3	1
Acute Pain	1.3	0.93	1
Pain Clinic	2.2	1.72	1
Pre-Op Clinic	0.9	0.57	1
Other	0.4	1.54	0
Total	7.8		

CRNAs/AAs

	Mean	+/- SD	Median
Paid for by Dept.	47.4%	44.5%	40%
Paid for by your Hospital	50.1%	44.1%	40%
By other sources	2.6	9.87%	0%

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

Average Department Clinical Coverage Monday-Friday

	Mean	+/- SD	Median
ORs	40.8	16	39
Off Site	10.9	10.4	8
OB	1.5	1.06	1
ICU	1.6	1.3	1
APS	1.3	0.9	1
Pain	2.2	1.72	1
Pre-Op	0.9	0.57	1
Other	0.4	1.54	0
Total	59.6		
Faculty/Sites	50.7/59.5 =	0.939	

Average Department Clinical Revenue

	Mean	+/- SD
Average Department Clinical Revenue	\$ 30,244,498	\$ 21,123,509
Clinical Revenue per FTE	\$ 516,055	\$ 256,820
Research Revenue	\$ 1,606,511	\$ 2,471,942 (Max \$11,500,000)
Research Revenue per FTE	\$ 20,326	\$ 24,621
Total Institutional Support	\$ 10,541,397	\$ 9,127,210
Total Institutional Support per FTE	\$ 196,491	\$ 144,207
Support from the Hospital	\$ 8,092,944	\$ 8,425,490
Support from Medical School	\$ 1,107,828	\$ 1,726,378
Support from other sources	\$ 1,304,625	\$ 3,045,381
Other income	\$ 684,364	\$ 2,315,391
Total Department Revenue	\$ 43,076,770	\$ 28,612,988
Total Department Revenue per FTE	\$ 740,693	\$ 231,042

Billing Production

	Mean	+/- SD
Total Anesthesia Units Billed	666,082	446,746
Total Anesthesia Units Billed Per FTE	11,983	6,964
Time Units per Case	11.5	4.33
Cases Billed	40,551	26,675
Total Work RVUs for Intraoperative Procedures (Line Placement/TEE/Blocks) (n=52)		32,640
How many work RVUs did you bill for your ICU Service last year? (n=55)	18,547	25,188
How many work RVUs did you bill for Pain Management last year?		
In-Patient	4,358	4,837
Outpatient	13,746	13,175

Dealing with Generational Issues in Academic Medicine

Billing Data

	Mean	+/- SD
What is your gross unit value?	\$119.00	\$ 35.30
What is your average \$ amount collected per unit?	\$ 37.00	\$ 12.57
What unit value do you receive from Medicaid?	\$ 17.10	\$ 6.38

Billing – Median Data

	Median
Total Anesthesia units	566,368
Total Anesthesia units billed per FTE	11,982
Total Anesthesia time units billed per case	10.6
What is the average unit dollar amount you collected?	\$35.00

Margin Analysis

	Mean	+/- SD
Margin (n=85)	\$ 833,057	\$3,864,251
Margin: Those with profit(n=58)	\$2,332,510	\$3,295,824
Margin: Those with loss (n=21)	-\$3,070,273	\$3,005,330

Compensation

How much additional compensation do you pay for the following subspecialty?	Mean	+/- SD	Median
For Departments paying additional comp.			
Cardiac	\$14,414	\$13,549	\$ 10,000
ICU	\$10,386	\$13,245	\$ 5,000
Pediatrics	\$14,193	\$16,597	\$ 10,000
Pain	\$12,580	\$18,331	\$ 10,000
OB	\$5,182	\$7,337	\$ 10,000
Neurology	\$ 2,284	\$4,408	\$ 0,000
Call – How much do you pay per hour for late/ weekend In-House Coverage	\$152.00	\$36.00	\$ 150.00

2014 Compensation Average total compensation including income plus pension contributions

Compensation includes income plus pension contribution	25%	Median	75%
Instructor	246,026	285,553	324,503
Assistant Professor	309,013	331,149	361,370
Associate Professor	328,000	367,110	402,450
Professor	341,004	376,145	426,655
Chair	501,280	544,266	606,802

Faculty Benefits

	Mean	+/- SD	Median
What is the average of non-clinical/ academic time for faculty (not counting the day after In-Hospital Call)	17.7%	8.5%	15.0%
Number of vacation days	24.6	5.95	24
Number of meeting days	7.4	3.86	7

Dealing with Generational Issues in Academic Medicine

Total Department Support (without CRNA Support) 2014

	Mean	+/- SD	Median
Support without CRNA Support	\$ 7,851,927	\$ 6,148,498	\$ 7,096,471
Support without CRNA Support per FTE	\$ 143,964	\$ 119,849	\$ 117,960

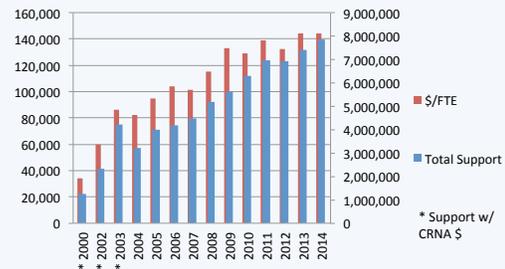
Mean Total Department Support (without CRNA Support)

	\$ Support	\$ Per FTE (Mean)
2009	\$ 5,630,386	\$ 133,196
2010	\$ 6,579,848	\$ 128,619
2011	\$ 7,008,978	\$ 140,435
2012	\$ 6,920,575	\$ 132,339
2013	\$ 7,413,000	\$ 144,000
2014	\$ 7,851,927	\$ 143,964

Mean Institutional Support

Total Support/FTE	2014	2013	\$
			\$ 196,441
			\$ 181,000
(Total support – CRNA Support)/FTE	2014		\$ 143,964
	2013		\$ 144,000
	2012		\$ 132,338
	2011		\$ 140,435
(Support without CRNA support)/Site	2014		\$ 7,851,927
			+ 59.6=
			\$ 131,744
	2013		\$ 137,277
	2012		\$ 128,831
	2011		\$ 134,934

Total Department Support (Without CRNA Support)



Trends 2014 vs 2013

Total support without CRNA Support per FTE	Stable
Reporting departments with a positive margin	Increased
Faculty per site	0.939 Is lower – not statistically significant
Clinical coverage out of OR per day	Increased

The Tsunami???

Is this all sustainable???

Dealing with Generational Issues in Academic Medicine



ECONOMICS, EDUCATION, AND HEALTH SYSTEMS RESEARCH
 Steven James
 RONALD B. MILLER

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

Amr E. Abouleish, MD, MBA¹, Donald S. Prough, MD², Steven J. Barker, MD, PhD³, Charles W. Whitten, MD⁴, Tamas Uchida, MD⁵, and Jeffrey L. Apfelbaum, MD⁶

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Productivity measurements based on "per operating room (OR) site" and "per case" are not influenced by staffing ratios and have permitted meaningful comparisons among small samples of both academic and private-practice anesthesiology groups. These comparisons have suggested that a larger sample would allow for clinical groups to be compared using a number of different variables (including type of hospital, number of OR sites, type of surgical staff, or other organizational characteristics), which may permit more focused benchmarking. In this study, we used such grouping variables to compare clinical productivity in a broad survey of academic anesthesiology programs. Descriptive billing and staffing data were collected for 1 fiscal or calendar year from 57 academic anesthesiology departments representing 39 hospitals. Descriptive data included types of surgical staff (e.g., academic medical centers and ambulatory surgical centers [ASCs]), billing and staffing data included total number of cases performed, total American Society of Anesthesiologists units (ASA) billed, total time units billed (15-min units), and daily number of anesthetizing sites staffed (OR sites). Measurements of total productivity (ASA/OR site) billed hours per OR site per day (H/OR/d), surgical duration (h/case), hourly billing productivity (ASA/h), and base units/case were compared. These comparisons were made according to type of hospital, number of OR sites, and type of surgical staff. The ASCs had significantly less ASA/OR site, fewer H/OR/d, and less h/case than non-ASC hospitals. Community hospitals had significantly less H/OR/d and h/case than academic medical centers and incident hospitals and a larger percentage of private-practice or mixed surgical staff. Academic staff had significantly less ASA/h, and significantly more h/case. ASA/h correlated highly with h/case ($r = -0.68$). This study showed that the hospitals at which academic anesthesiology groups provide care are not all the same from a clinical productivity perspective. By grouping based on type of hospital, number of OR sites, and type of surgical staff, academic anesthesiology departments (and hospitals) can be better compared by using clinical productivity measurements based on "per OR site" and "per case" measurements (ASA/OR, billed h/OR/d, h/case, ASA/h, and base/case).

(Anesth Analg 2003;96:802-812)

Benchmarks 2013

MEAN VALUES	FACILITY TYPE					
	All Groups (n=143)	All non ASC (n=111)	ASC (n=32)	AMC/Indigent* (n=80)	Children (n=11)	Community (n=20)
Sites	23.0	28.3	4.5	33.1	17.2	15.30
FTE	13.7	17.0	2.2	19.9	11.1	8.5
Staffing Ratio	1.9	1.8	2.3	1.8	1.6	1.8
tASA/case	14.3	15.6	9.8	16.6	13.6	12.8
Base/case	5.7	6.0	4.7	6.2	5.9	5.4
H/case	2.1	2.4	1.3	2.6	1.9	1.9
tASA/h	7.1	6.7	8.4	6.5	7.2	7.2
Case/OR/d	3.3	3.2	3.7	3.1	3.3	3.5
tASA/OR/y	11,210	11,900	8,816	12,320	10,717	10,871
H/OR/d	6.6	7.2	4.4	7.7	5.9	6.2

Comparing Apples to Apples: Updated clinical productivity benchmarking survey of academic anesthesiology departments demonstrates importance of benchmarking using data on similar facilities

In order to benchmark anesthesiology clinical productivity of a facility, current and detailed information is needed by organizational characteristics, e.g., type of facility, type of surgical staff, and number of anesthetizing sites (1) because there has not been a survey since 2003, we performed a follow-up survey of clinical productivity of academic programs.

Results: 48% of members responded with 143 facilities accounting for 2.5 million cases, almost 40 million billed ASA units, 3,290 anesthetizing sites, and 1,954 anesthesiologists. Median Values of all and some of the subgroups are shown in Tables 1 & 2.

Comparing Apples to Apples-Continued

Discussion: Academic departments are providing care at more facilities and larger facilities (as compared to 2003 survey). It is even more important to compare productivity of a facility with like facilities. Shorter surgical duration (e.g., ASC, Children's, Community, and smaller facilities) lead to more units billed per hour of care (tASA/h) which results in not having as many billed hours for similar productivity per OR (tASA/OR).

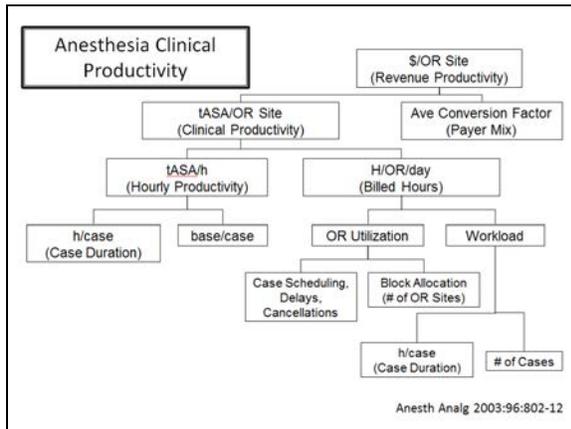
References. (1) *Anesth Analg* 2003; 96:802-812

2013 AAAC/SAAA Clinical Productivity Report

Key Findings:

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

Dealing with Generational Issues in Academic Medicine



Compliance Update

Judith Jurin Semo, PLLC

November 6, 2015
2:00PM – 2:30PM

Compliance Update 2015

SAAA 2015 Annual Meeting

November 6, 2015

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Disclosures

- ◆ In private law practice
 - Advise clients on regulatory compliance & transactions
- ◆ Objectives
 - Describe issues the HHS OIG has listed as a focus area in its FY 2013 Work Plan
 - Identify other compliance risk areas for anesthesia practices

Overview

- ◆ Compliance questions in academic settings
 - Who can write a post-op note?
 - Billing when coverage changes
 - Breaks
 - “Independence” for resident education
- ◆ Asking for CMS guidance
- ◆ And more

Acronyms Used

- ◆ CAC - Carrier Advisory Committee
- ◆ CoPs - Conditions of Participation for Hospitals (to participate in Medicare)
- ◆ HHS - Dep’t of Health & Human Services
- ◆ MAC - Medicare Administrative Contractor
- ◆ NCCI - National Correct Coding Initiative
- ◆ NGS - National Gov’t Services
- ◆ OIG - HHS Office of Inspector General

Reviewing the Rules

Teaching Rule (Medicare)

- ◆ 100% of allowance if teaching anesthesiologist involved in
 - Single case with a resident,
 - Two concurrent cases involving residents, or
 - Single anesthesia case w/a resident concurrent to another case paid under medical direction rules

Teaching Rule (Medicare)

- ◆ Teaching anesthesiologist, or different anesthesiologists in same group, must
 - Be present during all critical or key portions of the case
 - Be immediately available for entire case
- ◆ Documentation in record must indicate both presence for all critical/key portions & immediate availability

7 Steps of Medical Direction

- ◆ Perform preanesthetic exam
- ◆ Prescribe anesthetic plan
- ◆ Personally participate/most demanding parts (induction/emergence, if applicable)
- ◆ Ensure performance by qualified anesthetist
- ◆ Monitor at frequent intervals
- ◆ Remain physically present/available for immediate diagnosis
- ◆ Provide indicated post-anesthetic care

Risk Areas: Medical Direction

- ◆ Medical direction:
 - Not satisfying 7 steps of medical direction
 - Not documenting all 7 steps
 - Immediate availability
 - Documentation of handoffs
 - Breaks

Teaching Rule (Medicare)

- ◆ If, due to facts, teaching cases convert to medical direction (when >2):
 - Teaching anesthesiologist may not have
 - » Performed preanesthetic assessment &
 - » Prescribed the anesthetic plan
 - Would not satisfy medical direction
 - » Though teaching anesthesiologist present for all key portions

Post-Op Note

- ◆ Who can write a post-op note?
 - Question: Under what regulatory scheme?
 - » Medicare billing rules
 - Teaching rule
 - Medical direction
 - » Hospital CoPs – postanesthesia evaluation

Post-Op Note

- ◆ Medicare teaching rule (billing):
 - On/after 1/1/2010, 100% of Medicare PFS allowance paid if teaching anesthesiologist is involved in training up to 2 residents
 - » Teaching anesthesiologist must be present during all critical or key portions of the anesthesia service or procedure involved

Post-Op Note

- ◆ Medical direction rule (billing):
 - Seven steps of medical direction
 - Anesthesiologist must provide indicated post-anesthesia care
 - » Consider documentation

Post-Op Note

- ◆ Hospital CoPs - Postanesthesia evaluation completed & documented by individual qualified to administer anesthesia
 - Anesthesiologist
 - MD or DO (other than an anesthesiologist)
 - Dentist, oral surgeon, or podiatrist qualified under State law to administer anesthesia
 - CRNA
 - AA

Post-Op Note

- ◆ Hospital CoPs - Medical Record Entries
 - “When State law &/or hospital policy requires that entries in the medical record made by residents or non-physicians be countersigned by supervisory or attending medical staff members, then the medical staff rules & regulations must address counter-signature requirements and processes”

State Operations Manual, App. A, Sec. A-0450 (42 CFR § 482.24(c)(1))

Changes: When Cases No Longer Are Teaching Cases

Changes in a Case

- ◆ Billing when coverage changes
 - From 1-on-1 (or 1-on-2) w/residents
 - » To one-on-three or four with CRNAs
 - » No longer eligible for “teaching” rule
 - » May convert to medical direction, but
 - Always must consider if have satisfied medical direction rules in each case

Changes in a Case

- ◆ Billing when coverage changes
 - Need to look at specifics of each case to determine what services are billable
 - » When does case convert?
 - How much of case has been completed before conversion?
 - » How many concurrent cases?
 - ◆ No one easy answer
-



Breaks & Temporary Relief

Breaks

- ◆ If one-on-one
 - With either a CRNA or resident
 - Can step in & provide break relief
 - » No effect on medical direction
 - » No effect on teaching rule req'ts
-

Breaks

- ◆ Issues arise w/concurrent cases
 - For teaching cases:
 - » “The teaching anesthesiologist (or another anesthesiologist with whom the teaching physician has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure.”

Medicare Claims Processing Manual 100.1.2.A.4

Breaks

- ◆ CMS (Nov. 2009):
 - “Thus, different anesthesiologists in the same anesthesia group practice can be considered the teaching physician for purposes of the statutory requirement that the teaching anesthesiologist be present at the key or critical portions of the anesthesia service.”
-

Breaks

- ◆ If another teaching anesthesiologist is available to oversee Case 2, an anesthesiologist may be able to provide a break in Case 1 w/resident
 - ◆ For whom is a break provided?
 - Resident?
 - CRNA?
-

Breaks for Colleagues

- ◆ Ordinarily medically directing physician cannot provide a "break" for a CRNA
 - Would be personal performance
 - ▶ Cannot medically direct & personally perform at the same time
 - Issue: How to be immediately available?
 - ◆ Best approach:
 - Have same category of provider relieve
-

Breaks for Colleagues

- ◆ Has your MAC provided flexibility on breaks?
 - *E.g.*, NGS & Palmetto GBA policy on "Medical Direction & Temporary Relief"
 - NGS & Palmetto allow 3 ways to meet req't of uninterrupted immediate availability
 - ◆ Absent MAC policy, breaks "break" medical direction
-

NGS & Palmetto: Breaks & Temporary Relief

- ◆ Option 1:
 - Second anesthesiologist, not medically directing > 3 concurrent procedures, may assume temporary medical direction responsibility for relieving anesthesiologist
 - Must document transfer of responsibility on medical record
-

NGS & Palmetto: Breaks & Temporary Relief

- ◆ Option 2:
 - Policy & procedure may require that the relieved provider remain in immediate area & be available "to immediately return" to his/her case in event relieving anesthesiologist is required to be elsewhere
 - Must have adequate communications mechanisms
-

NGS & Palmetto: Breaks & Temporary Relief

- ◆ Option 3:
 - Policy & procedure require that a specified anesthesiologist (*e.g.*, Anesthesiologist of the Day or OR Dir.) remains available at all times to provide substitute medical direction services for anesthesiologists providing relief to anesthesia providers; AND
-

NGS & Palmetto: Breaks & Temporary Relief

- ◆ Option 3 (continued):
 - This individual (*e.g.*, the OR director) must not personally have ongoing med. dir. responsibilities that would preclude temporarily assuming responsibility for additional case(s)
-

Breaks: Practical Questions

- ◆ What is “temporary” relief?
- ◆ How long may a break be?
 - Need to define
 - Needs to be consistent with NGS or Palmetto (or other MAC) guidance
 - Your Department Compliance Committee should address

Breaks: Practical Questions

- ◆ What is immediate availability of the relieved CRNA or resident?
- ◆ Immediately available
 - Geographic immediate availability
 - » Cannot be offsite
 - Practical availability - ability to return
 - » Interruptible

Breaks: Practical Questions

- ◆ How far away can you be & still be immediately available?
 - Need to assess all areas
- ◆ OIG is looking at immediate availability
 - Do not be overly aggressive

Breaks: Practical Points

- ◆ Need to meet medical direction in other concurrent cases
 - Must participate in most demanding portions
 - Need some way to monitor the other concurrent case(s)
 - » And document frequent monitoring in other concurrent case(s)

Resident “Independence”

Resident “Independence”

- ◆ How do programs fulfill ACGME mandate of providing graded responsibility & indirect supervision
 - Without running afoul of CMS mandates for
 - » Supervision - participation in critical portions, and
 - » Documentation of involvement

Resident “Independence”

- ◆ ACGME:
 - “The education must culminate in sufficiently independent responsibility for clinical decision-making & patient care so that the graduating resident exhibits sound clinical judgment in a wide variety of clinical situations & can function as a leader of peri-operative care teams”

Resident “Independence”

- ◆ Two separate sets of rules – different purposes
- ◆ For billing, CMS (& other payors’) rules govern
 - Teaching: Must participate in critical portions of case
 - Medical direction: Similar req’t (most demanding portions); frequent monitoring

Resident “Independence”

- ◆ Bottom line: Must satisfy both
 - “Participating” for teaching can mean being in room to observe & be ready to intervene
 - Is remote monitoring sufficient?
 - » E.g., reviewing monitor or observing through door
 - No guidance – more risk
 - May not be sufficient

Asking for
CMS or MAC
Guidance

Requesting Guidance

- ◆ Be careful what you ask for
 - Clarity is desirable, but a negative response may create hardship
 - Consider previewing issue with
 - » CAC representative
 - » State Component Society
 - » ASA

PACU Delays
&
Anesthesia Time

PACU Delays & Anesthesia Time

- ◆ **Anesthesia time (Medicare):**
 - “Anesthesia time . . . starts when the anesthesia practitioner begins to prepare the patient for anesthesia services and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the beneficiary, that is, when the beneficiary may be placed safely under postoperative care.”

PACU Delays & Anesthesia Time

- ◆ **Issue: What happens when the patient “may be placed safely under postoperative care,” but no PACU bed is available?**
 - Medicare contemplates that the “anesthesia practitioner” is no longer with the patient when the patient may safely be placed under post-op care

PACU Delays & Anesthesia Time

- ◆ **Guiding issue:**
 - Is it medically necessary for anesthesia personnel to remain w/the patient?
 - » Should only bill for time that is medically necessary
 - Should document reason remaining w/patient

PACU Delays & Anesthesia Time

- ◆ **NCCI – In discussing anesthesia time & discontinuous time:**
 - “However, if it is medically necessary for the anesthesia practitioner to continuously monitor the patient during the interval time and not perform any other service, the interval time may be included in the anesthesia time.”
- ◆ **Underscores medical necessity**

Documenting Participation in Emergence

Emergence

- ◆ ***U.S. ex rel. Donegan v. Anes. Associates of Kansas City, PC* (June 9, 2015 WD Mo)**
 - **Claim: Emergence excludes PACU time**
 - » Experts testified that participation in emergence should be in OR
 - » Issue: Did group file false claims by billing for medical direction though “virtually never” participated in emergence in OR?

Emergence

- ◆ Court ruled for group
 - “Defendant defines “emergence” to include the patient’s recovery in the recovery room. Although this may not be the most widely held or most reasonable definition of “emergence,” it is a plausible definition. By extension, Defendant’s view that the regulation is satisfied by seeing the patient in the recovery room is a reasonable interpretation.¹¹”

Emergence

- ◆ Of concern: Ct’s comment that emergence extending to PACU may not be most reasonable or widely held view
- ◆ Ct also emphasized in its footnote:
 - “¹¹ The Court emphasizes it is making no ruling on whether seeing a patient in the recovery room is a reasonable interpretation of step three’s requirement to personally participate in *the most demanding aspects* of emergence.”

Emergence

- ◆ Case points to how even a group that is careful about compliance can end up in a whistleblower action
- ◆ Points to vulnerabilities in gray areas
 - Anesthesia billing involves many gray areas

Other Developments Conclusion

Anesthesia Remains a Focus

- ◆ Anesthesia remains on OIG work plan
 - Can expect more enforcement
- ◆ Whistleblower action v. Vanderbilt University Medical Center pending
 - Trial scheduled for May 2016
- ◆ Other enforcement action in the news

Conclusion

- ◆ Anesthesia billing is complicated
- ◆ There are many questions to which there are no good answers
- ◆ Continue to:
 - Educate staff
 - Require good documentation of services
 - Document decision-making on compliance decisions

PSH - ASA's Goals and Concerns

Daniel J. Cole, M.D.

November 6, 2015
2:35PM - 3:05PM

American Society of
Anesthesiologists®

PSH – ASA’s Goals & Concerns

Daniel J. Cole, M.D.
President
djcole@mednet.ucla.edu

Context
Why
What
Concern
Q&A

“It is not the strongest species that survive, nor the most intelligent, it is the one most adaptable to change”
-Charles Darwin

I skate to where the puck is going to be, not where it has been.
- WAYNE GRETZKY

The National Quality Strategy

APPROVED
MAR 2 8 2010

UPHELD
JUNE 2012

ACA

National Quality Strategy

The strategy is to concurrently pursue three aims:

NQS Priority

1. Making care safer by reducing harm caused in the delivery of care
2. Ensuring that each person and family members are engaged as partners in their care
3. Promoting effective communication and coordination of care
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
5. Working with communities to promote wide use of best practices to enable healthy living
6. Making quality care more affordable for by developing and spreading new health care delivery models

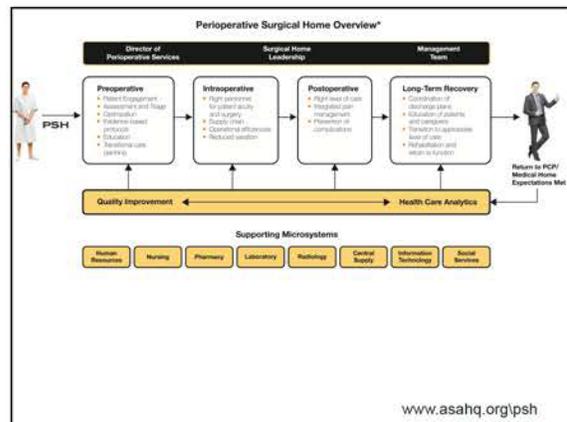
American Society of
Anesthesiologists®

Perioperative Surgical Home



Strategy without
tactics is the slowest
route to victory.
Tactics without
strategy is the noise
before defeat.

Sun Tzu



PSH-Why

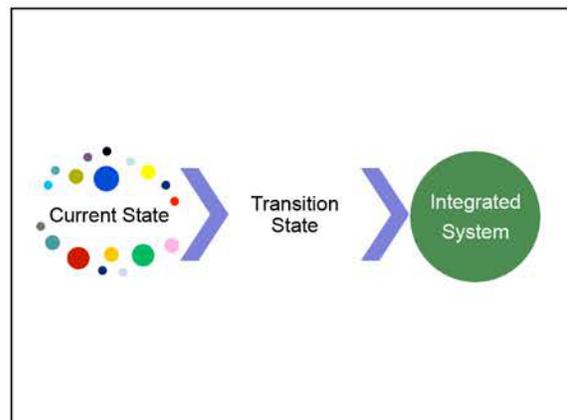
Quality & Safety

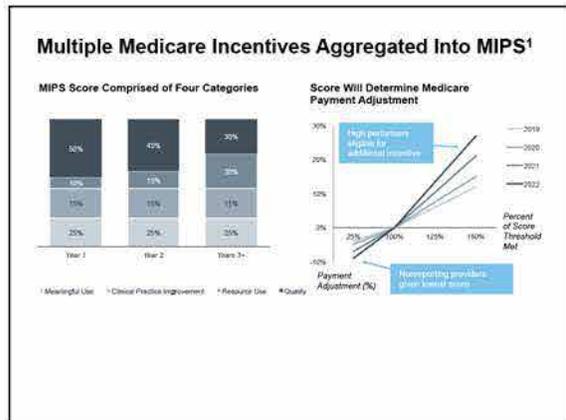
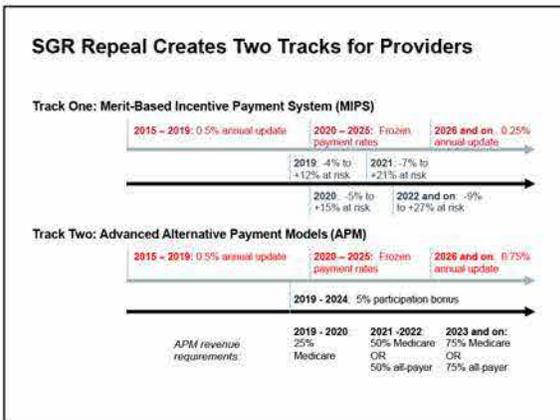
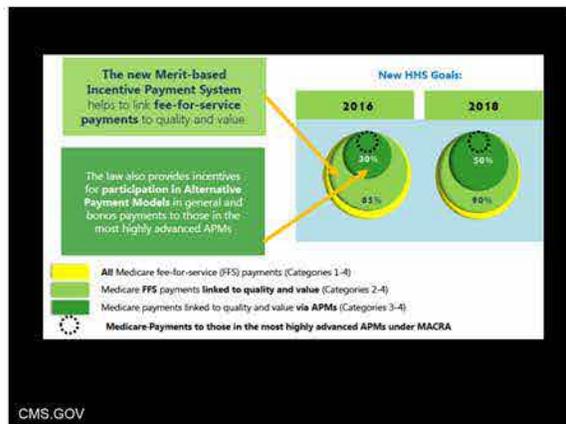
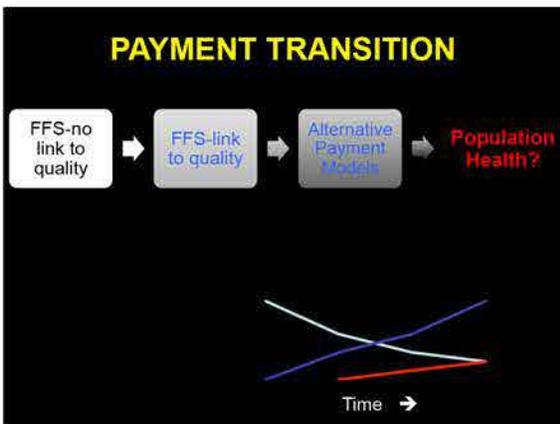
- Decrease complications
- Decrease readmissions
- Decrease mortality

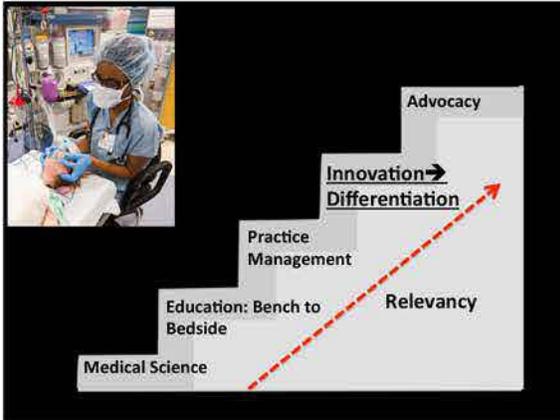
Improve Operational Efficiency

- Cost

**Strategically Positions our Specialty
Aligns with Alternative Models of Payment**



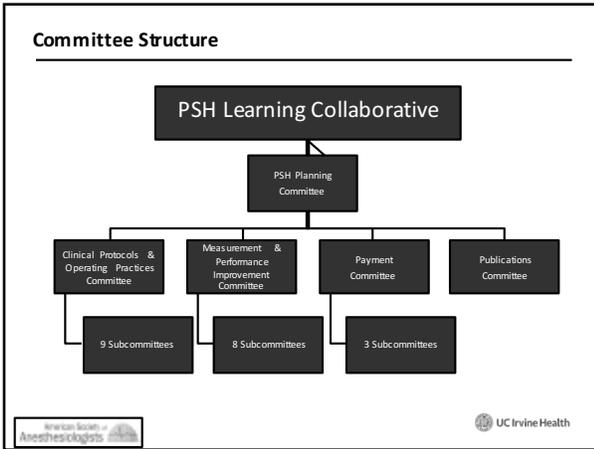




PSH – Successes and failures: What have we learned from the ASA Learning Collaborative?

Zeev N. Kain, M.D., M.B.A.

November 6, 2015
3:05PM – 3:25PM



- ### Key Activities
- #### Collaborative Operations
- Hosted 3 in-person National Meetings, with a 4th and final meeting planned for November 19-20
 - Convened 4 committees, as well as 20 subcommittees and cohorts
 - Provided 30 educational webinars
 - Offered 1:1 support from collaborative staff and subject matter experts through the Dedicated Partner program (e.g. monthly calls and customized implementation support offered to members' PSH teams)
 - Registered over 300 members for the PSH Community on PremierConnect (an online and mobile collaboration platform)
 - More than 180 discussion posts and replies have been posted on the community to date, enabling real-time peer-to-peer learning
- American Society of Anesthesiologists | UC Irvine Health

- ### Clinical & Operating Practices Committee (Art Boudreaux, Mark Schneider)
- Key resources developed include:**
- Stakeholder Identification Guide
 - Value Stream Mapping Toolkit
 - Infrastructure Checklist and Matrix
 - Critical Steps for PSH Implementation
 - Catalogue of Implementation Strategies
 - Sample Job Descriptions
 - IT Framework and Strategy
 - Protocol Repository (Case- and Disease-Specific)
 - Protocol Standardization Resources
- American Society of Anesthesiologists | UC Irvine Health

- ### Measurement & Performance Improvement (Zeev Kain, Rick Dutton)
- Identified and evaluated 148 potential metrics
 - Narrowed the list to the 13 Primary Metrics (133 data elements)
 - Developed specifications, a data dictionary, and a sample data file
 - Tested the feasibility of data collection for the major EMR systems
 - Revised the metrics in response to member feedback
 - Engaged Cerner and Epic in solutions to support data collection
 - Launched the data collection effort through a series of webinars
 - Successfully received data from multiple members to date, with others actively working through the process
- American Society of Anesthesiologists | UC Irvine Health

- ### Payment Committee (Peter Dunbar, Marc Leib)
- Cost Analysis Template and Responses
 - Value Proposition Matrix and Indicator Menu
 - Value Opportunities Tool
 - Medical Directorships Resources
 - Bundled Payment Program Resources
 - Co-Management Agreement Resources
 - MACRA/SGR Reform Resources
 - Met with representatives from CMS and multiple major commercial payors to educate them on the PSH model and value proposition
- American Society of Anesthesiologists | UC Irvine Health

PSH Collaborative: Pilot Programs

Pilot	Number of Pilots
Adenoidectomy - Tonsillectomy	1
Bariatrics	2
Breast	1
Cardiothoracic	4
Colorectal	8
Esophageal/Pancreatic	1
General Surgery	3
Glucose Control	1
Gyn/ Gyn Onc	3
Inflammatory Bowel Disease Surgery	1
Neurosurgery/ Neurovascular	3
Ortho (incl. joints (elective, replacement), hip/knee, shoulder, spine, trauma)	24
Spine (neurosurgery)	6
Urology (incl. cystectomy)	6
VTE Prevention	1
Total Pilot Program	65

American Society of Anesthesiologists | UC Irvine Health

PSH Collaborative Case Data Submitted (so far)



Organization	Total PSH Cases Submitted	Months of Data Received
Advocate Lutheran General Hospital	10	1
Children's National Medical Center	19	4
Kansas University Medical Center	137	1
St. Charles Health System	29	1
St. Francis Health System/TeamHealth	178	1
University of California, San Francisco	573	1
Virginia Commonwealth University	192	1
Total	1,138	10




Framework for Collaborative 2.0

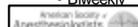
Two membership levels, depending on implementation readiness, timeline, and support needs

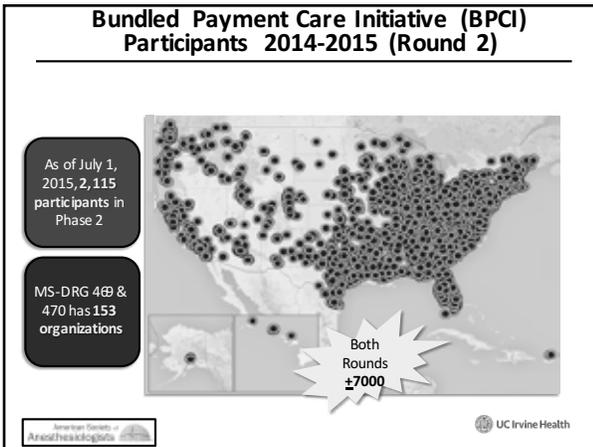
Core Collaborative

Designed for organizations that are earlier in their journey and primarily focused on the education, building capabilities, and preparation stages of transformation.

Key activities and support services include:

- Semi-annual in-person meetings
- Monthly educational webinars
- Monthly member sharing/networking calls
- Access to the implementation toolkit
- Access to clinical protocols, resources, and other tools
- Access to the PSH Core Community on PremierConnect
- Biweekly Community Digest and other communications





CCJR

41190 Federal Register / Vol. 80, No. 134 / Tuesday, July 14, 2015 / Proposed Rules

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

42 CFR Part 510
(CMS-0018-P)
RIN 0938-AS64

Medicare Program: Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Punishing Lower Extremity Joint Replacement Services

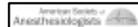
AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.
ACTION: Proposed rule.

SUMMARY: This proposed rule proposes to implement a new Medicare Part A...

3. *By express or overnight mail.* You may send written comments via express or overnight mail to the following address (ONLY Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-0018-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850).

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:
a. For delivery in Washington, DC: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 442-G, 11, Humphreys Building, 200 Independence Avenue SW, Washington, DC 20201.
b. Because access to the interior site is soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments. Comments received timely will also be available for public inspection, generally beginning approximately 3 weeks after publication of the rule, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, on Monday through Friday of the week beginning approximately 3 weeks after publication of the rule.

Medicare plans big payment changes for knee and hip replacements

California hospitals could cut inpatient costs 25% and save \$10 billion, study says



ASA | October 2015

Henry Ford's chief medical officer says...

Demand Destruction on the Horizon?

Impact of Population Health on Specialist Demand

Specialist	Change in Number of Physicians (Moderate Case Management)	Change in Number of Physicians (Aggressive Case Management)
Non-invasive Cardiologists	-22.3%	-44.6%
Anesthesiologists	-17.3%	-34.5%
Diagnostic Radiologists	-20.7%	-41.4%
ED Physicians	-22.1%	-44.3%
Neurologists	-31.0%	-63.2%

An Accelerating Trend Under Population Health

"You can see the challenge, right? Better care management means lower specialist appointments. These specialty services are our bread and butter—they drive most of our revenue—and without them I don't know what comes next."

Executive
Large Multi-Specialty Medical Group

1. Reference table is the net of the number of physicians needed to manage care for 100,000 base when adjusted with the...
2. Aggressive case management is the net of the number of physicians needed to manage care for 100,000 base...
3. The number of physicians needed to manage care for 100,000 base when adjusted with the...
Source: Deloitte Health Care Advisory Board members and analysis.

▶ **Timeline for the Next Iteration of the Collaborative**

Two-year timeline provides more time to collaborate, transform, and measure performance to demonstrate success

- April 1, 2016 – Launch date
- Spring 2016 - First in-person all-member meeting
- Summer 2016 - First Advanced Cohort PI sprint
- Fall 2016 - Second in-person all-member meeting
- Winter 2017 - Second Advanced Cohort PI sprint
- Spring 2017 - Third in-person all-member meeting
- Summer 2017 - Third Advanced Cohort PI sprint
- Fall 2017 - Fourth in-person all-member meeting
- Winter 2018 – Fourth Advanced Cohort PI Sprint
- March 30, 2018 – PSH 2.0 end date

19

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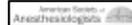
▶ **Harnessing the Transformative Power of Collaboration**

“I use not only all of the brain that I have, but the brains I can borrow.”

– Woodrow Wilson



20



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Financial Viability of PSH for the Department

Aman Mahajan, M.D., Ph.D.

November 6, 2015
3:50PM - 4:20PM

Financial Viability of PSH for the Departments.

*Aman Mahajan, MD, PhD
UCLA Health*

PSH is an innovative model of health care delivery that encompasses the full continuum of care for surgical patients—from the preoperative assessment and preparation, to the surgical course, through postoperative care and following discharge from the hospital. A key identifier and differentiator of the PSH is its physician leadership with the anesthesiologists (and anesthesiology departments) playing an important role as integrators and facilitators of the PSH approach.

While the need to implement a transformative approach to improving value for our patients is indisputable, it is unclear if/how models of perioperative medicine including PSH will remain financially sustainable in the long-term. There are costs involved any time value-based programs are implemented. Some of these costs are manifest, some remain ill defined. Some are fixed, others variable. Some costs are shared with the hospital, while others are primarily encumbered by the anesthesiology departments. Regardless, anesthesiology departments are implementing their version of PSH at some cost to the department and its faculty. For the model to be successful and sustainable, it is critical that financial viability of the model is established. The costs come in the form of salaries of personnel including faculty, nurses, staff, and residents assigned to the care of patients in the PSH. Additional investments are needed for training, informatics and analytics, equipment, other support services needed for successful implementation of the PSH. A financial return on the investment might not be apparent right away, as the PSH is best suited to serve value-based care models and not the current volume-based care models. Indeed some of the clinical services provided through the PSH are directly reimbursable to anesthesiology

and some of the anesthesiology departments have had greater success in creating a financially viable model. For many others, the gains are indirect—improved patient care is realized through achieving the triple aim of greater patient satisfaction, better outcomes and lower cost. The hospital may then provide financial support to the anesthesiology department for many of the services that are viewed as favorable towards reaching the optimal patient care. The challenge lies in being able to convince the hospital through meticulous outcomes and performance data that the PSH is truly bringing value. There is a significant movement amongst many academic medical centers to redesign their clinical funds flow whereby transfers are earmarked for programs that improve clinical care or incentives are built in the funds transfer schemes for programs that support hospital strategic goals of improving quality, performance and costs. Models such as PSH will become even more relevant in future with the expansion of the alternative payment schemes (bundles, ACO, etc). As the payment formula for anesthesia services shift from the ASA Relative Value Guide to a "base + time + outcome" formula, the PSH is one way for anesthesiologists to accommodate and remain relevant in this new payment paradigm.

Many have argued that while PSH is a tactical approach towards improving surgical care, the strategic goal for the specialty is to advance perioperative medicine. We need to continue to explore ways and means of seeking financial viability for approaches that advance perioperative medicine. The lecture will outline the methodology and approach employed by various anesthesiology departments, and their success in achieving financial viability of the PSH.

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Branding Anesthesiology as the Practice of Perioperative Medicine

Ronald G. Pearl, M.D., Ph.D.

November 6, 2015
4:20PM - 4:40PM

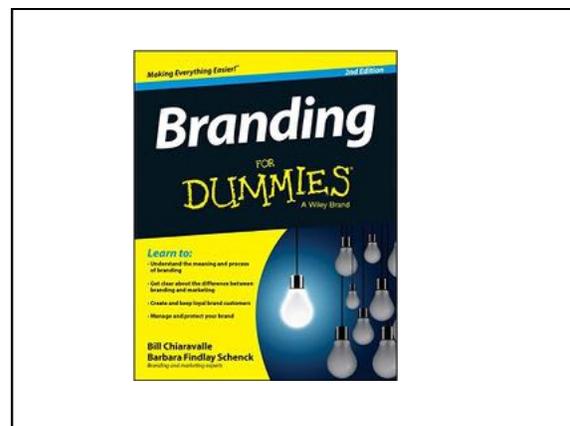
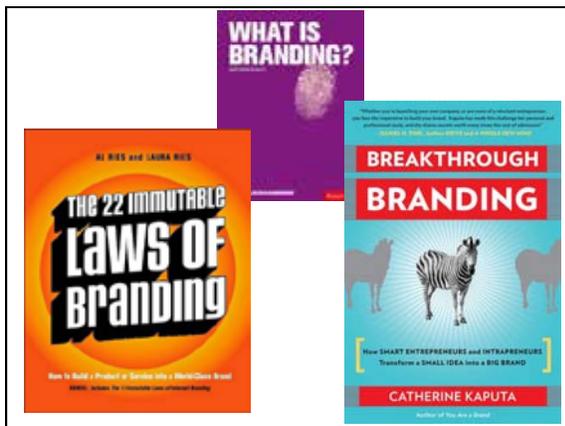
- A logo may be part of a brand, but a brand is not a logo
- A brand is what your customers think of when your name is mentioned



What Is Branding?

- “the process in which we shape our reputation and the expectations people have of us”
- “building and establishing expectations about the experience a person will have with a product, service, or company”
- “the art of communicating the essence of what a company stands for”
- “saying here’s who I am, what I stand for, what I offer”
- “the heartbeat of an organization. Who they are and who they want to be!”
- “a brand is a promise”

Masters in Branding student Sarah Hermalyn



Choosing A Brand

- Simplicity (one concept)
- Big idea
- Disruption (be different)
- Meaning (emotional connection with audience)
- Depth (layers of meaning)

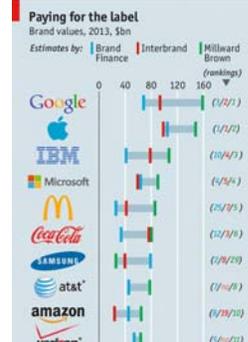
- Branding is about creating an emotional connection

The 7 Tenets of Branding

How To Brand

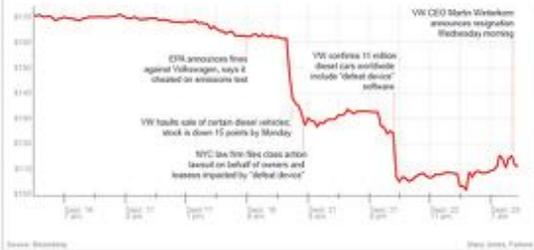
- Branding should capture your vision of success
 - How is it different from what is available today
- Branding is about knowing what you stand for
- Your brand is your identity
- Create an experience, not a product
- A brand should be memorable, easy to understand, inspirational
- Your brand is your promise to your customers
- Be true to your brand
 - Deliver on your promise

Value of the Brand



Brands account for more than 30% of the stock market value of companies in the S&P 500

Investors' reaction to Volkswagen emissions saga



Fundamental Branding Mistake

- Different people providing different messages



The Stanford Medicine Brand



PREEMPTIVE PREVENTIVE
PREDICTIVE PROACTIVE

Stanford MEDICINE

"Healing humanity, through science and compassion, one patient at a time"



To care,
To educate,
To discover



Stanford Healthcare Alliance Brand



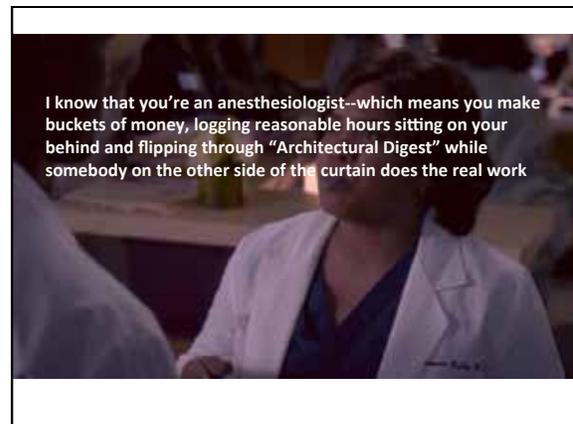
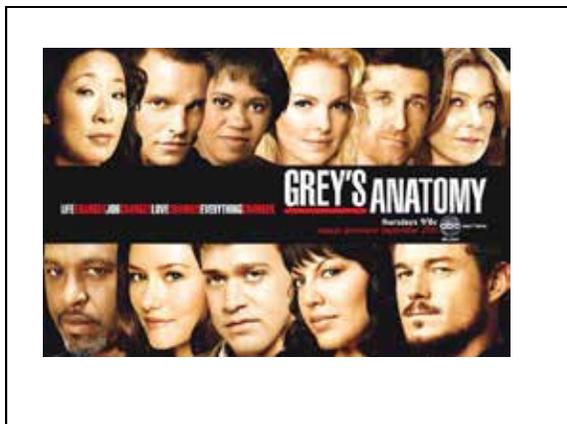
Quality of care
Integrity
Perverse incentives



What is the Brand of Anesthesia?

