HANDOUT

ASA Update

James D. Grant, M.D.

11/12/2016
7:00am – 7:20am

American Society of Anesthesiologists®

ASA Update

James D. Grant, MD MBA
President-Elect, American Society of Anesthesiologists

SAAA
Society of Academic Anesthesiology Associations

asahq.org

ASSOCIATIONS

American Society of Anesthesiologists
AMERICAN ANESTHESIOLOGY
Blue Cross Blue Shield of Michigan
Beaumont
OUWB School of MEDICINE
The Anesthesia Foundation
FAER Foundation for Anesthesia Education and Research
MSMS MICHIGAN STATE MEDICAL SOCIETY

Objectives

- Objectives: Participants will learn.
  - Key trends and challenges facing the specialty in the market, legislature and regulatory, nationally and in the states.
  - How ASA is working with members nationally and in the states to address current and emerging opportunities.

Objectives - continued

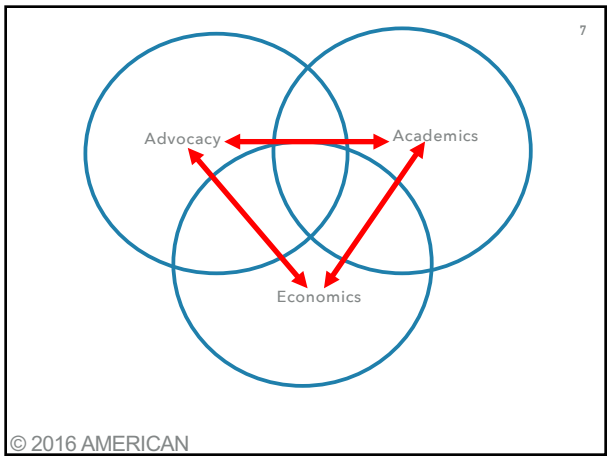
- Strategies to be discussed include:
  - ✓Moving from volume to value
  - ✓Perioperative Surgical Home .
  - ✓Public education endeavor…"When Seconds Count…Physician Anesthesiologists Save Lives.®" What we are learning.
  - ✓Veterans Affairs
  - ✓Changing Practice Landscape
  - ✓ASAPAC

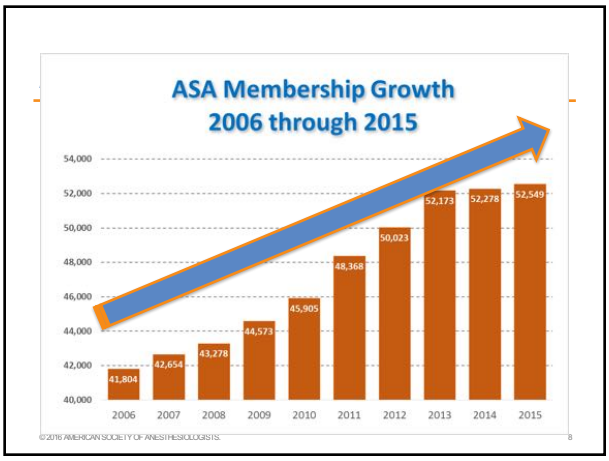
Thank you for you leadership.



For the outgoing President





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Health System Changes

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TRENDS IN VERTIGAL INTEGRATION

- The lines among different players involved in healthcare delivery are increasingly blurring with payers and companies from other segments converging on the provider space.

"1 in 5 Health Systems to Become payers by 2018"[1]

Providers are becoming payers

Payers are becoming providers

Companies from other segments are becoming providers

Henckel, Ascencion Health

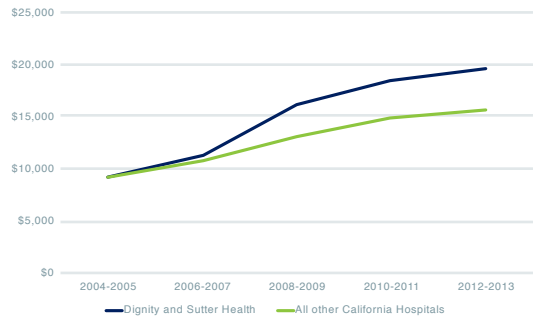
Source: http://www.healthleadersmedia.com/content/HEP-295415/1-in-5-Health-Systems-to-Become-payors-by-2018##

Impact of Changing Marketplace on Your Practice and ASA

- Dramatic **increase in hospital employment** and practices **consolidation**.
- Trend to **consolidation** is affecting diverse types of practices in both academic and private settings.
- ASA is committed to maintaining relevance to large practices as rapid **consolidation** continues, while assuring that we continue to meet the needs of ALL of our members regardless of their practice situation

 11

Hospital Prices in California

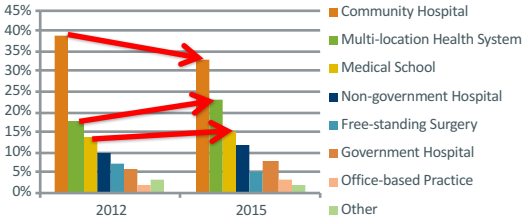


12

A consolidating industry

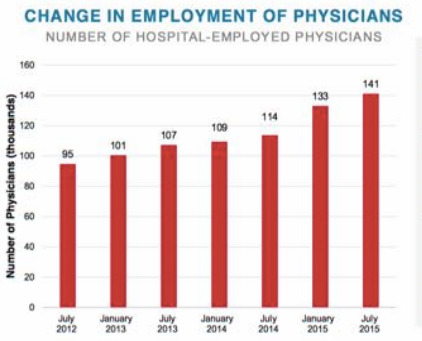
- All sectors
  - Insurance
  - Hospitals
  - Physicians and professional services
  - Pharmaceuticals and Devices
- Why?
  - Cost and complexity of business
  - Leverage in negotiations

Primary Clinical Work Settings



2012 ASA Member Needs Assessment, McKinley Advisors; 2015 ASA Member Needs Assessment, Avenue M Group

Between July 2012 and July 2015, the Number of Employed Physicians Increased to More Than 140,000



- Between 2012 and 2015, the