Stereotype of an Anesthesiologist

- Not (true) doctors
- Not very smart
- Not interested/good at dealing with patients
- Interested only in money and lifestyle
- Overpaid



NURSE ANESTHESIA • SAFE ANESTHESIA



Which ones are the anesthesiologists and which are the nurse anesthetists?

CAN'T TELL?

It's just as hard to tell the difference between their anesthesia education, the way they administer anesthesia, and their safety records.

Public Perceptions

- Many patients (up to 50%) do not know anesthesiologists are physicians
 - They are not “proper” doctors
- Confusion with nurse anesthetists
- Only 4% of patients can recall the name of their anesthesiologist
- Frequent belief that anesthesiologist leaves patient once the patient is asleep
- Frequently perceived as a technician
- Limited knowledge of any role of the anesthesiologist outside the operating room

Branding Anesthesiology As Perioperative Medicine?

- Perioperative medicine encompasses the care of the patient preparing for, having and recuperating from surgery...The medical knowledge distinct to this field includes that of operative risk and complications, of patient specific risks, of methods to reduce risk, and of the management of medical illness during this time period.
 - Wikipedia

Components of Perioperative Medicine

- Preoperative evaluation and optimization to assess risk and decrease it
- Intraoperative anesthesia using procedure-specific or risk-reduction protocols
- Immediate postoperative stabilization, including critical care medicine
- Guide patients through critical pathways, treating pain and nonsurgical morbidities and ensuring continuity of care

Beattie, “Training Perioperative Physicians”, *Anesthesiol Clin N Am* 2000; 18:515

Leading the Way

- Stanford: Anesthesiology, Perioperative and Pain Medicine
- Brigham: Anesthesiology, Perioperative and Pain Medicine
- UCSF: Anesthesia and Perioperative Care
- NYU: Anesthesiology, Perioperative Care and Pain Medicine
- Oregon: Anesthesiology & Perioperative Medicine
- MGH: Anesthesia, Critical Care and Pain Medicine
- Johns Hopkins: Anesthesiology and Critical Care Medicine
- University of Pennsylvania: Anesthesiology and Critical Care
- University of Chicago: Anesthesia & Critical Care
- University of Washington: Anesthesiology and Pain Medicine

Perioperative Medicine Curriculum

- Preoperative assessment and optimization
- Intraoperative anesthesia
 - Protocol-based
 - Patient centric
 - Emphasis on perioperative implications
 - Fast-track cardiac anesthesia
 - Prevention of postoperative complications
- Critical care management
- Pain management
- Management of postoperative complications
- Coordination of care

The Future Is Here

Kain, ZN, Fitch J, Kirsch JR, Mets B, Pearl RG:

The Future of Anesthesiology is Perioperative Medicine: A Call for Action

Anesthesiology 2015; 122:1192-5

CONSIDER the American Society for Anesthesiologists' (ASA) ongoing, significant change in response to healthcare reform legislation such as the Affordable Care Act of 2010, as well as market forces and the ongoing reevaluation of the American health care system. The members of anesthesiology and the changes that have occurred in the education and training of anesthesiologists have consistently supported the perioperative medicine movement. The ASA has been the driving force in perioperative medicine, anesthesia care, and pain medicine. It is time to present a proposal and rationale for changing the name of our specialty from "Anesthesiology" to "Anesthesiology and Perioperative Medicine"....



History, and ultimately flourish. However, the ASA is the largest and most visible of these associations. During a special meeting of the ASA, annual meeting, Dr. Kain, as the author of this article, proposed the motion to formally change the name of our specialty. This was further discussed and the vote of the house, with over 90% support, was in favor of our proposal. The Department of Anesthesiology and Perioperative Medicine (DAPM) is a proud member of both the ASA and the ASA's parent organization, the ASA. We are grateful to the ASA for its support in changing the name of our specialty to Anesthesiology and Perioperative Medicine (Anesthesiology). There were a total of 100 responses (100% 100% of the respondents were in

91% of surveyed members of Society of Academic Anesthesia Associations (SAAA) support a resolution to the ASA Board of Directors to change the name of our specialty to Anesthesiology and Perioperative Medicine

Benefits of Branding

- Accurate description of our leading programs
- Inspiring vision with an emotional connection to our consumers (patients and other physicians)
- Guide the future of our specialty
 - Disruptive technology will replace many of our current activities
 - Perioperative medicine is also a disruptive technology

Building A Strong Brand

- To the point
 - Simple statement of what you do
 - All employees understand it
- Consistency
 - Message is consistent
- Consumer focused
 - Benefits to the consumer
- Deliver on what you promise

Anesthesiology should be branded as the practice of perioperative medicine



Questions?



Realistic Mechanisms for Implementation of a PSH Curriculum Within the Context of Current RRC and ABA Rules

James P. Rathmell, M.D.

November 6, 2015
4:45PM – 5:15PM

Realistic Mechanisms for Implementation of a PSH Curriculum Within the Context of Current RRC and ABA Rules



James P. Rathmell, M.D.
Chair, Department of Anesthesiology, Perioperative and Pain Medicine, Brigham and Women's Health Care
Leroy A. Vandam & Benjamin G. Covino Professor of Anaesthesia, Harvard Medical School
Boston, Massachusetts USA



The Perioperative Surgical Home: Can (Should) a Curriculum be Implemented?



James P. Rathmell, M.D.
Chair, Department of Anesthesiology, Perioperative and Pain Medicine, Brigham and Women's Health Care
Leroy A. Vandam & Benjamin G. Covino Professor of Anaesthesia, Harvard Medical School
Boston, Massachusetts USA



Conflict of Interest

None

Society for Academic Anesthesiology Associations - Baltimore, MD - November 7, 2015

Learning Objectives

- Describe how the ACGME Program Requirements for residency training in Anesthesiology are established
- Describe how the ABA requirements for entry in to the examination system are established
- Provide a plan for enhancing resident education around the PSH concept (while meeting ACGME & ABA requirements)

Society for Academic Anesthesiology Associations - Baltimore, MD - November 7, 2015

ACGME and New Program Requirements

Case Study:
Adoption of the three month requirement for residency training in pain medicine

ACGME and New Program Requirements

- Pain Medicine Training Requirements
- Regional anesthesia, acute postoperative and chronic pain had become part of the majority of academic programs
 - Coalition among RC, ABA, and academic leaders were supportive
 - Little or no overlap with other specialties

ABA and New Program Requirements

Pain Medicine Training Requirements

- ABA recognized need for ALL trainees to gain experience in pain medicine
- Much of this training had moved outside of the operating rooms
- ABA was strongly supportive and helped lead the change

ABA, ACGME and New Program Requirements

Pain Medicine Training Requirements

- Strong support from the entire RC
- Strong support from academic leaders and ABA
- Concrete proposal (revised Program Requirements) -- attainable in all training programs

ABA, ACGME and New Program Requirements

Pain Medicine Training Requirements

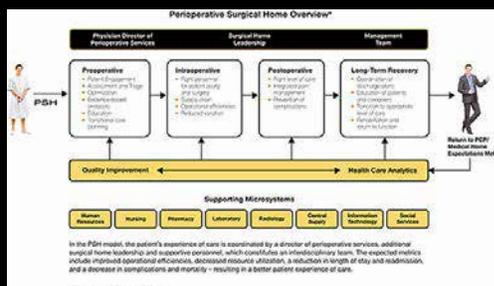
- ACGME leadership review and open comment period (input from PDs, Chairs, and other RCs)
- AMBS leadership review (input from member boards)
- Final approval

ABA, ACGME and New Program Requirements

Pain Medicine Training Requirements

- Upon adoption of new Program Requirements, ABA incorporates changes in to the BOI, which guides eligibility for entry in to the examination system
- Exam content outline typically evolves with the specialty rather than PRs

The Perioperative Surgical Home

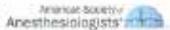


The Perioperative Surgical Home An Introduction

11/3/15

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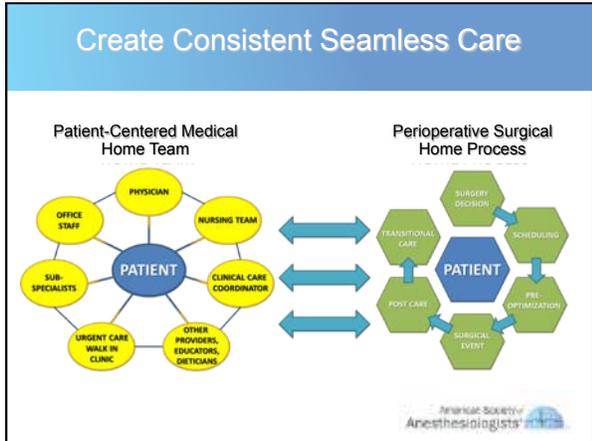
13 11/3/15 

What is the PSH?

The PSH is a patient-centered, physician-led interdisciplinary, and team-based system of coordinated patient care

- Spans the entire experience from decision of the need for any invasive procedure—surgical, diagnostic, or therapeutic—to discharge from the acute-care facility and beyond

11/3/15 



The Perioperative Surgical Home

What is happening across the country?

ANESTHESIOLOGY 2015 Journal Symposium



The Anesthesiologist and Healthcare Redesign

The Perioperative Surgical Home

- Enhanced Recovery After Surgery (ERAS)
- Preoperative Risk Optimization
- Appropriateness of Care
- Prehabilitation
- Patient-Centered Outcomes
- Optimizing Operating Room Efficiency



The Perioperative Surgical Home

Anesthesiologists must establish their value beyond the operating rooms

Do we have a clear idea of what constitutes the essential elements of the PSH?

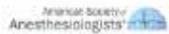


What is Anesthesiology's Role?

- **Natural evolution in practice and continuum of care from anesthesiologist inside OR to perioperative physician**
- **Already expert in:**
 - Preoperative evaluation
 - Management of intraoperative and PACU care
 - Critical care and pain medicine
- **Application of knowledge, skills and experience to all perioperative care**

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11/3/15



Key Components of the PSH

- **Leadership of perioperative care team**
- **Assessment of patient's current condition**
- **Preparative management: "prehabilitation" to optimize patient health status**
- **Intraoperative and intraprocedure care**
- **Postoperative care in PACU, ward, ICU**
- **Coordinate transitions of care**

20

11/3/15



Key Components of the PSH

- **Patient Experience**
- **Cost Analysis**
- **Quality Metrics**
- **Performance Improvement**
- **Data Management**
- **Collaboration: Surgeons, Hospital Administration, Other Stakeholders**
- **Outcomes Tracking**

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11/3/15



A Path to PSH Training for All Anesthesiologists

1. Gather thought leaders (underway)
2. Establish essential elements of PSH
3. Assure agreement and broad support

A Path to PSH Training for All Anesthesiologists

Other considerations...

- What are the essential elements of the PSH and how would training be enhanced by change?
- Can every training program meet new training requirements?
- Is this solely the domain of anesthesiologists?
- How is the PSH concept likely to evolve?

A Path to PSH Training for All Anesthesiologists

The role of the ABA:

- Key partner and stakeholder
- Program Requirements will drive eligibility criteria for entrance to the examination process
- Examination evolves with science and clinical practice

Conclusions

- Strong collaboration and agreement about what all anesthesiologists need to know is critical
- The PSH concept is new and no-one (yet) agrees on what constitutes a PSH
- Significant buy-in from stakeholders beyond anesthesiology will be critical



Boston Public Library

Boston, Massachusetts, 2012

Defining the PSH - ASA's Goals and Concerns

Daniel J. Cole, M.D.

November 6, 2015
8:15AM - 8:30AM

American Society of
Anesthesiologists®

PSH – ASA’s Goals & Concerns

Daniel J. Cole, M.D.
President
djcole@mednet.ucla.edu

Context
Why
What
Concern
Q&A

“It is not the strongest species that survive, nor the most intelligent, it is the one most adaptable to change”
-Charles Darwin

I skate to where the puck is going to be, not where it has been.
- WAYNE GRETZKY

The National Quality Strategy

APPROVED
MAR 2, 2010

UPHELD

JUNE 2012

ACA

National Quality Strategy

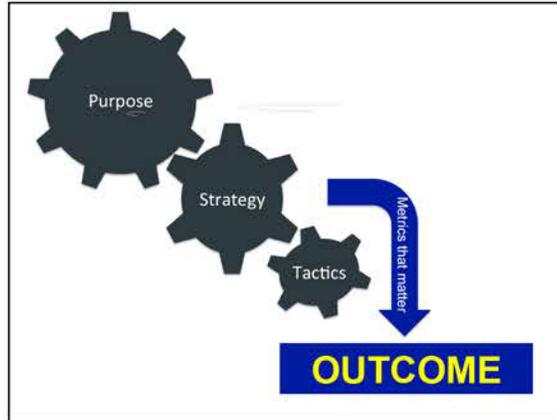
The strategy is to concurrently pursue three aims:

NQS Priority

1. Making care safer by reducing harm caused in the delivery of care
2. Ensuring that each person and family members are engaged as partners in their care
3. Promoting effective communication and coordination of care
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
5. Working with communities to promote wide use of best practices to enable healthy living
6. Making quality care more affordable for by developing and spreading new health care delivery models

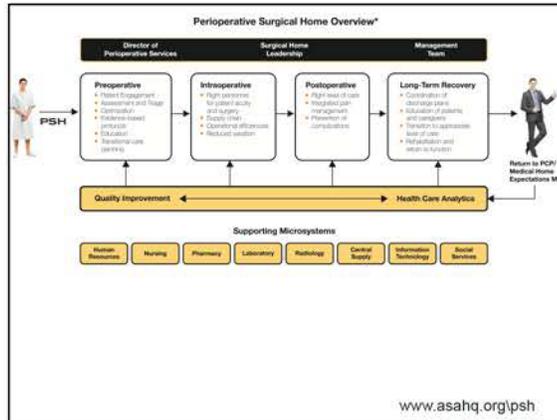
American Society of Anesthesiologists®

Perioperative Surgical Home

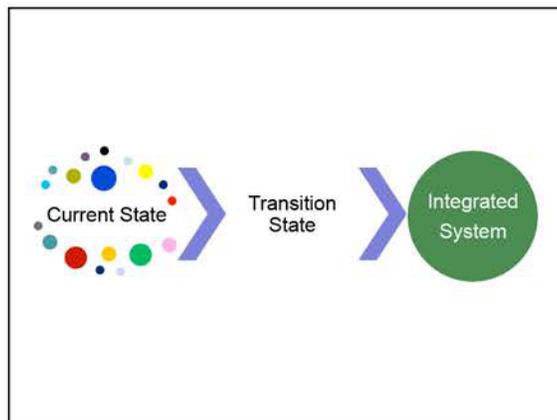


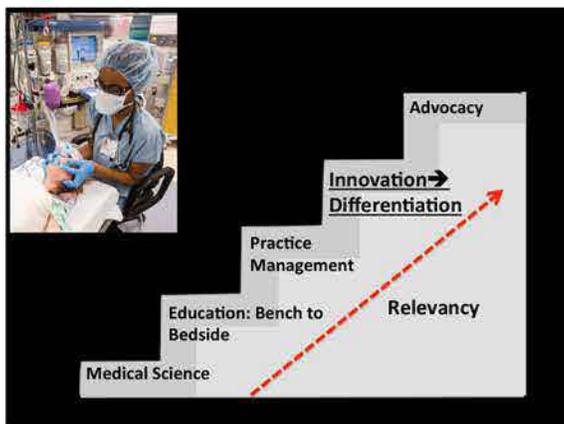
Strategy without tactics is the slowest route to victory. Tactics without strategy is the noise before defeat.

Sun Tzu



- ### PSH-Why
- Quality & Safety**
 - Decrease complications
 - Decrease readmissions
 - Decrease mortality
 - Improve Operational Efficiency**
 - Cost
 - Strategically Positions our Specialty**
 - Aligns with Alternative Models of Payment**





Panel: Three Programs' Approaches to Development and Implementation of a PSH Residency Curriculum

Matthew D. McEvoy, M.D.

November 6, 2015
8:30AM - 9:30AM

Audit of Compliance
Review LOS, compic, readm
Preadmission counseling
No Bowel Preparation
OPD/Fluid loading to 2 hours preop

Development and Implementation of a PCS Residency Curriculum: ERAS, Surgical Home, or a 3rd Way?

Components

Matthew D. McEvoy, MD
 Vice-Chair for Educational Affairs and Program Director
 Associate Professor of Anesthesiology
 Vanderbilt University Medical Center

Structured review
Standardized
Avoid IV opioids*

Vanderbilt Department of Anesthesiology
 Uncompromising quality in clinical care, research and education.
Compassionate. Creative. Committed. Collaborative.

Goals and Objectives

At the end of the presentation, the learner should be able to:

- Discuss the difference between Enhanced Recovery After Surgery Pathways (ERAS) and the Perioperative Surgical Home
- Describe the implementation of a successful Perioperative Consult Service (PCS) residency curriculum and the infrastructure it needs to succeed
- Understand the potential economic and training impact of implementing a PCS at their institution
- Describe possible future directions for a PCS curriculum at their institution, including target curricular content and service lines

Patients and Society and the System Also Want Better...and We Can Deliver

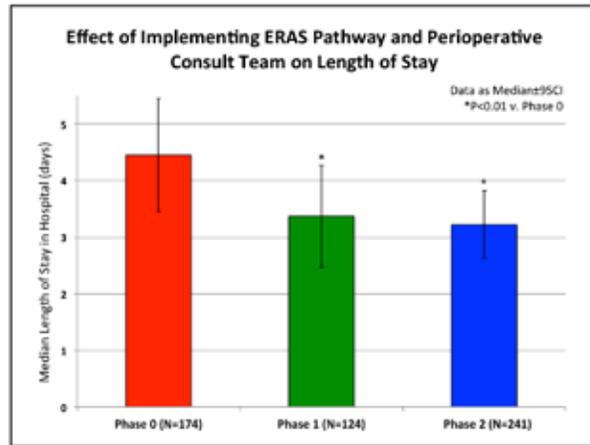
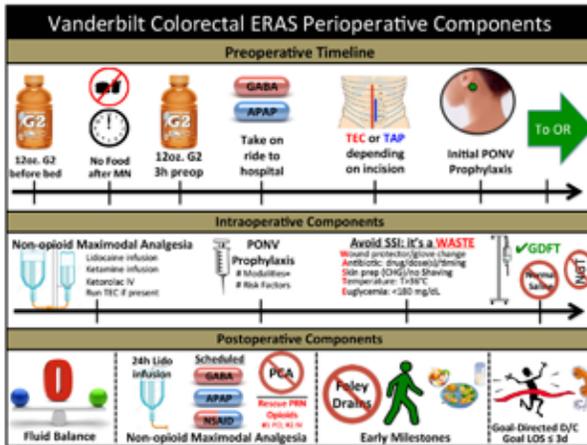
Triple Aim 1
Improve the individual experience of surgical care

Triple Aim 3
Reduce (or at least control) the per capita cost of surgical care

Triple Aim 2
Improve the health of the defined surgical population

Triple Aim Integrator: PCS

We Can Partner with Surgeons to Bend the Curve for Patients & Systems of Care



Colorectal ERP

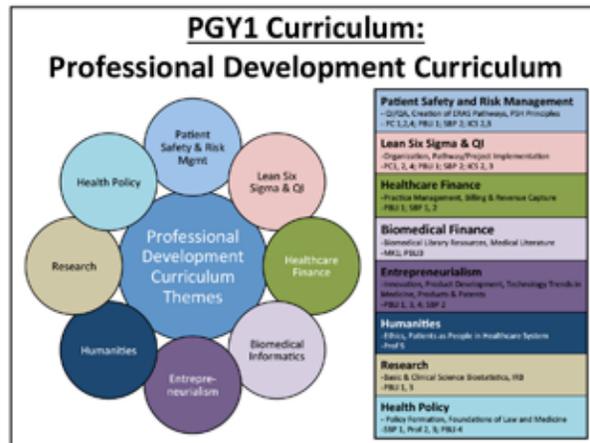
Effect of Implementation of Major Study Outcomes

	Phase 0 (N=179)	Phase 1 (N=124)	Phase 2 (N=241)	O v. 1	1 v. 2	O v. 2	P
Mean Resource LOS (days)	5.3	4.5	4.3	0.47	0.15	0.01*	<0.01*
Median Resource LOS (days)	4.24	3.32	3.32	<0.01*	0.61	<0.0001*	
Reoperation	18 (10.1%)	13 (10.5%)	15 (6.22%)	1	0.15	0.20	
Readmissions	21 (11.7%)	18 (14.5%)	34 (14.1%)	0.49	0.92	0.48	
Hospital Cost	100%	98%	83%				0.05*

* significant at 5% level; † Non-parametric Median Test for no difference in median cost among all phases

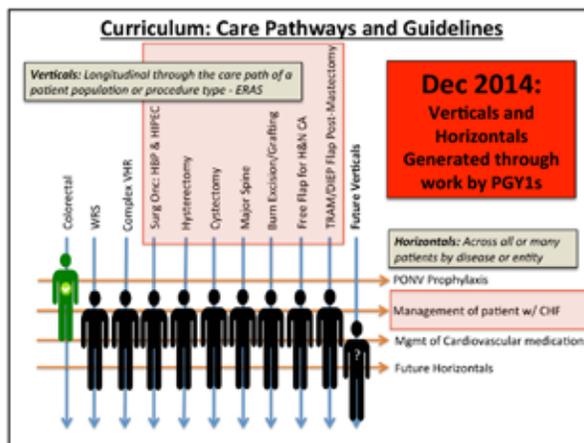
- Started June 2014: Exemplary Level (top decile) for LOS in NSQIP and have reduced median rLOS by 22% and cost by 17% since then.

McEvoy MD, et al. Periop Med, in submission



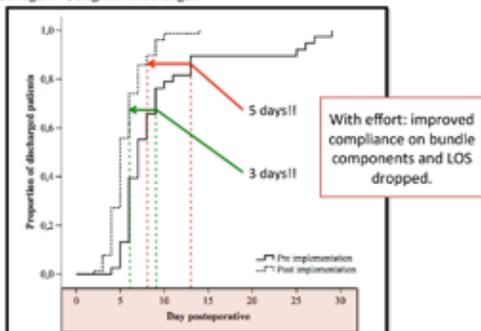
Curricular Components: Ecosystem

- **Departmental**
 - Vision:
 - Faculty:
- **Didactics**
 - Monthly Rotation Orientation
 - Book
 - Website: frequent updates
- **Experiential**
 - Daily Care Cycle (see below)
 - Monthly meetings with surgical services
 - Resident on the VUMC LOS Reduction Committee
 - Quarterly Grand Rounds to review data
 - Let them build and improve (e.g. preop workflow redesign and goal-directed discharge)



Diffusion of Enhanced Recovery principles in gynecologic oncology surgery: Is active implementation still necessary?

Jeanny JA. de Groot^{1,2,3,4}, Lilian E.J.M. van Es¹, José M.C. Maessen^{4,5}, Cornelis H.C. Dejong^{4,5}, Roy F.P.M. Kruitwagen^{3,4}, Brigitte F.M. Slangen^{3,4}



World J Surg (2015) 9:506-511
DOI 10.1007/s12010-014-2740-3

ORIGINAL SCIENTIFIC REPORT

F. Gillies · S. M. C. Acosta · J. M. C. Maessen · C. H. C. Dejong · C. D. Herkes · T. van der Weijden · M. F. van Noordwijk

Sustainability of an Enhanced Recovery After Surgery Program (ERAS) in Colonic Surgery

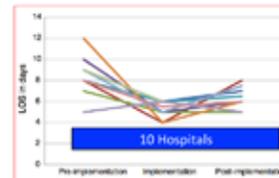


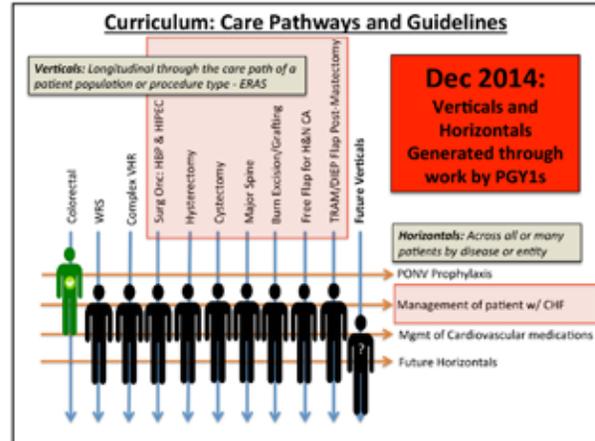
Fig. 1 Median length of stay per hospital in the pre-implementation, implementation, and post-implementation phases of the Enhanced Recovery after Surgery Program (ERAS); ten hospitals reached the same result; those findings are shown as one line

Regression toward the Pre-Implementation State

- Median LOS increased from 5.25 to 6 days
- Protocol adherence decreased from 75 to 67 %
- Postoperative care elements dropped considerably

Surgical Oncology ERP

	Phase 0 (N=95)	Phase 1 (N=123)	Difference (days)	% change	P
Mean rLOS	8.26	6.61	-1.65	-20%	0.02
Median rLOS	6.26	5.32	-0.94	-15%	
SD	6.40	3.84	-2.55	-40%	



**PERIOPERATIVE
SURGICAL HOME**

The Perioperative Surgical Home (PSH)

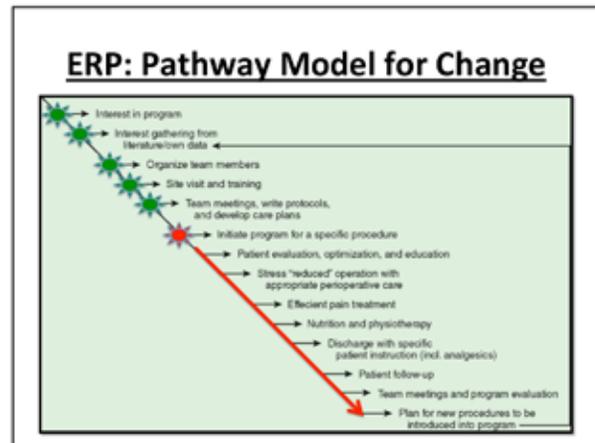
A Comprehensive Literature Review for the American Society of Anesthesiologists

By
Wesley R. Gatt, PhD, MBA, FRCPC
Kathy J. Lee, MD
Frank S. Posner, MD
Karin P. Young, MD, PhD

Published by the American Society of Anesthesiologists (ASA)
June 12, 2014

ASA's Journal
Franklin D. Rowland, PhD, MD
Director of Quality & Patient Research, ASA

The PSH is a patient-centered, physician-led, multidisciplinary, and team-based system of coordinated care. It guides the patient through the entire surgical experience from decision for the need for surgery until 30 days post discharge from a medical facility. The goal is to create a better patient experience and make surgical care safer; thus, promoting a better medical outcome at a lower cost. **[AGREE with this, but what about their cited 'models?']**



Paradigm Shift: ERAS *via* APCS

- Key factors prolonging stay after surgery:
 - Ileus
 - Need for IV analgesia
 - Need for IVF secondary to gut dysfunction
 - Bed rest caused by lack of mobility due to the above
- **APCS + ERAS** represents a paradigm shift in perioperative care:
 - Re-examines traditional practices, replacing them with evidence-based best practices **when necessary**.
 - Comprehensive in scope, covering **all components** of patient's perioperative journey with surgeon **and** anesthesiologist

Our Methods

- **Philosophy**
 - Standardization, where possible, improves routine processes of care
 - Adherence to principles more important than recipe
 - Warning, this is a protocol – it does not have a brain
- **Metrics**
 - LOS, Readmissions
 - Pre-op/Intraop "Compliance"
 - Postoperative "Compliance"
 - PDSA to Learn of Other Areas for Improvement

Automated Systems: VAPIR

VAPIR-Periop Consult Service Cases - Inbox

Wednesday, Oct 21, 2015 at 2:02 PM

To: stacy.jack@vanderbilt.edu, andrew.vanderbilt@vanderbilt.edu, [Gabby Dutt](mailto:Gabby.Dutt), [Kimberly Cooper@vanderbilt.edu](mailto:Kimberly.Cooper@vanderbilt.edu), and 18 more...

Reply-To: jan.vanderbilt@vanderbilt.edu

VAPIR-Periop Consult Service Cases

Cases located in ORMS for the Perioperative Consult Service tomorrow:

Start Time	Room	Status	Surgeon	Medical History/Procedure	Procedure
2015-10-21 08:30:00	WORD FM 04	M	...	...	HEPATICOTOMY RESECTION RIGHT (47133)
2015-10-21 10:30:00	WORD FM 24	M	...	...	INCISIONAL HERNIOPHYPTIC RECURRENT 2ND/3RD (958)
2015-10-21 10:30:00	WORD FM 22	M	...	...	LOWER ANTERIOR RESECTION (44148)
2015-10-21 08:30:00	WORD FM 27	M	...	...	CLOSURE, LIEKOTOMY/HOLEOSTOMY (44625)
2015-10-21 14:30:00	WORD FM 30	M	...	...	LAPAROSCOPIC GASTRIC BYPASS (40640)
2015-10-21 11:00:00	WORD FM 30	M	...	...	LAPAROSCOPIC GASTRIC BYPASS (40640)
2015-10-21 08:30:00	WORD FM 30	M	...	...	LAPAROSCOPIC GASTRIC BYPASS (40640)
2015-10-21 08:30:00	WORD FM 30	M	...	...	LAPAROSCOPIC PARTIAL BOWEL RESECTION (40609)
2015-10-21 08:30:00	WORD FM 36	M	...	...	IMPLANTATION OF MESH (0986)
2015-10-21 08:30:00	WORD FM 22	M	...	...	CLOSURE, LIEKOTOMY/HOLEOSTOMY (44625)
2015-10-21 11:30:00	WORD FM 04	M	...	...	SMALL BOWEL RESECTION (4122)

Automated email generated by the Vanderbilt Anesthesiology and Perioperative Research Informatics Division. Contact ORMS_Tech_Support for assistance.

Perioperative Consult Patients for 10/24 - Draft

Send Message To: stacy.jack@vanderbilt.edu, [Kla_Kell Mahesh](mailto:Kla_Kell_Mahesh), stacy.jack@vanderbilt.edu, and 18 more...

Perioperative Consult Patients for 10/24

Dear Team,

You will be caring for patients on the Anesthesiology Perioperative Consult Service tomorrow.

For perioperative 1 patients, the service will care for the patients while in-house, including writing preoperative medication orders and performing relevant blocks. The new patients on the perioperative 1 protocol tomorrow are below.

The clinical guidelines can be found here: https://www.mc.vanderbilt.edu/top-gho/vnet/index.html?pa_url=https://www.mc.vanderbilt.edu/3dopenfacult%28doc%2D336588nu%2D1 (copy and paste if link is dead)

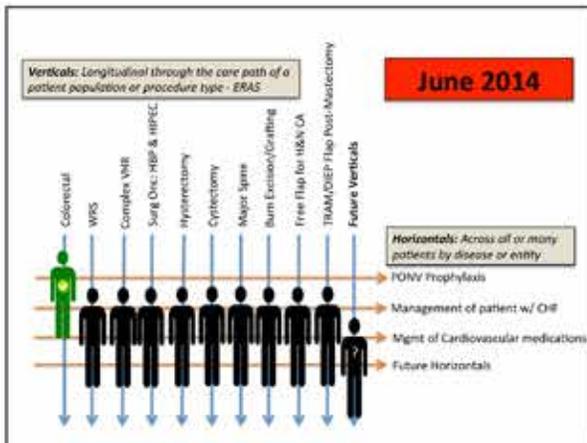
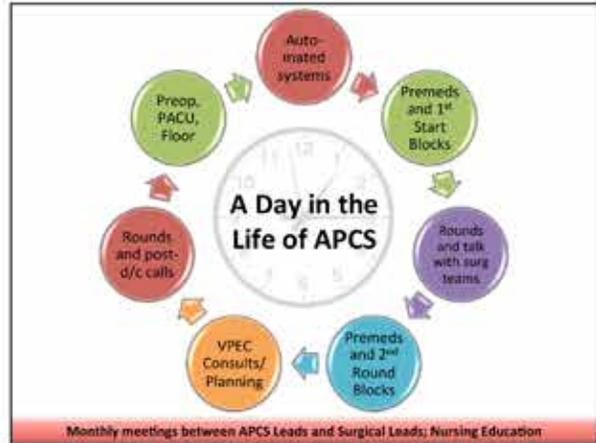
Please review the appropriate protocol for your patient if you are unfamiliar with these, as there are key intraoperative components of the protocols and differences between protocols. The surgical oncology patients follow the colorectal protocol.

We have added the new TRAM/DIEP free flap patients to the perioperative service, the new protocol has been added to the above link.

We have also added the new Donor Nephrectomy patients to the perioperative service, the new protocol has been added to the above link.

*Please add the lidocaine infusion to your PACU orders and bring the drip to PACU.
 *For bariatric surgery patients, please give either 1mg dilaudid or 5mg methadone IV (preferred) if no contraindications.

Dr. M. Dr. Cooper
 Dr. M. Dr. Cooper
 Dr. M. Dr. Cooper
 Dr. M. Dr. Cooper



Panel: Three Programs' Approaches to Development and Implementation of a PSH Residency Curriculum

Leslie C. Thomas, M.D.

November 6, 2015
8:30AM - 9:30AM

Perioperative Surgical Home: A Roadmap for Implementation in Anesthesia Residency Training

Leslie C Thomas, MD
Director Acute Pain Service
Director Regional Anesthesia
Ochsner

- No financial disclosures

Goals and Objectives

- Describe a Roadmap for implementation of PSH Training in Residency
- Define what a Perioperative Surgical Home is
- Importance of PSH in Future Anesthesia Models
- Explain Implementation and Results of PSH within a Multidisciplinary Teaching Hospital
- Evolution of PSH Resident Rotation in Same Hospital
- PSH Resident Rotation Competencies

2006 Task Force- Future Paradigms in Anesthesia Practice

- Advised Anesthesiology training programs to “expand focus beyond the OR to include Perioperative mgt”¹
- Patient Protection and Affordable Care Act 2010:
 - included promotion of **Accountable Care Organizations**- multiple providers jointly accountable for **achieving targeted quality and reduction in cost for patient population**
 - 2/3 of hospital costs being related to surgical care
 - **anesthesiologists must assume responsibility of preop/postop process**³
- 2012 ASA reaffirmed commitment to perioperative care

Perioperative Surgical Home

- Evolving Concept
- Proactive, coordinated, team based approach to patient care
- Patient involvement key
- Supported by ASA :
 - March 2015 ASA Board of Directors Cmt on Future Models of Anesthesia Practice : Rec ASA & ABA to **“appoint committee to critically examine and redesign residency training, with intention of preparing trainees to meet healthcare needs of future through expanded education and training in perioperative medicine”**²

Perioperative Surgical Home

Broaden The Scope Of Practice & Expand The Role Of The Anesthesiologist To “Perioperativist” For Surgical Care



Promote Standardization, Improve Clinical Outcomes And Decrease Resource Utilization By Providing Greater Patient-centered Continuity Of Care Throughout The Preoperative, Intraoperative, And Postoperative Periods

Ochsner PSH Implementation

- Primary Total Hip Arthroplasties Chosen as Patient Population
 - Healthgrades identified THA not meeting Milleman Benchmark LOS criteria
 - Acute Pain Service Involvement- includes acute pain anesthesiologist, resident, nurse
 - Acute Pain Resident Involvement
- ASA Perioperative Surgical Home Review June 2014⁴

Ochsner Implementation of PSH

- Preoperative, intraoperative, postoperative stakeholders identified & met
- Care pathways of all phases were drawn out
- Collaborative Leadership Team Weekly meetings held for continual process improvement
- 3 month process
- ASA Perioperative Surgical Home Review June 2014⁴

Ochsner Team Members

- **Preoperative Clinic:** Anesthesiologist, Internal Medicine Physician, **Anesthesiology Resident;** Social Work, PT, OT, Nursing, Discharge Planners
- **Intra-operative Team:** Regional Anesthesiologist and **Regional Anesthesia Resident;** Orthopaedic Surgeon and Resident
- **Postoperative Team:** Acute Pain Anesthesiologist, **Anesthesiology Acute Pain Resident,** Acute Pain Nurse, Orthopaedic Surgeon and Resident, Social Work, Nursing

Pathway Driven Team Based Approach

	In clinic	Pre-op Clinic	Day of Surgery	Post-Op Day 1	Post-Op Day 2	Discharge Goals
Assessment	Pre-op assessment	Pre-op assessment	Pre-op assessment	Post-op assessment	Post-op assessment	Post-op assessment
Activities	Pre-op assessment	Pre-op assessment	Pre-op assessment	Post-op assessment	Post-op assessment	Post-op assessment
Medication	Pre-op assessment	Pre-op assessment	Pre-op assessment	Post-op assessment	Post-op assessment	Post-op assessment
Treatment	Pre-op assessment	Pre-op assessment	Pre-op assessment	Post-op assessment	Post-op assessment	Post-op assessment
Discharge Planning	Pre-op assessment	Pre-op assessment	Pre-op assessment	Post-op assessment	Post-op assessment	Post-op assessment

Pre-op Process

- Ortho Clinic-patient scheduled for surgery
- Joint Class - to learn about the surgical procedure as well as expectations during the perioperative period.
- All patients seen in Anesthesiologist Directed Preoperative Center
 - **Risk Stratification**: Decrease testing⁵, decreased LOS⁶
 - **High Frailty scoring**⁸: direct patients toward "prehabilitation" therapies designed to improve strength and functioning going into surgery with physical therapy, nutritional support and anemia correction
- Emphasis is placed on setting expectations for early discharge (as early as post-op day #1).

Intra-operative Phase

- Standardized anesthetic management with neuraxial anesthesia and analgesia
- Standardized fluid mgt
- Standardized multimodal pain management

Postoperative Phase

- Standardized Total Joint Arthroplasty Order sets Utilized
- Coordination of care between Ortho, PSH resident/staff, PT, OT, Case Manager, Social Worker
- First PT session in PACU, then twice daily thereafter
- Daily rounds are made by the PSH team to medically manage and coordinate the patient's postoperative care.
- Low frailty patients who perform well in physical therapy are eligible for discharge on POD 1

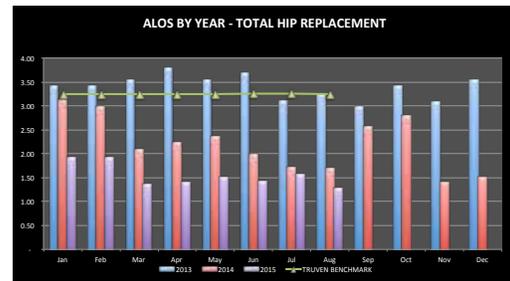
Resident Involvement in PSH

- Acute Pain Resident
 - Rounding on all total joint patients already
 - natural flow to expand to include postoperative management
 - Integral part of successful PSH implementation
 - Ease of participation –expanded role of already assigned Acute Pain Resident

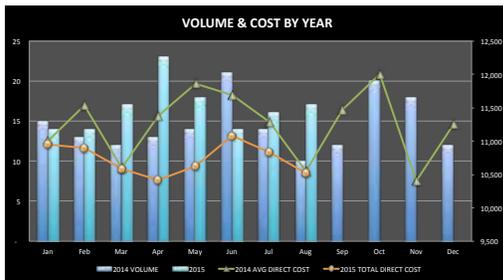
Workflow for Resident

- Monday meeting- discuss patients for the week with all team members present
- Day of Surgery
 - patient seen in preoperative area
 - Standardized intraoperative protocol
 - standardized postoperative order sets
- Daily AM rounding and medical management with Regional Anesthesia/Acute Pain Attending
- Discharge planning coordination

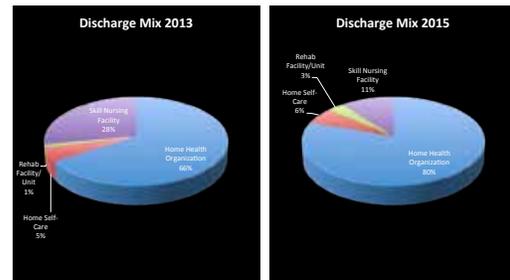
Results of PSH THA



PSH THR Decreased Cost



Discharge Mix Comparison



PSH Success

- In 2014 our institution realized an additional net income of \$201,921 through the additional hospital capacity created from length of stay reduction in the THA patients.
- In 2015, \$49,296 of additional net income is estimated for the THA patients.
- In 2015, the addition of the TKA patients to the PSH program is estimated to produce \$259,440 of new net income.

AQI Scores

- 86% Top Box Score Recommend
- 87% Top Box Score Anesthesia Care
- 74% Pain < 5
- 63% PONV Free
- Utilization of AQI data for Resident Quality Improvement Projects

Expansion of Ochsner PSH

- Expanded to TKR-Incorporation of nurse practitioner model unsuccessful
- PSH Rotation became formalized for resident assigned to Acute Pain Service
 - Importance of PSH Rotation & alignment with ASA Vision as Anesthesiologists being peri-operative physicians
 - Attractive selling point in job market

PSH Results TKR



PSH Rotation Now

- Encompasses 2 week period
- CA1
- CA 3
- Weekly lecture with Hospitalist, Surgeon
- Keyword presentation at end of rotation
- Integration of PSH Rotation with Preoperative Rotation

Preoperative Clinic Rotation

- One month
- Standardized pre-op risk stratification process for total joint arthroplasties³
- Included in Pre-op Rotation
 - Sleep clinic: OSA, CPAP, sleep reports
 - Blood bank: matching, typing, etc
 - Pulmonary Function Lab
 - Cardiac Testing: EKG Course, Non Invasive Cardiac Testing Center (stress tests)

Ochsner PSH Resident

- On Day of Surgery:
 - Ensures continuity with preop plan
 - Ensures standardized intraop clinical pathways are followed
- Standardized postoperative orders in PACU

PSH Resident Postoperative Care

- Postoperative Care
- SCAMPS** – Standardized Clinical Assessment and Management Plans⁷
- OSA, Chest Pain, Acute Renal Injury, Fever
 - Protocols placed in EMR
 - expanded as medical issues arise

Competency Based

- Professionalism
 - Accountability to Patients
- Communication Skills
 - Interaction between different providers
- Patient Care
 - Apply SCAMP
- Medical Knowledge-
 - Weekly lectures, resident keyword presentation
- Practice Based Learning and Improvement
 - Refine SCAMP
- Systems Based Practices
 - Future Clinical Pathways-OB, Urology

PSH Rotation Summary

- Arthroplasty Model very successful
- Expansion to other service line- OB begun, Urology next
- Ease of Implementation within Existing Residency Program

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Panel: Three Programs' Approaches to Development and Implementation of a PSH Residency Curriculum

Navid Alem, M.D.

November 6, 2015
8:30AM - 9:30AM

Teaching the Anesthesiologist of the Future the Perioperative Surgical Home

NAVID ALEM, MD
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DISCLOSURES: NONE

Learning Objectives

- Defining the Perioperative Surgical Home vs. Perioperative Medicine
- Identifying the proposed competencies needed to succeed as perioperative specialists
- Describing the inherent challenges in learning these competencies in perioperative care
- Illustrating one example of a curriculum in perioperative care

Discussion of Perioperative Medicine vs. the Perioperative Surgical Home

- Current anesthesiology educational curricula can proactively evolve to enlist future trainees with an enhanced professional identity as perioperative physicians
- While many components of the PSH care model are already included in the current resident curriculum¹⁻³, there are still opportunities for progression
- New educational perspectives can be described to ensure that training in the clinical, leadership and business aspects of this intricate approach to coordinated perioperative care is provided during residency training
- Better understanding of and training in overall perioperative *medicine* will be beneficial
- While “perioperative medicine” and the “perioperative surgical home” are not synonymous terms, they are related in that the PSH care model provides a forum for anesthesiologists to further implement perioperative medicine in the care they provide for patients
- An augmented foundation in perioperative medicine that enables future anesthesiologists to usher a surgical patient to longitudinal recovery is very valuable⁴⁻⁵
- Internationally, successful models such as enhanced recovery after surgery (ERAS) have positioned anesthesiologists as perioperative medical specialists⁶⁻⁷
- Perioperative Medicine aims to deliver the best possible pre-, intra-, and postoperative care to meet the needs of patients undergoing major surgery⁴.

What are the distinct and diversified competencies that are needed in order to succeed as perioperative specialists?

- This was the question for a task force of the American Society of Anesthesia that was convened in spring of 2014⁸ (Key Reference that includes listed Competencies)
- Ideally, the six core ACGME competencies of interpersonal and communication skills, knowledge for practice, patient care, practice-based learning, professionalism, and systems based practice must also be embedded in instructional designs in order to appropriately address educational milestones⁹
- Professional Identity as a “Perioperative Expert”
- Competencies designed to enhance communication & understanding across disciplines
- There are several tangible opportunities to improve perioperative patient

- Opportunity to unencumber others

Challenges of Teaching the PSH

- How does one teach something that is novel and still dynamically being defined?
- How does one teach something with certain elements at the edge of the scope of the original training that they had?
- How does one institute a new curriculum in the rigors of an existing anesthesiology residency?
- Who and where does one resource out to for the instruction of the competencies?
- How does one account for varying motivation for both learners and teachers to pursue broadened training?
- How does one broaden the scope of teaching without compromise of the quality of teaching that transpires in intraoperative care?

Illustrating one example of a curriculum in perioperative care

- **Figure 1-The PSH Rotations at UC Irvine Health**

	Clinical Base	CA-1	CA-2	CA-3
Rotation prior to PSH Implementation	Elective	Preoperative Clinic	Post Anesthesia Care Unit (PACU)	Elective
Rotation after PSH Implementation	Foundation in the PSH (PSH-0)	Perioperative Risk Reduction & Optimization (PSH-1)	Recovery after Surgery Principles & Pathways (PSH-2)	Design, implementation and management of PSH Pathways (PSH-3)
Rotation Length (weeks)	4	4	4	4

- An interactive & multimodal learning environment that was supportive and stimulates inquiry with active participation was ideal and would be valued by our adult learners¹⁰
- There was a diverse pool of innovative teachers such as physician subspecialists, case managers, nursing managers, physical therapists, IT specialists, pharmacists that we could resource out to
- Material taught should be evidence-based, best practice
- Not all of the competencies created by the ASA taskforce could realistically be covered
- Made a realistic “dream list” & started to network throughout the hospital for educational opportunities
- Took an unrestrained approach: Fundamental first question was, “who is ideal to recruit for teaching this unique experience?”
- Similar to other existing competencies, these new ones ultimately entailed direct patient care and rounding, focused didactic activities, independent required reading, seminars, project development, and research enterprises

- Experiences were carefully coordinated and clerical support was made readily available for the residents
- Often times in conjunction with the care specialist, learning goals and objectives were created
- Thus far has been promising as obtained through 360 evaluation¹¹ and via open forum discussion
- Ideally, as the rotation develops, it will transition to using a Kirkpatrick model of evaluation that incorporates an evaluation of reaction, learning, behavior and results¹²

New for this year

- Introduction of a foundations in PSH rotation in the PGY-1 Year
- Didactic Schedule (Figure 2)
- Further integration of Simulation Training
- More of a focus on design, implementation, and continued management of PSH clinical pathways
- Approved for a 4 week medical student rotation in PSH
- One year curriculum in Perioperative Medicine for Fellows

Figure 2- Didactic Topics on PSH Rotations

What is the PSH?	What is Enhanced Recovery After Surgery (ERAS)?	Perioperative Pain Management
Perioperative Smoking Cessation	Perioperative Nutrition Optimization/Carbohydrate Loading	Perioperative Acute & Chronic Hepatic Disease Management
Perioperative Adrenal Insufficiency	Perioperative TIA/CVA	Perioperative COPD Management
Acute Coronary Syndrome	Perioperative Heart Failure Management	Perioperative Diabetes & Glucose Management
Perioperative Acute & Chronic Kidney Disease	Postoperative Diarrhea	Perioperative Nausea/Vomit
VTE Prophylaxis & Treatment	Skin & Wound infection/Breakdown	Urinary Tract Infections
Anemia optimization, workup & management	Central Line Associated Infection	Malnutrition Therapy
Acute Delirium	Challenges in an Opioid Tolerant Patient	Postoperative Ileus
Perioperative Sepsis	Obstructive Sleep Apnea	Perioperative Pneumonia
Perioperative Cardiac Dysrhythmia	Perioperative Coronary Stent Management	Postoperative Fever Workup & Management

Summary

- Eventually, we will need a consensus-based and consistent curriculum for residency programs to follow¹³
- Taking advantage of new practice opportunities that have developed with the PSH model of care delivery will position future trainees to have fulfilling practices both now and in the future
- One prelude to this is a transparent alignment of resident educational content to further integrate competencies in perioperative care.

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Those Hard-to-Assess Milestones

Catherine M. Kuhn, M.D.

November 6, 2015
1:30PM - 1:50PM



Those Hard-to-Assess Milestones

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Disclosure

- No financial interests
- No other conflict of interest
- Member, Anesthesiology Milestones Committee



Milestones vs Competencies

- More explicit description of expected knowledge, skills, attitudes, performance
- “an important point in the progress or development of something : a very important event or advance” (Merriam-Webster)
- “Specific behaviors, attributes or outcomes in the six general competency domains to be demonstrated by residents during residency.” (ACGME)



Milestones

- Benefit For Residents
 - Explicit expectations of residents
 - Identifies areas to work on
 - Improve evaluation of residents in all 6 general competencies
 - More defined feedback from faculty to residents
 - Earlier identification of under-performers
 - Provides aspirational goals for over-achievers

N. Cohen 2013 ACGME presentation

Milestones

- Benefit For the Program
 - Guide curriculum development
 - Guide accreditation requirement revision
 - Earlier identification of under-performers
- Benefit For the Public
 - Better definition of graduating resident
 - Use for Program Accreditation
 - Possible use for Board Certification

N. Cohen 2013 ACGME

Desirable Characteristics of Milestones

- Manageable number
- Meaningful items
- Measurable

- We tried!

ACGME Core Competencies

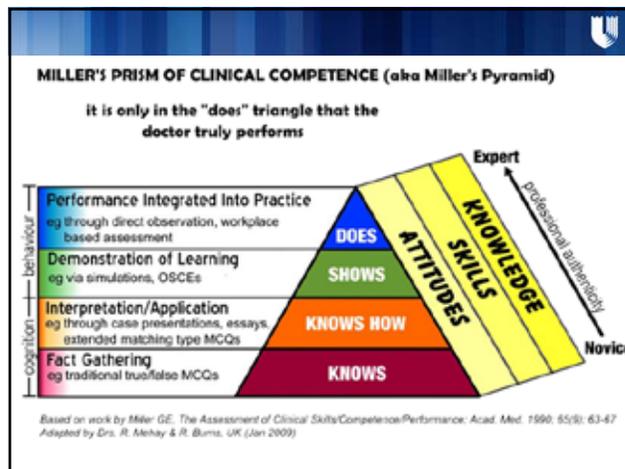
- Medical Knowledge
- Patient Care
- Interpersonal Communication
- Professionalism
- Systems-Based Practice
- Practice-Based Learning and Improvement

Competencies/milestones of interest

- Professionalism
- Systems-Based Practice
 - (health) System Improvement
- Practice-Based Learning and Improvement
 - Personal improvement

Assessment of Milestones

- Requires observation of behavior
- Requires judgment of performance
- Rater training, development, and practice is more important than the tools used to assess
- Knows vs Does attributes
 - Especially for SBP, PR, PBLI



Pitfalls in Pursuit of Objectivity

- Objectifying risks loss of authenticity
- Can't evaluate competencies in isolation from each other
- Assessing clinical performance has strong subjective influences
- Holistic impressions have validity and should be incorporated into evaluations

Ginsburg et al. Acad Med 2010; 85:780-786.

Assessment of "Does"

- Start with what is observable, not the competency
- Elicit explanations for ratings
- Value all ratings
 - Inexperienced vs experienced faculty
 - Hawks and Doves
 - Avoid halo effect
- Balance ratings by increasing number of assessments

Ginsburg et al Acad Med 2010;85: 780-786

Assessor/Faculty training

- Deliberate practice to develop expertise in assessment
- Assessors need a shared mental model, not just knowledge of the form or the instrument

Professionalism 3: Commitment to institution, department and colleagues

- Ability to establish employment and licensure
- Onboarding/registration process for hospital (and program)
 - Timeliness
 - Attention to detail
 - Communication with staff
 - Predictors?



The screenshot shows a web interface for 'Resident Management' with a search bar for 'Doe, Jane'. The main content area is titled 'Orientation' and lists several items under the '2015 Hiring/Credentiaing Package' for '10/8/2015 (Immediate)'. The items include:

- Form Document: Status: **Bad**
- US Social Security Card - Must be received by April 6, 2015
- Copy of Social Security Card: Status: **Complete** (10/14/2015 JBI)
- Application for Appointment - Deadline April 24, 2015
- 2015-16 Duke University Hospital - Application for Appointment to the Associate Medical Staff: Status: **Complete** (10/8/2015 LJ)
- 2015-16 Duke University Hospital Application Part 2 - Disciplinary Actions/Liability Insurance Form: Status: **Submitted**
- 2015-16 Duke University Hospital Application Part 3 - Professional Liability Insurance Form: Status: **Complete** (10/8/2015 LJ)
- Duke References Form #1: Status: **Submitted**
- Duke References Form #2: Status: **Submitted**
- Agreement of Appointment (Contract): Status: **Requested**
- Signed 2015-2016 Agreement of Appointment (Contract): Status: **Requested**
- Medical School/Postgraduate Training USMLE Transcripts
- Official Medical School Transcript: Status: **Complete**

Use data that already exists to create an assessment tool

- Program onboarding
- Institutional onboarding
- License renewals, compliance with ACLS, training modules, etc.

Is this behavior predictive

- Probably!



Conscientiousness Index

- Measure of Professionalism
- Quantifiable
- Correlates with subjective opinions
 - Peer evaluations of professionalism
- Point system:
 - Attendance
 - Turning in documentation (evals)*
 - Compliance with policies (flu vaccine)*
 - Submission of data

McLachlan et al Acad Med 2009; 84:559-565
Finn et al. Med Educ 2009;43:960-7

Professionalism: multiple determinants

- Positive association between resident knowledge, clinical skills, and conscientious behaviors (evaluation completion)
- Included:
 - Multirater assessment
 - ITE scores
 - Mini-CEX scores
 - Completion of evaluations*

Reed et al, JAMA 2008; 300:1326-1333

SYSTEMS-BASED PRACTICE EXAMPLES

EMR Data

- Handoff accuracy
- Anesthetic Cost
- Vital sign metrics/variability
- Metrics—pain scores, nausea scores, LOS

Institutional Level: GME Incentive Program

SBP example

Program	Department	Notes	Med Program	Med	Emergency	ED/ICU	ED/ICU	ED/ICU	ED/ICU	ED/ICU	ED/ICU	ED/ICU	ED/ICU	ED/ICU	ED/ICU	ED/ICU	ED/ICU	ED/ICU	ED/ICU
Overall	Emergency	ICU/ED - Report of Unnecessary History, Re-examination, Physical Exam	45%	47.5%	50%	52.5%	55%	57.5%	60%	62.5%	65%	67.5%	70%	72.5%	75%	77.5%	80%	82.5%	85%
Overall	Quality & Patient Safety	Emergency Department Medication Within 30 Days	15.2%	15.5%	15.8%	16.1%	16.4%	16.7%	17.0%	17.3%	17.6%	17.9%	18.2%	18.5%	18.8%	19.1%	19.4%	19.7%	20.0%
Overall	Quality & Patient Safety	Emergency Department Medication Counsel Time	48	47	46	45	44	43	42	41	40	39	38	37	36	35	34	33	32
Program Specific Data (Time Report)																			
Emergency	Quality & Patient Safety	Emergency Department Medication Counsel Time	75	74	73	72	71	70	69	68	67	66	65	64	63	62	61	60	59
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	100	99	98	97	96	95	94	93	92	91	90	89	88	87	86	85	84
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	120	119	118	117	116	115	114	113	112	111	110	109	108	107	106	105	104
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	140	139	138	137	136	135	134	133	132	131	130	129	128	127	126	125	124
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	160	159	158	157	156	155	154	153	152	151	150	149	148	147	146	145	144
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	180	179	178	177	176	175	174	173	172	171	170	169	168	167	166	165	164
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	200	199	198	197	196	195	194	193	192	191	190	189	188	187	186	185	184
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	220	219	218	217	216	215	214	213	212	211	210	209	208	207	206	205	204
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	240	239	238	237	236	235	234	233	232	231	230	229	228	227	226	225	224
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	260	259	258	257	256	255	254	253	252	251	250	249	248	247	246	245	244
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	280	279	278	277	276	275	274	273	272	271	270	269	268	267	266	265	264
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	300	299	298	297	296	295	294	293	292	291	290	289	288	287	286	285	284
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	320	319	318	317	316	315	314	313	312	311	310	309	308	307	306	305	304
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	340	339	338	337	336	335	334	333	332	331	330	329	328	327	326	325	324
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	360	359	358	357	356	355	354	353	352	351	350	349	348	347	346	345	344
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	380	379	378	377	376	375	374	373	372	371	370	369	368	367	366	365	364
ICU/ED	Quality & Patient Safety	Emergency Department Medication Counsel Time	400	399	398	397	396	395	394	393	392	391	390	389	388	387	386	385	384

Institutional Level: GME Incentive Program

Trainee Reporting in SRS-RL-6

Goal = 164/mo

1381 reports filed AY 15
73 reports filed AY 14

Other ideas for SBP

- Complicated clinical rotations (surg, OHN)
 - VA or similar with less resources
 - Patients with less support
 - Rotations with conditional independence
- Faculty observation
 - Psych (inpatient services)
- Elements of QI projects
 - IM, peds, psych, Urology, OHN

Making the milestones relevant

- Incorporation of Milestone language into corrective action documents
- “Your performance was judged to fall short of expected competencies in professionalism.”
- Demonstrated by the following specific issues (source)
 - Dishonest about reasons for missed time from work
 - Failure to comply with program policy for time off

- These concerns are translated into the Pediatric Milestones for further clarification.
- The following pediatric milestone is found to be below that expected for your level of training:
- Professionalism Conduct—(Milestone level 2)
- Demonstrates lapses in professional conduct under conditions of stress or fatigue, that lead others to engage in reminding about and, enforcing professional behaviors as well as resolving conflicts; there may be some insight into behavior, but an inability to modify behavior when placed in stressful situations

- You will be expected, at a minimum, to demonstrate the following behavior (Professionalism level 3)
- Conducts interactions in nearly all circumstances with a professional mindset, sense of duty, and accountability; demonstrates conduct that illustrates insight into her own behavior, as well as likely triggers for professionalism lapses, and is able to use this information to remain professional
- This means no further issues with dishonesty and no unexcused absences

Summary

- Competencies and milestones can't be assessed in isolation
- There is value in subjectivity--assuming sufficient raters and information
- Make use of existing processes and systems to identify links to Milestone assessments
- Link Milestones to performance reviews

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Mapping Milestones to EPAs

Susan D. Wolfsthal, M.D.

November 6, 2015
1:50PM - 2:10PM

PROCESSES AND CHALLENGES IN MAPPING MILESTONES TO EPAS

SUSAN D. WOLFSTHAL, MD

The overarching principle in developing our evaluation tools was to identify and map entrustable professional activities (EPAs) created by the Internal Medicine community to the residents' various rotations. To ensure faculty had the opportunity to observe resident skills in a variety of settings and rotations, our curriculum committee selected 24 EPAs that were then mapped to all rotations and to the ACGME reporting milestones. The committee ensured that each EPA was appropriately represented across the spectrum of rotations and that each reporting milestone had an adequate number of EPAs mapped to that milestone. Rather than using the curricular milestones, our curriculum committee chose the EPAs as a more specific and goal directed measure of residency performance for our evaluation tools. Descriptive anchors were not provided for each EPA. Instead, faculty were trained to rate the resident as to the amount of supervision they required for each EPA. These nine supervision categories spanned from a very early learner requiring constant close supervision to a resident ready for independent practice who demonstrates high achievement or is aspirational. Clear descriptions of each supervisory class are provided at the top of each evaluation form. The 9-point numerical rating scale for each milestone is not revealed to the faculty. A general normative scale was added at the end of the form for faculty to rate the resident on the overall degree of supervision required and the overall performance compared to their peer group.

The key steps in developing our evaluation tool included the following:

1. Identifying the EPAs (curricular milestones) that would be most effectively observed and assessed during each rotation.
2. Mapping the EPAs to the reporting milestones and ensuring each EPA and reporting milestone was adequately represented across the spectrum of rotations.
3. Establishing the levels of supervision that would apply to residents from the early days to the completion of their residency training.
4. Training faculty in using milestones and direct observation in evaluating residents.
5. Reviewing the final numeric scores semi-annually against written comments and other parameters and tools to validate the scoring system.

The faculty were offered workshops at the beginning of the process to review the concept of milestones and the structure of the new evaluation system. Suggestions were provided as to how to evaluate the milestones using direct observation. The slides were distributed to the entire clinical teaching faculty. Ongoing workshops are planned to reinforce concepts and teach skills to faculty members.

Several pitfalls were identified through implementation of this evaluation tool:

- The system requires close monitoring for scores that are too high or too low for a PGY level. This variation may be due to a struggling resident or one who is exceptional, but can also be due to a faculty member not attending to the supervisory levels and needing re-direction.
- Setting up the process in E-Value was extremely time consuming. Once created, the results are easy to obtain and follow.
- The global comparative score that compares residents to their peers appears to correlate with milestone achievements, thus providing some internal validation of the milestone process.

Low score notifications are set for each PGY level to provide real time information about residents scoring below expected milestones. After using the milestones for two years, tracking results provide critical markers in identifying residents who are either not meeting expected competency or those who are performing at a high level. The results have provided a cluster of residents for each of training year thus allowing a more clear distinction among the three classes of residents. By focusing on the EPAs, the CCC has implemented targeted remediation plans that focus on behaviors that can be tracked over time.

Attachments:

1. Slides from presentation
2. Grid mapping EPAs to evaluations for each resident rotation
3. Grid mapping EPAs to reporting milestones
4. Example of final evaluation forms: MICU and Endocrinology elective

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Process and Challenges in Mapping Milestones to EPAs

Susan D. Wolfsthal, MD
 Professor of Medicine
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 Residency Program Director
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 University of Maryland School of Medicine

Overview

- Several challenges evident
 - Deciding on use of curricular milestones vs EPAs
 - Defining EPAs that measure resident performance
- Develop process to map observed skills to EPAs and ACGME reporting milestones
- Appreciate barriers and pitfalls in validating evaluation process using EPAs and milestones
- The unknown... overall validity, usefulness and ability to provide effective resident feedback

Recipe for Mapping

- Identify curricular milestones or EPAs through faculty consensus
- Establish rating scale based on learner and supervisory levels
- Map curricular milestones and EPAs to
 - Each evaluation
 - 6 ACGME competencies
 - ACGME reporting milestones
- Faculty development
- Validation

ACGME Definition of Milestones

- Competency-based developmental outcome expectations that can be demonstrated progressively by residents and fellows from the beginning of their education through graduation to the unsupervised practice of their specialty.
- Key words
 - Competency-based
 - Developmental
 - Outcomes
 - Demonstrated progressively
 - Unsupervised practice

Entrustable Professional Activities

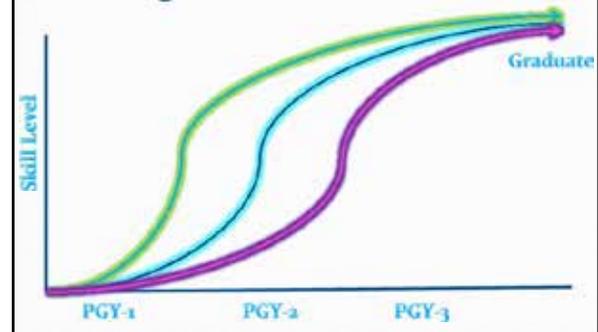
- Society entrusts us to certify that our graduates are capable of independent practice
- How do we:
 - Know they are ready for independent practice?
 - Measure it along the way?
 - Use a common language that allows trainees to understand where they excel or need improvement?



Internal Medicine Milestone Project

- Under the ACGME and ABIM
 - 142 milestones that track development of IM residents
 - Clustered into Entrustable Professional Activities (EPAs) that summarize resident competency
 - Reported in usual 6 competencies
- Allows measurement over time by defining
 - Critical deficiencies
 - Skills developed from early to advanced learners
 - Residents ready for independent practice

Achieving Milestones for Residents



Overarching Principle

- Identify and map entrustable professional activities (EPAs) to residents' various rotations
- Curriculum committee
 - Selected 24 EPAs
 - Mapped to all rotation evaluations
 - Mapped to ACGME reporting milestones

EPAs over Curricular Milestones

- EPAs more specific and goal directed measure of residency performance
- Descriptive anchors not provided
- Faculty development
 - Rating residents
 - Direct observation
 - Degree of supervision compared to peers
 - Overall performance compared to peers

Developing Evaluation Tool

- Identified EPAs (curricular milestones) that would be most effectively observed and assessed during each rotation
- Mapped EPAs to reporting milestones ensuring each EPA and reporting milestone was adequately represented across spectrum of rotations
- Established levels of supervision that would apply to residents from early days to completing of training
- Trained faculty in using milestones and direct observation in evaluating residents
- Reviewed final numeric scores semi-annually against written comments and other parameters and tools to validate scoring system

Types of evaluations

- Outpatient rotations
 - Continuity medical clinic
 - Ambulatory blocks
- Inpatient rotations
 - GIM and Med-ID
 - MICU, CCU, Blue, Pink
 - Night / day float
 - ER, ECS, MOD
- Others
 - Electives
 - Research
 - Practice based learning exercises
 - Quality improvement projects

Rotation specific evaluations

- Different milestones for different rotations
 - MICU versus Continuity medical clinic
 - Elective versus Emergency medicine
- Specific wording
 - Management of patients critically ill patients
 - Implement preventive health care appropriate to patient's risk factors, gender and age
- More general wording applicable to several rotations
 - Lead family meeting
 - Advocate for patient
 - Be professional with peers, faculty and staff

Mapping EPAs to Evaluations

Entrustable Professional Activities	Evaluations											
	Continuity Clinic	Emergency Medicine	Family Medicine	ICU	Internal Medicine	OB/GYN	Pediatrics	Preventive Medicine	Psychiatry	Residency	PGY-1	
1. Manages a patient seen in clinic for a chronic medical condition												
2. Manages a patient seen in clinic for an acute medical condition												
3. Manages a clinic session efficiently so that patient care proceeds at an appropriate rate												
4. Recognizes clinical situations in which there is a need for urgent or emergent medical care, including life-threatening conditions												
5. Manages routine clinic tasks including follow-up of diagnostic testing, patient calls or inquiries, prescription refills, or other administrative tasks associated with an outpatient practice in a timely and efficient manner												
6. Obtains the medical history accurately and in a timely manner												
7. Utilizes standards and practices age-appropriate screening and preventive care												
8. Manages the care of patients with acute common diseases inpatient setting												
9. Manages the care of patients with acute complex diseases in the inpatient setting												
10. Performs all tasks associated with admitting a patient to the hospital												
11. Manages the day to day care of a patient admitted to the hospital on the medicine service												
12. Coordinates the ability to manage the admission and ongoing care of patients in a critical care unit												
13. Manages transitions of care associated with admission, change in responsible provider during hospital stay and discharge												
14. Consults other specialists, appropriately, and provides appropriate information to the consulting provider												
15. Provides critical medical consultation to non-medical specialties												
16. Provides preoperative assessment and perioperative care												
17. Conducts family meetings and communicates plan of care to the patient and their caregivers and/or loved ones												
18. Demonstrates professionalism during all interactions with colleagues, other health team members, the patient, caregivers, and the patient's family or loved ones												
19. Continues learning and improvement through feedback and self-assessment												
20. Demonstrates the ability to utilize information resources to answer clinical questions, appraise the quality of the literature, and appropriately applies evidence based practice to patients												
21. Demonstrates commitment to supporting patient safety, improving personal performance and leading improvement opportunities within the system												
22. Utilizes team practice as it applies to treatment of chronic medical illness and compares the results with best practice standards												
23. Demonstrates commitment to the education of patients, their families and members of the healthcare team												
24. Participates as an educator for patients based on their educational needs												
TOTAL	13	13	12	8	3	7	4	12	7	3	2	4

Challenging EPAs – PBL and SBPI

- Method
 - Use EPAs mapped to these reporting milestones
 - Additional evaluation forms for these activities
- Practice based learning activity
 - Two PBL projects done each year
 - Done during ambulatory block rotations
- System based practice and improvement
 - Required QI project done during PGY-2 and 3 years

Other Observations of Competency

- Several opportunities for formal observation
- Observed by faculty and supervising residents or fellows
 - Mini-CEXs (6/year during PGY-1 and 2)
 - Competency assessment tools (CATs) for end of life and palliative care (4 total by mid-PGY-3)
 - Assessment of procedural competency with log books
- In-training examinations

Mapping curricular milestones to the 6 ACGME competencies

- Determine which ACGME competency relates to each milestone
 - Gathers and synthesizes information → Patient care, Clinical knowledge, Interpersonal and communication skills
 - Works effectively with interprofessional team → Interpersonal and communication skills, Professionalism
- Mapping provides score for each competency useful at semi-annual feedback sessions

Mapping curricular milestones to reporting milestones

- Determine how each milestone relates to final reporting milestone
- Reporting milestones
 - Approximately 20-24 milestones with levels
 - 6 yes/no questions for each of 6 competencies
- Paper trail as to how milestone level determined for each fellow

Entrustable Professional Activities

Evaluations

#	Entrustable Professional Activities	Evaluations														
		Continuity Clinic	Inpatient GIM	MICU	CCU	NACR/NF/DF/MAO	ER/ECS/MOD	FPO	ABR	Resident of intern	Intern of resident	Medical Student of Resident	QI project	Electives	PBL Activities	Research
1	Manages a patient seen in clinic for a chronic medical condition	1						1	1							
2	Manages a patient seen in clinic for an acute medical condition	1						1	1							
3	Manages a clinic session efficiently so that patient care proceeds at an appropriate rate	1						1	1							
4	Recognizes clinical situations in which there is a need for urgent or emergent medical care, including life-threatening conditions		1	1	1	1	1			1	1					
5	Manages routine clinic tasks including follow up of diagnostic testing, patient calls or inquiries, prescription refills, or other administrative tasks associated with an outpatient practice in a timely and efficient manner	1														
6	Updates the medical record accurately and in a timely manner	1	1	1	1		1									
7	Understands and practices age-appropriate screening and preventive care	1														
8	Manages the care of patients with acute common diseases inpatient setting		1		1	1				1	1					
9	Manages the care of patients with acute complex diseases in the inpatient setting			1	1					1	1					
10	Performs all tasks associated with admitting a patient to the hospital		1			1				1						
11	Manages the day to day care of a patient admitted to the hospital on the medicine service.		1	1	1					1						
12	Demonstrates the ability to manage the admission and ongoing care of patients in a critical care unit			1	1											
13	Manages transitions of care associated with admission, change in responsible provider during hospital stay and discharge		1	1	1	1				1						
14	Consults other specialties appropriately and provides appropriate information to the consulting provider	1	1	1	1					1						
15	Provides internal medicine consultation to non-medical specialties													1		
16	Provides preoperative assessment and perioperative care	1						1								
17	Conducts family meetings and communicates plan of care to the patient and their caregivers and/or loved ones.		1	1												
18	Demonstrates professionalism during all interactions with colleagues, other health team members, the patient, caregivers, and the patient's family or loved ones	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
19	Displays learning and improvement through feedback and self assessment	1	1	1	1			1		1				1	1	
20	Demonstrates the ability to utilize information resources to answer clinical questions, appraise the quality of the literature, and appropriately applies evidence based practice to patients	1	1	1	1			1		1	1					
21	Demonstrates commitment to supporting patient safety, improving personal performance and finding improvement opportunities within the system												1		1	
22	Evaluates own practice as it applies to treatment of chronic medical illness and compares the results with best practice standards															1
23	Demonstrates commitment to the education of patients, their families and members of the healthcare team	1	1							1	1					
24	Functions as an advocate for patients based on their individual needs	1	1	1	1					1	1					
TOTAL		13	13	12	12	5	3	7	4	12	7	1	2	3	4	1



**University of Maryland
Internal Medicine**

Subject:
Evaluator:
Site:
Period:
Dates of Activity:
Activity: MICU A
Form: Resident EPA Evaluation

Please assign a level for each competency based on these definitions:

- **Critical deficiency:** Lack of competency in specific area.
- **Very early learner, needs constant and close supervision:** Intern who is functioning at a medical student level and needs constant supervision.
- **Early learner, needs close supervision:** Beginning intern who needs close supervision.
- **Mid-level early learner, needs occasional close supervision:** Mid to late-year intern who meets competencies of an early learner and needs occasional close supervision.
- **Advanced learner, needs distant supervision:** PGY-2 or 3 resident who practices within the scope of residency training with faculty supervising their work.
- **Advanced learner, nearing ability for unsupervised practice:** PGY-2 or 3 resident who is more advanced and beginning to demonstrate readiness for unsupervised practice.
- **Ready for unsupervised practice:** Resident in final year of training who is ready to graduate and practice independently.
- **Ready for unsupervised practice, demonstrates achievement in most milestones:** Resident in final year of training who demonstrates high achievement and is ready to graduate and practice independently.
- **Aspirational:** Truly outstanding resident who consistently demonstrates high achievement, is regarded as a role model, and is ready to graduate and practice independently.
- **Did not assess**

(Question 1 of 17 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Recognizes clinical situations in which there is a need for urgent or emergent medical care, including life-threatening conditions	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 2 of 17 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Updates the medical record accurately and in a timely manner	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 3 of 17 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Manages the care of patients with acute complex diseases in the inpatient setting	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 4 of 17 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Manages the day to day care of a patient admitted to the hospital on the medicine service	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 5 of 17 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Demonstrates the ability to manage the admission and ongoing care of patients in a critical care unit	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 6 of 17 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Manages transitions of care associated with admission, change in responsible provider during hospital stay and discharge	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 7 of 17 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Consults other specialties appropriately and provides appropriate information to the consulting provider	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 8 of 17 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Conducts family meetings and communicates plan of care to the patient and their caregivers and/or loved ones	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 9 of 17 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Demonstrates professionalism during all interactions with colleagues, other health team members, the patient, caregivers, and the patient's family or loved ones	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 10 of 17 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Displays learning and improvement through feedback and self assessment	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 11 of 17 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Demonstrates the ability to utilize information resources to answer clinical questions, appraise the quality of the literature, and appropriately applies evidence based practice to patients	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 12 of 17 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Functions as an advocate for patients based on their individual needs	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 13 of 17 - Mandatory)

	Significantly more supervision required	Slightly more supervision required	Same level of supervision	Slightly less supervision required	Significantly less supervision needed
Degree of supervision required compared to most residents at the same level of training.					

(Question 14 of 17 - Mandatory)

	Significantly below expected level	Slightly below expected level	At expected level	Slightly above expected level	Significantly above expected level
Overall performance compared to most residents at the same level of training.					

(Question 15 of 17 - Mandatory)

Resident Strengths:	
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(Question 16 of 17)

Suggested Areas for Improvement:	
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(Question 17 of 17 , Confidential)

Confidential Comments:

This area is for providing positive or negative feedback that you do not feel comfortable giving directly. These comments will NOT go directly to the intern, resident or medical student concerned. They will go to the program directors who may contact you for further details.

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**University of Maryland
Internal Medicine**

Subject:
Evaluator:
Site:
Period:
Dates of Activity:
Activity: Endocrinology
Form: Resident EPA Evaluation

Please assign a level for each competency based on these definitions:

- **Critical deficiency:** Lack of competency in specific area.
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- **Did not assess**

(Question 1 of 13 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Manages a patient seen in clinic for a chronic medical condition	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 2 of 13 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Manages a patient seen in clinic for an acute medical condition	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 3 of 13 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Updates the medical record accurately and in a timely manner	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 4 of 13 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Manages the care of patients with acute common diseases inpatient setting	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 5 of 13 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Manages the care of patients with acute complex diseases in the inpatient setting	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 6 of 13 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Provides internal medicine consultation to non-medical specialties	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 7 of 13 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Demonstrates professionalism during all interactions with colleagues, other health team members, the patient, caregivers, and the patient's family or loved ones	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 8 of 13 - Mandatory)

	Critical deficiency	PGY-1 Very early learner, needs constant supervision	PGY-1 Early learner, needs close supervision	PGY-1 Mid-level early learner, needs occasional close supervision	PGY-2-3 Advanced learner, needs distant supervision	PGY-2-3 Advanced learner, nearing ability for unsupervised practice	Senior Resident Ready for unsupervised practice	Senior Resident Ready for unsupervised practice, demonstrates high achievement	Senior Resident Aspirational	Did not assess
Displays learning and improvement through feedback and self assessment	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	0

(Question 9 of 13 - Mandatory)

	Significantly more supervision required	Slightly more supervision required	Same level of supervision	Slightly less supervision required	Significantly less supervision needed
Degree of supervision required compared to most residents at the same level of training.					

(Question 10 of 13 - Mandatory)

	Significantly below expected level	Slightly below expected level	At expected level	Slightly above expected level	Significantly above expected level
Overall performance compared to most residents at the same level of training.					

(Question 11 of 13 - Mandatory)

Resident Strengths:	
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(Question 12 of 13)

Suggested Areas for Improvement:	
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(Question 13 of 13 , Confidential)

Confidential Comments:

This area is for providing positive or negative feedback that you do not feel comfortable giving directly. These comments will NOT go directly to the intern, resident or medical student concerned. They will go to the program directors who may contact you for further details.

Remediation of the “Problem” Resident via GME

Harendra Arora, M.B., B.S.

November 6, 2015
2:10PM – 2:30PM



Remediation of the “Problem” Resident

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

Disclosures

- I have no conflicts of interest or financial disclosures
- I am not an expert in remediation of “problem” residents

Learning Objectives

- Define “problem” resident.
- Identify “problem” residents in need of remediation
- Design a remediation plan that is specific to the learner’s areas of difficulty
- Identify resources to assist in remediation of a “problem” resident

Problem Resident: Academic and/or Misconduct

- “one who fails to meet the standard of performance in one or more ACGME competency.”
- We all have them
- We know when we see one
- “Problem” can present in different “forms”

“Problem” can present in different forms

Academic

- Patient care (PC)
- Knowledgebase (MK)
- Application of knowledge (PC, MK)
- Ability to improve (PBLI)
- Poor documentation (PC, P, SBP)

Conduct (or misconduct)

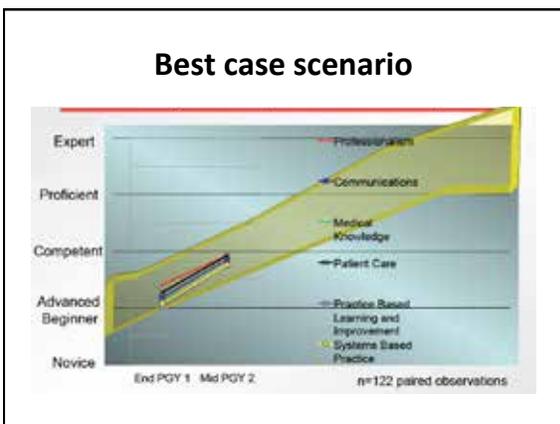
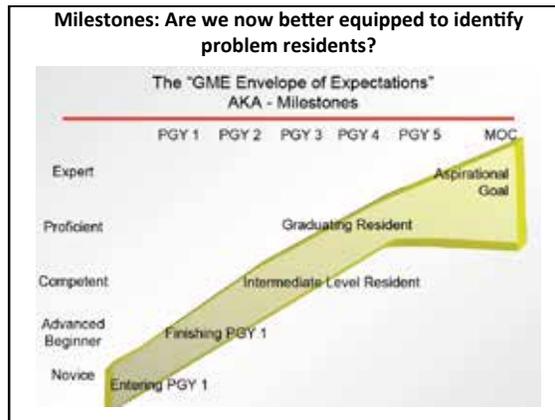
- Behavior (P)
- Violation or disregard of rules (P)
- Lying, theft, harm (P, PC)
- Poor communication skills (ICS)

Problem in dealing with “Problem” Resident

- Documentation by faculty often lacking
 - Unwilling to complete evaluations
 - Evaluations may not represent actual performance
 - Vocalize concerns but unwilling to document
- We are not trained in remediation of problem learners
- Problem presents in different shapes and forms

Residents: Students and Employees

Employees	Students
<ul style="list-style-type: none"> • No discrimination • Follow written policies • Comply with employment contracts • Provide notice 	<ul style="list-style-type: none"> • Feedback / assessments • Adequate opportunity for improvement / correction • Due process • Provide notice



Goal of NAS

The actions of the ACGME must fulfill the social contract, and must cause sponsors to maintain an educational environment that assures:

- the safety and quality of care of the patients under the care of residents today
- the safety and quality of care of the patients under the care of our graduates in their future practice
- the provision of a humanistic educational environment where residents are taught to manifest professionalism and effacement of self interest to meet the needs of their patients

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How to identify “problem” resident?

- Develop a comprehensive multisource evaluation infrastructure
 - Direct observation by faculty
 - Peer review from fellow residents
 - 360°s from patients, RN’s, others
 - Conferences, Journal clubs, Case-based assessments, OSCEs, SIM
 - Timeliness of documentation (duty hour logs, case logs, etc)
 - Performance on ITE, Basic ABA exam

Identify “Problem” Resident

- Rule of thumb: Get faculty to

Document
 Document
 Document

Resident assessment fallacies

- Subjective assessment
- Inter-rater variability
- Resident or assessor having a "bad" day
- **Compensation fallacy:** Erroneously labeling residents as "good" who have some strong characteristics (professionalism) that "cancel out" their unsatisfactory characteristics (patient care/judgment)
- **Halo effect:** some residents are truly outstanding in one or two areas, and deficiencies in other areas are overlooked

Problems with Post-rotation Evaluations

- Grade inflation
- Attending physicians' lack of willingness to document poor performance
- Lack of knowledge about how to document performance concerns
- Comments section often does not correlate with the numeric ratings

[J Grad Med Educ. 2012 March; 4\(1\): 47-51.](#)

Daily Real-time Feedback

- Written and Verbal
- Concern / Praise cards
- Add a box for confidential comments that only PDs can see

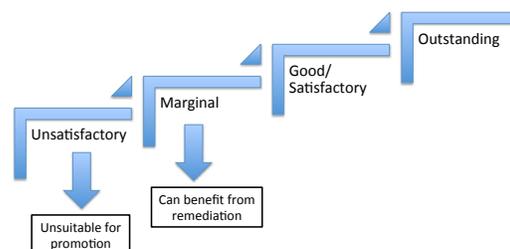
Competence problems that should be documented:

- Lack of or poor judgment
- Inadequate clinical skills/patient care
- Deficient technical or procedural skills
- Ineffective communication skills
- Inability to acquire and integrate professional standards into one's repertoire of professional behavior
- Lack of personal insight or self-awareness
- Inability to control personal stress or emotional reactions that interfere with professional functioning (conduct or emotional problem)

Red Flags

- Tardiness,
- Poor documentation (includes case logs, duty hour logs, conference attendance, etc)
- A disproportionate amount of attention by training personnel is required
- Grumbling from peers
- The trainee's behavior does not change even after feedback, remediation efforts, and / or time

Resident Performance



6 Worrisome D's

- Depression
- Deprivation (sleep, food)
- Distraction (finances, family/SO, illness)
- Disability (neurocognitive, physical)
- Disordered personality (ADHD, borderline)
- Drugs (alcohol, narcotics)

Designing Appropriate Remediation

- Clinical competence Committee plays a critical role
 - Identifies deficiencies in context of core competencies and milestones
 - Reviews block rotations
 - Identifies task-oriented demonstration of skills
 - Individualized educational plan

CCC: Individualized Educational Plan

- Arranges mentor/coach preferably, outside of CCC (core faculty, master clinicians)
- Sets timeline with goals
- States ramifications of failure to achieve goals
- Arranges follow-up to assess progress

Context issues to be considered:

- Support systems
- Adjustment issues to new setting both personally and professionally
- Changes in status (finances)
- Impact of significant life events
- Personal risk factors (substance abuse, ADD, other psychiatric disorders, etc.)
- Could just be "burnout"

Implementing the Individualized Educational Plan (IEP)

- CCC recommendations forwarded to PD
- Ultimate decision to execute IEP rests with the Program Director
- Remediation may or may not include probation
- Involve GME (DIO) and legal office in case IEP will possibly lead to non-promotion, nonrenewal of contract, no credit, extension of training, suspension, withdrawal from program, termination

Letter of Deficiency

- Clear and explicit description of deficiency
 - Competency / milestone-based
- Detailed, well-written remediation plan with clear expectations during remediation phase
 - Timeline
 - Requirements
- Explicit statement of consequences in case of failure
 - Probation, termination, non-renewal

When delivering letter of deficiency...

- Have a witness in the room
- Bring charts, evaluations, milestones data, etc
- Be explicit about no audio or video recording of the meeting
- Document meeting minutes including specific mention of resident's reaction / understanding of the deficiencies
- Provide grievance policy when issuing a warning, probation or termination letter (including due process)

Ensure a paper trail

- Maintain detailed minutes of the CCC meeting
- Save all emails to and from the "problem" resident
- Upload all formal academic counseling into the residency evaluation system
- Document all meetings with the problem resident (including positive ones)

Review of the Decision

- Meeting with another PD / DIO
- Reviewer
 - Meets with the resident; reviews file; meets with other faculty if needed
- A Second Review:
 - Hospital CMO or another official (institution-specific)
 - Meeting with the resident; review of initial report / findings
 - Renders a final decision

Examples of "Problem" Residents

Taking Care of Our Own

Physicians are people too; the UNC "Taking Care of Our Own" initiative



- Funded through the Sanders Clinical Scholars Program
- Helps struggling house-staff and faculty
- Appropriate professional referral for individuals needing mental or physical help
- Program also provides "burnout / wellness" education
- Confidential

Determine whether the corrective action plan has been successful

- Successful completion of all remediation steps
 - Satisfactory evaluations
 - Achieves anticipated milestones for promotion
- Remove from remediation
- Continue to monitor progress
- If maintains upwards trajectory, no further action

Determine whether corrective action has been successful

- If corrective action plan, unsuccessful
 - Follow through on the plan as was laid out
 - Follow the timeline
 - Document, Document Document
- Involve GME (DIO), legal office, Chair, CCC
- If still no sign of improvement, termination may be inevitable
- Consider offering voluntary withdrawal by the resident from the program as opposed to dismissal

Court Reversal

Irby & Milam, Acad Med, 1989

“The courts will not reverse decision to dismiss a student or to not reappoint a resident where the decision is based upon the faculty members’ professional judgment and a review of the entire record”

For Effective Remediation

A Complimentary Approach that brings together:

- Institutional buy-in
 - DIO, legal office
 - Everyone understands protocol / process
- Interpersonal
 - Frequent constructive feedback
 - Assess / Provide support system
- Psychosocial
 - Ensure understanding (process, desired outcomes)
 - Assess emotions
 - Assess cognitive styles
 - Seek expert assistance (psychiatric / psychological)

Thank you

Everything You Always Wanted to Know – Version 2.0

Paul W. Kranner, M.D.

Amy Murray, M.D.

November 6, 2015
3:30PM – 5:00PM

Session Name
AACPD responses

Date Created
11/6/2015 2:49:25 PM

Average Score
0.00%

Active Participants
108

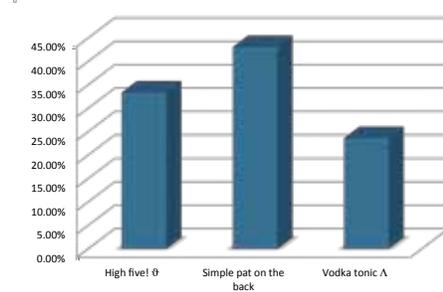
Questions
57

Total Participants
108

Results by Question

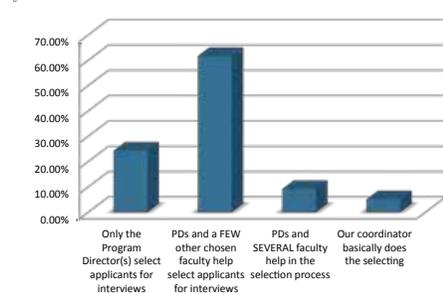
1. Last year's Match results left me feeling like I should get a: (Multiple Choice)

	Responses	
	Percent	Count
High five! J	33.33%	24
Simple pat on the back	43.06%	31
Vodka tonic L	23.61%	17
Totals	100%	72



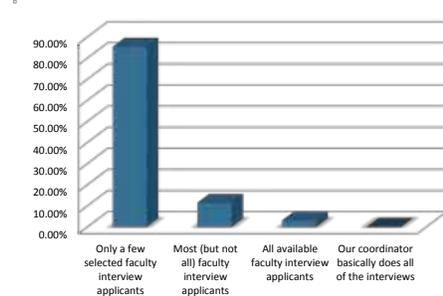
2. When it comes to faculty involved in SELECTING applicants to interview: (Multiple Choice)

	Responses	
	Percent	Count
Director(s) select applicants for interviews	24.24%	24
Faculty help select applicants for interviews	61.62%	61
Faculty help in the selection process	9.09%	9
Coordinator basically does the selecting	5.05%	5
Totals	100%	99



3. When it comes to faculty involved in INTERVIEWING applicants: (Multiple Choice)

	Responses	
	Percent	Count
Most selected faculty interview applicants	85.42%	82
Most (but not all) faculty interview applicants	11.46%	11
All available faculty interview applicants	3.13%	3
Coordinator basically does all of the interviews	0.00%	0
Totals	100%	96



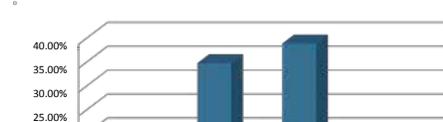
4. In preparation for applicant interviews: (Multiple Choice)

	Responses	
	Percent	Count
Faculty receive some sort of interview training	32.32%	32
Faculty receive training, but it might be a good idea	57.58%	57
Faculty don't see the reason for any extra training	10.10%	10
Totals	100%	99

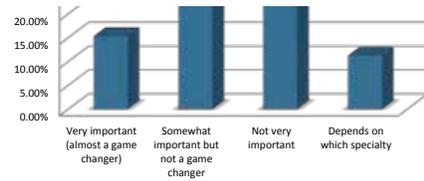


5. How important is it for an applicant to have a letter of recommendation from a specialty OUTSIDE anesthesiology (Multiple Choice)

	Responses	
	Percent	Count
Very important (almost a game changer)	15.31%	15
That important but not a game changer	34.69%	34
Not very important	38.78%	38

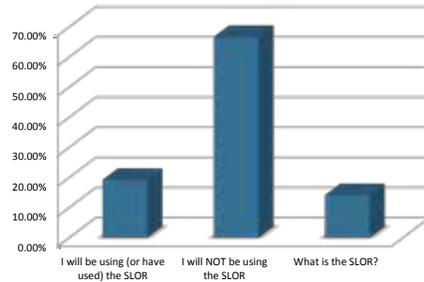


Depends on which specialty	11.22%	11
Totals	100%	98



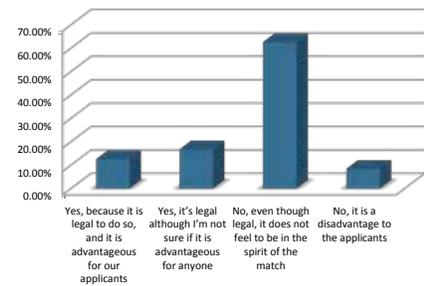
6. Last year, 47% of Program Directors responded that they would NOT use the Standardized Letter of Recommendation (SLOR). This year: (Multiple Choice)

Responses		
	Percent	Count
will be using (or have used) the SLOR	19.19%	19
I will NOT be using the SLOR	66.67%	66
What is the SLOR?	14.14%	14
Totals	100%	99



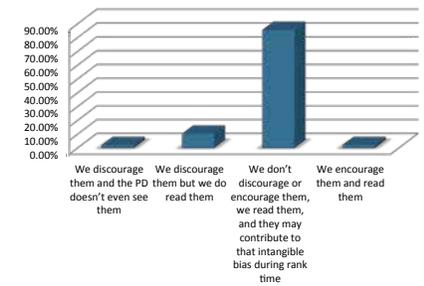
7. Do you provide your applicants any information regarding their rank positions? (Multiple Choice)

Responses		
	Percent	Count
it is advantageous for our applicants	12.50%	12
it sure if it is advantageous for anyone	16.67%	16
not feel to be in the spirit of the match	62.50%	60
it is a disadvantage to the applicants	8.33%	8
Totals	100%	96



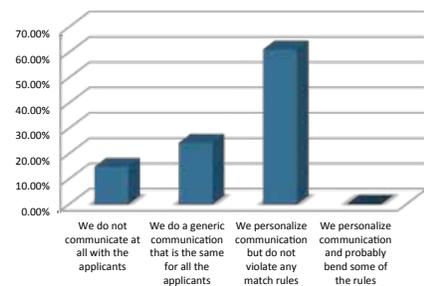
8. When it comes to thank you notes from the applicants: (Multiple Choice)

Responses		
	Percent	Count
them and the PD doesn't even see them	2.06%	2
discourage them but we do read them	10.31%	10
to that intangible bias during rank time	85.57%	83
We encourage them and read them	2.06%	2
Totals	100%	97



9. When it comes to post-interview communication back to the applicants: (Multiple Choice)

Responses		
	Percent	Count
communicate at all with the applicants	14.74%	14
that is the same for all the applicants	24.21%	23
tion but do not violate any match rules	61.05%	58
and probably bend some of the rules	0.00%	0
Totals	100%	95

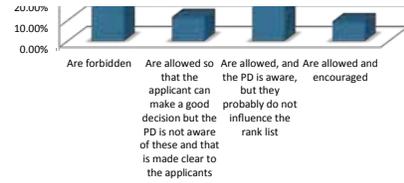


10. Second visits: (Multiple Choice)

Responses		
	Percent	Count
Are forbidden	19.15%	18
and that is made clear to the applicants	11.70%	11
probably do not influence the rank list	59.57%	56

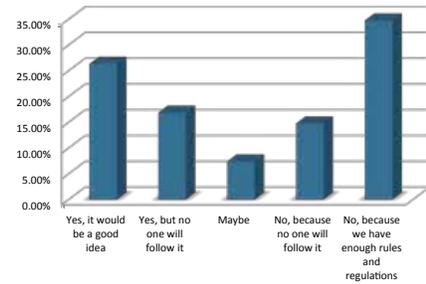


Are allowed and encouraged	9.57%	9
Totals	100%	94



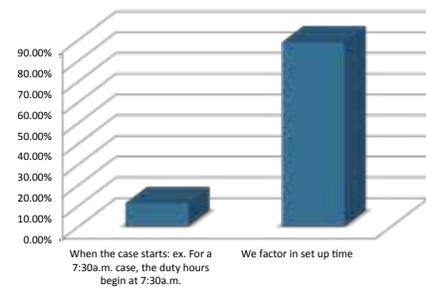
11. Should AACPD create a statement on post-interview communication and second visits much like APDIM did? (Multiple Choice)

Responses		
	Percent	Count
Yes, it would be a good idea	26.32%	25
Yes, but no one will follow it	16.84%	16
Maybe	7.37%	7
No, because no one will follow it	14.74%	14
We have enough rules and regulations	34.74%	33
Totals	100%	95



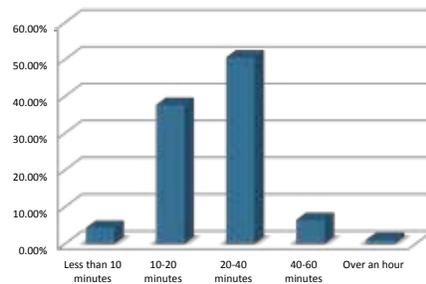
12. Do you start clocking duty hours when the case starts or when the resident arrives to set up? (Multiple Choice)

Responses		
	Percent	Count
When the case starts: ex. For a 7:30a.m. case, the duty hours begin at 7:30a.m.	11.22%	11
We factor in set up time	88.78%	87
Totals	100%	98



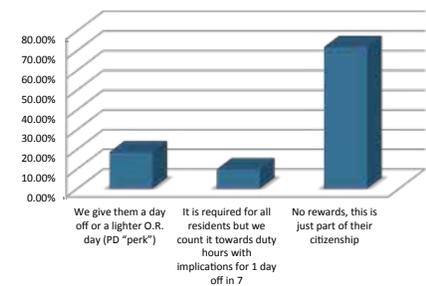
13. How long should "set up" take for the average resident for an average case? (Multiple Choice)

Responses		
	Percent	Count
Less than 10 minutes	4.30%	4
10-20 minutes	37.63%	35
20-40 minutes	50.54%	47
40-60 minutes	6.45%	6
Over an hour	1.08%	1
Totals	100%	93



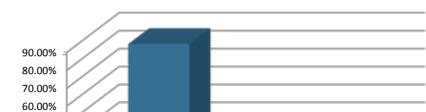
14. How do you recognize efforts of residents who participate in extra activities for the program, such as helping out with weekend interviews? (Multiple Choice)

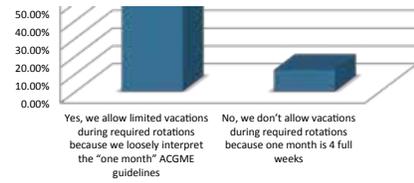
Responses		
	Percent	Count
We give them a day off or a lighter O.R. day (PD "perk")	18.48%	17
It is required for all residents but we count it towards duty hours with implications for 1 day off in 7	9.78%	9
No rewards, this is just part of their citizenship	71.74%	66
Totals	100%	92



15. Do you allow residents to take time away from the program during required rotations? (Multiple Choice)

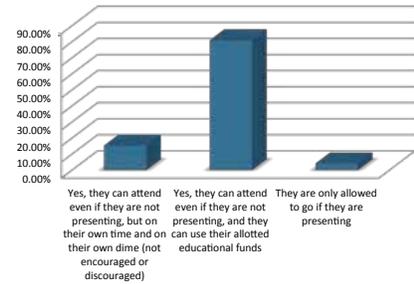
Responses		
	Percent	Count
Yes, in line with the "one month" ACGME guidelines	88.00%	88
No, because one month is 4 full weeks	12.00%	12
Totals	100%	100





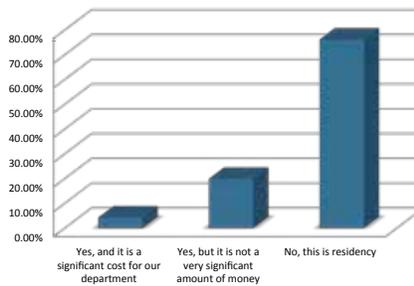
16. Are residents allowed to attend a scientific meeting if they are NOT presenting? (Multiple Choice)

Responses		
	Percent	Count
Yes, on their own dime (not encouraged or discouraged)	15.15%	15
No, they cannot use their allotted educational funds	80.81%	80
They are only allowed to go if they are presenting	4.04%	4
Totals	100%	99



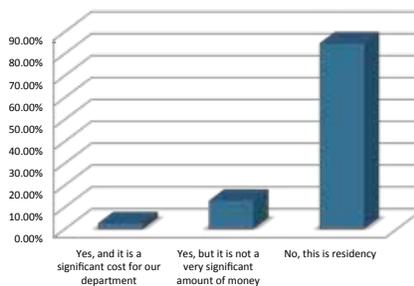
17. Does your department pay residents to work after a certain time of the regular day (NOT the same as moonlighting or scheduled call pay) (Multiple Choice)

Responses		
	Percent	Count
Yes, it is a significant cost for our department	4.17%	4
Yes, but it is not a very significant amount of money	19.79%	19
No, this is residency	76.04%	73
Totals	100%	96



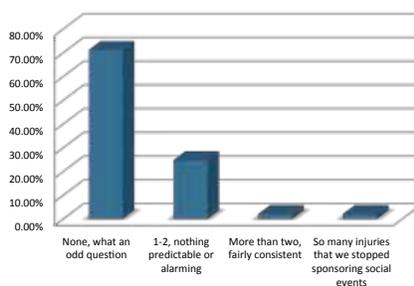
18. Does your department pay residents to work after a certain time of the regular day (NOT the same as moonlighting or scheduled call pay) (Multiple Choice)

Responses		
	Percent	Count
Yes, it is a significant cost for our department	2.56%	2
Yes, but it is not a very significant amount of money	12.82%	10
No, this is residency	84.62%	66
Totals	100%	78



19. How many resident or faculty injuries have occurred at departmentally-sponsored social events (like picnics/softball games) in the last three years? (Multiple Choice)

Responses		
	Percent	Count
None, what an odd question	71.13%	69
1-2, nothing predictable or alarming	24.74%	24
More than two, fairly consistent	2.06%	2
So many injuries that we stopped sponsoring social events	2.06%	2
Totals	100%	97

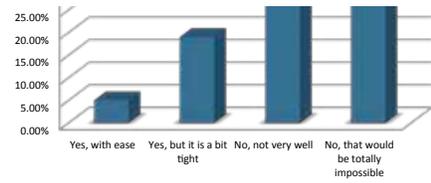


20. Can you run the operating rooms without the residents? (Multiple Choice)

Responses		
	Percent	Count
Yes, with ease	5.00%	5
Yes, but it is a bit tight	19.00%	19
No, not very well	31.00%	31

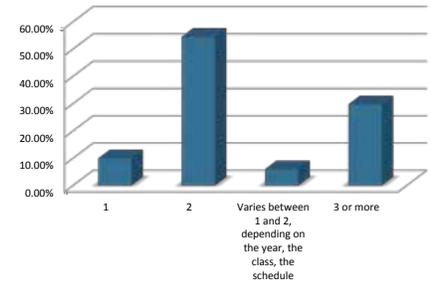


No, that would be totally impossible	45.00%	45
Totals	100%	100



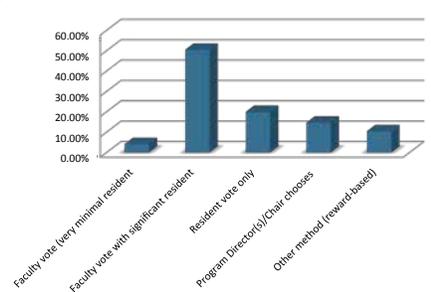
21. How many Chief Residents do you have per year? (Multiple Choice)

Responses		
	Percent	Count
1	9.90%	10
2	54.46%	55
Varies between 1 and 2, depending on the year, the class, the schedule	5.94%	6
3 or more	29.70%	30
Totals	100%	101



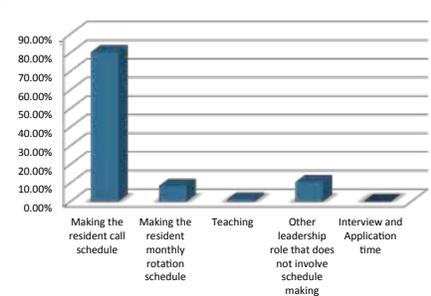
22. How are your chiefs chosen? (Multiple Choice)

Responses		
	Percent	Count
Faculty vote (very minimal resident input)	4.21%	4
Faculty vote with significant resident input	50.53%	48
Resident vote only	20.00%	19
Program Director(s)/Chair chooses	14.74%	14
Other method (reward-based)	10.53%	10
Totals	100%	95



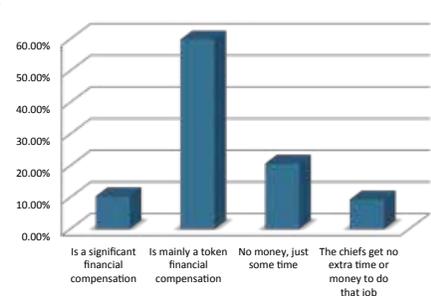
23. The major role and responsibility of the chief residents are: (Multiple Choice)

Responses		
	Percent	Count
Making the resident call schedule	80.21%	77
Making the resident monthly rotation schedule	8.33%	8
Teaching	1.04%	1
Other leadership role that does not involve schedule making	10.42%	10
Interview and Application time	0.00%	0
Totals	100%	96



24. Compensation for our chief residents: (Multiple Choice)

Responses		
	Percent	Count
Is a significant financial compensation	10.31%	10
Is mainly a token financial compensation	59.79%	58
No money, just some time	20.62%	20
They get no extra time or money to do that job	9.28%	9
Totals	100%	97

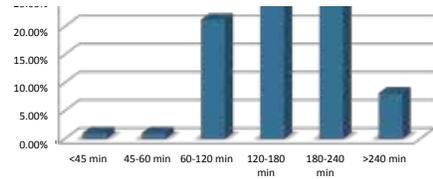


25. How many hours of dedicated/protected didactic time per the average week do you offer for each CA level? (Multiple Choice)

Responses		
	Percent	Count
<45 min	1.01%	1
45-60 min	1.01%	1
60-120 min	21.21%	21

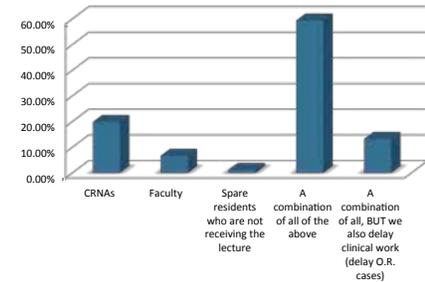


120-180 min	37.37%	37
180-240 min	31.31%	31
>240 min	8.08%	8
Totals	100%	99



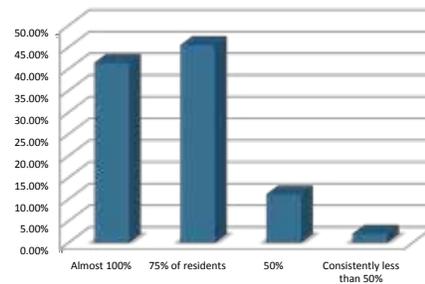
26. Last year, 37% of PDs reported that didactic lectures were offered during the typical work day. How do you relieve the residents? (Multiple Choice)

Responses		
	Percent	Count
CRNAs	19.78%	18
Faculty	6.59%	6
Residents who are not receiving the lecture	1.10%	1
A combination of all of the above	59.34%	54
delay clinical work (delay O.R. cases)	13.19%	12
Totals	100%	91



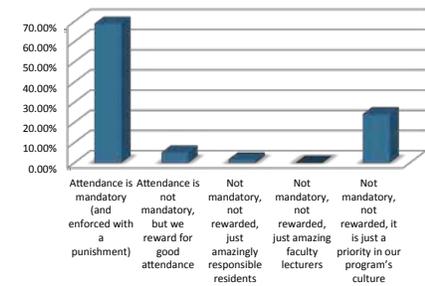
27. Our resident attendance rate at lecture (excluding residents who are post call/on call/vacation) is: (Multiple Choice)

Responses		
	Percent	Count
Almost 100%	41.41%	41
75% of residents	45.45%	45
50%	11.11%	11
Consistently less than 50%	2.02%	2
Totals	100%	99



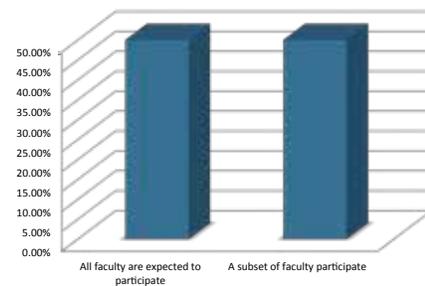
28. For those who answered almost 100%, choose WHY it is such a high attendance: (Multiple Choice)

Responses		
	Percent	Count
Attendance is mandatory (and enforced with a punishment)	68.97%	40
Attendance is mandatory, but we reward for good attendance	5.17%	3
Residents are just amazingly responsible	1.72%	1
Attendance is mandatory, but we reward, just amazing faculty lecturers	0.00%	0
Attendance is mandatory, but we reward, just a priority in our program's culture	24.14%	14
Totals	100%	58



29. When it comes to faculty expected to participate in teaching the residents during didactic sessions: (Multiple Choice)

Responses		
	Percent	Count
All faculty are expected to participate	50.00%	47
A subset of faculty participate	50.00%	47
Totals	100%	94

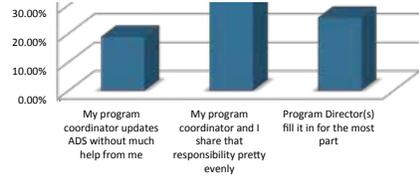


30. When it comes to updating the ADS: (Multiple Choice)

Responses		
	Percent	Count
Faculty fill in ADS without much help from me	18.89%	17
Faculty share that responsibility pretty evenly	55.56%	50
Faculty and I fill it in for the most part	25.56%	23

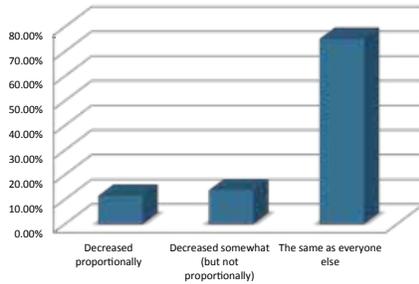


Totals	100%	90
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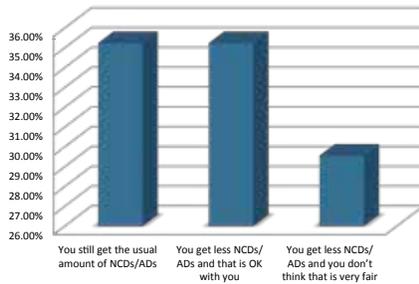
31. If you have 40% protected time (0.6 FTE), the amount of call you take is: (Multiple Choice)

Responses		
	Percent	Count
Decreased proportionally	11.36%	10
Decreased somewhat (but not proportionally)	13.64%	12
The same as everyone else	75.00%	66
Totals	100%	88



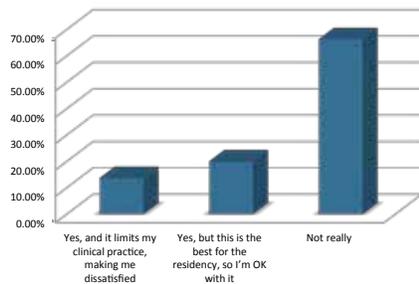
32. If you are getting NCDs or ADs, on a month when you take vacation: (Multiple Choice)

Responses		
	Percent	Count
Still get the usual amount of NCDs/ADs	35.23%	31
Get less NCDs/ADs and that is OK with you	35.23%	31
Get less NCDs/ADs and you don't think that is very fair	29.55%	26
Totals	100%	88



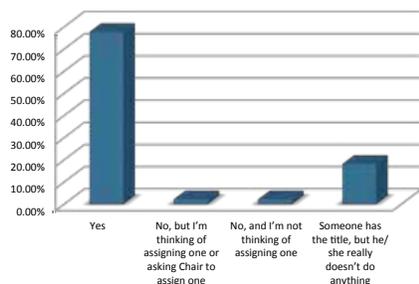
33. The administrative burdens of the PD can affect the clinical role. Does your role as PD impact the types of cases you are assigned? (Multiple Choice)

Responses		
	Percent	Count
Yes, and it limits my clinical practice, making me dissatisfied	13.68%	13
Yes, but this is the best for the residency, so I'm OK with it	20.00%	19
Not really	66.32%	63
Totals	100%	95



34. I have an Associate or Assistant Program Director: (Multiple Choice)

Responses		
	Percent	Count
Yes	77.66%	73
No, but I'm thinking of assigning one or asking Chair to assign one	2.13%	2
No, and I'm not thinking of assigning one	2.13%	2
No, but he/she really doesn't do anything	18.09%	17
Totals	100%	94

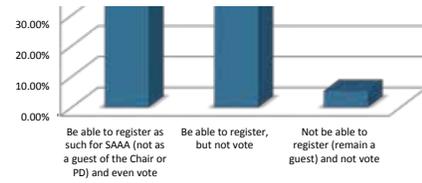


35. I think the Assoc./Asst. PD should: (Multiple Choice)

Responses		
	Percent	Count
Be the Chair or PD) and even vote	54.26%	51
Be able to register, but not vote	40.43%	38
Not register (remain a guest) and not vote	5.32%	5

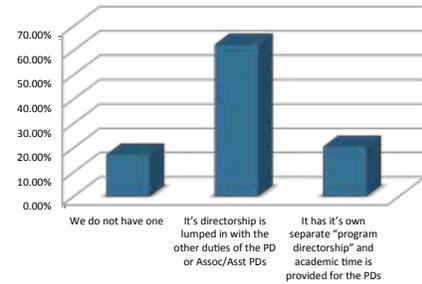


Totals	100%	94
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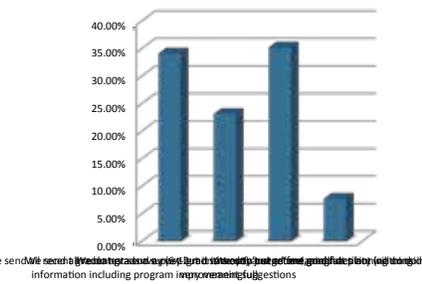
36. When it comes to the "fundamental clinical skills education"...formerly known as the Clinical Base Year: (Multiple Choice)

Responses		
	Percent	Count
We do not have one	17.20%	16
er duties of the PD or Assoc/Asst PDs	62.37%	58
academic time is provided for the PDs	20.43%	19
Totals	100%	93



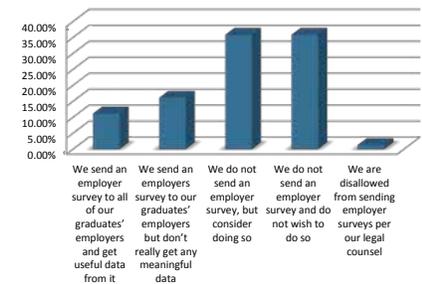
37. When it comes to post-grad surveys: (Multiple Choice)

Responses		
	Percent	Count
ng program improvement suggestions	34.07%	31
ood" activity (nothing very meaningful)	23.08%	21
t graduates but will consider doing so	35.16%	32
nd one, and not planning on doing so	7.69%	7
Totals	100%	91



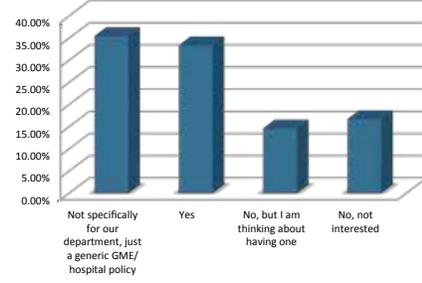
38. When it comes to employer surveys: (Multiple Choice)

Responses		
	Percent	Count
employers and get useful data from it	11.11%	9
ut don't really get any meaningful data	16.05%	13
mployer survey, but consider doing so	35.80%	29
loyer survey and do not wish to do so	35.80%	29
mployer surveys per our legal counsel	1.23%	1
Totals	100%	81



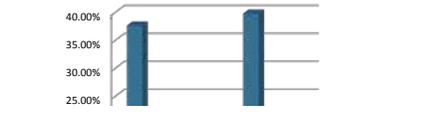
39. Does your program have a policy on texting/web browsing/device using in the operating room? (Multiple Choice)

Responses		
	Percent	Count
ent, just a generic GME/hospital policy	35.42%	34
Yes	33.33%	32
o, but I am thinking about having one	14.58%	14
No, not interested	16.67%	16
Totals	100%	96

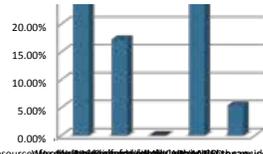


40. When it comes to departmentally- funded Board Prep (Multiple Choice)

Responses		
	Percent	Count
NCED exam (Board Review Courses)	37.63%	35
We only provide for the BASIC exam	17.20%	16
only provide for the ADVANCED exam	0.00%	0



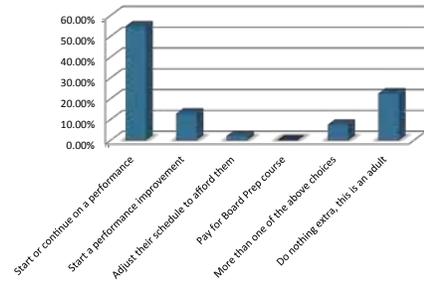
3 their professional meeting allowance	39.78%	37
ents do not get any meeting allowance	5.38%	5
Totals	100%	93



to provide resources for the program (e.g., providing a meeting allowance for the program) meeting allowance

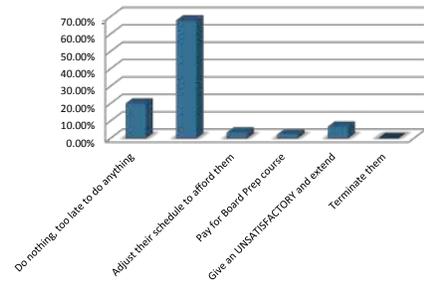
41. You have a CA2 who just found out they barely passed the BASIC exam and is below the 15th percentile on the ITE. What do you do? (Multiple Choice)

Responses		
	Percent	Count
Start or continue on a performance improvement plan AND give unsatisfactory to ABA	54.84%	51
Schedule to afford them more study time	12.90%	12
Pay for Board Prep course	2.15%	2
More than one of the above choices	0.00%	0
Terminate them	7.53%	7
Do nothing extra, this is an adult	22.58%	21
Totals	100%	93



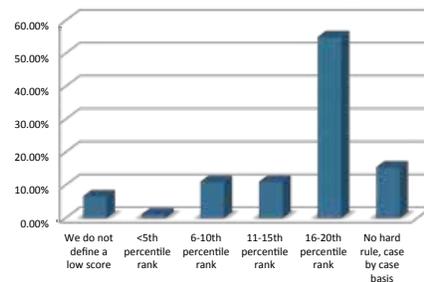
42. Your CA3 scores in the single digit percentile on the ITE in February. What do you do? (Multiple Choice)

Responses		
	Percent	Count
Do nothing, too late to do anything	20.00%	18
Start or continue on a performance improvement plan	67.78%	61
Schedule to afford them more study time	3.33%	3
Pay for Board Prep course	2.22%	2
Extend by 6 months (+/- improvement plan)	6.67%	6
Terminate them	0.00%	0
Totals	100%	90



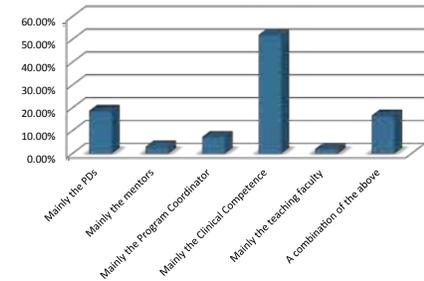
43. How do you define the low score on the Medical Knowledge Milestone for ITE? (Multiple Choice)

Responses		
	Percent	Count
We do not define a low score	6.59%	6
<5th percentile rank	1.10%	1
6-10th percentile rank	10.99%	10
11-15th percentile rank	10.99%	10
16-20th percentile rank	54.95%	50
No hard rule, case by case basis	15.38%	14
Totals	100%	91



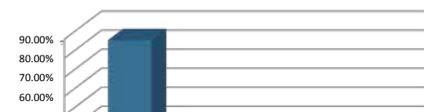
44. Who is populating the Milestone "report card"? (Multiple Choice)

Responses		
	Percent	Count
Mainly the PDs	18.75%	18
Mainly the mentors	3.13%	3
Mainly the Program Coordinator	7.29%	7
Mainly the Clinical Competence Committee	52.08%	50
Mainly the teaching faculty	2.08%	2
A combination of the above	16.67%	16
Totals	100%	96

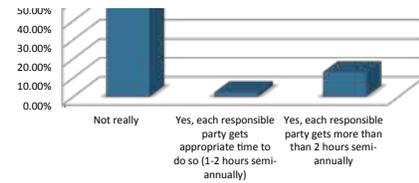


45. Is there any protected time for filling out Milestone report card? (Multiple Choice)

Responses		
	Percent	Count
Not really	85.11%	80
Some time to do so (1-2 hours semi-annually)	2.13%	2
More than 2 hours semi-annually	12.77%	12

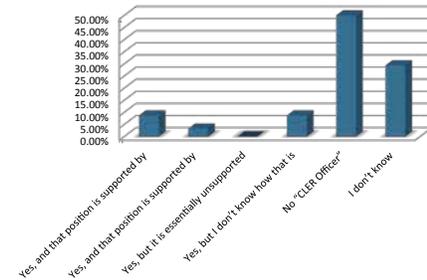


Totals	100%	94
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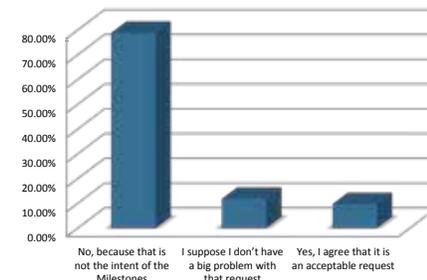
46. Do you have a dedicated "CLER Officer" at your institution (separate from the Chief Quality Officer and DIO)? (Multiple Choice)

Responses		
	Percent	Count
It position is supported by the hospital and that position is supported by GME	8.70%	8
It is supported by anyone, more voluntary	3.26%	3
but I don't know how that is supported	0.00%	0
No "CLER Officer"	8.70%	8
I don't know	50.00%	46
I don't know	29.35%	27
Totals	100%	92



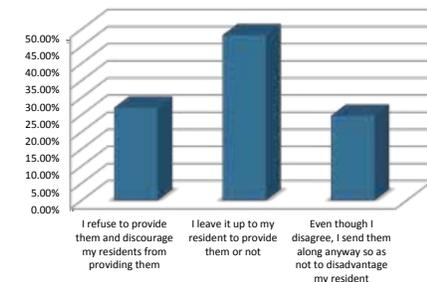
47. Do you agree with fellowships requesting applicants' Milestone scores? (Multiple Choice)

Responses		
	Percent	Count
that is not the intent of the Milestones	78.72%	74
It has a big problem with that request	11.70%	11
I agree that it is an acceptable request	9.57%	9
Totals	100%	94



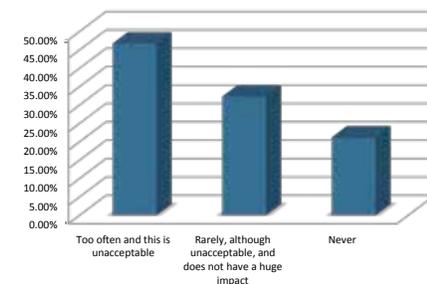
48. If you disagree with fellowships asking for Milestone scores: (Multiple Choice)

Responses		
	Percent	Count
I encourage my residents from providing them	27.06%	23
I encourage my resident to provide them or not	48.24%	41
so as not to disadvantage my resident	24.71%	21
Totals	100%	85



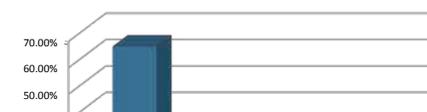
49. Our nearly-graduated CA3s are asked to arrive to their fellowships (for orientation/occupational health visit, etc...) BEFORE July 1st: (Multiple Choice)

Responses		
	Percent	Count
Too often and this is unacceptable	46.67%	42
Rarely, although unacceptable, and does not have a huge impact	32.22%	29
Never	21.11%	19
Totals	100%	90

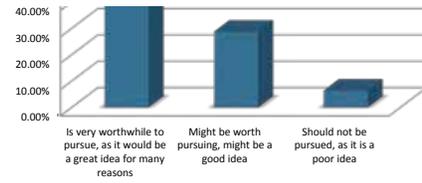


50. The discussion regarding the possibility of all fellowships starting in August: (Multiple Choice)

Responses		
	Percent	Count
It would be a great idea for many reasons	64.89%	61
It might be worth pursuing, might be a good idea	28.72%	27
It should not be pursued, as it is a poor idea	6.38%	6

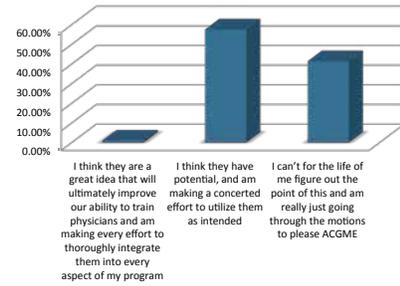


Totals	100%	94
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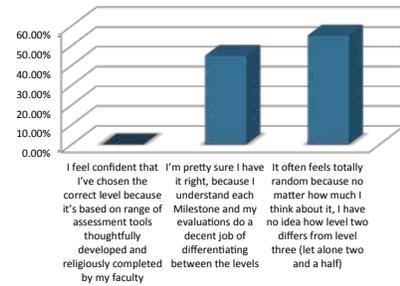
51. What best describes your current view of the Milestones? (Multiple Choice)

Responses		
	Percent	Count
them into every aspect of my program	1.01%	1
erted effort to utilize them as intended	57.58%	57
through the motions to please ACGME	41.41%	41
Totals	100%	99



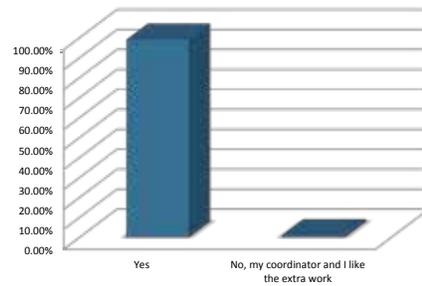
52. When assigning a specific Milestone level to a resident: (Multiple Choice)

Responses		
	Percent	Count
nd religiously completed by my faculty	0.00%	0
ob of differentiating between the levels	44.90%	44
n level three (let alone two and a half)	55.10%	54
Totals	100%	98



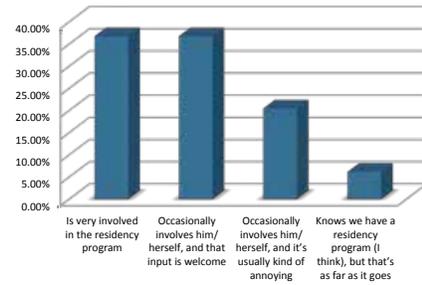
53. The ACGME and ABA should place a high priority on integrating their systems so that Milestones data only needs to be entered into one site: (Multiple Choice)

Responses		
	Percent	Count
Yes	98.99%	98
ly coordinator and I like the extra work	1.01%	1
Totals	100%	99



54. My Chair: (Multiple Choice)

Responses		
	Percent	Count
ery involved in the residency program	36.73%	36
him/herself, and that input is welcome	36.73%	36
rsself, and it's usually kind of annoying	20.41%	20
am (I think), but that's as far as it goes	6.12%	6
Totals	100%	98

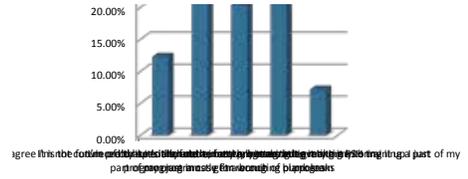


55. Regarding the Perioperative Surgical Home: (Multiple Choice)

Responses		
	Percent	Count
ctively making it a part of my program	12.24%	12
nto my program just in case I'm wrong	31.63%	31
rogram mostly for recruiting purposes	20.41%	20

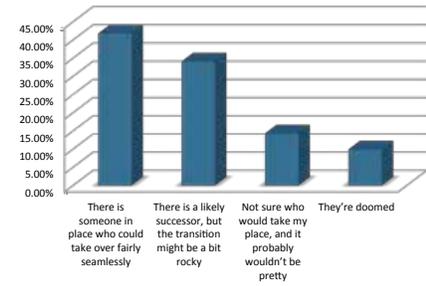


g it up I just get a bunch of blank looks	28.57%	28
ing PSH training a part of my program	7.14%	7
Totals	100%	98



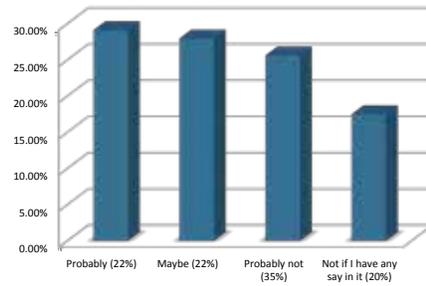
56. If you won the lottery tonight and your program never saw you again: (Multiple Choice)

Responses		
	Percent	Count
who could take over fairly seamlessly	41.76%	38
, but the transition might be a bit rocky	34.07%	31
ace, and it probably wouldn't be pretty	14.29%	13
They're doomed	9.89%	9
Totals	100%	91



57. Will you still be the program director in 5 years? (last year's responses in red) (Multiple Choice)

Responses		
	Percent	Count
Probably (22%)	29.07%	25
Maybe (22%)	27.91%	24
Probably not (35%)	25.58%	22
Not if I have any say in it (20%)	17.44%	15
Totals	100%	86



Core Program Experience with Milestones

Robert R. Gaiser, M.D., M.S.Ed.

November 6, 2015
8:15AM - 8:40AM

Core Program Experience with the Milestones

Robert Gaiser, M.D.

Core Program Director – Hospital of the University of Pennsylvania

Milestone Definition –

1. A stone by the side of a road that shows the distance in miles to a specified place
2. An important point in the progress or development of something – a very important event or advance

Googled Greatest Milestones in Medicine

1. Sanitation – The Poor Act of 1834 set a minimum standard of living for every member of society which introduced sanitation with a significant decrease in the death rate
2. DNA – DNA was first researched in 1953 at the University of Cambridge
3. Anesthesia – Noted to be better than alcohol or opiates for surgery
4. Germ theory – Dr. Semmelweis noted a colleague died after performing an autopsy bare-handed in a woman who died from during labor – Introduced hand washing
5. Unconscious mental processes – Introduced by Freud who felt that the subconscious primarily drove actions
6. Created memories – memories are influenced by words of person asking

10 Most Important Milestones in Your Life

1. Hitting rock bottom
2. Falling in love
3. Getting your heart broken for the first time
4. Realizing what you are passionate about
5. Getting fired from your job for the first time
6. Getting the job of your dreams
7. Losing a close friend
8. Getting married
9. Becoming a parent
10. Buying your first home

It is important to understand the concept of milestone in that it is not an achievable goal, rather an important point in the progress of development. Most milestones are identified by reflecting back over events. For the Milestones, these represent a chance to assess where a resident/fellow is located in the continuum of becoming a physician with specialty expertise.

For Anesthesiology and the Subspecialties, Milestones are one piece of performance data for the Next Accreditation System. Milestones are competency-based developmental outcomes of knowledge, skills, attitudes, and beliefs that residents should be able to progress through from the beginning of training through graduation with the hope of continuation throughout one's career (based upon the six core competencies). The Milestones were developed by a committee with representation from the ACGME and the ABA. In regards to validity, the Milestones would have face validity in that it covers the concept it is supposed to measure. For Core Anesthesiology, there are 25 milestones: 10 for Patient Care; 1 for Medical Knowledge; 2 for Systems-Based Practice; 4 for Practice-Based Learning and Improvement; 5 for Professionalism; and 3 for Interpersonal and Communication Skills. The first phase of the NAS was initiated in July 2013 with seven specialties reporting milestones. July 2014 Anesthesiology began

assessing and in July 2015 fellowships in Anesthesiology will accumulate data and assign Milestone Assessments.

Some Lessons Learned:

1. The world did not end. All core programs that started in 2014 also finished in 2015.
2. The RC will begin to use milestone data for programs in 2015.
3. Milestones are not meant to be final summative evaluations. However, some programs use them as such.
4. Milestones provide feedback about a program. If one person is not meeting a milestone, then it may be due to the individual. If several are below what other programs are achieving, it is time to evaluate the program. What is working? What should be changed in the program to assist the resident with assignment of the milestones?
5. Assignment of milestones takes TIME – be prepared.
6. Educate the Clinical Competence Committee. This is the group who assigns the final milestone level. Previously, it was to determine whether progress was satisfactory or unsatisfactory (competent/not competent).
7. Use multiple sources of data to assist with milestones. Data from nursing colleagues, other members of health care team, medical students, and residents will be helpful in final decisions.

Be prepared for a lot of information on your incoming fellows from ACGME residencies – Common requirement for 2016:

II.A.1 – Fellowship programs must receive verification of each entering fellow-s level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program.(core)

Some Parting Thoughts: Milestones for a Program Director of a Specialty Program

1. Being appointed program director
2. Dealing with the first difficult fellow
3. Receiving the first thank you note from a fellow
4. Meeting a past fellow five years later and hearing how you made a difference
5. Meeting a past fellow 10 years later and hearing how you made a difference
6. Hearing of a complicated a patient who received care from a previous fellow and did well because of your teaching
7. Your first positive fellow survey
8. Your first negative fellow survey
9. Your first hug from a fellow
10. Moving to the next phase knowing that you trained an individual to take your job and the transition goes seamless

References:

1. Beeson MS, Vozenilek JA. Specialty milestones and the next accreditation system: An opportunity for the simulation community. *Sim Healthcare* 2014;9:184-191.
2. French JC, Dannefer EF, Colbert CY. A systematic approach toward building a fully operational Clinical Competency Committee. *J Surg Ed* 2014;71:e22-e27.
3. Sillah NM,. The New Accreditation council for Graduate Medical Education Next Accreditation System Milestones Evaluation System: What is expected and how are plastic surgery residency programs preparing? *Plast Reconstr Sug* 2015;136:181.

Crunching Milestones Data for your CCC

Elizabeth H. Ellinas, M.D.

November 6, 2015
8:40AM - 9:05AM

CRUNCHING MILESTONES FOR YOUR CCC

SAAA/AASPD

NOVEMBER 2015

LIBBY ELLINAS, MD

Program Director OB Anesthesiology
Chief: Obstetric Anesthesiology

Assistant Dean Faculty Affairs
Medical College of Wisconsin

DISCLOSURES: I have no financial disclosures.

OBJECTIVES:

1. Explore the interaction between milestones and evaluations.
2. Discuss the ways in which core programs have prepared the milestones for their CCCs and suggest how those methods might be adapted to fellowships.
3. Describe the ways in which the fellowship milestones differ from the core program milestones.
4. Formulate ways in which fellowships might adapt the milestones for use as formative, summative, and self- evaluations.

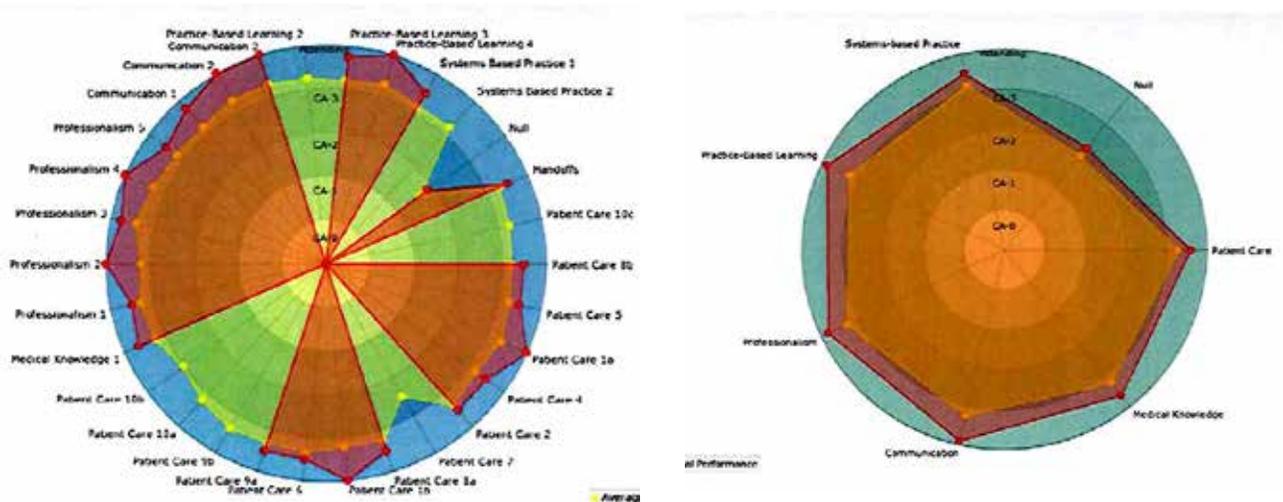
My Experience as chair of the Core CCC for Medical College of Wisconsin

Evaluation of the Core Program Milestones was clearly going to be a large task:

1. 1848 data points for CCC members to evaluate per required 6-mo evaluation period.
2. Too much for the CCC to handle without computer assistance or a lot of program-coordinator time to compile folders, and faculty non-clinical time to look at each folder.
3. Partnered with UW Whitewater students looking for a senior computer project. They created, and continue to work on, a specialized program for us which directly connected/linked our evaluations to the appropriate milestones.

Computer Program Output:

1. Summary View: The Core CCC receives a summary view of the results for each resident that provides the average summary score for each milestone and for each competency.
2. Spider graphs: For each resident, a spider graph is generated that shows his/her evals for that quarter relative to classmates.
3. Example: Here's an example for a very strong CA3:
Red is the resident. Yellow is the class average.



Milestones for the Fellowships

LEllinas p.2 SAAA

Each Fellowship created its own Milestones, completed in approximately Sept-Oct 2015.

1. First report: Due Jan 2016 (which is the report for July-Dec 2015).

2. Levels: Still 5 levels – level 4 is grad “target” not “requirement”

- a. From the Milestones documents description of Levels:
- b. Level 4: The fellow has advanced so that he or she now substantially demonstrates the milestones targeted for fellowship. This level is designed as the graduation target.

3. Why do fellowships need milestones?

Answers to Frequently Asked Questions about the Milestones are available on the Milestones web page: <http://www.acgme.org/acgmeweb/Portals/0/MilestonesFAQ.pdf>.

The Milestones are designed to help fellowships produce highly competent physicians to meet the 21st century health and health care needs of the public.

For fellowship programs the Milestones will:

- Provide a rich descriptive, developmental framework for CCCs.
- Guide curriculum development of the residency or fellowship
- Support better assessment practices
- Enhance opportunities for early identification of struggling residents/fellows

For residents/fellows, the Milestones will:

- Provide more explicit and transparent expectations for performance
- Support better self-directed assessment and learning
- Facilitate better feedback for professional development

4. Can Fellowships have only Milestones, or, Can Milestones be Metrics?

Quotes from ACGME:

- a. “Milestones do not represent the totality of any discipline, but rather form a robust foundational core.”
- b. “Milestones *should not* be used as the sole criteria for these important decisions.”
- c. “The assessment program will need to include multiple forms of assessment and utilize multiple assessors. No single assessment method or tool is sufficient to judge something as varied and complex as clinical competence.”
- d. That said, can align evals with Milestones, and/or create evals that map to Milestones

5. What the Milestones Can Do for your Program: Clarify requirements

- a. Program requirements for OB Anesthesia require both QI and research projects: What are the requirements in a practical sense?
- b. OB Milestone for QI (SBP2)
 - i. Level 4: Substantially participates and utilizes data
 - ii. Level 5: Leads a pt safety initiative and ensures implementation
- c. OB Milestone for Research (PBLI1)
 - i. Level 4: Designs and Implements a clinical research study
 - ii. Level 5: Presents an abstract at a meeting or submits a manuscript
- d. Pain Milestone QI (PBLI2)
 - i. Level 4: Demonstrates the ability to apply principles of QI to improve care
 - ii. Level 5: Able to lead projects [that] utilize common principles and techniques of quality improvement to continuously improve pain care for a panel of patients
- e. Pain Milestone for Research (MK3)

- i. Level 4: Presents scholarly activity at local or regional meetings, and/or submits an abstract summarizing scholarly work to regional/state/ national meetings, and/or publishes non-peer- reviewed manuscript(s) (reviews, book chapters)
- ii. Level 5: Presents at a national meeting or publishes a peer-reviewed manuscript

6. What the Milestones Can Do for your Program: Clarify requirements for Milestones not present in core

- a. Cost Awareness: Peds Anesthesia
 - i. Level 4: Consistently incorporates cost awareness and cost-benefit analysis into clinical practice. Initiates programs to reduce costs and improve efficiency of clinical care.
 - ii. Level 5: Leads a team or teams to determine the most cost-effective strategies for all aspects of a procedure. Participates in LEAN and other reengineering projects to improve clinical care and reduce costs.

7. What the Milestones Can Do for your Program: Clarify graduation requirements

- a. Can a fellow graduate if they have not met every milestone at the required level?
- b. Level 4 is a target and not a requirement.
- c. “Making decisions about readiness for graduation is the purview of the fellowship program director.”

8. What the Milestones Can Do for your Program: Identify fellows in need of early help.

- a. “Milestones are intended to be used as a *formative* framework to guide curricula, assessment, and CCC deliberations in programs.”
- b. While the requirement is to evaluate fellow Milestones every 6 mos, we have both fellow and faculty complete a milestone evaluation 2 months into the fellow’s year.
- c. This gives a good idea of where the fellow is starting, and whether there are disconnects between what the fellow v. the faculty think regarding fellow performance.

9. Preparing for Milestone Evaluations

- a. New Math:
 - OB: 4 PC, 2 MK, 3 SBP, 2 PBLI, 3 Prof, 1 ICS = 15 total
 - Peds: 3 PC, 2 MK, 3 SBP, 2 PBLI, 3 Prof, 1 ICS = 14 total
 - Pain: 6 PC, 3 MK, 4 SBP, 4 PBLI, 4 Prof, 3 ICS = 24 total
 - Cardiac: 2 PC, 4 MK, 3 SBP, 2 PBLI, 3 Prof, 1 ICS = 15 total
 - CCM: 5 PC, 2 MK, 3 SBP, 2 PBLI, 3 Prof, 1 ICS = 15 total
- b. For me: One fellow x 15 milestones = 15 (not 1800)
- c. Fifteen doesn’t seem too many Milestones for one evaluation?
- d. We kept all of our previous evaluations
- e. We use our core-program electronic system with the OB milestones exactly as written.
- f. Faculty then access the Milestones at 2, 6 and 12 mos to evaluate each resident.

Common Milestones for All the Subspecialties

Mark Stafford-Smith, M.D., CM,
CRCP(C), FASE

November 6, 2015
9:05AM - 9:30AM

COMMON MILESTONES FOR THE SUBSPECIALTIES

Mark Stafford-Smith, MD, CM, FRCPC

Disclosures: None pertinent to the presentation topic.

Objectives:

1. Upon completion of this learning activity, participants should be able to distinguish fellow educational goals that are common among fellowships
2. Upon completion of this learning activity, participants should be able to identify fellow educational goals that are better served by education activities with collected groups of fellows from several programs rather than the smaller groups possible with individual fellowships
3. Upon completion of this learning activity, participants should be able to describe the one institution's experience with combining fellowships for learning of some fellowship education topics.

Developing education activities for small fellowships - The problem:

A vast majority of AASPD one-year subspecialty programs are small. For example, 43 of 57 ACTA fellowships participating in the 2015 SF Match enroll 3 or fewer trainees annually. The strengths of small programs are well recognized, including enhanced opportunities for faculty interaction, mentorship, and clinical oversight. However, in comparison to typically large anesthesia residency programs, smaller fellowship programs pose challenges and require different solutions to effectively deliver some education topics and achieve milestone goals.

This discussion outlines several creative strategies that involve combining fellowships to increase participant numbers. Suitable topics and issues are typically those that require similar or identical coverage among fellowships and those that involve group work, particularly where larger numbers of trainees can justify the invitation and involvement of subject experts. Various strategies are outlined below, including an approach at one department where the collective efforts and combining of resources among several fellowships has met with success.

Multi-Site Solutions:

Travelling to a central location to generate larger groups of anesthesia trainees, and even faculty, from the same subspecialty has been used successfully for some topics. For example, the “Boot Camp” offered by the Children’s Hospital of Philadelphia (CHOP) attracted 29 pediatric fellows and 20 fellowship directors in its August 1, 2015 (4th) iteration. This one-day/\$150 event reviews simulation scenarios for the new pediatric anesthesia fellow including PALS algorithms and crisis resource management. Skill stations also provide hands-on introductions to complicated airway tools and algorithms as well as to ultrasound and vascular access techniques.

Online strategies are useful to communicate some topics, particularly those involving lectures by experts. The Society of Cardiovascular Anesthesiologists’ Fellowship Lecture Series is an example (<https://www.scahq.org/FellowshipCareerOpportunities/AdultCardiothoracicAnesthesiologyFellowships/FellowshipLectureSeries.aspx>). This series has been available since 2011 and currently includes 15

presentations that receive steady use. Sampled data indicate approximately 1300 views per year for the past several years, including participants from across the Americas, Europe, Asia, and Oceania.

Single-Site Solutions:

Institutional GME office activities are commonly used by institutions to facilitate onboarding activities and achieve administrative efficiencies. GME offices often also provide hospital-wide education initiatives that are useful.

Single department activities that formally combine the forces of multiple anesthesia fellowships are relatively novel. Nonetheless, this presenter is aware of at least two that have existed for at least a decade (Duke University, University of Toronto) including an established “Office of Fellowship Education” and “Director of Fellowship Education.” At both institutions, such structures have endured and been perceived as very constructive, by the fellowships involved, their Residency Office, and Department Chair. Examples of the types of activities among fellowships facilitated by such structures are outlined below.

Anesthesiology Department Office of Fellowship Education:

Since this presenter has participated in the Office of Fellowship Education at Duke University Department of Anesthesiology, activities at this institution will be used as an example of the potential gains from such a structure. The Office of Fellowship Education was proposed in early 2006 following a period of informal sharing of resources among programs to solve fellow issues. Currently, under the collaborative leadership of the Director of Fellowship Education, Program Directors and Coordinators, this group gathers to meet formally twice annually: broadly, the Fall meeting is to obtain feedback on current initiatives, the Spring to develop new initiatives. In 2006, the Department roster included 17 fellows among 6 fellowships, but this has since grown to 33 fellows among 8 fellowships (4 fellowships enroll 3 or fewer fellows).

Onboarding and other administrative responsibilities were initially managed separately by each fellowship but have steadily become more centralized to enhance efficiency, supported by Department and University investment in a Coordinator of Fellowship Education. This individual assists local program coordinators with added expertise in education (e.g., ACGME regulations, MedHub programming, ICGME Report Requirements, etc.). The Coordinator of Fellowship Education has been supported to attend educational offerings (e.g., annual ACGME meeting, visa management).

Efficiencies achieved through inviting experts have made it possible to streamline onboarding events and required activities for all fellowships to a single session (e.g., greeting from the Chair, pharmacy policies, infusion pump management) with the perception that *fellows are reliably available to participate in clinical activities much sooner* than prior to this structure. The event is attended by Program Directors who subsequently use the gathering to review program goals and objectives for the year with fellows.

A social event is scheduled early in the academic year for all Department Fellows and their families at a weekend lunch-time forum at the home of the Director of Fellowship Education. While there are obvious merits to such an occasion, *particular value in terms of social support is noted for fellows and their families arriving from other locations entering smaller fellowships*. Initiating social relationships for this group often results in long lasting friendships.

Department policies have been aligned for all fellowships through collaborative discussion. During early discussions, wide variation in policy by fellowships was exposed (e.g., interviewing budgets/meals, fellow academic funds, expenditure policies, phone policies). In general, unwitting outliers among the fellowships have gladly aligned, and the Department has overall seen a considerable cost saving.

A weekly late afternoon seminar series has contributed in many ways to facilitating fellowship Milestone goals. Notably, although the primary goal of this session is to address educational topics common to all fellowships, the social aspect for fellows (particularly those from small programs) of having a larger peer-group has been a positive aspect of this activity. Various topics that are common educational goals among fellowships are listed below:

Residency Oral Board Exam Preparation - (topic expert participants – 4 national examiners) early - strategic, later – practice orals.

Research Methodology and Participation – Research mentor assignment, EndNote use, statistics, abstract writing, interim findings presented to faculty, manuscript writing, Department Academic Evening presentation.

The Fellow as an Educator – Flipping the classroom, education styles (Kolb), making good slides.

Leadership – (topic expert participant – professional coach) personality profiles evaluated (PeopleMap), conflict management, transactional analysis, mindfulness.

Ethics - (topic expert participant – hospital ethicist) – case discussion.

Quality Assurance – (topic expert participant – QI faculty) classroom overview, run chart usage, group project (5-6/group), interim findings presented to faculty, Academic Evening presentation.

Clinical Operations/Business Management - (topic expert participant – VC of Clinical operations, Department Business Manager) care redesign and the perioperative surgical home, drug shortages, building and opening a new hospital, introducing an EMR.

Career Decisions and Development - (topic expert participant – senior academic faculty member, state representative for ASA – private practitioner) – career progression, academics vs. private practice.

Women in Medicine – Invited junior and senior women faculty discuss.

Global Health - (topic expert participants – faculty) Ghana nurse practitioner school, Guatemala.

Jurisprudence - (topic expert participant – lawyer)

Clinical Topics – Management of the VAD patient, new anticoagulants, the adult congenital heart patient, pain management, integrating new science into your practice.

Finally, *a separate fellowship graduation* has replaced the activity that was previously an appendage to the resident graduation event. Since fellow graduates (and future alumni) considerably outnumber resident graduates each year, this has also been seen as a worthwhile investment by the Department Chair.

The Military and the Match

Darian C. Rice, M.D., Ph.D.

November 6, 2015
1:30PM - 1:50PM

Military and the Match

SAAA 2015 Annual Meeting

Darian Rice, MD, PhD
CDR MC USN
Naval Medical Center Portsmouth

Disclaimer

- The views expressed in this presentation are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, or the United States Government.

Objectives

- Describe the timeline for graduate medical education in the military system.
- Compare and contrast the current military and civilian graduate medical education application and selection processes.
- Understand the impact of current practices in the military on civilian GME selection.

GME in the Military

- Internship/PGY-1 application follows a similar timeline as the civilian Match, although results are known in December.
 - ERAS/NRMP vs. MODS
- However, in the military, 4th year medical students apply for *internship only*.
 - Most will complete internship at a military hospital.
 - A select few will be allowed to request a civilian deferment for internship +/- residency.
 - May apply to ERAS and military match without conflict.

Post-internship in the Military

- During internship, they apply for follow-on residency training and/or operational assignment as a General Medical Officer (GMO).
 - Most will complete an operational tour as a GMO, flight surgeon or diving medical officer.
 - Usually 2-4 years
 - A select few will be permitted to go straight through in residency training, depending on specialty and needs of the military.

Operational Medicine



Residency Training in the Military

- Application for residency follows a similar timeline as the civilian match, although results are known in December.
- Apply during last year of GMO tour.
 - Most will apply for military residency.
 - Some may be approved for deferment to civilian training, depending on the needs of the military.
 - May apply to ERAS and military match without conflict.

Fellowship Training in the Military

- Current military system and the (new) Fellowship Match system are out of sync.
- Fellowships have moved towards the Match which involves a year and a half process, starting with application in January.
- Military GME selection remains ~ 6 month process (July – Dec), and is too late to apply through the fellowship Match.

Fellowship Training in the Military

- The only current option is selection outside the Match, after the results of the Military GME selection board are released in December.
 - Benefit to civilian programs is that the position is fully funded by the military.

Fellowship Training in the Military

- The military is now moving towards a “Pre-Select” option for fellowship.
 - Will occur 2 years in advance and will allow timely participation in the fellowship Match.
 - Likely won't be in effect until 2018

Questions?



Contact Info

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Residency Program Director
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Naval Medical Center Portsmouth, VA
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NRMP Match Experience & Tips, Concerns and Data from Pediatrics

Susan R. Staudt, M.D., M.S.Ed.

November 6, 2015
1:50PM - 2:10PM

THE PEDIATRIC ANESTHESIOLOGY NRMP MATCH EXPERIENCE 2011-2016

SUSAN STAUDT, MD, MED
PRESIDENT ELECT PAPDA
FALL 2015
SAAA MEETING, BALTIMORE

HISTORICAL PRE MATCH ISSUES

APPLICANTS:

- Offer time pressures-
- Insufficient interview time-
- Gaming by some programs to curtail interviewing
- Nontransparent / variable rules
- Early filling precludes some CA-2's from the specialty before they rotate on peds



2010 - ASA resident section requests Match

HISTORICAL Pre Match Issues

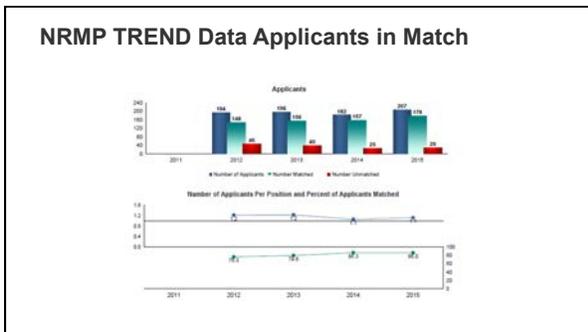
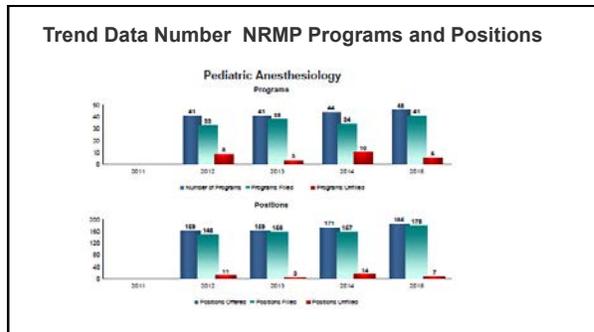
PROGRAMS/PD's

- Interview season creep/length
- Withdrawals
- Multiple specialty interviewers
- Poaching/gamesmanship
- Loss of /unpredictable A time



PAPDA

- Unhappy residency PD's
- "Policing" members



2015-16 Academic Year ACGME and NRMP DATA

Number of Programs: ACGME 51 NRMP 48 (94%)

Positions: ACGME: 228* NRMP: 186 (81.6%)

Number of Filled Positions (ACGME): 228 Match Filled positions (NRMP): 178 (78%)

3.9 US Grad rankings/ position
NRMP all specialties ave (US grads)= 4.3 (pain=4.7 peds surg= 25)

"out of Match" filled positions: 50 (22%)

ACGME approved / program unfilled positions: 10 (4.2%)

2015 Peds Anes Match Survey - 4th Match

208 Match participants
 179 matched (87%)
 121 responded to survey (68%)

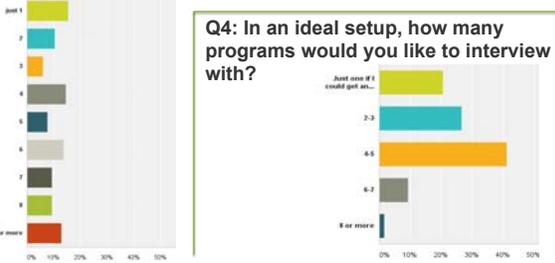
52 Programs in Match
 46 Programs filled (85%)
 179/190 match positions filled (94%)
 37 PD's responded to Match Survey (71%)



Applicant: How did you fare in the 2015 Match?



How many programs did you interview with?



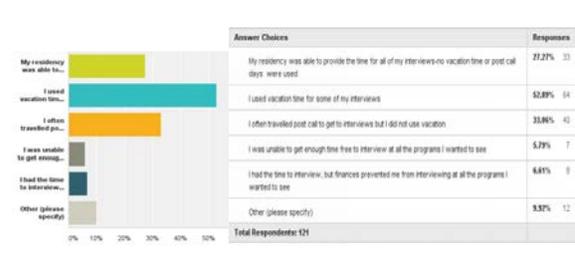
How did your number of interviews compare with your preference?

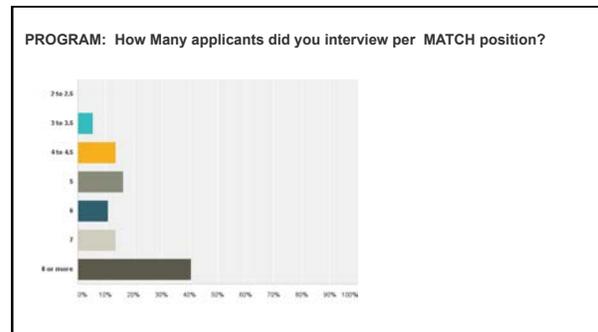
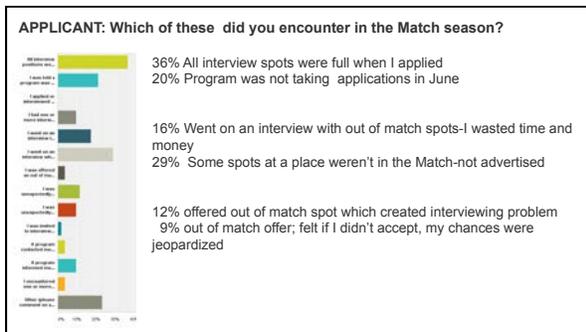
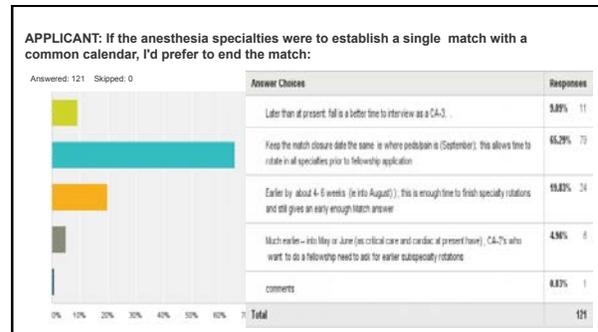
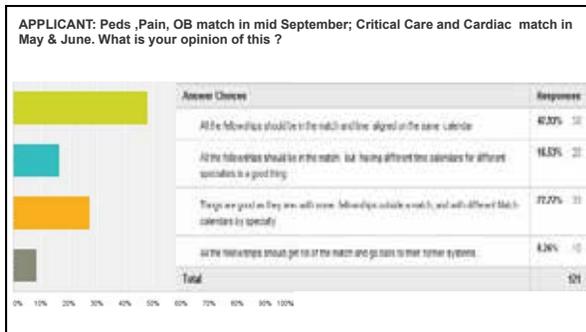
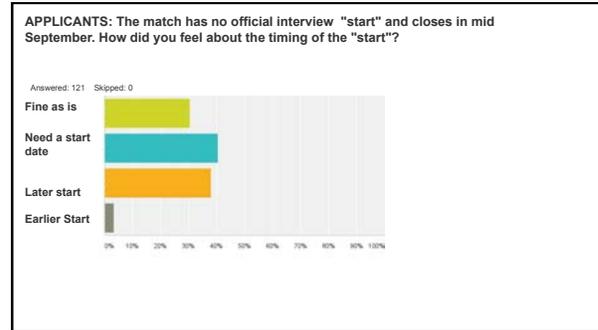
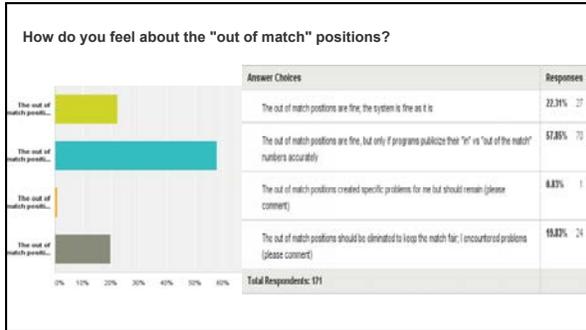


How many "in the match" fellowship slots were there in your interview schedule?

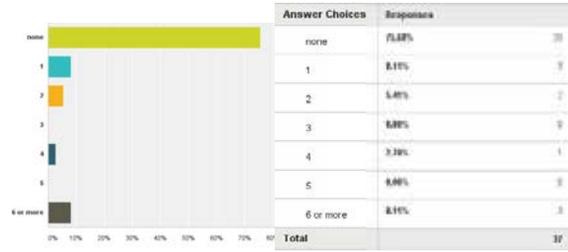


How did you obtain the time to interview at different programs?

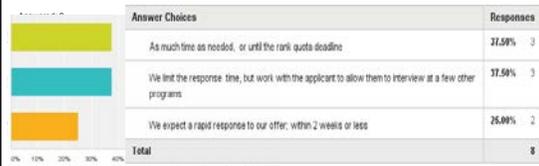




PROGRAM: How many positions did you have outside the 2015 Match?



PROGRAM: How much time do you give applicants to consider an out of match offer?



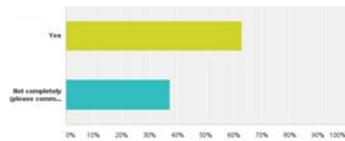
PROGRAM: How are applicants who decline your out of match offer ranked?



PROGRAM: Which of the following would your center be willing to follow regarding out of match positions?



PROGRAM: Are you satisfied with the Match process? (13 PD comments)



Match doesn't work on our small scale-we should abandon it (1)
 Out of Match positions create gamesmanship and need to be eliminated (6)
 Out of Match positions negatively impacts me/my program recruitment (6)

SUMMARY THOUGHTS...

- Time for a unified subspecialties match calendar (?)
- Trainees want a common application service (ERAS?)
- PEDS needs to find a way to be "all in" the match
- Exposure has improved for the "average" fellowship
- Lengthy Interview Season remains an issue
- Despite trainee time and financial costs...
- The MATCH is here to stay....



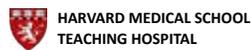
San Francisco Match Experience & Tips

Douglas C. Shook, M.D., FASE

November 6, 2015
2:10PM - 2:30PM

The SF Match Experience

Douglas C. Shook, MD, FASE
Director, Cardiothoracic Anesthesia Fellowship
Director, Cardiac Interventional Anesthesia
Department of Anesthesiology



Disclosures

Edwards Lifesciences - Speaker
St Jude Medical - Speaker

Prior to the ACGME (Before 2007)

- Each program had their own deadlines
- Applicants and program were pitted against each other
- Most programs accepted primarily internal candidates

ACGME Accreditation - 2007 (Significant Change Occurred)

- Program Directors Committee in the SCA
- Communication and collaboration
- Application process more organized

Initial Attempt at Improvement (Application Process)

- Set a decision date for applicants
- Prior to the date an applicant could not be forced to accept an offer from a program
- Empowered the resident applicants

Made Continued Modifications (Close to a Match)

- Set a date when applicants would be informed of program offers
- Applicants had to accept one of the offers within 7 days
- Subsequent scramble

Exceptions (Critical to the Process)

- Internal candidates
- Two-year fellowships
- Couples applicants
- Military applicants
- International applicants

Despite All Of Our Hard Work Problems Still Occurred

Actual Email

I have had three internal residents and three external applicants contact me in the past two days regarding fellowship offers that have a deadline of next week if they want to keep the position. I know in the past this can be both programs making offers that expire and also residents trying to force programs to make decisions early. I feel that the problem this year is much worse than in past years. I know there isn't much we can do about this but it only reinforces the need for a match. I don't like discussing with residents why this is happening despite the statement on the SCA website.

Obstacles to the Match

- Which company?
- Buy-in from the majority of the programs
- Who will financially back the process
- Checks and balances to assure accuracy

Which Company?

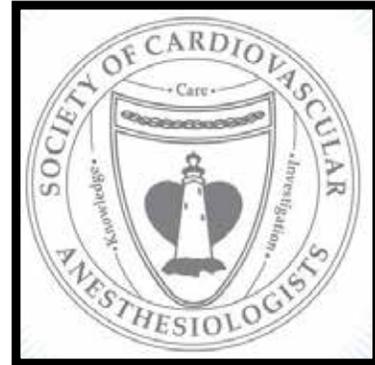
Which Company?

Program Buy-In (2012)

- **54/58 (93%) programs**
- **165/176 (94%) positions**

Key: Maintaining the Exceptions

Financial Backing



Accuracy

- **SF Match - rigorous and legitimate process**
- **Exceptions occur outside SF match**
- **Match results reviewed by the Executive Board of the Program Directors Committee prior to dissemination to the applicants and programs**

Timeline

- **November - Applications available**
- **Jan to May - Interviews**
- **Early June - Rank lists due**
- **Mid June - Match results sent out**

Three Years of Success

	2013	2014	2015
Programs	54	55	57
Positions Offered	168	174	183
Positions Filled	166	172	182
Positions Remaining	2	2	1

Three Years of Success

	2013	2014	2015
Applicants	230	213	211
Matched	166	172	182
Remaining	64	41	29
Exceptions	44	54	32

Program Buy-In Today (2015)

- **57/58 (98%) programs**
- **183/184 (99.5%) positions**

Strength of the Match Process

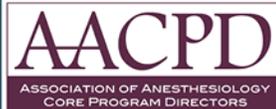
- **Acceptance - both programs and applicants**
- **Only 1 program not participating**
- **Exceptions are critical to success**
- **Fixed the program/applicant politics**
- **Easy to manage and reliable**
- **Data to track applicants and programs**
- **Available positions quickly filled**
- **Common application since 2015**

Areas for Improvement

- **Managing the exceptions**
- **Two-year combined applicants**
- **Date of the match in early June**
- **Programs interview more applicants**
- **Applicants apply to more programs**

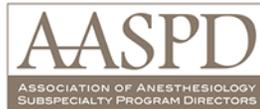
HANDOUT

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HANDOUT

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Interviewing Tips

Mary Somers, MS, NCC, BCC

November 6, 2015
10:30AM - 11:00AM

Choosing the Right Resident: Tips from the Business World

Mary Somers, MS, NCC, BCC
Associate Director of Admissions
Johns Hopkins University
Carey Business School
Baltimore, MD



Agenda

- Introduction
- What does the Prospective Resident Want?
- Defining the “Best-fit” Candidate (BFC)
- Strategies for Identifying your BFC’s
- Exploring for Potential
- Exercise
- Seven-Steps for Successful Recruiting



Challenges of Medical School Students in Residency Selection

- High likelihood of excessive education debt
- Time and cost of residency interview process
- Uncertainty about residency program fit, including selection of specialty (a major career decision)
- Fit may be supplanted by urgency of being awarded a residency at all
- Intense competition—not everyone is first in their class
- May be deciding with a trailing partner or spouse – another medical school graduate seeking a residency?

Challenges of Program Directors

- Enormous primary responsibilities in patient care, teaching, research
- Far too many candidates for limited positions
- Difficult to differentiate between candidates
- Inconsistent interviewing process
- Accuracy of residency program description
- Not thoroughly evaluating residency selection experience in order to improve future selections
- Others?



Psychometric testing in resident selection in Anesthesiology programs (2009)

- High-competency and low-competency residents were evaluated on measures of:
 - Fine-motor dexterity
 - Executive functioning
 - Processing speed
 - Attention
 - Personality



Psychometric testing in resident selection in Anesthesiology programs (2009)

No significant differences on **fine-motor dexterity, executive functioning, processing speed, or attention.**

However, high-competency residents scored significantly higher on measures of **cooperation, self-efficacy, and adventurousness and lower on neuroticism, anxiety, anger and vulnerability.**

Beyond Competencies—Evaluating Potential (2009)

Four Eras of Talent-Spotting

1. Physical attributes (size, health, strength)
2. Intelligence, experience and past performance
3. Competency movement (still prevalent)
 - Evaluate of specific characteristics and skills that helped predict outstanding performance

Beyond Competencies—Evaluating Potential (2009)

Four Eras of Talent-Spotting (cont)

4. Potential—due to volatile, uncertain, complex and ambiguous environments
 - Beyond having the right skills, but also the potential to learn new ones



Beyond Competencies—Evaluating Potential (2009)

Potential can be measured with 85% accuracy.



Beyond Competencies—Evaluating Potential (2009)

Five Indicators

- Motivation
- Curiosity
- Insight
- Engagement
- Determination



Strategies for Improving Interviews

What are some strategies that can help you strengthen the current application process?

- Mine an applicant’s personal and professional history.
- Conduct in-depth interviews including career discussions.



Strategies for Improving Interviews – Formulating Questions

- Ask for concrete examples.
- Go deep when you explore:
 - Motivation
 - Curiosity
 - Insight
 - Engagement
 - Determination



Sample Questions to explore level of curiosity

- What do you do to broaden your thinking, experience or personal development?
- What steps do you take to seek out the unknown?
- Can you tell me about a time you learned something beyond the requirements of your studies?



Exercise

Think about your top residents—who excelled and thrived in the program? What do you remember most? Specific examples? Describe them under the indicators of POTENTIAL.

- **Curiosity**
- **Motivation**
- **Interests**
- **Engagement**
- **Determination**
- **Intelligence**
- **Values**
- **Leadership Abilities**
- **Others?**



Exercise (cont)

Describe those residents—in as great detail that our limited time will allow.

- Why were they so successful?
- What are some examples that demonstrate what made them unique and memorable while in your program?
- Do you know what they are doing now?

Seven-Step Process for Successful Selection of Residents (2009)

- **Anticipate the Need**
 - Residency selection should be a year-round process (preparation, evaluating program, checking on current residents)
 - How many residents slots are available?
 - Ask what can we do to strengthen applicant interest in our program?
- **Specify the Residency Position**
 - Be as clear as possible re the description program and organization.
 - Ensure that all materials (esp. website) convey this information.

Seven-Step Process for Successful Selection of Residents (2009)

Develop the Pool

- What can you do so you aren't limited only by those who apply?
- Where are the strongest candidates?

Assess the Candidates

- Use a small number of high-caliber, well-trained, properly motivated interviewers.
- Employing rigorous behavioral event interviews (look for potential).



Seven-Step Process for Successful Selection of Residents (2009)

Assess the Candidates (cont)

- Conduct detailed reference checks.
- Include top stakeholders in candidate assessment.

Close the Deal

- Demonstrate active support for candidate's interests and career goals.
- Describe the residency realistically.

Seven-Step Process for Successful Selection of Residents (2009)

Integrate the Resident

- Use veteran top performers as mentors.
- Make sure resident is continually checking in (beyond clinical training) even when there are no problems.



Seven-Step Process for Successful Selection of Residents (2009)

Audit and Review

- Look for problems immediately as well as successes in resident's performance.
- Review recruiting practices – what worked, what didn't? What can be improved for next year?
- Identify and reward those who interviewed exceptionally well.
- Hold assessors accountable for quality of evaluations.

Closing

Goal was to provide a business perspective on identifying, selecting, onboarding the best residents

- Evaluating Potential
- Seven-Step Process



Further Discussion

How can you help the new resident succeed from match to arrival (housing, etc) and beyond?

- Orientation/Onboarding
- Unique skills of resident, how do they fit in?
- Continuous support throughout residency (beyond clinical training)
- Regular check-ins
- Others?

Thank You!

Mary Somers, MS, NCC, BCC

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Special Thanks to:

Heather Tapager, JHU Business Librarian
Joanne Shay, MD, MBA, Assistant Professor, JHU School of Medicine
Department of Pediatric Anesthesiology

References

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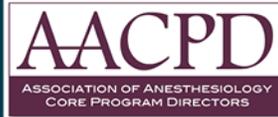
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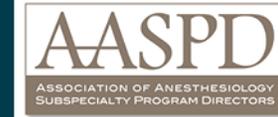
HANDOUT

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Recruiting the Successful Resident: Examining Barriers, Pitfalls, Tips, and Trends Noted in the Literature

Russell K. McAllister, M.D.

November 6, 2015
11:00AM - 11:20AM



Objectives

- Discuss the literature related to choosing successful residents
- Discuss the role of the MSPE in identifying the ideal resident
- Discuss pitfalls in the selection process
- Discuss ways to identify the unprofessional candidates
- Discuss tips for improving the quality of the candidates that you interview

Do our interview scores predict success in residency

- Selection Committee scores were evaluated to see if they correlated with subsequent resident success
- They concluded that their residency selection process scores did not accurately predict which applicants would subsequently excel in their program

Metro DG et. al. *Anesth Analg* 2005; 100:502-5

What parts of the MSPE are important to us?

- A survey of Anesthesiology PD's found that they viewed the following as useful for predicting successful residents:
 - Academic progress
 - Academic history summary
 - Comparative clinical performance to classmates
 - Overall academic ranking
- They found the following as less predictive of success:
 - Unique characteristics
 - Appendix E (school demographics)
 - Pre-clinical comparative performance to classmates
 - Summary statement
 - Professional behaviors/attitudes

** Swide C, et. al. *J Clin Anesth* 2009;21:38-43.

Unprofessional behavior in medical school-What does it mean?

- Unprofessional behavior in medical school has been tied to subsequent disciplinary actions by the state medical boards*
- Another study revealed that 15/71 anesthesiology residents were noted to have unprofessional behavior that also translated into significant problems in other areas of their training**
- 21/71 of the residents were rated as excellent overall, and none of them had any comments describing unprofessional behavior**
- The conclusion was that clinical excellence and unprofessional behavior rarely coexist**

*Papadakis MA et. al. *Acad Med* 2004;79:244-9.

**Rhoton MF. *Acad Med* 1994;69:313-5.

Are the MSPE's honest?

- Evaluation of Dean's Letters from 532 students from 99 US Medical Schools applying to Internal Medicine residency programs
- The presence of six variables were examined:
 - Failing grade (preclinical)
 - Marginal grade (preclinical)
 - Failing Grade (clinical)
 - Marginal grade (clinical)
 - Leave of absence
 - Requirement to repeat an entire year of med school
- 77% of students had at least one of the six variables

Edmond M et. al. *Acad Med* 1999;74 (9) 1033-35.

Are the MSPE's honest?

- Of those 77 students, the Dean's Letter often failed to mention the variable
 - Failing grade (preclinical)-**27% (8/30) failed to mention**
 - Marginal grade (preclinical)-**41% (9/22) failed to mention**
 - Failing Grade (clinical)-**33% (3/9) failed to mention**
 - Marginal grade (clinical)-**26% (5/19) failed to mention**
 - Leave of absence- **40% (8/20) failed to mention**
 - Requirement to repeat an entire year of med school-**50% (2/4) failed to mention**
- Conclusion: Some Deans suppress negative information and potentially obfuscate the residency selection process

Edmond M et. al. *Acad Med* 1999;74 (9) 1033-35.

Plagiarized personal statements??

- New study-13.6% of IMG applications and 4% of US grad applications were judged to contain plagiarized content using screening software and careful review
- Likely underestimated due to techniques to thwart the detection software
- Most common source of plagiarized content?: www.medfools.com/personalstatements

Parks LJ et. al. *A A Case Rep.* 2015 Oct 8

Proliferation of medical schools in the U.S.

- Leads to increasing numbers of unmatched students
- Increasing pressure on the Deans to get their students successfully matched
- Students who don't match are left with a large amount of debt and no way to pay it back because they cannot get post graduate training

Unprofessional behavior in medical school-How do we measure it?

- Program directors in anesthesiology have demonstrated a lack of confidence in the MSPE assessment of professional behaviors*
- Medical school Deans seem very reluctant to include negative comments on the MSPE because they know that this will likely mean extreme difficulty for that student to match into a residency program
- Medical students are also very savvy at contesting these negative remarks and having them stricken from the MSPE

*Swide C, et. al. *J Clin Anesth* 2009;21:38-43

Identifying the disruptive or unprofessional candidates

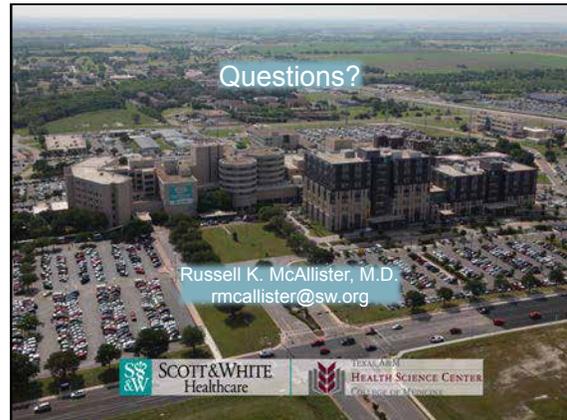
- Notice what they do when they think no one is watching (not foolproof)
 - Disruptive hotel staff interactions
 - Program administrator input
 - Resident input from tour/ride to dinner
- Utilize the residents as a resource
 - Interactions at dinner
 - Phone follow ups
- Closely look at the ERAS "Limiting Factor" section
 - Arrests/Convictions
- Google searches can sometimes turn up interesting information (blogs etc)

Anesthesiology Program Directors have less information with which to base selection decisions

- Class rank is being abandoned by many schools in favor of pass/fail designations
- Misleading MSPE summary "code words" that mean different things at each school
- Difficult to interpret grading systems that use non-standard wording for grade assignments
- Letters of Recommendation rarely distinguish the top students from the bottom students
- Everyone gets an "A" in anesthesiology
- Lack of an "Anesthesiology Shelf Exam"

Tips I have learned from 16 years of recruiting

- Focus on schools you have successfully recruited from in the past (geographic footprint) for the majority of your invites
- Be honest about the strengths and weaknesses of your program
- Invite and interview early (they run out of money and cancel later in the season)
- Make sure the residents are involved
- Consider having resident ambassadors with full voting privileges on the selection committee
- Ditch the restaurant- hold the event at a faculty home with catered food
- Interviewees that you don't match with will often generate good applicants in future years



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Cognitive Simulation Training Use During Resident Applicant Interviews: Exploring A New Frontier Into Higher Order Thinking

Alan William Kulig, M.D.

November 6, 2015
11:20AM - 11:40AM

**SAAA Best Practice:
Choosing The “Right”
Resident**

Alan Kulig, M.D.
Baystate Medical Center
Tuft University School of Medicine
Springfield, MA

**Cognitive Simulation Training
Use During Resident Applicant
Interviews:
Exploring A New Frontier Into
Higher Order Thinking**

Alan Kulig, M.D.
Baystate Medical Center
Tuft University School of Medicine
Springfield, MA

Disclosures

- No financial disclosures

The Problem



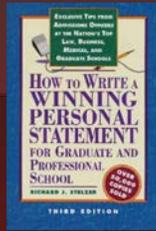
**Standard Application
Metrics**



**Measuring Success
Is Not Always Linear**



Personal Statements Letters of Recommendation



Dean's Letter



National Board Scores



Program Fit



Cognitive, Behavioral and Emotional Intelligence



Higher Order Cognitive Skills

- Sound Knowledge Base Application
- Good Judgment
- Situational Awareness
- Team Leadership / Triage
- Critical Thinking
- Analytical Decision Making
- Diplomacy / Advocacy
- Psychological Resilience



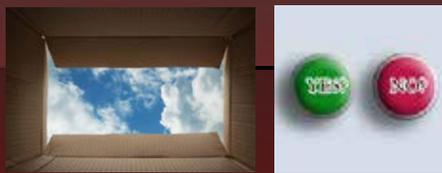
Standard Application Metrics



The Formal Interview



Traditional Interview



Other Interview Strategies

Multiple Mini-Interview Behavioral Interview



Multiple Mini-Interview



Behavioral Interview



Medical Students Are Doing Their Homework



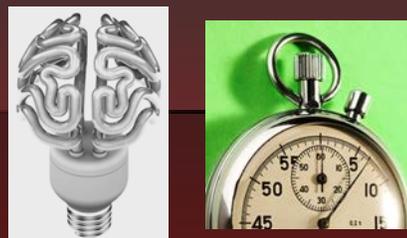
Blink and Gut Response



Bias and Inaccurate



Our Objective



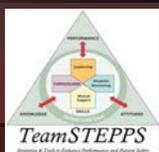
Necessity Is The Mother Of Invention - Plato



Best Practice Simulation Training



Team STEPPS 2-Challenge Rule



The 2-Challenge Rule

- Definition: All health care providers are obligated to question medical decision making repeatedly when they witness a potential patient safety breach, using advocacy and inquiry



Setting The Stage



Simulation Scenario

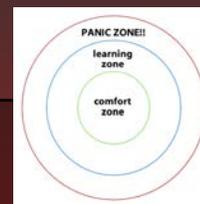
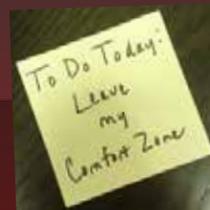
- 58 year old man for an elective inguinal hernia repair under GA

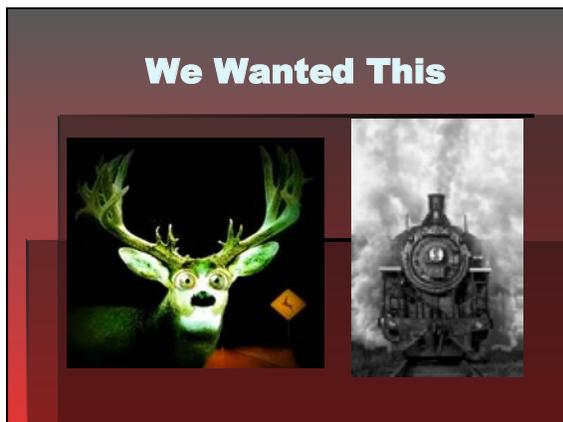


Advocate “CAN CUSSS”

- Advocacy / Inquiry
- Consensus Build
- Alternatives
- Normalize
- Concerned
- Uncomfortable
- Safety
- Second Opinion
- Stop

Our Primary Objective





<u>HIGHLY DESIRABLE</u>	<u>DESIRABLE</u>
85% of > National Boards Top Quartile Dean's Ranking Excellent Letters / Statements Excellent Interview	70-84% National Boards 2 nd Quartile Dean's Ranking Very Good Letters / Statements Very Good Interview
<u>PROBABLY UNDESIRABLE</u>	<u>UNDESIRABLE</u>
60-69% National Boards 3 rd Quartile Dean's Ranking Mediocre Letters / Statements Mediocre Interview	59% or < National Boards 4 th Quartile Dean's Ranking Poor Letters / Statements Poor Interview

<u>HIGHLY DESIRABLE</u>	<u>DESIRABLE</u>
Excellent credentials Excellent simulation	Excellent credentials Satisfactory or poor simulation or Mediocre credentials Excellent or satisfactory simulation or Poor credentials Excellent simulation
<u>PROBABLY UNDESIRABLE</u>	<u>UNDESIRABLE</u>
Mediocre credentials Poor simulation or Poor credentials Satisfactory simulation	Poor credentials Poor simulation

Best Fit



REDCap Survey



Survey Results



Survey Results

- 70% of surveys completed
- 60% reported that the simulation did not affect their ranking of our residency program
- 32% ranked our program higher
- 8% ranked our program lower

Survey Results

- The simulation added an additional layer of stress
- Some wondered how their performance would affect their rank status

Survey Results

- 100% of respondents were confident or very confident that they would both speak up and know what to say if they encountered a patient safety breach
- 47% subsequently taught others principles of the 2-Challenge Rule
- 10% employed it clinically

Survey Results

- 94% of respondents stated that they would apply principles learned about the 2-Challenge Rule to patient care experiences in the future.



Open Response Comments



Comments

- “One of a kind – made you think on your toes”
- “Really unique and put me in a situation I could expect from residency”
- “A novel experience”
- “It was something different – made me think of the field in a different way”

Comments

- “I learned how important it is to think on your feet and that some questions you cannot be prepared for”
- “Once in a lifetime wonderful experience and the lessons that I learned I will carry and practice during my medical career”
- “It pushed me out of my comfort zone and I appreciated that”

Pilot Limitations



Next Steps



Scenario Change



Survey



Reflective Practice



Longitudinal Studies



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The End





Representation of Academic Anesthesiology

Beverly K. Philip, M.D.

November 6, 2015
12:30PM - 1:30PM

Academic Anesthesiology and ASA

Beverly K. Philip, MD
Vice President for Scientific Affairs
American Society of Anesthesiologists
Professor of Anaesthesia
Harvard Medical School
Founding Director, Day Surgery Unit
Brigham and Women's Hospital
Boston, U S A

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Disclosures

Beverly K. Philip, M.D.

I have no disclosures to report relevant to this presentation



ASA Strategic Plan 2015-2017

- Membership
- Advocacy
- Education
- Patient Safety & Quality
- Developing Care Models
- Partnerships
- Scientific Discovery
- Charitable Activities
- Health Policy

Rev July 2015

ASA Strategic Plan – and Action 2015-2017

- Membership
- Advocacy
- Education
- Patient Safety & Quality
- Developing Care Models
- Partnerships – **Subspecialties. ABA.**
- Scientific Discovery
- Charitable Activities
- Health Policy

Rev July 2015

ASA Strategic Plan – and Action 2015-2017

- Membership
- Advocacy
- Education
- Patient Safety & Quality – **Registries**
- Developing Care Models
- Partnerships
- Scientific Discovery
- Charitable Activities
- Health Policy

Rev July 2015

ASA Strategic Plan – and Action 2015-2017

- Membership
- Advocacy – **Federal research funding: 2015 & 2016**
- Education
- Patient Safety & Quality
- Developing Care Models
- Partnerships
- Scientific Discovery
- Charitable Activities
- Health Policy

Rev July 2015

ASA Strategic Plan – and Action 2015-2017

- Membership
- Advocacy
- Education
- Patient Safety & Quality
- Developing Care Models
- Partnerships
- Scientific Discovery
- Charitable Activities
- Health Policy – **Pt safety initiative Postop Delirium**

Rev July 2015

ASA Strategic Plan – and Action 2015-2017

- Membership
- Advocacy
- Education
- Patient Safety & Quality
- Developing Care Models
- Partnerships
- Scientific Discovery – **FAER**
- Charitable Activities
- Health Policy

Rev July 2015

Foundation for Anesthesia Education and Research

- Vital role in
Creating new knowledge
Successful support of early-career
anesthesiology researchers

"In a review of nearly 400 FAER awardees since 1987, approx 80% currently hold full-time academic appointments and their research productivity (<19,000 papers) and research success (391 NIH grants totaling nearly \$450 million) are high."

Page1, Hudetz. ANESTHESIOLOGY 2015; 123:683-91

ASA Supports FAER Revenues YTD Total 8/31//15

Donations-ASA	2,000,000
Donations-Corporate	352,888
Donations-Other Societies	15,500
Donations-Component Societies	63,690
Donations-Individuals	82,938
Donations-Practice Groups	12,750
Donations-Foundations	20,250
Donations-Schools	246,225
Attendance Fees	3,000
Total Revenue	2,797,241

Plus, Decreased expenses with ASA relationship \$50K/yr

FAER Executive Committee 4/23/15

ASA Supports FAER Positioning for a Successful Future

- FAER Grants & Programs ~\$2.5M/yr 70% budget
- FAER Reserves \$22,528,801.64
- ASA Donations last 10 years \$19,566,492.

And ASA Will Continue Support

\$2M / year.

Access to Professional Fundraising

Promotion to Increase Donor Pool



> 15K Attendees

Major Plenary Lectures



**Emery A. Rovenstine Lecture:
Without Science There Is Little
Art in Anesthesiology**
James C. Eisenach, M.D.
Monday, October 26
8-9:15 a.m.
Hall H

As physicians, we care for patients in a very particular way, applying constantly changing scientific knowledge and communicating this to patients and their families, one case at a time. The best physicians are lifelong learners of science, and also honest, compassionate communicators. This lecture focuses on how you can apply practical approaches to better learn and represent science while closely listening to and communicating with those in your care.



**John W. Severinghaus Lecture
on Translational Science:
Disruptive Technology in
Anesthesiology**
Steven L. Shafer, M.D.
Tuesday, October 27
8:30-9:30 a.m.
Hall H

Anesthesiology was founded on the most disruptive technology imaginable: rendering the human brain reversibly insensible. In the decades after ether, we continuously introduced disruptive technology such as local anesthesia, fluid therapy, new classes of drugs and endotracheal intubation. Modern critical care can be traced directly to a disruptive invention by John Severinghaus - the blood gas machine.

Anesthesiology® Journal Sessions



**24th Journal Symposium
The Anesthesiologist
and Health Care Redesign**
9 a.m.-12 p.m. | Upper 4
Sunday, October 25

The 2015 Journal Symposium will highlight up-and-coming and noteworthy concepts in health care redesign. The title of the 2015 Journal Symposium is "The Anesthesiologist and Health Care Redesign" and will focus on optimization of current systems to complete reconceptions and how anesthesiologists can be at the center of these important projects.

Moderators:

James Rathmell, MD
Warren Sandberg, MD, PhD

Speakers:

*Using Data to Improve
Operating Room Throughput*
Peter Dunn, MD, Retsef Levi, PhD
*Redesigning Surgical Patient
Care from Decision to Discharge*
Jonathan Wanderer, MD, MPhil
*Designing a New Hospital for
Surgical Care*
Brett Simon, MD, PhD

Anesthesiology® Journal Sessions

New



**Anesthesiology Initial
Results of Major Trials Session**
Sunday, October 25
1:10-3:10 pm | Upper 20A

Anesthesiology is sponsoring a Major Trials session this year to provide a forum for initial presentation of major randomized clinical trial results.

Moderators: Professor Paul Myles, Daniel Sessler, MD

Brunch!

14th Annual Celebration of Research Brunch Session

Monday, October 26

9:35-11:05 a.m. | Upper 20D

Brunch will be provided

Moderator: James C. Eisenach, M.D, Editor-in-Chief of *Anesthesiology*, Department of Anesthesiology Wake Forest University School of Medicine, Winston-Salem, NC

Speakers:

2015 ASA Excellence in Research Award, Emery N. Brown, M.D., Ph.D., Professor of Computational Neuroscience and Health Sciences and Technology; MIT-Harvard, Division of Health Sciences and Technology, Boston, MA

2015 Presidential Scholar Award, Mark D. Neuman, M.D., Assistant Professor, Department of Anesthesiology and Critical Care, University of Pennsylvania, Philadelphia, PA

- SOAP/FAER Gertie Marx Lecture: *Are We Speaking the Same Language? Improving Outcomes Through Multidisciplinary Collaboration and Clear Communication*
David J. Birnbach, MD, MPH
- 15th FAER-Helrich Research Lecture
Can We Do Better? How Big Data Can Help
Laurent Glance, MD
- FAER Medical Student Anesthesia Research Fellowship Symposium
- FAER Academy of Research Mentors in Anesthesiology Workshop: *The Pathway to Scientific Independence*
- FAER Panel/FAER Academy of Education Mentors in Anesthesiology Panel: *How Can FAER's New Education Mentorship Academy Help Anesthesiology Educators?*

Best Abstracts: Clinical Sciences and Basic Sciences

Best Abstracts: Clinical Sciences
Saturday, October 24
1:10-3:10 p.m. | Upper 4

Best Abstracts: Basic Sciences
Sunday, October 25
1-3 p.m. | Upper 4

Moderators:
J. David Clark, MD, PhD
Brian P. Kavanagh, MB
Piyush M. Patel, MD

Research Abstracts 2015

Submitted	Accepted	
1412	1144	81.02%
Presented		
Oral	149	
Poster Discussion	165	
Poster (ePoster)	802	

Scientific Abstracts

- Oral: sessions of 6
- Poster Discussions: sessions of 8
- E-posters, grouped thematically
 - Technology problems
 - Discussion "fifth" monitor
- CME vs non-CME for e-posters:
 - ACCME constraints: Location. COI verification.
- E-posters On Demand (2016)
 - Access to all scientific poster discussion and e-poster presentations throughout the conference and three months post-meeting. Ability to interact with author.

NEW This Year Top 8 each, of 232

Mentored Poster Discussions: Young Investigator: Basic Science
Roderic Eckenhoff, M.D.
Monday, October 26 | 1:15-2:45 p.m.
Upper 11 A

Mentored Poster Discussions: Young Investigator: Clinical Science
Evan Kharasch, M.D., Ph.D.
Sunday, October 25 | 10-11:30 a.m.
Upper 11 A

Research is Available All Day, Every Day

In ASAP Frequently. Months in advance.

Reinvigorating the Science

The scientific program has been redesigned with prominent positioning and timing of the featured research symposia and the addition of new scientific mentoring sessions. Mark your calendars for:

- **Severinghaus and Rovenstine** lectures presented by
 - Steve Shafer, M.D., editor-in-chief of *Anesthesia & Analgesia*
 - James C. Eisenach, M.D., editor-in-chief of *Anesthesiology*
- **FAER-Helrich Research Lecture** and Journal events
- **Major Trials** session
- **Best of Basic** sessions
- **Clinical Science** sessions
- **Wood Library-Museum of Anesthesiology Patrick Sim Forum on the History of Anesthesiology**
- **Journal Symposium** focusing on Anesthesiologist and Health Care Redesign

Testimonial



"Whatever your clinical or research interests, there are cutting-edge scientific sessions to interest every attendee at the meeting."
— Joy L. Hawkins, M.D.

8/9/15

You asked, we delivered

Past attendees requested changes to maximize learning and expand networks. We listened, and now we're delivering!

- **Reinvigorating the science**
 - **Severinghaus and Rovenstine** lectures presented by Steve Shafer, M.D., editor-in-chief of *Anesthesia & Analgesia*, and James C. Eisenach, M.D., editor-in-chief of *Anesthesiology*
 - **FAER-Helrich Research Lecture** and Journal events.
 - The Journal symposium, focusing on the Anesthesiologist and Health Care Redesign

9/3/15

In the ASA Newsletter "Monitor" Celebrating Science

- 🌐 September 2015 K Domino, S Soriano
"Celebration of Science at ANESTHESIOLOGY 2015"
- 🌐 August 2015 J Hawkins, W Furman
"The Latest Science in Anesthesiology: Join Us"
- 🌐 May 2015 B Philip
" Science and Education, Moving Forward" .

ASA Needs Your Help

Science and Education
Are Our Specialty's Future

ASA Invites You To Lead





MOCA 2.0

Daniel J. Cole, M.D.

November 7, 2015
8:00AM – 8:30AM


THE AMERICAN BOARD OF ANESTHESIOLOGY

MOCA 2.0 Update

DANIEL J. COLE, M.D.

DEPT OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE
 DAVID GEFEN SCHOOL OF MEDICINE
 UNIVERSITY OF CALIFORNIA, LOS ANGELES
 DJCOLE@MEDNET.UCLA.EDU

DISCLOSURES

- Professional
 - Board of Directors, ABA
 - Board of Directors, ABMS
 - President, ASA
- Financial
 - None

 THE AMERICAN BOARD OF ANESTHESIOLOGY 2

AGENDA

- Why MOC?
- What is MOC?
- What is MOCA 2.0?

 THE AMERICAN BOARD OF ANESTHESIOLOGY 3

SOCIAL CONTRACT PUBLIC TRUST

- Patients' interests above our own
- Assure competence through self-regulation**
- Demonstrate morality and integrity
- Address issues of societal concerns
- Be devoted to the public good

Cruess RL, et al. Perspectives in Biology and Medicine 51:579, 2008

 THE AMERICAN BOARD OF ANESTHESIOLOGY 4

Clinical Experience and Quality

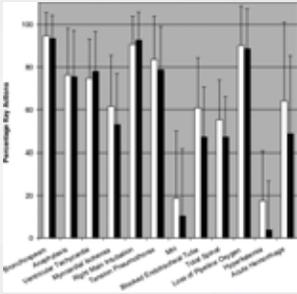
"... decreasing performance with increasing years in practice"
 Choudhry NK, et al. Ann Intern Med 2005;142:260

"Each additional year since graduation was associated with a 0.58% increase in the mortality of a physician's patients"
 Norcini JJ, et al. Health Affairs 2010;29:1461-1468

 THE AMERICAN BOARD OF ANESTHESIOLOGY 5

ANESTHESIOLOGY

- 61 specialists each managed 8 of 12 randomly selected, scripted, intraoperative simulation exercises
- Participants were expected to recognize and initiate appropriate therapy for intraoperative events during a 5-minute period



Henrichs BM, et al. Anesth Analg 2009;108:255

 THE AMERICAN BOARD OF ANESTHESIOLOGY 6

Purpose
Move the quality curve
 Discriminator

- Strategic Priorities
 - Physician engagement
 - Close individual and national practice gaps
- Development & Implementation Principles
 - Relevance to practice
 - Impact on quality
 - Physician burden

ABA THE AMERICAN BOARD OF ANESTHESIOLOGY 7

MOCA PERCEPTION SURVEY

INVITED 29,000
 You spoke, we listened:

- A majority of respondents said **Part 3 (Exam)** and **Part 4 (Improving Medical Practice)** were the most challenging

You said you wanted:

- A more relevant program

28% Responsiveness

ABA THE AMERICAN BOARD OF ANESTHESIOLOGY 8

	Traditional MOCA	MOCA 2.0
Part 1	Professional Standing	No change
Part 2	Lifelong Learning <ul style="list-style-type: none"> 250 Category 1 CME credits: <ul style="list-style-type: none"> 90 Self-Assessment 20 Patient Safety 	250 Category 1 CME Credits (including 20 Patient Safety) <ul style="list-style-type: none"> <u>Self-Assessment CME no longer required</u>
Part 3	Assessment <ul style="list-style-type: none"> 200-question MOCA Exam Taken once every 10 years 	Assessment <ul style="list-style-type: none"> <u>MOCA Minute™ replaces the MOCA Exam</u>

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	Traditional MOCA	MOCA 2.0
Part 4	Improvement in Medical Practice <ul style="list-style-type: none"> Simulation Case Evaluation 	Improvement in Medical Practice <ul style="list-style-type: none"> <u>Variety</u> of options, <u>flexibility</u> to complete relevant activities Point System weights activities Simulation an option; ABA encourages participation
Fee:	\$2,100 every 10 years	\$210 annually

ABA THE AMERICAN BOARD OF ANESTHESIOLOGY 10

Results of MOCA Minute™ Pilot 2014

- Diplomate feedback has been very **positive**
- Diplomates who actively participated in the MOCA Minute™ Pilot **scored higher** on their subsequent MOCA exam than those who did not participate
- Beginning in **January 2016**, the **MOCA Minute™ will replace the MOCA exam**, expanding the MOCA Minute™ pilot to include all MOCA participants with certificates that expire in 2016 or later

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MOCA MINUTE™ Feed back

Diplomates will get immediate feedback on questions, plus

- References/Links to educational resources
- A critique
- Opportunity to provide feedback on questions



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MOCA Minute™ 2016

MOCA Minute™ represents an intensive **longitudinal** assessment:

- ABA diplomates will answer a minimum of **30** questions per **calendar quarter** over 10 years
- ABA diplomates will build and continually-update a profile of their content knowledge over the course of their career

MOCA 2.0™ PRACTICE PROFILE FOR PERSONALIZED LEARNING

Practice Area and Location

Select a percentage for each practice area (total total 100%). Your selections will guide your MOCA Minute question content. MOCA Minute questions are not available for Anesthesiology and Pediatric Anesthesiology.

Anesthesiology	0
Cardiac Anesthesiology	0
Critical Care Anesthesiology	0
General Anesthesiology	0
Neuro Anesthesiology	0
Obstetric Anesthesiology	0
Pain Medicine	0
Perfusion Anesthesiology	0
Regional Anesthesiology/Neuro Pain	0
Therapeutic Anesthesiology	0
Transfusion	0
Unlabeled Other	0

Select a Practice location. Please use practice location

Practice Location:

Reset Selections Save

MOCA MINUTE™ Question Topics

General anesthesia – the base of knowledge

New knowledge areas – topics diplomates need to learn quickly (e.g., Ebola)

Subspecialty-related questions – based on your practice profile

MOCA 2.0, Part 4 Point System

25 Points per 5-year period

- You may choose from **several activities** which will provide flexibility and relevance to your practice

MOCA 2.0, Part 4 Point System Requirement: 25 points every 5 years

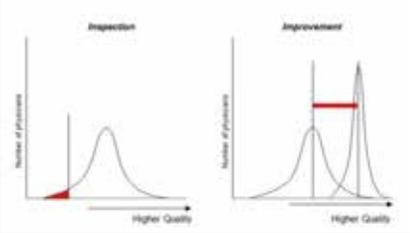
Activity	Points per hour	Maximum number of points per 5-yr
High fidelity simulation participation	3	20
High fidelity simulation follow-up	3	5
Institutional / departmental quality improvement project leader	1	25
Clinical pathway development leader	1	25
Clinical pathway development participant	1	15

Activity	Points per hour	Maximum number of pts
Part 4 Activities offered by other ABMS Boards	1	25
Completing an improvement plan based on feedback from FPPE, 360 reviews, PEC surveys, PQRS data, or quality data registries	1	15
Individual or Group ASA PPAI Modules	1	25
ABMS Multi-specialty Portfolio Program	1	15
Self-directed case evaluation , M&M, or Case Discussion (if presenting your case)	1	15
Point of care learning	1	15

MOCA

Purpose

- Move the quality curve



QUESTIONS?

Communications Center: Phone: (866) 999-7501
 Fax: (866) 999-7503
 Email: coms@theABA.org

MOCA Email: Email: MOCA@theaba.org



SAAA Director to ASA Update

Zeev N. Kain, M.D., M.B.A.

November 7, 2015
8:30AM - 9:00AM



American Society of Anesthesiologists

ASA BOD-HOD 2015 Report

Zeev Kain, MD, MBA
 ASA Director, Academic Anesthesiology Component

Jeff Kirsch, MD
 ASA Alternate-Director, Academic Anesthesiology Component




ASA Organization

Overall Governance

Administrative Council
 Board of Directors
 House of Delegates

Overall Operations

Division of Professional Affairs
 Division of Administrative Affairs
 Division of Scientific Affairs




ASA Leadership

 President Daniel J. Cole	 President Elect Jeffrey Plagenhoef	 First Vice President James D. Grant	 VP for Professional Affairs Stanley W. Stead	 VP for Scientific Affairs Beverly K. Philip
 Secretary Linda J. Mason	 Treasurer Mry Dale Peterson	 Assistant Secretary John F. Dorbrowski	 Assistant Treasurer Michael Champeau, MD	 Speaker, House of Delegates Steven L. Sween
 Vice Speaker, House of Delegates Ronald L. Harler				




Section on Professional Affairs:

The VA Issue




Report of VP Professional Affairs

- population health. Population health may be defined as the health and health outcomes of a group of individuals, often clustered according to geography, employer or insurer. Health and health outcomes are driven by delivery of healthcare and by individual behavioral, genetic, social, physical and economic factors. Our current FFS model, where payment is focused upon delivery of a service, will change to one where an episode of care is viewed as a cost center




Committee on POM

Committee on Performance and Outcomes Measurement: Annual Report

- Comment: Testimony indicated concern regarding the quality measure generation process, but broader discussion affirmed that the current process is effective and also under continuing improvement. Testimony indicated that the House of Delegates and ASA members have had, and will continue to have, the opportunity for input in the performance measure development process. When developing measures, the Committee on Performance Outcomes Measurement utilizes committee expertise as well as additional resources (e.g. other committees, Anesthesia Quality Institute, methodologists).




Committee on Ethics

- **Comment:** Testimony was heard concerning the *ASA Guidelines for the Ethical Practice of Anesthesiology*, specifically that all ASA members are reminded that the ASA Ethical Guideline includes point number 5: "Physician anesthesiologists should provide preoperative evaluation care and should facilitate the process of informed decision-making, especially regarding the choice of anesthetic technique" regardless of whether the physician anesthesiologist is personally performing, medically directing, or supervising care.



American Society of
Anesthesiologists

QMDA

- **Deep Sedation standards**
- **5.** The committee recommends that the *Statement on Documentation of Anesthesia Care* (2013), which appears in redacted and clean format in this handbook as reports 411-2.5 and 411-2.6, respectively, be approved as revised.



American Society of
Anesthesiologists

Committee on Future Models of Anesthesia Practice Interim Report

- **Approved** the recommendation that the ASA president engage with the president of the ABA to jointly appoint a committee to critically examine and redesign residency and fellowship training, with the intention of preparing trainees in anesthesiology to meet the healthcare needs of the future through expanded education and training in perioperative medicine.



American Society of
Anesthesiologists

Committee on Scientific Affairs

- **Comment:** Testimony supported the charge and work of the Task Force on Environmental Sustainability, and acknowledges the value and ongoing need for future activity.
- **Approval** of the amended document *Statement on Nonobstetric Surgery During Pregnancy*, found in redacted and clean versions in this handbook as reports 526-3.3 and 526-3.4, respectively.
- **Approval** of the amended document *Statement on Pain Relief During Labor*, found in redacted and clean versions in this handbook as reports 526-3.6 and 526-3.7, respectively.



American Society of
Anesthesiologists

Committee on Scientific Affairs

- **Approved** the recommendation to appoint Evan D. Kharasch, M.D., Ph.D., to the position of Anesthesiology editor-in-chief.
- **Jim Eisenbach** was appointed as CEO of FAER



American Society of
Anesthesiologists

Committee on Finance

- **Comment:** Richard P. Dutton, M.D., M.B.A., is to be commended for his leadership as Executive Director of the Anesthesia Quality Institute (AQI) and for the spirit of innovation and commitment to quality that he brought to AQI and ASA in this role.
- **Comment:** The committee would like to recognize Denham S. Ward, M.D., Ph.D., for his many years of service to the Foundation for Anesthesia Education and Research.



American Society of
Anesthesiologists

The Committee on Global Humanitarian Outreach (GHO)

- ❑ Expand the Lifebox program to provide pulse oximeters to countries in need in Central and South America.
- ❑ Approve the Global Scholars Program, which would provide support for young leaders in the specialty of anesthesiology from low and middle-income countries to attend the 2015 ASA Annual Meeting.
- ❑ Support the Resident International Scholarship Program, establishing one-month resident scholarships to help CA1 and CA2 residents learn the international practice of anesthesia in a pediatric orthopedic hospital in Ethiopia.



Academic Caucus: Enhanced Alignment with the ASA

- ❑ There are currently a total of 5 geographic Caucuses at the ASA
- ❑ This new caucus would be to serve as a body of thought leaders in academic anesthesiology that will interact with the leadership of the ASA
- ❑ This new caucus will identify issues that are of vital importance to academic anesthesiology and will convey them to the ASA leadership.





RRC Update

Robert R. Gaiser, M.D., M.S.Ed.

November 7, 2015
9:20AM – 9:50AM

Anesthesiology RC Update

Robert Gaiser, MD
Chair
 Anne Gravel Sullivan, PhD
Executive Director

SAAA November 7, 2015



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Disclosures

No conflicts of interest to report



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Objectives

- Provide update on changes to Program Requirements
- Provide update on Single Accreditation System
- Describe annual program review process and milestone data collection
- Provide update on Regional Anesthesiology and Acute Pain Medicine subspecialty
- Review RC Initiatives in 2016
- Answer questions



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New RC Members and Leadership

Chair: Robert Gaiser, MD, MEd

Vice Chair: Cynthia Wong, MD

New RC Members:

- David Simons, DO
 - Lancaster Regional Medical Center, Lititz, PA
 - Chair and Medical Staff President

- Tim Clapper, PhD
 - University of Colorado-Colorado Springs
 - Education and Simulation Consultant
- Keith Baker, MD, PhD
 - Critical Care and Pain Medicine
 - Massachusetts General Hospital



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What's New in the Program Requirements?



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Changes to Program Requirements July 1, 2016

Resident and Fellow Eligibility

- **All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs^(Core)**
 - Royal College of Physicians and Surgeons of Canada (RCPSC) or College of Family Physicians of Canada (CFPC) acceptable
 - Interns from AOA programs seeking ACGME accreditation acceptable during transition into SAS
- **Applies to Interns, Transfers and Fellows**
 - Programs must receive verification of each applicant's level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program. ^(Core)



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Changes to Program Requirements July 1, 2016

Can an international fellow applicant who completed a non-ACGME residency be accepted as a fellow for July 1, 2016?

Yes



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Changes to Program Requirements July 1, 2016

Fellowship Eligibility

“Exceptionally qualified” candidates are now permitted by RC

These candidates must have documented:

- Completion of non-ACGME training
- Comparison of performance to peers
- Additional evidence of:
 - Research
 - Scholarship
 - Leadership



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“Exceptionally-Qualified” Candidates

Must be:

- Reviewed by PD/recruitment committee
- Approved by GMEC or subcommittee

Must have:

- Satisfactory performance on USMLE 1, 2 (and 3 if eligible)
- ECFMG certificate if international
- Baseline milestone assessment within 6 weeks or ACGME-I report
 - Remediation if unsatisfactory
 - Overseen by CCC and GMEC



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Program Requirement Changes-SAS

Existing AOA-accredited programs can apply to receive Pre-Accreditation Status from 2015-2020

- Institutions must apply for pre-accreditation before programs
- Cores & Subspecialties apply together

Anesthesiology Program Applications

- 13 AOA Programs surveyed intend to apply
- Intentions of 121 AOA internships vary (i.e. apply, merge, close)
- Interns from a program in pre-accreditation status will be held to the less restrictive 2013 eligibility policies per MOU



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Program Requirement Changes-SAS

- List of pre-accredited institutions/programs will appear on [public webpage](#)
- **RC will not penalize core programs for accepting CBY candidates from AOA internships during early stages of application process (2016-17)**
- Osteopathic Recognition applications open
 - Reviewed by Osteopathic Principles Committee
 - Any program may apply
- For more information, visit [SAS webpage](#)



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Program Director Qualifications

II.A.3. Qualifications of the program director must include:

- Requisite specialty expertise and documented educational and administrative experience acceptable to RC (Core)
- Current certification in the specialty by the ABA* or specialty qualifications that are acceptable to the RC (Core)
- Current medical licensure and appropriate medical staff appointment (Core)
- Licensure to practice medicine in the state where the institution that sponsor the program is located (certain federal programs are exempted) (Core)
- *RC will consider AOA-certified Program Director



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Program Director Qualifications

- **Qualifications of the program director must include:**
 - Faculty experience, leadership, organizational and administrative qualifications and the ability to function effectively within an institutional governance.
 - Significant academic achievements in anesthesiology, such as publications, the development of educational programs, or the conduct of research
- Increase in junior faculty taking on Program Director role
 - Requires Mentoring Plan
- Succession planning
 - Appoint Associate Program Director



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Case Logs

- New Adult Cardiac and OB case logs implemented summer 2015
 - Fellows required to use logs beginning July 1, 2016
- Revisions to Pediatric Anesthesiology case logs implemented September 2016
 - Residents required to use now



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Other RC Activities

- Regional Anesthesiology and Acute Pain Medicine Fellowship PRs being finalized
 - Draft Program Requirements posted for Review and Comment this summer, second posting in mid-December
 - Final Program Requirements and Impact Statement by March 2016
 - Implementation July 1, 2016
 - Application available approx. May 2016
- Revisions to Multi-Disciplinary Pain Medicine Fellowship Program Requirements slated for 2016-17



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Other ACGME Activities

- Milestones 2.0 work beginning early 2016
- Symposium on Physician Well-Being November 17-18, 2015
- ACGME will launch cross-specialty Innovation Program
 - Anesthesiology Innovation programs will apply for cross-specialty Innovation Program
 - Programs must track resident case log and milestone data if unable to use ADS



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Preparing for Program Annual Review

New Accreditation System



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Data for RRC Annual Program Review

- Programs enter data in ADS
 - Milestones (winter and spring)
 - Resident & Faculty Surveys (Jan-April)
 - Case logs (Final entry July-August)
 - Annual Update (Major Changes, Response to Citations-Sept-Oct)
- ***Programs should enter faculty and resident scholarly activity, as well as new certifications before June 30th***



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New RC Meeting Timeline

- Winter RC meeting
 - Agenda Priority is Annual Program Review
 - Most accreditation decisions made
 - Feb 18-19, 2016 (agenda close Dec 4, 2015—earlier for core applications)
- Spring RC meeting
 - Follow-up on small number of programs (e.g. site visits, clarifying information)
 - April 14-15, 2016 (agenda close Feb 12, 2016)
- Fall meeting for new applications
 - Date TBD; likely September



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RC Annual Review Process

A program is reviewed

- If it received citations since July 1, 2013 (the inception of the NAS)
- If it is currently on Continued Accreditation with Warning or Probation
- When multiple issues identified among review metrics (e.g. low resident survey scores, low faculty scholarly activity)




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Post Annual Review

- RC will send Letter of Notification to every program every year
 - Confirming accreditation status
 - Listing citations (new, extended, resolved)
 - Indicating if additional information is needed
 - Site Visit
 - Clarifying report
 - Progress report



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Departmental LoN

To: core PD
Cc: sub PDs, DIO

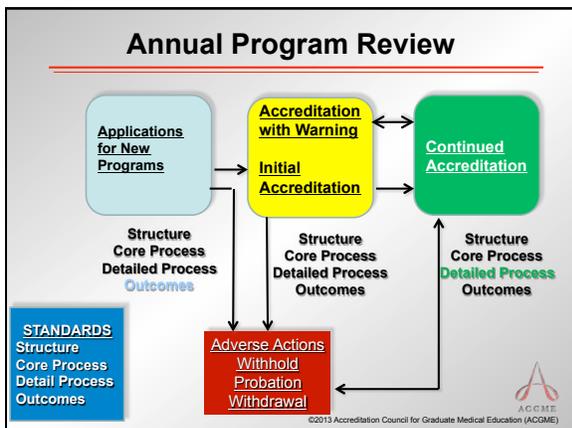
Sub 1: Continued Accreditation

Sub 2: Probation. Program will receive separate letter: LTR designation

Sub 3: Program not reviewed at meeting because it received initial in 2012, and has no/limited NAS data. ** designation




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Continued Accreditation

- Continued Accreditation - substantial compliance with requirements
- Outcomes will be reviewed annually by RRC
- Can innovate around detailed requirements
- Over 95% of programs receive CA




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Continued Accreditation with Warning

- Continued Accreditation with Warning – areas of non-compliance jeopardize accreditation status
- No permanent increase in complement permitted
- No announcement to residents needs to be made
- Status public on website



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Initial Accreditation

Status assigned to Applications

- Core programs will have site visit **prior** to RC review.
- Fellowships don't need prior site visit but will receive one within 2 years of Initial Accreditation
- IA with Warning
- Withhold – **can be appealed**
- No Probation
- Programs must adhere to all requirements, including detailed



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Appeal Options

Adverse actions open to appeal

- Accreditation Withheld
- Probationary Accreditation
- Withdrawal of Accreditation
- Withdrawal of Accreditation Under Special Circumstances

Non-voluntary reduction in resident complement by the RRC is also open to appeal



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Adverse Actions

What has changed

- No proposed adverse actions
- Adverse accreditation status can only be conferred following a site visit
- Programs with adverse accreditation status cannot request an increase in resident complement
- Probation cannot exceed 2 consecutive annual reviews



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Relationship of Core & Subs

Fellowships must have a relationship with a core residency program

- Self-study visits of core and associated fellowships will occur at the same time
- Adverse action in core results in the same (administrative) status for their associated fellowships
 - Withdrawal of core means withdrawal of all associated fellowships
- New fellowships can only be started if core status is Continued Accreditation



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Annual Review Process 2014-15

- 129 core programs reviewed
- 241 subspecialty programs reviewed
- Criteria for review included:
 - Resident & Faculty survey
 - Case logs
 - Faculty & Resident scholarly activity
 - Attrition & Omission
 - Major Changes (e.g. PD, DIO, CEO)



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RC Outcomes—2014-15

- 352 Programs given Continued Accreditation
- Four Programs given CA with Warning
- Two requests for clarifying information
- 12 Site Visits
- Two New CBYs
- Two Programs given Initial Accreditation with 2 years



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Questions?

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Executive Director, RC for Anesthesiology
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ABA Update

James P. Rathmell, M.D.

November 7, 2015
10:20AM – 10:50AM



THE AMERICAN BOARD OF ANESTHESIOLOGY

2015 ABA Report

Society of Academic Anesthesiology Associations

JAMES P. RATHMELL, M.D.
SECRETARY, AMERICAN BOARD OF ANESTHESIOLOGY

BRIGHAM AND WOMEN'S HOSPITAL
BOSTON

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Robert R. Gaiser, M.D. Hospital of the University of Pennsylvania	Santhanam Suresh, M.D. Lurie Children's Hospital of Chicago
William W. Hesson, J.D. University of Iowa Hospitals and Clinics (Ret.)	David O. Warner, M.D. Mayo Clinic

DISCUSSION OVERVIEW

- RTID Refresher
- Primary Certification Updates
- Subspecialty Certifications
- Program Directors' Meetings
- Alternate Entry Pathway (AEP)
- MOCA 2.0

RTID REFRESHER

RTID REPORTING REQUIREMENTS

- Programs should:
 - Complete new Resident Enrollment Forms every 6 months – by **Jan. 31** and **July 31**
 - Assess and report clinical competence every 6 months – by **Jan. 31** and **July 31**
 - Assessment of residents' clinical competence to align with **ACGME Anesthesiology Milestones**
 - Attestation of **7 Essential Attributes**
 - Assess whether resident can **perform independently** the entire scope of practice in the specialty or subspecialty without accommodation or with reasonable accommodation, at end of training program



CLINICAL COMPETENCE COMMITTEE (CCC) REPORT AND MILESTONES

- CCC Report: core tool for evaluating residents' training and performance against milestones
- Competencies on CCC Report include milestone descriptors of subcomponents
 - Levels of performance assigned to each subcomponent



SAMPLE CCC REPORT

Basic Exam Performance		Pass/Fail	Level
Item	Score	Pass/Fail	Level
Basic Exam Performance			

Patient Care		Yes/No	Level	Level	Level	Level
Item	Score	Yes/No	Level	Level	Level	Level
1. Demonstrate appropriate concern for patients and a commitment to caring and professional responsibilities						
2. Use appropriate clinical skills						
3. Demonstrate appropriate use of a broad background of general medicine in the management of patients related to the specialty of anesthesiology						
4. Demonstrate the application of general anesthesia to patients for conscious sedation and intubation, and mechanical ventilation management						
5. Demonstrate the application of general anesthesia to patients for conscious sedation and intubation, and mechanical ventilation management						
6. Demonstrate the application of general anesthesia to patients for conscious sedation and intubation, and mechanical ventilation management						
7. Demonstrate the application of general anesthesia to patients for conscious sedation and intubation, and mechanical ventilation management						
8. Demonstrate the application of general anesthesia to patients for conscious sedation and intubation, and mechanical ventilation management						
9. Demonstrate the application of general anesthesia to patients for conscious sedation and intubation, and mechanical ventilation management						
10. Demonstrate the application of general anesthesia to patients for conscious sedation and intubation, and mechanical ventilation management						

ABA THE AMERICAN BOARD OF ANESTHESIOLOGY 8

PRIMARY CERTIFICATION

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STAGED EXAMINATIONS

- Staged examinations
 - Complement ACGME movement toward competency-based training and promotion
 - Designed to encourage residents to engage in more sustained study over the course of residency training
- Residents who complete their four-year CA training **on or after June 30, 2016** will take the staged exams
- Residents who complete training before June 30, 2016 will take the traditional Part 1 and Part 2 Exams

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STAGED EXAMINATIONS

- BASIC Examination** administered for the first time in July 2014
- ADVANCED Examination** will be administered July 29-30, 2016 and then twice each year in January and July
- APPLIED Examination** will replace the Part 2 (Oral) Examination in 2017, and will eventually include an Oral Structured Clinical Examination (OSCEs)

ABA THE AMERICAN BOARD OF ANESTHESIOLOGY 11

2015 PART 2 EXAMINATION ABA ASSESSMENT CENTER

- More than **1,900** candidates participated in their Part 2 Examination in the new Assessment Center. We expect the same in 2016
- ABA Director David Warner, M.D. will share more information about the Part 2 and other exams during his presentation

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2016 PART 2 EXAMINATIONS

- Nine administration weeks
 - Seven spring exam weeks (March to June)
 - Two fall exam weeks (September)
- Specific dates are posted at www.theaba.org



EXAMINER RECRUITMENT

- The ABA had **239** active examiners at the start of 2015
- In preparation for the APPLIED Examination, the ABA recruited **118** more in 2015 and will pursue another **62** in 2016

GOAL: 405 Examiners by 2019

SUBSPECIALTY CERTIFICATION

SUBSPECIALTY CERTIFICATION

- The ABA currently offers subspecialty certification in:
 - Critical Care Medicine
 - Pain Medicine
 - Hospice & Palliative Medicine
 - Sleep Medicine
 - Pediatric Anesthesiology
- **2015 is last year** to register with “Grandfathering Criteria” for Pediatric Anesthesiology Examination



SUBSPECIALTY EXAM REGISTRATION

- Physicians who wish to take subspecialty certification exams must:
 - Hold an unexpired license
 - **Be certified by the ABA**
- Fellows must take and pass the Part 2 Exam prior to registering for a subspecialty exam
 - They should register for a spring Part 2 Exam if they wish to take the subspecialty exam in the same year as their Part 2

PROGRAM DIRECTORS' MEETINGS

PROGRAM DIRECTORS' MEETINGS

- The ABA will host Program Directors' meetings in 2016 to share updates on changes to our assessment programs
- Topics for discussion include:
 - Staged exam process update
 - Resident survey results
 - Substance use disorder among residents
 - MOCA 2.0 – the Maintenance of Certification in Anesthesiology Program redesign



ALTERNATE ENTRY PATHWAY

ALTERNATE ENTRY PATHWAY (AEP)

- **Purpose:** To encourage **outstanding** internationally trained and certified anesthesiologists, who come to the United States, to become productive research members of U.S. academic anesthesiology programs



AEP STATISTICS

July 2007 – Dec. 2014

# of Individuals Nominated	127
# of Programs Approved	32
# of Individuals Approved	64
# of Individuals Eligible for Certification	25
# of Individuals Now Certified	31

MOCA 2.0™

MOCA 2.0™ GOAL



To create a web-based, lifelong learning platform that promotes and supports personalized knowledge acquisition, assessment and demonstration of proficiencies.

MOCA 2.0™: 2016

- What can diplomates expect in 2016?
 - MOCA 2.0™ launches on **Jan. 4**
 - Participants include all diplomates enrolled in MOCA who have unexpired certificates (**approx. 20,000**)
 - MOCA **Parts 3 and 4** underwent significant changes
 - **MOCA Minute™ pilot** (Part 3) is the core of MOCA 2.0
 - ABA Director Dan Cole, M.D., will provide more details in his MOCA 2.0 presentation

QUESTIONS?

Communications Center:
Phone: (866) 999-7501
Fax: (866) 999-7503
Email: coms@theABA.org

Mail Correspondence:
ABA Secretary
4208 Six Forks Rd, Suite 1500
Raleigh, NC 27609-5765



ITE Update

David O. Warner, M.D.

November 7, 2015
10:50AM - 11:20AM


THE AMERICAN BOARD OF ANESTHESIOLOGY

2015 ABA EXAMS REPORT

Society of Academic Anesthesiology Associations

David O. Warner, M.D.
 CHAIR, ABA EXAMINATIONS COMMITTEE
 CHAIR, ABA RESEARCH COMMITTEE
 MAYO CLINIC
 ROCHESTER, MN

QUESTION EDITORS

ITE/BASIC/PART 1 EXAMS

71 Junior Editors	
14 were selected in 2014	
Write questions (18/year)	
Revise questions based on feedback	

42 Senior Editors & Committee Members
Edit questions
Mentor junior editors

ABA THE AMERICAN BOARD OF ANESTHESIOLOGY 2

QUESTION DEVELOPMENT

- Question generation for the ABA Examinations: BASIC, Part 1 and ITE
 - **More than 1,000** questions generated
 - Two senior editors meetings and 10 webinars to review items
 - ITE and BASIC Exam forms reviewed by exams committees in September 2015
 - Part 1 form to be reviewed in January 2016

ABA THE AMERICAN BOARD OF ANESTHESIOLOGY 3

2016 IN-TRAINING EXAM

- Internet-based exam delivered via vendor (Internet Testing Systems)
 - Exam may be delivered any time from **12 a.m. EST on Thursday, Feb. 18 to 11:59 p.m. EST on Monday, Feb. 22** with multiple administrations
- Remains a secure, proctored exam
- Direct connections to the Internet are strongly preferred, but laptops with wireless connections may be used
- Systems check is required on every computer used for the ITE
- Administration guidelines will be distributed in December 2015

ABA THE AMERICAN BOARD OF ANESTHESIOLOGY 4

2016 ITE RESULTS REPORTING

- **Personal Performance Reports** include information about individual performance on BASIC and ADVANCED items
 - Scale score based on the whole exam
 - Percent Correct Scores based on BASIC and ADVANCED items, respectively
 - Performance within content/category areas
 - Keywords associated with items answered incorrectly
- **Program Summaries** include information about program performance on BASIC and ADVANCED items
 - Program performance on individual items compared to entire test-taking population at each training level

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ITE: REPORTED CATEGORIES

- Anatomy
- Mathematics, Statistics, Computers
- Pharmacology
- Physics, Monitoring and Anesthesia Delivery Devices
- Anesthesia Procedures, Methods and Techniques
- Physiology
- Subspecialties: Critical Care, Obstetric Anesthesia, Pain, Pediatric Anesthesia
- Organ-based Clinical: Cardiovascular, Endocrine/Metabolic, GI/Hepatic, Hematologic, Neurologic/Neuromuscular, Renal/Urinary/Electrolytes, Respiratory

ABA THE AMERICAN BOARD OF ANESTHESIOLOGY 6

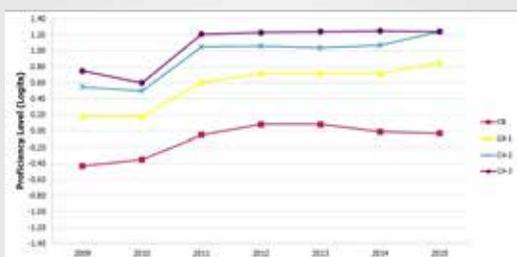
ITE & PART 1/ADVANCED EXAMINATIONS QUESTION TYPES

- Graphics
 - Still shots of a monitor screen
 - Ultrasound images
- Video clips
 - From a simulator or real-time bedside monitor
 - Basic level TEE video clips

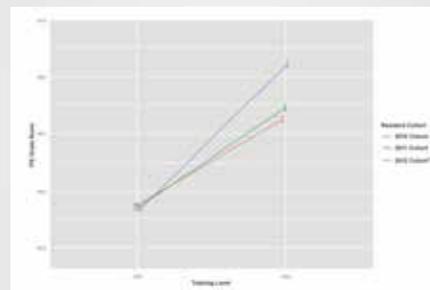
PAIN MEDICINE ITE

- In 2013, the ABA began offering a **Pain Medicine ITE (ITE-PM)**
- Additional subspecialty ITEs will likely be added in the future as our item banks grow

IN-TRAINING EXAM PERFORMANCE BY TRAINING LEVEL & EXAM YEAR

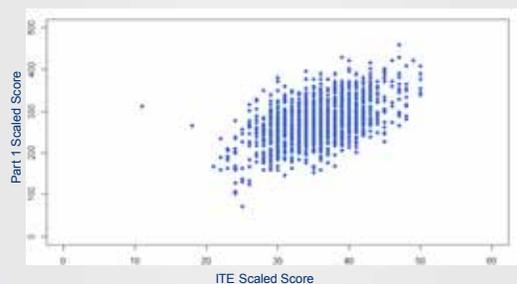


CA-1 TO CA-2 ITE GROWTH TRADITIONAL VS. STAGED COHORTS



* Indicates cohorts in the staged examinations system

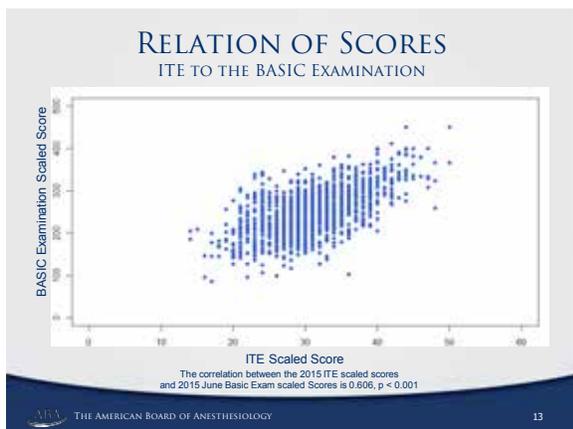
RELATION OF SCORES 2015 ITE TO 2015 PART 1 EXAMINATION



The correlation between the 2015 ITE scaled scores and 2015 Part 1 Exam scaled Scores is 0.528, $p < 0.001$.

RELATION OF SCORES ITE TO FIRST ATTEMPT ON PART 1 EXAM

Scaled Score	N	2015 Part 1 Scaled Score Mean (S.D.)	Part 1 Pass Rate
≤25	31	190 (54)	35%
26-30	206	244 (45)	76%
31-35	537	265 (39)	94%
36-40	534	285 (43)	97%
41-45	191	308 (42)	99%
≥46	42	350 (46)	100%



RELATION OF SCORES ITE TO THE BASIC EXAM

Scaled Score	N	2015 June BASIC Scaled Score Mean (S.D.)	BASIC Pass Rate
≤25	251	215 (49)	84%
26-30	520	231 (40)	96%
31-35	537	255 (39)	99%
36-40	246	285 (41)	100%
41-45	71	333 (37)	100%
≥46	11	349 (51)	100%

- ### PART 1 EXAMINATION SCORING
- Standard-setting study conducted every 5 years
 - Following exam administration, preliminary item analysis conducted (difficulty & discrimination)
 - Key validation for items
 - negative discrimination
 - no clear correct answer

- ### STANDARD-SETTING PROCESS BASIC AND ADVANCED EXAMS
- A third BASIC Exam standard-setting study will be conducted in 2016 with a panel of program directors
 - The Hofstee Method
 - Combined panel member judgments about an **appropriate passing score** and an **appropriate pass rate**
 - A standard-setting study for the ADVANCED Exam will be conducted in 2016

2015 PART 1 EXAM RESULTS

- Candidates were randomly assigned to examine on either Monday or Tuesday
- Key validation eliminated 6 items
- 73% of candidates passed

N	Mean Scaled Score	Standard Deviation	Pass Rate	Reliability
2,264	240.27	79.44	73.1%	0.93



2015 BASIC EXAM RESULTS

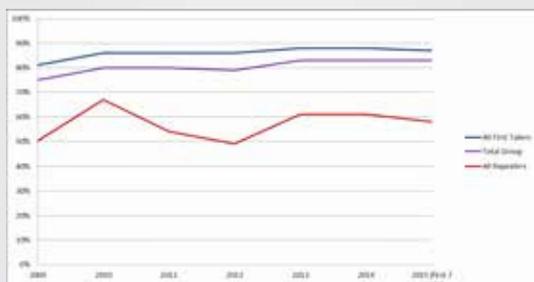
- Candidates were randomly assigned to examine on Friday or Saturday
- Key validation eliminated 6 items and rekeyed 2 items
- 95.8% of candidates passed

N	Mean Scaled Score	Standard Deviation	Pass Rate	Reliability
1,643	249.75	50.51	95.8%	0.76

2015 BASIC EXAM 10% LETTERS

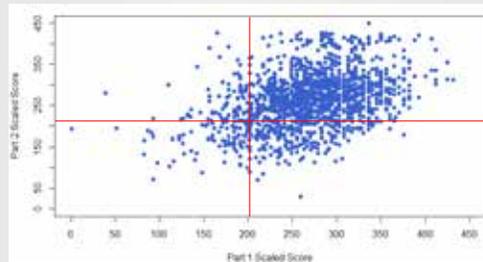
- In 2014, the ABA sent congratulatory letters to examinees who scored in the **top 10%** on the BASIC Examination
 - Program Directors also received copies of these letters
- All 2015 BASIC Exam top 10% letters will go out in **early December**. Program Directors will receive copies
- In 2016, these letters will go out after each BASIC Exam administration

PART 2 EXAM SUCCESS RATES



RELATION OF SCORES

2015 PART 2 (FIRST 7 WEEKS) TO FIRST ATTEMPT ON PART 1 EXAMINATION



The correlation between the 2015 Part 2 Exam (first 7 weeks) scaled scores and First Attempt Part 1 Exam scaled Scores is 0.391, $p < 0.001$

STAGED EXAMINATIONS



BASIC Examination

- Focuses on scientific basis of clinical anesthetic practice
- Residents are strongly encouraged to take it as soon as eligible



ADVANCED Examination

- Emphasis will be on subspecialty based practice and complex clinical issues, but will include content from entire BASIC /ADVANCED Exam content outline
- Offered for the first time - **Friday, July 29** and **Saturday, July 30, 2016**



APPLIED Examination

- Will replace the Part 2 (Oral) Examination in 2017, and will eventually include both the oral exam and Objective Structured Clinical Examinations (OSCEs)

TRANSITION TO STAGED EXAMS

- Residents who will complete training **before June 30, 2016** will take the traditional **Part 1 and Part 2 Exams**
- Residents who began their four-year training in anesthesiology on or after July 1, 2012 and will complete their training **on or after June 30, 2016** will take the **staged exams**
 - Encourages residents to engage in more sustained study over the course of residency training
 - Aligns with ACGME Milestones

DURATION OF CANDIDATE STATUS

- Candidates who completed residency training **prior to Jan. 1, 2012** have until Jan. 1, 2019 to satisfy all certification requirements.
- Candidates who complete residency training **on or after Jan. 1, 2012**, have seven years from the last day of the year in which residency training was completed to satisfy all certification requirements.

2016 BASIC EXAM ADMINISTRATION

- 2016 BASIC Exam administrations held at Prometric testing centers:
 - **June 2016:** Friday, June 10, and Saturday, June 11
 - **November 2016:** Friday, Nov. 18, and Saturday, Nov. 19
- Exam dates align with training reporting periods
- Residents randomly assigned to Friday or Sat. exam
- Residents must register for exam with ABA (March 1 for June exam), then schedule seat with Prometric
- ABA staff will work with Prometric to ensure smoother exam scheduling going forward –

IF A RESIDENT FAILS THE BASIC EXAM...

- It can be taken six months later
- After failing a second time, a resident:
 - automatically receives an unsatisfactory (“U”) for that reporting period
 - will continue to receive a “U” until the exam is passed
- Failing the examination three or more times will extend residency training



THE OSCE

- OSCE intended to assess domains that are difficult to assess in written or SOE formats
 - For example, communication skills
- Development process underway; **Implementation postponed beyond 2017**

WWW.THEABA.ORG

- Sample questions, content outlines and blueprints are available on the ABA website
- Blueprint wrap-around information includes:
 - Examination purpose
 - Exam content
 - Exam specifications
 - Exam administration information
 - Tables showing the number and relative percentage of questions in each of the blueprint content categories



QUESTIONS?

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 Fax: (866) 999-7503
 Email: coms@theABA.org

Mail Correspondence: ABA Secretary
 4208 Six Forks Rd, Suite 1500
 Raleigh, NC 27609-5765



Panel: To Participate or Not to Participate – That is the Question (MOCA: Participate)

Deborah J. Culley, M.D.

November 7, 2015
11:20AM – 12:00PM

ABA THE AMERICAN BOARD OF ANESTHESIOLOGY

MOCA: TO PARTICIPATE OR NOT TO PARTICIPATE

DEBORAH J. CULLEY, M.D.
CHAIR, MOC COMMITTEE, ABA

BRIGHAM & WOMEN'S HOSPITAL, BOSTON

DISCLOSURES

- Director - American Board of Anesthesiology
- Member - Anesthesiology RRC (ACGME)
- Vice Chair - Continuing Certification Committee (ABMS)

MOCA GOAL

MOCA: To demonstrate a commitment to lifelong learning, quality clinical outcomes and patient safety

MOCA 2.0™:
To create a web-based platform that supports personalized knowledge acquisition, assessment and demonstration of proficiencies



WHY PARTICIPATE IN MOCA?

- Diplomates spoke, the Board listened
- MOCA 2.0™ is coming; it promotes knowledge acquisition and retention
- Participation has benefits that outweigh costs
- Offers self-regulation for physicians by physicians

MOCA PERCEPTION SURVEY

INVITED 29,000

You spoke, we listened:

- A majority of respondents said **Part 3 (Exam)** and **Part 4 (Improving Medical Practice)** were the most challenging

You said you wanted:

- A more relevant program
- Simulation and the exam eliminated
- Something less burdensome/costly

28% RESPONSE

MOCA 2.0™ IS COMING

- MOCA 2.0™ will help diplomates integrate customized educational resources into their daily practice. We are:
 - Replacing exam with **MOCA Minute™ pilot**
 - Adding a **practice profile** to customize the MOCA Minute™
 - Making the Part 4 high-fidelity **simulation optional**



MOCA 2.0™ IS COMING

- In 2017, we are adding:
 - Functionality to search CME by topic
 - MOCA 2.0™ dashboard to track knowledge and gaps
 - An online repository to store certificates and other important documents



 THE AMERICAN BOARD OF ANESTHESIOLOGY 7

MOCA FEES AND REVENUE

- The ABA is moving to a \$210 annual fee; Committed to not raising fees
- Clearing up misperceptions:
 - The Board **does not** sell or generate income from CME products
 - The Board generates its revenue from its exams
 - A majority of this revenue funds exam-related expenses



 THE AMERICAN BOARD OF ANESTHESIOLOGY 8

MOCA 2.0™ & KNOWLEDGE RETENTION

- MOCA Minute™ allows diplomates to quickly and continuously assess their knowledge, then **guides them to learning resources**
- Diplomates who actively participated in the 2014 MOCA Minute™ pilot **scored higher** on their subsequent MOCA exam than those who did not participate

 THE AMERICAN BOARD OF ANESTHESIOLOGY 9

MOCA MINUTE™ ASSESSMENT FOR LEARNING

- **Spaced education and retrieval practice** are more effective approaches to addressing **knowledge retrieval and retention**
- In more than 16 randomized trials, **physicians improved long-term knowledge retention** by answering questions over spaced intervals of time*
- MOCA Minute™ offers **practical, self-directed learning**
- It will help physicians more accurately self-assess knowledge and help the Board identify those who are falling behind relative to their peers

*B. Price Kerfott, M.D., EdM, "Brain Science Provides New Approach to Patient Safety Training" Patient Safety & Quality Healthcare, Nov./Dec. 2014, Volume 10, Issue 6

 THE AMERICAN BOARD OF ANESTHESIOLOGY 10

NTL PARTICIPATION – WHY NOT?

- You will **not risk losing certification by participating in MOCA**
- You may **withdraw without penalty**
- You are already meeting MOCA requirements if you are:
 - maintaining your medical license
 - exceeding average CME requirements (25 credits per year)
 - participating in quality improvement activities
- Participating in the MOCA Minute™ will help you **identify knowledge gaps** and **steer you to related CME**, helping you take a strategic approach to learning

 THE AMERICAN BOARD OF ANESTHESIOLOGY 11

BENEFITS OUTWEIGH COSTS

- According to a recent Forbes commentary piece*:
 - a physician's time accounts for **90%** of the cost associated with MOC participation
 - Board-certified physicians make **\$100,000** more than physicians who are not certified



*Keeping Up With The Latest Medical Science: Costs Versus Benefits, Steve Pociask, Forbes, Sept. 21, 2015

 THE AMERICAN BOARD OF ANESTHESIOLOGY 12

PHYSICIAN SELF-REGULATION

- The ABA Board of Directors is made up of 12 practicing anesthesiologists and one public member
- We use our clinical experience and ABMS guidelines to set standards
- Most physicians agree that maintaining medical knowledge is critical
- We are proactively engaging diplomates in an agile redesign process to keep MOCA relevant

**As physicians, we are in the best position to regulate our practice.
If we don't, who will?**

THANK YOU!



Panel: To Participate or Not to Participate – That is the Question (MOCA: Not Participate)

Randolph H. Steadman, M.D., M.S.

November 7, 2015
11:20AM – 12:00PM

Participation in MOCA: NO!

Randolph H Steadman, MD, MS
Professor and Vice Chair
Department of Anesthesiology
David Geffen School of Medicine at UCLA

DISCLOSURE

Chair, ASA Editorial Board for Simulation-based Training
Director, UCLA Simulation Center, an ASA Endorsed Program
Funded research, AHRQ

Objectives

After participation in this session, in regards to MOCA® you will:

1. Recognize the key elements in the controversy surrounding participation
2. Appraise the merits of the debate
3. Conclude whether participation adds value

The Purpose of MOC is Confusing

- Is MOC to reassure the public that physicians meet a “minimal standard” similar to the primary certification?
- Or is the goal to improve all physicians?

The Purpose of MOC is Confusing

- The goal of MOC is to “assure the public that board certified physicians or diplomates demonstrate a commitment to quality clinical outcomes and patient safety.”

<http://www.theaba.org/MOCA/About-MOCA>

Incompetency is Not Identified or Remediated by MOC

- The existence of an examination (Part 3) seems to suggest a “competency” bar
- This confuses Diplomates
- As of Jan 2016, the exam is eliminated

It is a Waste of Time and Money

- Time = money
- Current fee: \$2100 per 10-year cycle
- Becomes a \$210 annual participation fee under MOCA 2.0

<http://www.theaba.org/MOCA/About-MOCA>

It is a Waste of Time and Money

- This does not include:
 - The cost of simulation
 - The cost of other Part 4 activities
 - The cost of travel
 - Time off work
- What is reasonable?

ABMS Boards Have a Conflict of Interest

- This has been most glaring for the ABIM

TECH & SCIENCE Medical Mystery: Making Sense of ABIM's Financial Report



After months of delay, the American Board of Internal Medicine (ABIM) finally filed its latest financial reports with the IRS. Which means it's time to return to a fantasyland where up is down, black is white and money is hidden.

Newsweek May 21, 2015

TECH & SCIENCE Medical Mystery: Making Sense of ABIM's Financial Report

BY HEAT BROWNE/ILLUSTRATION BY JEFFREY M. HARRIS

Beginning in the early 1990s, the ABIM ordered certified doctors to be recertified, again and again. Without the ABIM seal of approval, lots of internists and subspecialists can't get jobs and can't admit patients to hospitals. So by taking advantage of that monopolistic power, the ABIM has forced hundreds of thousands of physicians to follow recertification processes that doctors complain cost them tons of money (paid to the ABIM), require tons of time (taken from families and medical practices) and accomplish nothing.

Newsweek May 21, 2015

Part 4 is Unethical

- Practice improvement modules constitute an experiment – that of changing practice to demonstrate a positive result
- Without IRB oversight PPAI (now termed Improvement in Medical Practice) violates the Nuremberg Code of 1947 and the Declaration of Helsinki

Kempen PM. Anes Analg 2014; 118: 1378

My Institutional Practice Improvements Don't Count

- "I'm on institutional and departmental QA committees, and develop practice guidelines and clinical pathways, so why don't these activities count?"

It Must Not be Important – Not Everyone Has to Participate

- MOC is not required for Diplomates with non-time-limited certificates issued before 2000

It is Not Evidence-Based

- Where's the proof that MOC is meaningful?

The Public is Unaware of Any Significance

- 2003 Gallup poll funded by ABIM
 - Less than 1/3 of respondents knew if their doctor was certified
- A substantial minority of physicians are not certified (~25%)
 - No public outcry
 - Valuable patient care provided

Kempen PM. Anes Analg 2014; 118: 1378

The Content is Not Relevant to Me

- This may be the most compelling argument
- Why do I need to study OB or pediatric anesthesia if I no longer provide services for these patients?
- Why do I need to attend a simulation session that includes these patients if I have no opportunities to perform practice improvements in this area?

Conclusion

- New elements in 2.0 give Diplomates:
 - Options regarding what activities they select
 - Formative feedback that is specific to their needs
- MOC is evolving as is the evidence
- The value decision is yours



Data, Transparency & Engagement: Forces for Transformation in Academic Medicine

Vivian Lee, M.D.

November 7, 2015
12:30PM - 1:30PM

TRANSPARENCY

And Engagement

VIVIAN S. LEE, M.D., Ph.D., M.B.A.
 SENIOR VICE PRESIDENT UNIVERSITY OF UTAH HEALTH SCIENCES
 CEO UNIVERSITY OF UTAH HEALTH CARE
 DEAN UNIVERSITY OF UTAH SCHOOL OF MEDICINE

SOCIETY OF ACADEMIC ANESTHESIOLOGY ASSOCIATIONS 2015

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Who is the

UNIVERSITY

of Utah...

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ACCESS

- 4 Hospitals
- 11 Community Clinics
- 14 Regional Partners
- 10% of the Continental U.S.
- 1,380 Physicians

DISCOVERY

- \$270 Million+ Grants in FY2015
- 2,500 Peer-Reviewed Papers
- 810+ Grants Received 2015
- NO Comprehensive Cancer Center

EDUCATION

- School of Medicine
- College of Nursing
- College of Pharmacy
- College of Health
- School of Dentistry

1.4 MILLION Patient Visits

\$3.2 BILLION Expense Budget FY15

50% IN 5 YEARS

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By the way,

WHERE

is Utah...

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THE NEW YORKER

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UTAH HAS THE BEST HEALTH AT THE LOWEST COST

Healthiness

Affordability

Worst Health/ Most Affordable

Best Health/ Most Affordable

Worst Health/ Least Affordable

Best Health/ Least Affordable

UT \$5,801

WA \$4,276

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UNIVERSITY OF UTAH HEALTH SCIENCES

What the Dean
EXPECTS FROM
 the (Anesthesiology) Dept.

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WHAT THE DEAN SEES

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CHANGE IS UPON US

BETTER LIKE THIS? **OR LIKE THIS?**

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CHANGE IS UPON US

BETTER LIKE THIS? **OR LIKE THIS?**

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UNDERSTAND THE DEAN'S VISION

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ANESTHESIOLOGY'S CONTRIBUTIONS

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FIND THE ALIGNMENT

health care SOLUTION?

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Engagement &
TRANSPARENCY
to Transform University Health Systems

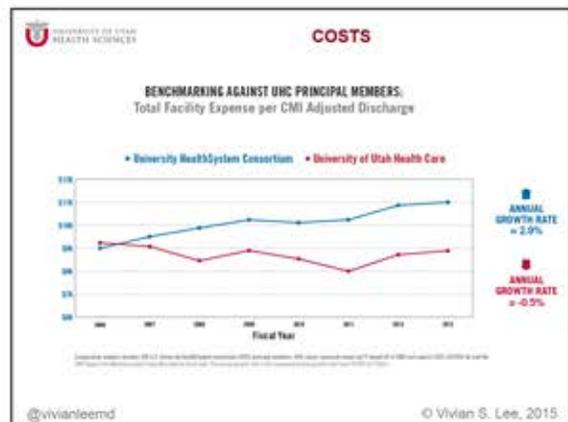
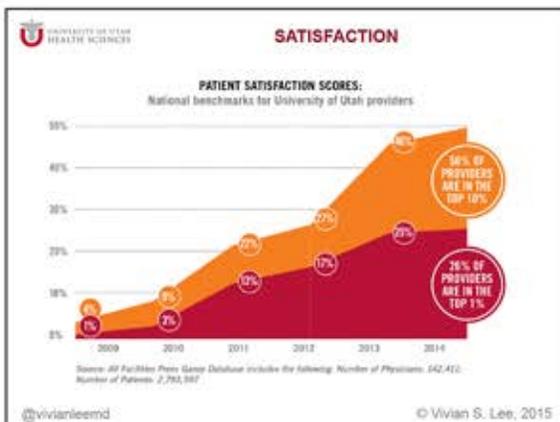
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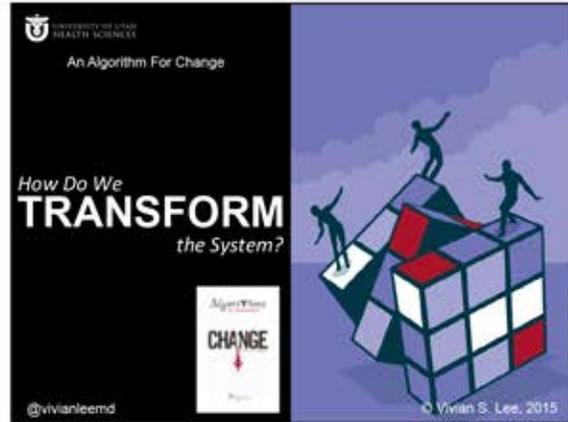
THE TRANSFORMATION

V = $\frac{Q + S}{\$}$

(VALUE) (QUALITY) (SERVICE) (COST)

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HOW WE MEASURE SATISFACTION

CARE PROVIDER

	Very Poor	Poor	Fair	Good	Very Good
1) Friendliness/courtesy of the care provider					
2) Explanations the care provider gave you about your problem or condition					
3) Concern the care provider showed for your questions or worries					
4) Care provider's efforts to include you in decisions about your treatment					
5) Information the care provider gave you about medications (if any)					
6) Instructions the care provider gave you about follow-up care (if any)					
7) Degree to which care provider talked with you using words you could understand					
8) Amount of time the care provider spent with you					
9) Your confidence in this care provider					
10) Likelihood of your recommending this care provider to others					
11) Comments (describe good or bad experiences)					

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HOW WE ENGAGE FACULTY WITH DATA

	National Rank		
	2011	2012	2013
MD - Cardiology			
Care Provider Section	29	63	81
Friendliness/courtesy of CP	28	59	76
CP explanations of prob./condition	29	67	80
CP concern for questions/worries	31	63	80
CP efforts to include in decisions	29	67	84
CP information about medications	28	62	74
CP instructions for follow-up care	28	52	68
CP spoke using clear language	29	59	76
Time CP spent with patient	31	55	72
Patient's confidence in CP	40	73	93
Likelihood of recommending CP	24	61	89

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HOW WE ENGAGE FACULTY WITH DATA

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CONTRIBUTING TO A NATIONWIDE SOLUTION

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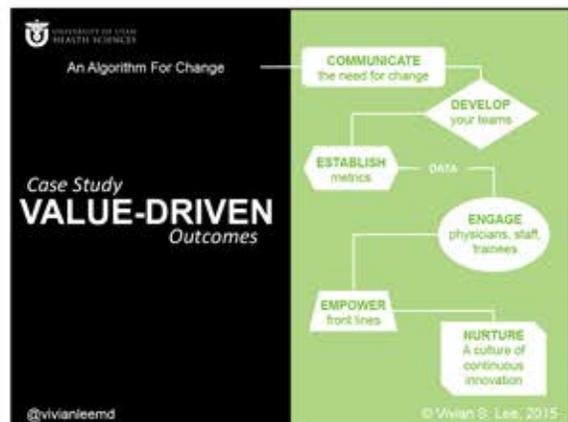
CONTRIBUTING TO A NATIONWIDE SOLUTION

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THE TRANSFORMATION FROM VOLUME TO VALUE

$$V \text{ (VALUE)} = \frac{Q \text{ (QUALITY)} + S \text{ (SERVICE)}}{\$ \text{ (COST)}}$$

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UNIVERSITY OF UTAH HEALTH SCIENCES

THE TRANSFORMATION FROM VOLUME TO VALUE

Harvard Business Review

The Big Idea

THE STRATEGY THAT WILL FIX HEALTH CARE

"For a field in which high cost is an overarching problem, the absence of accurate cost information in health care is nothing short of *astounding*."

Robert S. Kaplan and Michael E. Porter
"The Big Idea: How to Solve the Cost Crisis in Health Care" *HBR*, September 2011



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VALUE DRIVEN OUTCOMES



You Don't Want to Know

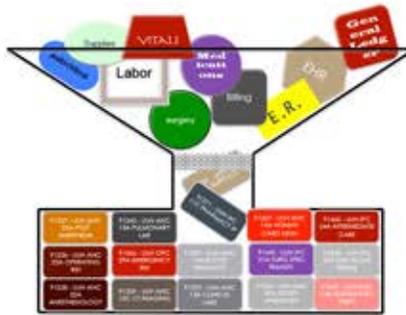
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547

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VALUE DRIVEN OUTCOMES



Value

Cost

Quality

VIDALI

Labor

Medical Services

Pharmacy

Other

E.R.

Gain and Value

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VDO ALLOCATE EXPENSES



Laboratory

Supply

Pharmacy

Diagnostic Imaging

Other

Operating Room Utilization

Accommodation

Cost Type Groupings

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VALUE-DRIVEN OUTCOMES - APPENDECTOMY

Day 1 (08:00am - 10:00am)

Day 2 (08:00am - 02:00pm)

Day 3 (08:00am - 02:00pm)

Day 4 - 1 (08:00am - 02:00pm)

Emergency Department (10:00am - 11:00am)

Operating Rooms

Surgical ICU

Step down and Floor Units

Laboratory

Pharmacy

Other Services

Total Cost of Providing Patient Care

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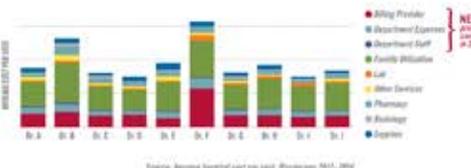
UNIVERSITY OF UTAH HEALTH SCIENCES

VDO ALLOCATE EXPENSES

UNIVERSITY OF UTAH - AVERAGE COSTS OF CARE FOR TOTAL JOINT REPLACEMENT

Value-Driven Outcomes (VDO) Report

DRS 470 - Major joint replacement of the lower extremity



NEW Department Costs added in 2014

Billing Provider

Department Expenses

Department Staff

Facility Utilization

Lab

Other Services

Pharmacy

Radiology

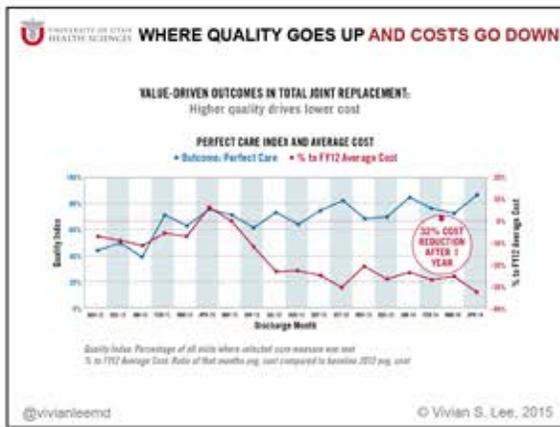
Supplies

Source: Average hospital cost per case, *Healthcare* 2012-2014

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DATA FOR A LEAN PROCESS

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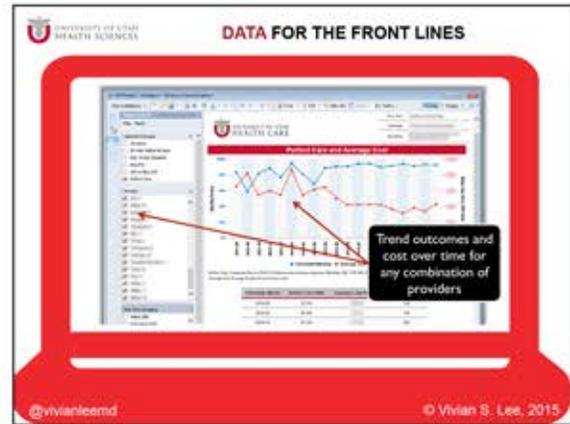
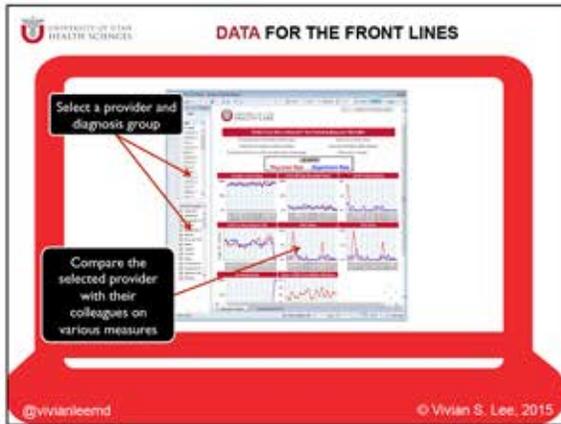


DATA FOR THE FRONT LINES

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DATA FOR THE FRONT LINES

Key Operating Room Areas

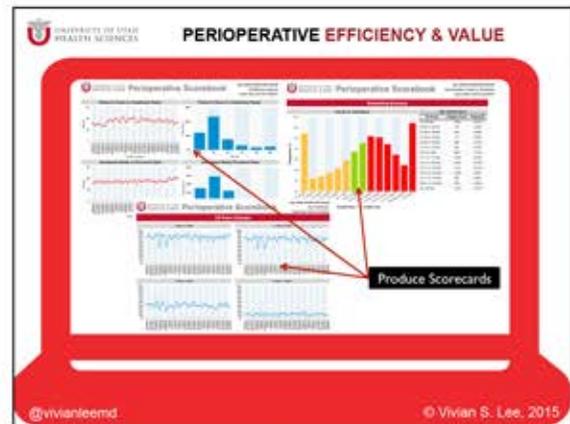
Space Labor

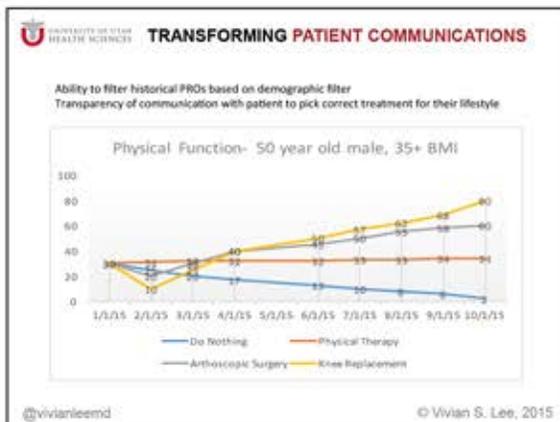
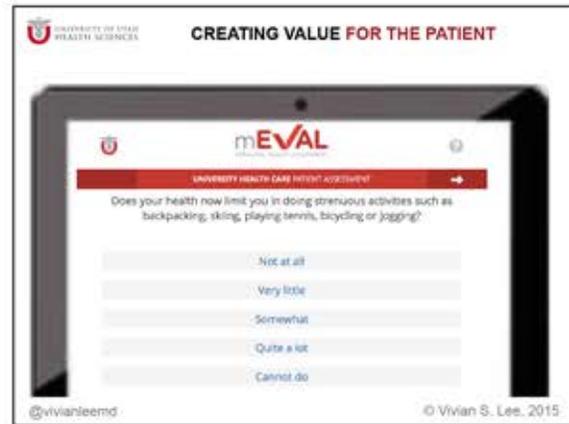
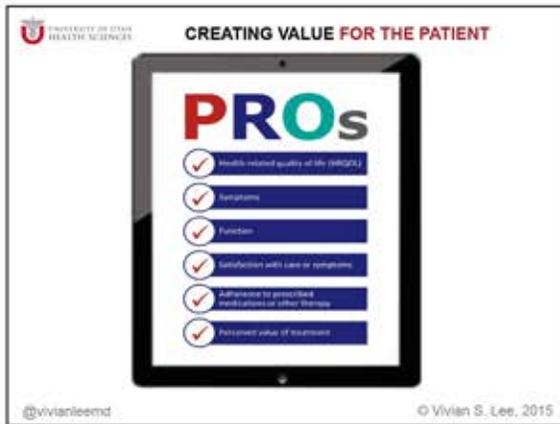
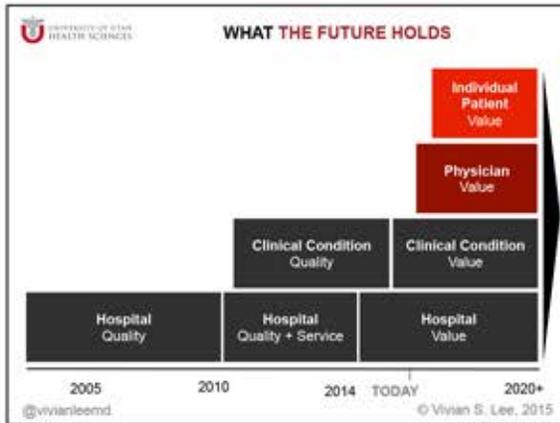
Supplies/Implants Pre-Op Care Post-Op Care

Anesthesiology Equipment

Perioperative VALUE

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TRAINING FOR THE FUTURE



DATA-DRIVEN
PATIENT-CENTERED TRANSPARENT

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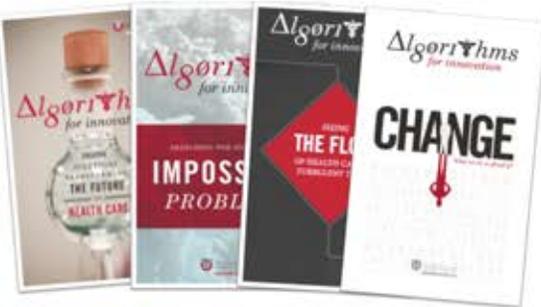
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“THE SECRET TO CHANGE IS TO FOCUS ALL YOUR ENERGY NOT ON FIGHTING THE OLD, BUT ON BUILDING THE NEW.”

-Socrates

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THANK
You

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ROCIETY OF ACADEMIC ANESTHESIOLOGY ASSOCIATIONS 2015

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Whether, How and Why Departments Should/Shouldn't Make Accommodations for its Members with Learning Disabilities

Michael G. Fitzsimons, M.D., FCCP

November 7, 2015
1:30PM - 2:00PM

**Whether, How, and Why Departments Should/Shouldn't Make Accommodations for its
Members with Learning Disabilities**

Society of Academic Anesthesiology Associations

November 7, 2015

Baltimore, MD

Michael G. Fitzsimons, M.D., FCCP

Department of Anesthesia, Critical Care, and Pain Medicine

Massachusetts General Hospital

Boston, MA 0214

Disclosures

I am not an expert in this area, but throughout my career in medicine as a Flight Surgeon, Clinical Competency Committee Chairperson, Fellowship Program Director, and Division Chief, I have had to deal with the impact of illness on the health of an individual as well as their career and personal identity.

The question of whether academic Departments of Anesthesiology should offer accommodations to individuals with learning disabilities requires that leaders understand the basic definition of disability, prevalence, impact, and means to offer assistance to our colleagues. The framework for these decisions must balance our quality and safety responsibilities to the patient, with compassion for the disabled individual¹. Facilitating the entry of those individuals with learning challenges and others with physical, sensory, and motor disability will allow us to form a truly

inclusive and diverse cadre of healthcare providers, many of who, with appropriate accommodations, are able to deliver great care².

Prevalence and Background

The World Report on Disability notes that nearly 1 billion people worldwide suffer from some disability³. It is estimated that nearly 57 million American citizens are currently living with a disability, a number greater than the entire population of Canada. The number grows as the population ages. Approximately 8% of those under fifteen are disabled, but by the age of 65, nearly 50% have a condition that impairs their daily living⁴. The numbers are increasing⁵.

Disabled individuals in society have lower levels of education and employment⁶. They have higher rates of poverty and are more likely to become victims of crime and domestic violence.

Medically they suffer higher rates of depression, anxiety, and stress. This is coupled with higher rates of obesity and tobacco use. Disabled women are less likely to obtain Pap smears or have a mammogram⁶.

Context

The motto of the American Society of Anesthesiology (ASA) is “vigilance”. Our practice requires that we have the cognitive ability to review conditions and make sound decisions, the physical ability to perform often delicate procedures with accuracy and efficiency, we must have senses that allow us to see and hear alarms, verbally communicate our concerns, summon help or respond and react or immediately in order to provide care. We must have the emotional capability of control in crisis. Thus, certain disabilities may potentially hinder our ability to perform.

The management of motor, sensory, cognitive, or emotional disabilities is rarely black and white, but more often is a very hazy shade of gray. Learning disabilities among graduate medical education have been more poorly studied than physical, sensory, and motor disabilities. Very little has been published on disability among anesthesiologists or residents in *Anesthesiology*^{7,8,9,10}.

Several questions must be answered in order to determine whether academic medical centers should make educational and professional accommodations to facilitate both training and clinical practice.

What is a Disability?

The Rehabilitation Act of 1973 was the first attempt to ensure opportunities including equal access to education for individuals with disabilities. This primarily focused on programs receiving *federal funding*. This resulted in a significant increase in the number of handicapped persons seeking higher education. The Americans with Disability Act of 1990 (ADA) expanded rights to the private sector. The ADA defined a disabled person as one who has a physical or mental impairment that substantially limits one or more major life activity. This includes people who have a record of such impairment, even if they do not currently have a disability. The ADA also makes it unlawful to discriminate against an individual based on that person's association with a person with a disability¹¹. The ADA defines "qualified with a disability" as an individual who with or without reasonable accommodation, can perform the essential function of a position

¹². The ADA Amendments Act of 2008 attempted to relax strict standards of proof that a disability actually exists.

The term ‘major life activities’ generally includes functions which are typically required for daily life and are performed independently such as walking, sleeping, eating, sitting, standing, learning, hearing, lifting, reaching, and working. Another means of classifying functional limitations includes *basic action difficulties* (movement, sensory, emotional, cognitive) or *complex activity limitations* (limitations in self-care, social interaction, or work)⁵.

There is not a single universally accepted definition or a “disability”. The World Health Organization, Social Security Administration, as well as the American Medical Association have all established terminology¹³. It is critical to understand that the presence of a condition does not imply a disability; in fact this is a social stigma that infiltrates physician-patient or even employer-employee relationships. This may lead individuals to feel compelled to conceal a medical condition and not ask for assistance.

Conditions that *may* involve a disability can be generally divided into physical (sensory and motor), cognitive, and emotional. Examples are provided in Table 1.

Table 1 – Examples of conditions that *may* result in a disability

Physical Disability	Cognitive	Emotional
Visual impairment Hearing impairment Multiple sclerosis Cerebral palsy Amputation Spinal cord injury	ADHD Dyslexia Dyscalculia Dysgraphia Language processing disorders Non-verbal learning disability	Substance Use Disorders (SUD) Anxiety Depression Bipolar disorder

Chronic pain Latex allergy Vertigo		
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What is the incidence of disability throughout the spectrum of professional development including medical school, residency, and professional practice?

Several studies have examined the incidence of disability in US medical students. Wu et al. examined physical disability between 1987 and 1990¹⁴. Approximately 0.19% of over 33,000 students graduated with a physical disability. Nearly 50% of these individuals required some sort of device to facilitate their performance (wheelchair, cane, hearing aids, artificial limb, insulin pumps, electric carts, eye glasses). The vast majority of disabilities were present before admission to medical school. Moutsiakis et al noted an incidence of 0.15% between 2002 and 2005¹⁵. Eickmeyer et al reviewed medical school experience with disability between 2001 and 2010¹⁶. Less than 1% (0.56%) of students had a disability at matriculation and 0.42% upon graduation. Very little work has been done to determine the incidence of disability among physicians in graduate medical education. Takakuwa et performed a survey of directors of Emergency Medicine residency programs¹⁷. Sixty-two (62) of 4,644 residents were identified as having a disability (1.3%). The majority of disability were learning (29%) followed by depression/bipolar (12.9%), and musculoskeletal (9.7%). No article has been published that assessed the incidence of disability in the anesthesia community.

What impact does the presence of a disability have on a medical professional?

Searcy et al studied the course of medical school applicants that required additional time on the Medical College Admission Test (MCAT) and found that those applicants who required additional time had lower rates of passing Step examinations at each level and also graduated

from medical school at a lower rate than other colleagues¹⁸. Wu et al notes that the majority of medical students with a disability performed at an average or above average level¹⁴. Nearly 50% of the individuals required some sort of device to facilitate their performance (wheelchair, cane, hearing aids, artificial limb, insulin pumps, electric carts, eye glasses). Eickmeyer found that those medical students with a disability had a far higher rate of attrition from medical school than those without¹⁶. Takakuwa et al noted that 79% those residents in Emergency Medicine with a disability either graduated or were expected to graduate at the time of the study¹⁷. Individuals that disclosed a disability prior to matriculation were more likely to graduate.

Our discussion thus far had revealed that medical students with a disability graduate at a lower rate than peers without. Neal-Bolyn et al interviewed 20 medical professionals having a disability and five findings were noted (Table 2)¹⁹. Findings revealed that disabled healthcare providers rarely seek accommodations and often struggle with disclosure of their condition. They do not disclose their condition nor seek accommodations. They also experience emotional roller coasters from anger and grief to optimism.

Table 2 – Career Trajectory of the Disabled Practicing Healthcare Provider

Disability Impact	Manifestation
Narrow career choice and trajectory	Initial specialty choice, job changes
Disclosure of condition to employer or supervisor?	Individual struggles alone
Rarely seek legally guaranteed workplace accommodations	Do not receive assistance and workplace continues with environment not accepting of disabilities
Interpersonal interactions reflect institutional climate	Assumptions made that an individual cannot perform tasks
Reactions to work-place disability-related challenges run from anger, grief, to resilience and optimism	Feelings of being undervalued but have a high tolerance for compromise and negotiation at work

Neal-Boylan L, et al Acad Med 2012;87:172-178

What are the legal rights of an individual with a disability and what are the rights of an institution in managing a disability?

The legal rights of an individual with a disability are outlined well in the three key federal acts, Rehabilitation (1973), ADA (1990), and the ADA Adjustments Act (2008). Specific challenges have been brought to court made regarding decisions by institutions. *Jakubowski v Christ Hospital* (2010) resulted in the recognition that an employer has an obligation to participate in an “interactive process” to assess possible accommodations for a disability²⁰. Legal challenges have specifically included medical training. These largely focus on the impact of management of a disability during training and the burden the program will have to accept to offer accommodations. *Doherty v Southern College of Optometry* addressed whether an examination that required dexterity should be waived for a disabled individual. The court held that a course that is “reasonable and necessary” does not need to be eliminated nor altered²¹. An example of “reasonable and necessary” in an anesthesiology residency would include the ability to perform intubation. *Wynne vs. Tufts University School of Medicine* determined that deference must be paid to an institution as long as that institution demonstrates that an effort was made to investigate alternatives to a particular activity²². *Southeastern Community College v Davis* (1997) made the key determination that an accommodation is “not reasonable” if it creates an undue financial or administrative burden, or that the accommodation would fundamentally alter the nature of the program²³. The question of whether a trainee is afforded the protections of a student or whether they are considered an employee has been subject to litigation. The ADA requires that employees establish processes where individuals with disabilities have equal opportunities to (1) apply and work in a job for which they are qualified, (2) have the chance to be promoted, (3) have equal access to benefits offered to other employees, and (4) are not harassed because of a disability.

The employer has several rights, and accommodations are not simply requests that must be granted (Table 2).

Table 3 – Limitations on the obligation to provide accommodations

<p>There is no obligation to provide an accommodation that would assist on and off the job (prosthetic limb) No obligation to remove or alter essential job functions No obligation to lower production or performance standards No obligation to tolerate violations of conduct rules necessary for operation of business</p>

What are “accommodations” in management of disability and how does a program implement them?

An accommodation is considered any modification or adjustment to a job or work environment that enables a qualified person with a disability to apply for or perform a job. The term also encompasses alterations to ensure that a qualified individual with a disability is afforded the rights and privileges in employment equal to those of employees without disabilities. In the simplest term, an accommodation is an activity to remove a *workplace barrier*. These barriers may be physical or administrative. The obligation to provide reasonable accommodations for job applicants or employees with disabilities is one of the key non-discrimination requirements in the ADA's employment provisions²⁴. Accommodations are condition specific. Not all individuals with a certain condition may require accommodations and not all individual with a condition require the same accommodation. Some accommodations are general and apply to many conditions (Table 2). While others are more case specific.

Table 2 – Non-specific Accommodations

<p>Sensitivity training for coworkers Maintain open lines of communication Allow communication with the individual's physician</p>
--

Flexible medical leave
 Breaks
 Check-lists/"To do" lists/ Reminders
 Part-time work
 Assistance with development of strategies to assist with problems *before* they occur
 Establishing mentoring programs with faculty that understand disability
 Assessment of appropriate technical needs rather than rigid general standards

Should or shouldn't academic departments of anesthesiology offer accommodations to trainees and faculty members?

When considering whether academic departments of anesthesia should make not only basic but exceptional efforts to accommodate individuals with disabilities decision makers will need to balance their responsibility to three populations: the patient, the aspiring or attending physician, and the effect on society as a whole. Medical ethics has traditionally stressed that our primary responsibility is to assure the well-being, and more recently the safety, of the patient. The Accreditation Council for Graduate Medical Education (ACGME) has avoided specifics on disabilities in specific common program requirements but under the institutional requirements notes that, "The Sponsoring Institution must have a policy, not necessarily GME-specific, regarding accommodations for disabilities consistent with all applicable laws and regulations"²⁵. A residency applicant or a current trainee is under no obligation to disclose a past, present, or even potential future disability at the time of application. Even if a disability has required accommodations in the past, this does not need to be disclosed. When an individual does request "modifications", accommodations, or chooses to disclose a disability, leadership is obligated by law to engage in an "interactive process" *with* the individual in order to determine whether accommodations are needed and whether those accommodations are reasonable. A mere superficial assessment without a concerted good faith effort may place the employer and others in legal jeopardy. Direct reference to the ADA or even the term "accommodation" is not

necessary, “plain English” may be used. Additionally a surrogate such as a friend, family member, health professional, or rehabilitation counselor may request specific accommodations²⁶. The “interactive process” involves a good faith discussion between the individual and supervisor regarding what is needed. If the disability is not obvious then additional information may be requested but only enough to assist with the determination of appropriate accommodation. An employer may not request an entire medical record but may ask the employee’s physician for a description of how the disability will affect their position, how long they anticipate the impact, and recommendations for specific modifications to their routine tasks.

When determining whether an accommodation is “reasonable” two major factors are considered, cost and whether the essential function of the position must be modified. A cost-benefit analysis by the employer includes the cost of initiating the accommodation as well as the sustaining cost over time. It is the burden of the employer to determine whether an accommodation is too expensive. Many accommodations for the learning disabled resident are quite inexpensive considering the benefit that is obtained in both the short- and long-term (Table 3).

Table 3- Potential Reasonable Accommodations for the Learning Disabled Resident

Additional time on examinations Explicit written instructions Explicit feedback Check-lists Allowance for notes in the operating room Individual tutoring Extra examinations (practice)

Organizations are appropriately looking at diversity among their cadre. The majority of these efforts are focused on addressing barriers to gender, racial, ethnic, and sexual orientation, yet

disability is rarely discussed. Whether intentional or accidental, this manifests as underrepresentation of a portion of the population in the healthcare profession. The incidence of physical, sensory, cognitive, and emotional disabilities in medical students, residents, and practicing physicians is lower than reported in society. Those individuals that are disabled but successfully navigate the training necessary to enter the healthcare profession often continue to face unnecessary physical and nonphysical barriers²⁷. Healthy Persons 2020 established several goals applicable to medical education. These included expansion of disability and health training opportunities for public health and healthcare professionals as well as the inclusion of people with disabilities in all health promotion efforts²⁸. Ultimately the question on whether or not to offer an accommodation must not lose sight of the delivery of excellent patient care.

Academic Departments of Anesthesia that wish to serve a growing diverse population must first obtain the skills and expertise for understanding the individuals, the contributions they make, and the needs they may have. There is no better resource than a practicing physician who has direct personal experience with a disability. A willingness to actively and openly work to remove physical and non-physical barriers, and to consider alternative educational options, will allow us to truly increase the representation of the disabled among our faculty. This increased representation will allow us contribute to the betterment of healthcare for disabled persons.

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Strategies to Prevent Burnout of Leaders in Academic Medicine

Mark Hyman Rapaport, M.D.

November 7, 2015
2:00PM – 2:30PM

Strategies to prevent burnout in leaders in academic medicine

Mark Hyman Rapaport MD
Department of Psychiatry and Behavioral Science
Emory University School of Medicine

A LITTLE ABOUT THE BIOLOGY OF STRESS

INDIVIDUAL VARIATION

Ancestral environment prior to conception affects behavior of descendant generations

F0 female rats exposed to fungicide – Mate preference affected in F3 generation

Transgenerational epigenetic imprints on mate preference

David Crews^a, Andrea C. Gore^{a*}, Timothy S. Hou^a, Nygerma L. Dangleben^a, Michael Spinetta^a, Timothy Schaller^a, Matthew D. Anway^a, and Michael K. Skinner^{a*}

Proc Natl Acad Sci U S A. 2007; 104(12):5085-5090

Social defeat of F0 male mice – F1 generation showed depression-like behavior

Paternal Transmission of Stress-Induced Pathologies

David M. Dietz, Quincey LaPlant, Emily L. Wams, Georgia E. Hodes, Scott J. Russo, Jian Feng, Ronald S. Osting, Vincent Vialou, and Eric J. Nestler

Biol Psychiatry. 2011

Also: Mansuy, Roth, Bale and others

3

Ancestral environments affect biology of descendants



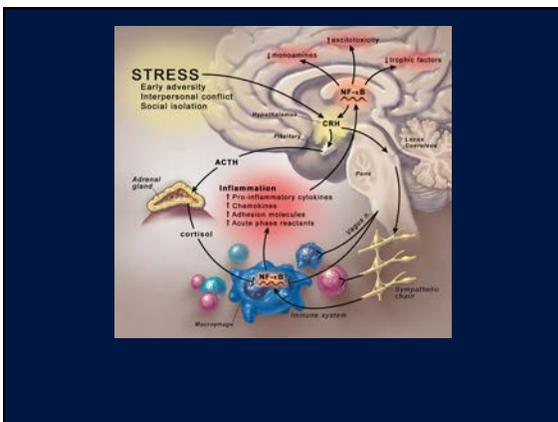
BRIEF REPORT

Transgenerational Effects of Posttraumatic Stress Disorder in Babies of Mothers Exposed to the World Trade Center Attacks during Pregnancy

Rachel Yehuda, Stephanie Mulholland Engel, Sarah R. Brund, Jonathan Seckl, Sue M. Marcus, and Gertraud S. Barkovits

The Journal of Clinical Endocrinology & Metabolism. 2011; 91(11):4115-4120

4



Major Clinical Disorders Associated with Inflammation and Stress

- **Cardiovascular Disease**
 - Inflammatory markers (CRP/IL-6) are potent predictors of disease outcome; involvement of inflammation in plaque formation
- **Diabetes/Metabolic Syndrome/Obesity**
 - Inflammatory markers (CRP) predict disease development; high correlation between insulin resistance and IL-6 and other inflammatory markers
- **Cancer**
 - Activation of inflammatory signaling pathways (e.g. NF-kB) implicated as a fundamental mechanism of carcinogenesis and chemotherapy resistance

KEY TAKE HOMES ABOUT STRESS BIOLOGY

- EACH OF US IS UNIQUE- GENETICS, EPIGENETICS, GENE X ENVIRONMENT EXPERIENCES
- WE CAN CHANGE OUR BIOLOGICAL RESPONSES TO DIFFERENT TYPES OF PHYSICAL AND PSYCHOLOGICAL STRESS
- STRATEGIES NEED TO BE TAYLORED TO THE INDIVIDUAL BUT CERTAIN BASIC CONCEPTS APPLY

CHARACTERISTICS, KNOWLEDGE, AND SKILLS OF A SUCCESSFUL LEADER

Some of the initial sources of dissonance

Traditional Skills needed to Advancement in Academic Medicine

- Research acumen
- Grant writing skills
- Paper writing skills
- Ability to make research presentations
- Independent entrepreneur
- Gamesmanship

Skills needed to be a successful leader

- *Management skills*: **budgets**, hiring, evaluating personnel, firing, setting and achieving short-term goals
- *Leadership skills*: **communicating**, creating a vision, establishing values, creating/changing a culture, strategic planning and implementation, tactical planning and execution, managing above-below- and across an organization

Characteristics of successful leaders

- Honesty
- Humility
- Collaborative
- Compassionate
- Willing to take reasonable risks
- Willing to admit mistakes
- Willingness to grow and change
- Bravery
- Communicators
- Flexibility
- Resilient

“The other things needed”

- Intelligence- both intellectual and social
- “Fire in the belly”
- Intellectual and emotional maturity
- A willingness to put the success of others before your own and be able to celebrate their accomplishments
- A desire to teach and educate (in the larger sense)

WHY WE GET INTO TROUBLE AND WHAT SETS US UP FOR BURNOUT

Internal systems issues
External systems issues
Individual issues

A Department is a meta-stable state

- There are always *anticipated issues*:
 - Personnel (hiring, HR, faculty development, leaving)
 - Budget
 - Education/training
 - Research
 - Patient-related/clinical services
 - Community relations/philanthropy
 - Resource needs
- You can predict that *unpredictable crises and opportunities* will arise (just not when or what)

Internal systems issues

- We need to:
 - Delegate and hold people accountable (the *right team*)
 - Develop *systems* to manage: HR issues, recruitment, budgets, program and research planning/implementation, training concerns, continuous process improvement
 - *Communicate*, we never do a good enough job doing it
 - Protect *time to think strategically and tactically*

External systems issues

- Most leaders are “*middle men*” and must manage above and below and across
- *Alignment/misalignment* problems cause tremendous stress and burnout
- *Changes in systems*: ACA act, CMS requirements, healthcare system expectations, School of Medicine expectations, funding sources, NIH/ DOD, *perturb all!*
- What if our bosses cannot lead?
- Finances!

Individual issues

- “No (wo)man is an island” or “it takes a village to be a successful leader”
- Transference.....makes our world.....
- Most of the time it is not personal.....although it may feel like it is.....and occasionally it is personal
- Work relationships versus friendships...if you want unconditional positive regard...get a dog.
- “Rich people’s problems”

But what can we do about it?

When you feel overwhelmed or
under continual stress

STOP!

Is this the right job, the right
place, and the right time?

Are you doing what makes you happy
(at least for the majority of the
time)?

Overwhelmed: why?

- Perspective- there are times when we have a *platter-full of food on our dinner plate*, do you see a way out? If not, **get help**: peers, a coach, your boss, friends, your administrative team
- What is going on with the *rest of your life*
- *The telescope phenomena*: the need to tease apart tasks and timelines
- Turn off all of your gadgets, you may be *too connected* to get work done and you are using your gadgets to keep you from starting to dig out
- Are these *rich peoples problems*?
- What can you delegate?
- What can wait?

Less may be more

Working more hours is frequently **not** the
answer

Being scheduled to the point of fatigue and
distraction decreases problem-solving skills,
patience, communication skills and efficiency

Look, listen and learn

- What types of circumstances create the most stress for you?
- Ask others for advice and feedback
- Are there skills you need to learn?
- Are there better ways to address these situations in the future?
- Are there mechanisms (or people) that can help you with these tasks?

“To thy own self be true”

- Do you make time for your own well being:
 - Sleep and rest
 - Exercise
 - Some things in life to look forward to
 - Family & Friends
 - Controlling your own schedule
 - Trying something new
 - Taking “real” vacations

Resources

- AAMC
- Harvard leadership development programs
- Stress reduction programs: mindfulness programs, compassionate meditation programs
- Executive coaching

Work to live!... Do not live to work

- There are intrinsic biological differences in how we handle stress
- If one is under continual stress, stop and identify the sources:
 - is it the fit with the job?
 - Is the infrastructure missing?
 - Is there a misalignment?
 - Are there external factors?
 - Have I collapsed the telescope?
 - What can I change and how?
 - Am I out of balance? Why and what can I do to fix it?
- You can fix it !



Approaches To Transform A Disruptive Physician Into A Productive Member Of Your Faculty

Mohammed M. Minhaj, M.D., M.B.A.

November 7, 2015
2:30PM - 3:00PM

Approaches To Transform A Disruptive Physician Into A Productive Member Of Your Faculty

Mohammed M. Minhaj, MD, MBA
 Vice-Chair for Finance & Operations
 Associate Chair for Faculty Development
 Department of Anesthesia & Critical Care
 Medical Director for Physician Support & Professionalism
 University of Chicago Medicine

No Disclosures

Outline

- What is Disruptive Behavior?
- The Impact of Disruptive Behavior
- Dealing with the Disruptive Provider

What is Disruptive Behavior?



You ask me if I have a God complex...
 Let me tell you something: I AM God.

How Common is Disruptive Behavior?

- 1-5 % of individuals in organizations may be considered disruptive
- Problem: this was once celebrated in medicine.



Behaviors that undermine a culture of safety
 Intimidating and disruptive behaviors can foster medical errors.

<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

What is Disruptive Behavior?

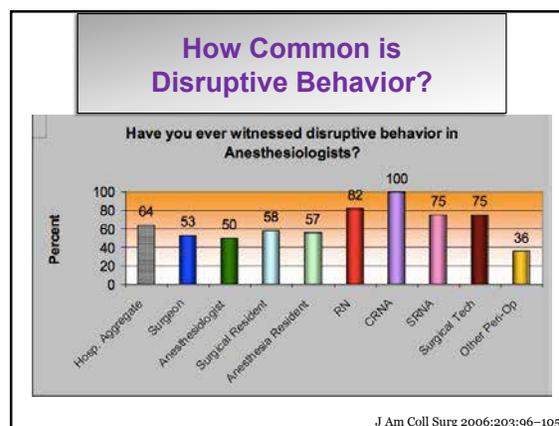
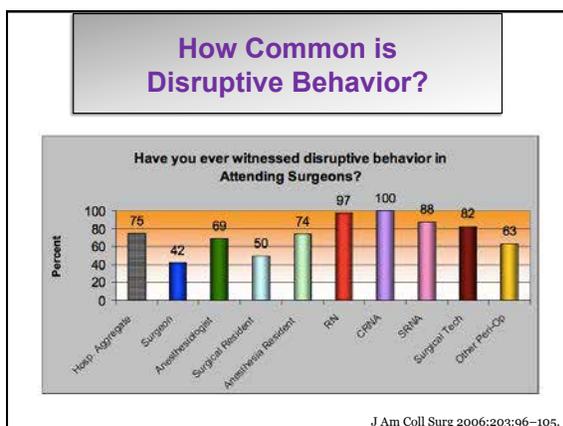
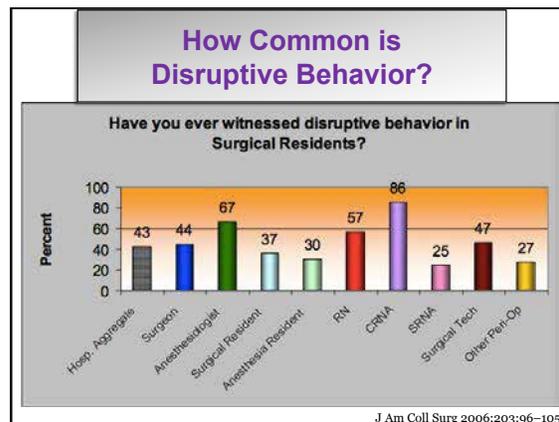
Disruptive Behavior = Workplace Bullying

Impact and Implications of Disruptive Behavior in the Perioperative Arena

Alan H Rosenthal, MD, MBA, Michelle O'Daniel, MD, MBA

- Study Design:
 - 25 question customized survey
 - distributed in large urban academic medical center, having difficulty managing disruptive behavior in OR
 - 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.



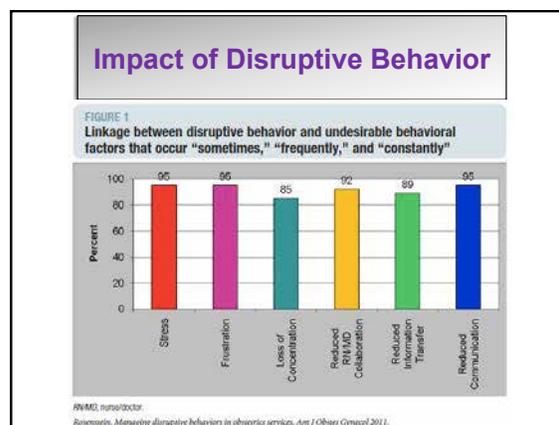
EDUCATION

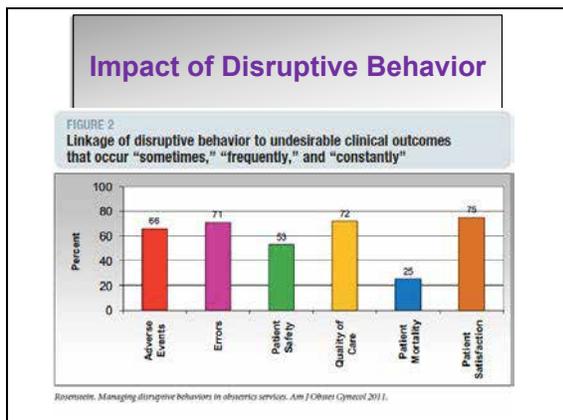
Impact and Implications of Disruptive Behavior in the Perioperative Arena

Alan H. Rosenbloom, MD, MBA, Michelle O'Daniel, MD, MBA

- **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**
 - Significant **negative impact on patient care**
 - Impact on career decisions

J Am Coll Surg 2006;203:96-105.





Is there Legal Guidance?

- April 2008—\$325,000 jury award for hospital employee who sued cardiac surgeon for bullying him
- March 2008—New York state law establishing a cause of action for employees who are subjected to an abusive work environment
- The 'right to criticize' is **NOT** the right to malign

Martin WF. Is Your Hospital Safe? Disruptive Behavior & Workplace Bullying

How does the Disruptive Provider See Themselves?

Usually very believing the point of

THE PHYSICIAN EXECUTIVE JANUARY/FEBRUARY 2003

How do Others See the Disruptive Provider?

- Arrogant
- Entitled
- Bully
- Morale Killer

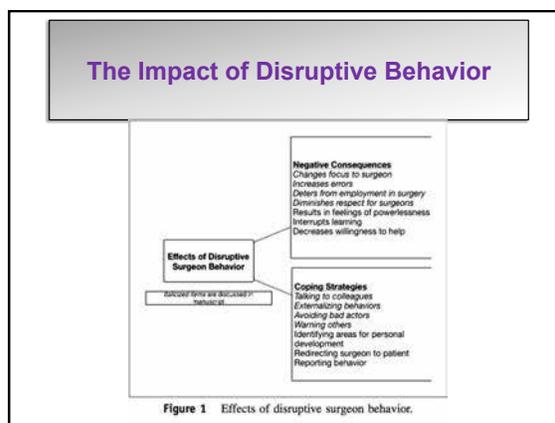
Anesthesiology 2005; 110:760-2 Copyright © 2005, the American Society of Anesthesiologists, Inc. Lippincott Williams & Wilkins, Inc.

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 confidence in anesthesiology, 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



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)
- Decreases respect for physicians and changes career paths for students (*J Am Coll Surg* 2006;203:96-105.)
- Reduces morale amongst other workers if behavior does not change--? Punishment (*Academic Radiology* vol 20:9 2013)

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
 - Not including costs of readmissions, litigation, infection or time spent managing these situations

Rawson J. Acad Radiol 20(9) Sep 1074-76.

The Impact of Disruptive Behavior

TABLE 2. Program Director Time Needed to Support Impaired Resident.

Impaired Resident Support	Time Spent
Discovery phase	12 hours
Time investigating complaint	5 hours
Time meeting with resident	4 hours
Time meeting with others - DIO, CMO, chair, attorneys	3 hours
Decision/treatment phase	55 hours
Time meeting with resident to plan for treatment	5 hours
Time meeting with others - DIO, CMO, chair, attorneys	2 hours
Estimated that it would take up ~ 8 workdays/impaird provider	
Redesign of schedule/curriculum for resident absence	8 hours
Weekly reports	24 hours
Supporting resident, his/her family, and other residents through treatment process	12 hours
Return-to-work phase	9 hours
Paperwork for school, hospital, medical board, Family Medical Leave Act	2 hours
Graduation and future employment	6 hours
Paperwork/phone calls for summary residency, fellowship application, practice interview, medical staff application	2 hours
Time meeting with resident	2 hours
Time meeting with others - DIO, CMO, chair, attorneys	2 hours

CMO, chief medical officer; DIO, designated institutional official.

Outline

What is Disruptive Behavior?

The Impact of Disruptive Behavior

Dealing with the Disruptive Provider

Dealing with the Disruptive Provider

Rule #1: 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

Maxine A. Papadakis, M.D., Arienne Teherani, Ph.D., Mary A. Banach, Ph.D., M.P.H., Timothy R. Knetter, M.B.A., Susan L. Rattner, M.D., David T. Stern, M.D., Ph.D., J. Jon Veloski, M.S., and Carol S. Hodgson, Ph.D.

Table 1. Description of the 740 Violations among 235 Physicians That Led to Disciplinary Action on the Part of 40 State Medical Boards.

Type of Violation	No. (%)
Unprofessional behavior	
Use of drugs or alcohol*	108 (15)
Unprofessional conduct	82 (11)
Conviction for a crime	46 (6)
Negligence	42 (6)
Inappropriate prescribing or acquisition of controlled substances	39 (5)
Violation of a law or order of the board, of a consent or rehabilitation order, or of probation	32 (4)
Failure to conform to minimal standards of acceptable medical practice	31 (4)
Sexual misconduct	29 (4)
Failure to meet requirements for continuing medical education or other requirements	26 (4)
Fraud or inappropriate billing practices (e.g., Medicare billing irregularities)	20 (3)
Failure to maintain adequate medical records	19 (3)
Failure to report adverse actions against oneself in accordance with rules of the board	10 (1)
Conduct that might defraud or harm the public	10 (1)
Other (less than 1% of any single category)	52 (8)
Total	551 (74)
Incompetence	
Health-related problems, incompetence, or impairment	44 (6)
Unknown†	
Violation imposed by another board or agency	87 (12)
License revocation or suspension	28 (4)
Inappropriate treatment or diagnosis of patients or malpractice	7 (1)
Other or not available (less than 1% of any single category)	23 (3)
Total	145 (20)

Predictive variables			
Male sex — no. (%)	129 (12.3)	242 (13.4)	0.001
Undergraduate science GPA	0.84±0.03	0.84±0.03	0.002
MCAT 2 score	0.64±0.04	0.64±0.04	<0.001
Did not pass state or more medical school courses — no. (%)			
One first attempt	99 (21.1)	48 (12.8)	0.001
In years 2–3	45 (18.1)	39 (8.3)	<0.001
In years 3–4	24 (10.2)	26 (5.7)	0.001
NEBME Part 1-UTIMILE Step 1 z score	0.24±0.09	0.44±0.09	0.002
Displayed unprofessional behavior in medical school — no. (%)	92 (39.1)	90 (19.2)	<0.001

Unprofessional Behavior Characteristics (Unadjusted analysis):

- Irresponsibility
- Diminished capacity for self improvement
- Poor initiative
- Impaired relationships with students, nurses, faculty, and residents

Annals of Internal Medicine | ACADEMIA AND CLINIC

Performance during Internal Medicine Residency Training and Subsequent Disciplinary Action by State Licensing Boards

Maxine A. Papadakis, MD; Gerald K. Annals, PhD; Linda L. Blank, Eric S. Holmboe, MD; and Rebecca S. Lipner, PhD

- 66171 physicians entering IM programs b/t 1990-2000
- Compared disciplined vs. non-disciplined physicians

Table 2. Performance and Demographic Characteristics of Internal Medicine Residents*

Characteristic	Physicians Not Disciplined (n = 49,832)	Physicians Disciplined† (n = 3,339)
Reference category		
Male sex (no. [%])	24,916 (50)	1,673 (50)
2-3	14,802 (30)	911 (27)
4-5	10,114 (20)	691 (21)
6-7	9,000 (18)	565 (17)
8-9	1,000 (2)	61 (2)
10-11	1,000 (2)	61 (2)
12-13	1,000 (2)	61 (2)
14-15	1,000 (2)	61 (2)
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Managing the Disruptive Provider— AMA/Joint Commission Approach

TABLE 1. Essential Steps that an Organization Should Take to Deal with Disruptive Behaviors as Outlined by the American Medical Association.

- Clearly state which behaviors will not be tolerated.
- Adopt bylaw provisions or policies for intervening in situations where a physician's behavior is identified as disruptive.
- Establish a process to review or verify reports of disruptive

TABLE 3. Guiding Principles for Hospital's Peer Review Process of an Alleged Disruptive Physician.

- They must operate with a reasonable belief that they are improving the quality of patient care.
- They must only make their decision to revoke or refuse renewal of staff privileges after a reasonable effort to obtain the facts.
- They must provide a fair hearing.

Grogan MJ, Knechtges P, The Disruptive Physician: A Legal Perspective

Managing the Disruptive Provider— Theoretical Models

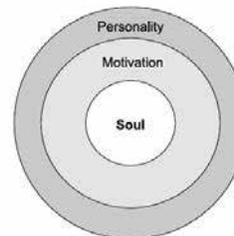


Figure 1. Theoretical Model.

Piper LE. A Theoretical Model to Address Organizational Human Conflict and Disruptive Behavior in Health Care Organizations

Managing the Disruptive Provider 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.'

Grogan MJ, Knechtges P, The Disruptive Physician: A Legal Perspective

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/>

Conclusions

- Disruptive behavior can adversely impact patient care and patient safety
- Disruptive behavior also has financial, social, and morale implications
- Creating a culture of 'zero tolerance' is not only an admirable goal, but a Joint Commission requirement
- Modifying behaviors with disruptive providers can be difficult but not impossible that requires a multifaceted approach

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**Full Time, Part Time and
Glide Time: Flexible
employment schedules for
anesthesiologists are
preferred over traditional
employment models. A
Pro/Con debate. (Pro)**
Jeffrey R. Kirsch, M.D.

November 7, 2015
3:30PM - 4:00PM

Full Time, Part Time and Glide Time: Flexible employment schedules for anesthesiologists are preferred over traditional employment models.

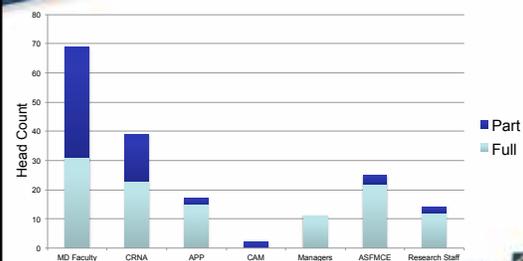
Do you care about the wellness of your faculty?

Jeffrey R. Kirsch, MD, Professor/Chair
OHSU Department of Anesthesiology and Perioperative Medicine

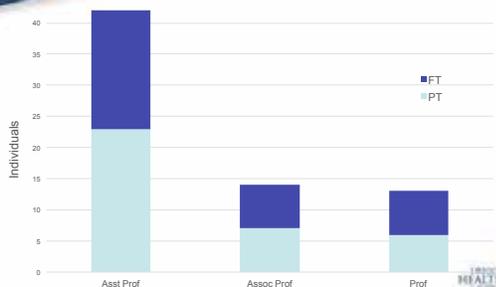
Allowing for some control over work schedule can create an environment of happiness and accomplishment



Distribution of full and part time in OHSU APOM



PT vs. FT by Academic Rank in OHSU APOM



Expense considerations of FT vs. PT at OHSU

- For FTE greater than or equal to 0.5
 - Full Dean & OHSU tax, healthcare, pension
 - Difficult to share office space
- For FTE below 0.5
 - No benefits; favors 0.6+0.4 FTE vs. 0.5+0.5 FTE
- Other financial considerations
 - Recruitment and on-boarding expense (administrative and proctoring) of replacing faculty who leave because of inability to work PT



Using OHSU Overhead Expense and hypothetical salaries

TYPE	FTE	Total Annual Expense
Full time MD	1.0	405,118
Part time MD	0.6	245,139
Part time MD	0.5	206,007
Part time MD	0.4	156,531
Full time CRNA	1	212,671
Part time CRNA	0.6	129,671
Part time CRNA	0.5	109,783
Part time CRNA	0.4	79,552
Full time staff	1.0	97,202
Part time staff	0.6	60,390
Part time staff	0.5	52,049
Part time staff	0.4	33,364



Financial Realities

	% save/(cost) to 1.0 FTE
MD	
0.6+0.4	0.8
0.5+0.5	(-1.7)
CRNA	
0.6+0.4	1.6
0.5+0.5	(-3.2)
Admin	
0.6+0.4	3.5
0.5+0.5	(-7.1)



More work hours is associated with reduced productivity

Memo to work martyrs: Long hours make you less productive

Bobo Seelbach | @RealPaperChase
Monday, 26 Jan 2015 13:39 AM EST

Working hours

Proof that you should get a life

Dec 9th 2014, 16:42 by C.W. | LONDON

The Economist

IRVING CLAWSON HEALTH & SCIENCE UNIVERSITY

Is full-time required for academic accomplishment?

- Academic productivity for anesthesiology faculty requires intense mentorship and significant time (Hindman et al., Anest Anal 2013;117;194)
- Would you rather pay a PT salary for a faculty member to be busy while they are at work vs. paying them full time salary for PT accomplishment?

IRVING CLAWSON HEALTH & SCIENCE UNIVERSITY

Survey study:

- Purpose: Determine opinion of practicing academic anesthesiologists in the United States about part time practice.
- IRB approved for waiver of consent
- Distribution through SAAA Newsletter and direct email requests
- Excellent response rate from each US region

IRVING CLAWSON HEALTH & SCIENCE UNIVERSITY

Demographic information (N=886)

- Gender
 - Male (535, 61%)
 - Female (340, 39%)
 - Transgender (2, 0%)
 - Genderqueer (2, 0%)
 - Other (2, 0%)
- Age range
 - 30-35 (154, 17%)
 - 36-40 (163, 18%)
 - 41-45 (112, 13%)
 - 46-50 (89, 10%)
 - 51 or older (368, 42%)

IRVING CLAWSON HEALTH & SCIENCE UNIVERSITY

Demographics (N=886)

- Years of practice
 - Less than 5: 27%
 - 6-10: 18%
 - 11-15: 10%
 - 16-20: 11%
 - 21-25: 12%
 - 26-30: 10%
 - 31 or greater 12%
- Academic Rank
 - Instructor: 8%
 - Assistant Prof: 51%
 - Associate Prof: 22%
 - Professor: 19%
- Do you have children-dependents living at home?
 - Yes: 60%
 - No: 40%
- What is your total FTE
 - 1.0: 74%
 - 0.6-0.9 22%
 - 0.1-0.5 4%

IRVING CLAWSON HEALTH & SCIENCE UNIVERSITY

Top factor in choosing current position

- Practice opportunity (e.g. regional, OB etc) (255, 29%)
- Teaching/research opportunities (190, 21%)
- Close to family/friends (181, 20%)
- Other (74, 8%)
- Job or other opportunities for my partner (51, 6%)
- Opportunity for full time work (53, 6%)
- Opportunity for part time work (45, 5%)
- Prestige of the institution (37, 4%)

IRVING CLAWSON HEALTH & SCIENCE UNIVERSITY

For those who work 1.0 FTE; would you elect to work part time if giving the option

- Overall (n=628):
 - Yes 42%
- Male with less than 5 years of practice
 - Yes 33%
- Female with less than 5 years of practice
 - Yes 53%
- Male with more than 5 years of practice
 - Yes 41%
- Female with more than 5 years of practice
 - Yes 51%

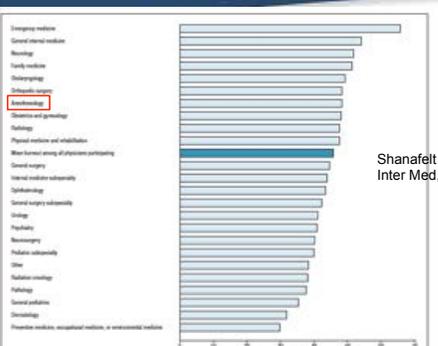


AAMC Evaluation of PT status in academic Medicine 2011 Evaluation

- Affords balance
- Satisfaction with
 - Professional relationships
 - Academic culture of their institutions; and from the
 - Flexibility
- Concerns
 - Negative attitudes from colleagues and administrators
 - Frustration with working over their contractual FTE



Burnout and Satisfaction with work-life balance Among US Physicians Relative to the General US Populations



Shanafelt TD et al. Arch Intern Med, 2012



Burnout, depression and suicidal ideation are common in physicians

- Population-based sample of US physicians (n=27,276)
- Compared with a probability-based sample of 3,442, physicians had:
 - More burnout (38% vs. 28%)
 - More dissatisfied with work-life balance (40% vs. 23%)
 - Significant depression (38%)
 - Significant incidence of suicidal ideation (6%)

Shanafelt TD et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. Arch Intern Med 172:1377, 2012



Burnout syndrome among critical care healthcare workers

Table 3. Independent risk factors associated with a higher level of burnout in intensivists

	High level of burnout (n=456)	Midrange level of burnout (n=205)	Low level of burnout (n=228)	Univariate	OR (95% CI)	Multivariate
Weekend (%)	31	29	21	<.001	1.88 (1.09-3.26)	0.02
Night shifts per month, number	6.0 ± 2.0	4.7 ± 2.0	4.6 ± 2.0	1.1	1.22 (1.02-1.29)	0.02
Night shifts before the survey (%)	19	18	12	0.68	1.60 (1.08-2.48)	0.02
Recall since the last nonworking week (days)	42 (20-80)	55 (17-85)	50 (21-85)	0.004	1.008 (1.005-1.009)	<.001
Conflict with a nurse (%)	18	11	6	<.0001	1.30 (1.02-2.80)	0.04
Conflict with a colleague internist (%)	21	15	6	<.0001	2.29 (1.75-4.26)	0.001
Relationships with nurses (0-10 rating scale)	8.8 ± 1.1	8.1 ± 1.6	7.8 ± 1.2	0.001	0.95 (0.93-0.98)	0.001
Relationships with chief nurses (0-10 rating scale)	8.2 ± 1.6	7.8 ± 1.9	7.1 ± 2.2	<.0001	0.77 (0.67-0.87)	0.001

Embrico N et al., Curr Open Crit Care 13:480, 2007



Burnout and Medical Errors Among American Surgeons Shanafelt TD et al., Ann Surg 2010;251:995

TABLE 5. Factors Independently Associated With Perceived Medical Errors on Multivariate Analysis

Characteristic and Associated Factors	Odds Ratio*	P
Positive depression screen	2.217	<0.0001
Burnout	2.016	<0.0001
Age ^b	0.985	0.001
Otolaryngologist	0.614	0.041
>50% time dedicated to nonpatient care (research, administration)	0.597	0.012
Retired	0.296	0.0400
Plastic surgeon	0.263	<0.0001
Gynecologic surgeon	0.243	0.050



Part-Time Physicians...Prevalent, Connected and Satisfied

Table 2. Multivariate Regression Means for Part-Time and Full-Time Physicians, Adjusted by Propensity Score

Variable	Part-time (SE)	Full-time (SE)	p Value
Physician job satisfaction	3.96 (0.10)	3.61 (0.04)	<0.001
Physician job stress	3.24 (0.10)	3.96 (0.05)	0.307
Intention to leave practice	2.00 (0.14)	2.12 (0.06)	0.407
Burnout	1.90 (0.10)	2.25 (0.04)	0.002
Work control	2.70 (0.07)	2.44 (0.03)	<0.001

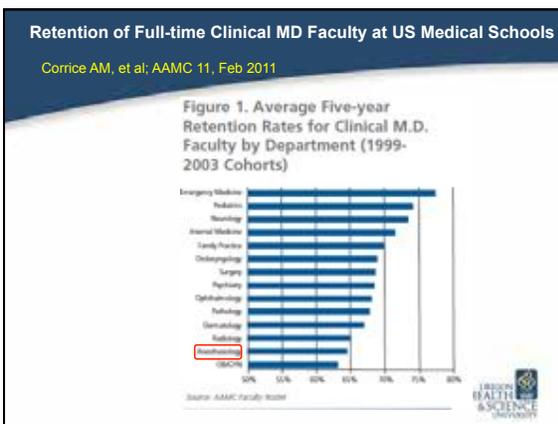
N=422 Mechaber HF et al., J Gen Intern Med 23:300, 2008



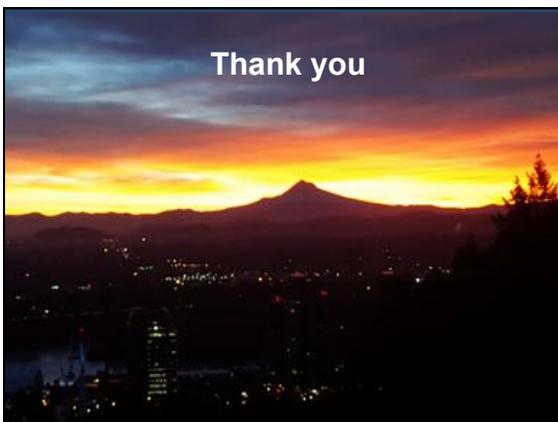
Part time anesthesiologists have better career satisfaction
(Afonso AM et al., J Clin Anesthesia 25:289, 2013)

Table 5. Linear regression model: predictors of career satisfaction among anesthesiologists

Variable	P-value
Board-certified	0.9712
Age	0.0859
Gender	0.4893
U.S. medical school	0.0193 *
Practice type	0.4516
Full-time or part-time	0.0319 *
Region of the country	0.8542
Hours per week	0.2500
Years of experience	0.6321
ASA member	0.7077
Satisfaction with profession in first few yrs of practice	< 0.0001 *
Domain	
Income	0.6092
Practice factor	0.5525
Peer factor	0.0300 *
Personal factor	0.0036 *

- Reasons to offer PT employment to your faculty
- The financial cost is low
 - Many desire to work PT
 - Retention will be higher
 - Burn-out will be lower
 - Productivity/FTE may increase
 - Medical Errors may decrease
 - PT will fill gaps when staffing is tight
 - They will still engage with the academic mission
- 





**Full Time, Part Time and
Glide Time: Flexible
employment schedules for
anesthesiologists are
preferred over traditional
employment models. A
Pro/Con debate. (Con)**
David A. Zvara, M.D.

November 7, 2015
3:30PM - 4:00PM

Full Time, Part time and Glide Time: flexible employment schedules for
anesthesiologists are preferred over traditional employment models.
SAAA Presentation November 2015

David A. Zvara, M.D.
Professor and Chair
The University of North Carolina at Chapel Hill

Finding balance in the workplace is important for all of us. This concept is perhaps best highlighted by the extremes in work conditions. Clearly, a part time employee working one day a week is likely to be disengaged whereas an employee working 80 to 100 hours a week will soon burn out. So what's the proper balance?

Recent trends in employment statistics show a global decline in work hours. Although not universal, this trend is present in many western societies. According to recent information, the majority of physicians work 40 to 60 hours per week and 25 % work between 60 and 80 hours per week. Anesthesiologists are among the highest paid physicians, and the average anesthesiologist works 51 hours per week. This is about the same as a general surgeon and more than the average family practice physician. In a survey of physicians at UNC, 13% were found to be part time employees. In the Department of Anesthesiology at UNC, 12 % are part time and this is evenly split between women in early child rearing stages and senior faculty in a preretirement condition. Is this healthy for the *department*?

No one knows the right balance of part time employees to full time employees. Many economists posit that workplace "happiness" is a myth. Some work shows that part time employees are not, in fact, "happier" nor more productive. Many argue just the opposite citing a need for full commitment and a passionate dedication toward the vocation in order to achieve great success. In our role as Chairperson, we must balance the need to satisfy an individual's need for a reduced work schedule with the corporate imperative of engagement, achievement and results oriented productivity.

There is a balance that we must find in our profession. Anesthesiology is threatened by outside agents vying for the commercial dollar associated with direct patient care. What separates physician anesthesiologists from other caregivers in the market is our responsibility to drive the research, education and systems healthcare management agenda. If we become complacent as a corporate unit and allow our specialty to be defined as one that is poorly engaged, part time in nature an attitude, we will certainly lose our place as a valued leader in leading this agenda.

We simply can't let that happen.

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JAMA. 2010 Feb 24; 303(8): 747–753.

AMA Insurance Profiles, 2014

<http://www.businessinsider.com/the-pros-and-cons-of-employing-part-time-workers-2013-11>

<http://www.inc.com/will-yakowicz/the-myths-and-lies-about-happiness-and-productivity.html>

That Used to be Us: How America Fell Behind in the World it Invented. Friedman and Mandelbaum, Picador, 2011

It's Your Ship. Michael Abraschoff , Grand Central Publishing, 2007

And special thanks to Vince Lombardi and Mike Tyson.



GME "101"

Lori K. Mihalich-Levin, J.D.

November 7, 2015
4:00PM – 4:30PM



Medicare GME "101"

Society of Academic Anesthesiology Associations

Lori Mihalich-Levin, J.D.
Health Care Partner
November 7, 2015

Disclosure of Financial Relationships

I, Lori Mihalich-Levin, J.D., have no relevant financial relationships to disclose.

November 7, 2015

2

DENTONS

Objectives

At the conclusion of the presentation, participants will be able to:

- Identify principle sources of public GME funding.
- Contrast Medicare direct graduate medical education (DGME) funding from indirect medical education (IME) funding.
- Discuss limits ("caps") on Medicare funded training positions.
- Identify limited exceptions to Medicare caps.

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3

DENTONS

Who finances resident education and teaching hospitals' special missions?

- Medicare (largest explicit payer – today's focus)
- Medicaid (last tally, 41 states)
- Children's GME (CHGME) program
- Private patient care revenues
- VA/DoD
- Other Federal and state programs

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DENTONS

Medicare Funding

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5

DENTONS

Medicare makes two different "education" payments

- Direct GME Payments (DGME)
 - Partially compensates for residency education costs
 - Paid based on "per resident amount"
- Indirect Medical Education (IME) Payments
 - Partially compensates for higher patient care costs because of presence of teaching programs
 - Add-on to inpatient DRG payment, based on formula that uses intern- and resident-to-bed (IRB) ratio

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DENTONS

Medicare funding is significant

Estimated Federal Fiscal Year 2012 (payments made to approximately 1,000 teaching hospitals):

DGME Payments = \$2.7 billion
 IME Payments = \$6.7 billion
 Total = \$9.4 billion

Source: GAO-13-709R Health Care Workforce Training Programs

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Medicare DGME Payments

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What are DGME payments intended to cover?

- Medicare's share of the costs directly related to educating residents, including:
 - Residents' stipends/fringe benefits
 - Salaries/fringe benefits of supervising faculty
 - Other direct costs (accreditation fees, etc.)
 - Allocated overhead costs

Note: To be counted for Medicare payment, residents must be in **approved programs**

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How are DGME payments calculated?

- **Step 1:** Determine the hospital's per resident base year cost amount - i.e. how much the hospital spent per resident back in 1984
- **Step 2:** Update (to current year) for inflation the base-year per resident amount (PRA)
- **Step 3:** Multiply the updated PRA by the number of resident FTEs in the current year (this amount capped by BBA resident limits)
- **Step 4:** Multiply by the hospital's ratio of Medicare inpatient days/total days (often called the "Medicare share")

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Initial residency period ("IRP") affects payment

- IRP = minimum accredited length for each specialty
- Residents training during their IRP are counted as 1.0 FTE
- Residents training beyond the IRP counted as 0.5 FTE.
 - Examples?
 - Fellowships
 - Retraining in a different specialty (depending on which specialty)
 - Repeating a year of training
- IRP is determined at beginning of residency and does not change

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Medicare pays its "share" of resident "costs":

EXAMPLE

Medicare Share * Per Resident Amount = Medicare Payment Per Resident

$35\% \times \$100,000 = \$35,000$ payment per primary care resident

$35\% \times \$90,000 = \$31,500$ payment per all other residents

$(35\% \times \$90,000) \div 2 = \$15,750$ payment for fellow

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Medicare IME Payments

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What are IME payments intended to cover?

- "Indirect" *patient care costs* associated with having a teaching program
- Higher inpatient operating costs because of the clinical environment where teaching occurs:
 - Unmeasured patient complexity not captured by the MS-DRG system
 - Other operating costs associated with being a teaching hospital (standby capacity, lower productivity, etc.)

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How are IME payments calculated?

- Payment is a % add-on to basic Medicare per case (MS-DRG) payment
- IME adjustment is based on statistical analysis - critical factor is intern and resident-to-bed ratios (IRB), meant to be proxy for teaching intensity
- Formula in the statute:

$$\% \text{ per case add-on} = \text{Multiplier X } ((1 + \text{IRB})^{0.405} - 1)$$

(For FFY 2016, multiplier X is 1.35)

- Short hand for IME: Hospitals get about a 5.5% increase in MS-DRG payments for every 10-resident increase per 100 beds

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Calculating the IME Payment

- Step 1: Determine the IRB ratio:
 IRB of Baltimore Hope Hospital = 340 residents/1332 beds = 0.255
 (Note: IME resident counts do NOT reflect weighted amounts like DGME counts do)
- Step 2: Use statistical formula and IRB to calculate IME%
 $1.35 \times ((1 + 0.255)^{0.405} - 1) \times 100 = 13.00\%$
- Step 3: Calculate the IME payment for each case
 EXAMPLE: IME add-on payment for MS-DRG 470 (major joint replacement) =
 $(\$11,378 \times 13.00\%) = \$1,479.14$

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Medicare Resident "Caps"

November 7, 2015

17 DENTONS

Medicare resident limits or "caps"

- Result of 1997 Balanced Budget Act (BBA)
- Generally speaking, a hospital's FTE caps = # of DGME and IME FTEs reported [1996 Medicare cost report](#).
- Limits may be different for DGME and IME
- No cap for dental or podiatry residents
- Different rules for inpatient rehab and psych facilities

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Very few exceptions to the caps

- **New Teaching Hospitals**
 - Get 5 years to start all programs; cap attaches in 6th year
 - Watch out for resident rotator issues
- **Rural Teaching Hospitals**
 - Cap = 130% of 1996 count (BBRA)
 - Cap can be adjusted for new programs
- **Rural Training Track Programs**
 - Urban hospitals can get cap adjustment to accommodate first year of these programs
- **Temporary and Permanent Adjustments Associated with Closed Hospitals and Programs**
 - Temporary slot – through end of displaced resident’s training
 - Permanent slot – awarded through application process (Section 5506 of ACA)
- **GME Resident Limit Affiliation Agreements**
 - A way to share cap slots under certain conditions

November 7, 2015 19 DENTONS

Counting Resident Time

November 7, 2015 20 DENTONS

Counting resident time matters for payment

- How many resident FTEs the hospital is able to count determines its DGME and IME payments
- It is NOT intuitive which time counts and which time does not
- Time-counting regulations are voluminous and complicated
- WHERE the resident is at a given moment is key factor

November 7, 2015 21 DENTONS

Resident time counted and not counted for Medicare DGME and IME payments (ACA § 5505)

DGME		IME	
Hospital	Non-Hospital	Hospital	Non-Hospital
Patient Care	Patient Care	Patient Care	Patient Care
Vacation/Sick	Vacation/Sick	Vacation/Sick	Vacation/Sick
Didactic	<i>Didactic (July 1, 2009+)</i>	<i>Didactic (Jan. 1, 1983+)</i>	NOT Didactic
Research	NOT Research	<i>NOT Research (Oct. 1, 2001+)*</i>	NOT Research

Note: Text in italics indicates language in the Affordable Care Act.

November 7, 2015 22 DENTONS

Thank you 

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 United States

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IOM Report and Physician Workforce Projections

Tannaz Rasouli

November 7, 2015
4:30PM – 5:00PM

The IOM Report on GME and Physician Workforce Projections: An Overview and Discussion

Tannaz Rasouli
Director, Government Relations
Association of American Medical Colleges

SAAA 2015 Annual Meeting
Baltimore, Maryland
November 7, 2015



The Three-Part Mission of Academic Medicine Advances Health and Health Care

Extraordinary Clinical Care

- **AAMC hospitals comprise only 5% of all hospitals but account for:**
 - ✓ 37% of charity care
 - ✓ 22% of all inpatient admissions
 - 25% of all Medicaid in-patient days
 - 18% of all Medicare in-patient days
- **88,577 full-time MDs work in medical school clinical departments**

Cutting Edge Research

- **Over half of NIH extramural awards support research at AAMC-member hospitals or member medical schools**

Education and Training

- **74% of all residents train at an AAMC hospital**



Guiding Principles on GME

Best carried out in an environment that is...

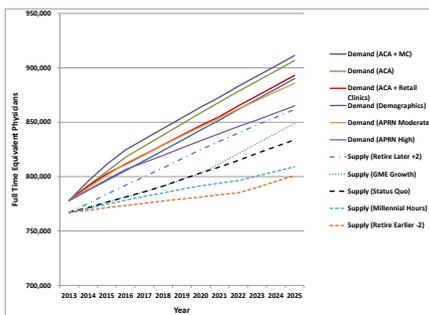
- **Team-focused.** Learners interact with a variety of medical specialties and other health professions.
- **Focused on core competencies.** There is significant educational infrastructure, oversight for teaching, and evaluation of ACGME core competencies.
- **Engaged with research.** Faculty are engaged in expanding medical knowledge through clinical research.
- **Multi-faceted.** Learners interact regularly with a diverse array of patients, conditions, and care settings throughout the community.
- **Focused on care innovation.** There is ongoing innovation in clinical care delivery and commitment to quality improvement and patient safety.



Physician Workforce Projections



Supply Versus Demand: All Physicians



Source: The Complexities of Physician Supply and Demand: Projections from 2013 to 2025. Prepared for AAMC by IHS, Inc. March 2015. <https://www.aamc.org/download/426248/data/the-complexities-of-physician-supply-and-demand-projections-from-2013-to-2025.pdf>



Projections for 2025



**Overall Shortage:
46,000 – 90,000 physicians**

Shortage in Primary Care:
12,500 – 31,100 physicians

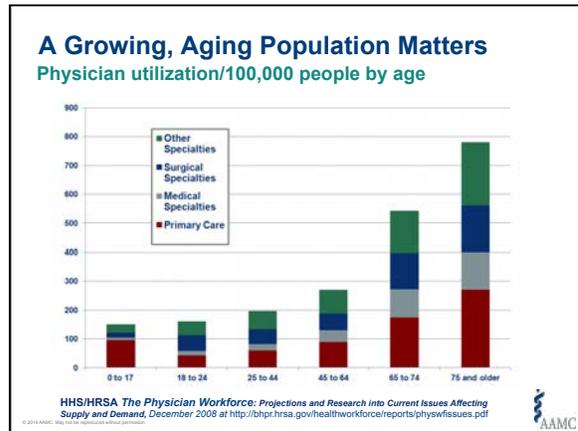
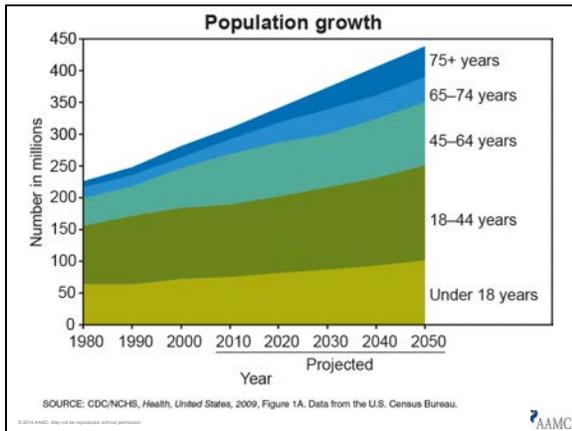
Shortage in Medical Specialties:
5,100 – 12,300 physicians

Shortage in Surgical Specialties:
23,100 – 31,600 physicians

Shortage in Other Specialties:
2,400 – 20,200 physicians

Source: The Complexities of Physician Supply and Demand: Projections from 2013 to 2025. Prepared for AAMC by IHS, Inc. March 2015. <https://www.aamc.org/download/426248/data/the-complexities-of-physician-supply-and-demand-projections-from-2013-to-2025.pdf>





The IOM Report

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AAMC's Response

IOM: <https://www.aamc.org/download/421856/data/aamcresponseioimreportingme.pdf>

E&C: <https://www.aamc.org/download/421894/data/aamcresponsestoenergyandcommerce.pdf>

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From the Report: Illustration of Impact

TABLE F-3 Illustration of impact of Changing to Combined PRA

	Number of Discharges	Total Hospital Discharge Payments	Current DRG Payments (Estimated)	Current DRG Payments (Estimated)	Current DRG Payments (Estimated)	Change in Hospital Payment per Discharge	Percentage Change in Hospital Payment per Discharge	Percentage Change in Total Discharge Payments
All Discharges	1,036	\$1,247	\$2,024	\$2,027	\$6,832	\$35,428	(\$3,403)	-14%
Number of discharges								
ICD-9	270	1,269	\$52	\$54	\$600	\$70,305	(\$2,446)	-3%
ICD-9-PCS	689	18,279	\$750	\$759	\$1,260	\$14,645	(\$2,271)	-15%
ICD-9-CM	196	17,989	\$156	\$155	\$1,040	\$13,588	(\$4,246)	-24%
ICD-9-AM	84	21,265	\$790	\$2,042	\$2,257	\$25,183	(\$1,491)	-7%
ICD-9-MMS	58	18,472	\$845	\$1,761	\$1,616	\$10,372	(\$4,722)	-31%
Discharge status								
1 = 99.2 percent	202	29,643	\$127	\$124	\$2,490	\$9,026	(\$1,361)	-15%
2 = 99.2 to < 99.5 percent	202	27,391	\$698	\$2,227	\$1,495	\$14,443	(\$4,971)	-34%
3 = 99.5 to < 99.7 percent	202	12,917	\$686	\$1,274	\$1,449	\$14,044	(\$1,489)	-11%
4 = 99.7 to < 99.9 percent	202	7,919	\$277	\$640	\$401	\$13,122	(\$8,146)	-61%
5 = 99.9 percent	204	5,794	\$340	\$720	\$487	\$14,124	(\$10,081)	-71%
Medical discharge type								
1 = 1940 discharges	202	3,140	\$145	\$276	\$131	\$48,372	\$8,367	-17%
2 = 1990-5 000 discharges	202	10,229	\$150	\$481	\$691	\$46,150	(\$1,781)	-4%
3 = 6000-9 000 discharges	202	10,529	\$414	\$391	\$606	\$26,664	(\$40,279)	-33%
4 = 9700-9800 discharges	202	16,494	\$692	\$1,132	\$1,421	\$10,048	(\$3,974)	-29%
5 = 7000 discharges	204	13,049	\$1,454	\$1,722	\$2,343	\$14,038	(\$46,762)	-33%

Source: IOM (Institute of Medicine). 2014. Graduate medical education that meets the nation's health needs. Washington, DC: The National Academies Press.

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Congressional Intent for IME Payments

"This adjustment is provided in light of doubts ... about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents ... The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals."

- House Ways & Means Committee Rept. No. 98-25, March 4, 1983, and Senate Finance Committee Rept. No. 98-23, March 11, 1983

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Sample Mission-Related, IME-Supported Patient Care Services

Mission-Related Patient Care and Community Services	COTH Teaching Hospitals	Federally Qualified Health Centers (FQHCs)	Other Ambulatory Settings
Lung Transplant Programs?	✓ (87%)	X	X
Liver Transplant Programs?	✓ (85%)	X	X
Heart Transplant Programs?	✓ (78%)	X	X
Level I Trauma Centers?	✓ (79%)	X	X
Bone Marrow Transplant Programs?	✓ (68%)	X	X
Burn Units?	✓ (68%)	X	X
Joint Commission Advanced Certification Comprehensive Stroke Centers?	✓ (74%)	X	X
24/7 Stand-by Services for Critically Ill or Injured Patients?	✓	X	X
Equipped and Staffed to Accept Transfers of Complex, Medically Vulnerable Patients?	✓	X	X
Incur Additional Costs Related to the Above Services?	✓	X	X
Eligible for IME Payments?	YES	NO	NO

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Themes and Alternative Strategies

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Themes from the Report

- **Implications of Medicare support.** Extending the stability of Medicare funding to other training programs.
- **Training in community-based settings.** Increasing support to community-based and ambulatory settings.
- **Maldistribution.** Addressing geographic distribution of training programs and graduates.
- **Evaluating shortages and specialty composition.** Determining and addressing future shortages of physicians in areas of greatest need.
- **Transparency and accountability.** Enhancing transparency of GME funds and accountability for training the workforce to meet future health care needs.

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Implications of Medicare Support

Tying Medicare GME payments to an institution's Medicare volume ensures Medicare pays only its share of the costs.

Other payers contribute little to no explicit funding to offset the costs of physician training and unique clinical missions.

Alternatives the Committee Could Have Explored

Augmenting existing support with contributions from other payers (e.g., "all-payer").

Stabilizing funding for existing federal programs outside of Medicare. For example:

- Title VII (e.g. Primary Care Residency Expansion program)
- Children's Hospitals GME

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Community-based Settings: What if hospital DGME payments were like community-based DGME?

	Teaching Hospital at/below cap (Cap: 25, FTE: 25)	Teaching Hospital above cap (Cap: 25, FTE: 40)	Teaching Hospital paid like FQHC/RHC (FTE: 25)	Teaching Hospital paid like CAH (FTE: 25)
DGME cost/resident	\$152,000	\$152,000	\$152,000	\$152,000
Medicare Share (% of bed days)	40%	40%	40%	40%
Medicare Reimb./Resident	\$41,480	\$41,480	\$60,800	\$61,408
Total DGME Costs for All Residents	\$3.800 million	\$6.080 million	\$3.800 million	\$3.800 million
Total Medicare DGME Reimb.	\$1.037 million	\$1.037 million	\$1.520 million	\$1.535 million
Percent of DGME Costs Recovered	27%	17%	40%	40.4%

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Community-based Settings

Federally qualified health centers (FQHC), rural health clinics (RHC), and critical access hospitals (CAH) are currently eligible for DGME.

The level of DGME funding they receive from Medicare simply corresponds to their (generally low) Medicare volume.

Alternatives the Committee Could Have Explored

Augmenting existing support with contributions from other payers.

- Expansion of Medicaid GME support?

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Maldistribution

Caps for rural hospitals allowed room for growth and rural hospitals can expand their caps to add new residency programs. Caps do not apply to CAHs.

Other hospitals can become “new” teaching hospitals.

Alternatives the Committee Could Have Explored

Medicare Rural Training Track (RTT) program:

- Incentivizes partnerships between urban hospitals and rural hospitals and non-hospital clinical settings.
- Residents must train at the rural site for over half their training.

Start-up funding to non-teaching hospitals?

The role of factors unrelated to training such as clinical reimbursement and the practice environment.

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Evaluating Shortages and Specialty Composition: Validity of Workforce Projections

Transformation of the delivery system holds much promise, but it will take time, and its course (and effect on utilization) is largely unknown.

In the meantime, the “knowns” include an aging population requiring greater health care services across disciplines.

Alternatives the Committee Could Have Explored

AAMC-supported legislation would address only a fraction of projected shortages, relying on other reforms to address the remainder. No single approach is sufficient on its own.

Factors other than GME financing “are far more important” in influencing “the makeup and productivity of the physician supply.”

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Transparency & Accountability

AAMC-supported legislation aligns with the report's transparency and accountability recommendations.

Transparency

H.R. 1201 directs HHS to issue an annual report on Medicare GME payments, including data on:

- DGME & IME payments to each hospital;
- DGME costs of each hospital, as reported on Medicare cost reports;
- Number of FTEs at each hospital counted for DGME/IME purposes;
- Number of FTEs at each hospital not counted for DGME/IME; and
- Factors contributing to higher patient care costs at each hospital, including:
 - Costs of trauma, burn, and other stand-by services;
 - Provision of translation services for disabled/non-English speaking patients;
 - Costs of uncompensated care;
 - Financial losses with respect to Medicaid patients; and
 - Uncompensated costs associated with clinical research.

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Transparency & Accountability

AAMC-supported legislation aligns with the report's transparency and accountability recommendations.

Accountability

H.R. 1201 directs HHS to implement IME payment adjustments based on whether a teaching hospital trains residents in:

- A variety of clinical settings and systems;
- Multispecialty and interprofessional teams;
- The relevant cost and value of diagnostic & treatment options;
- The delivery of evaluation and management (vs. procedural) services; and
- Other “patient care priorities.”

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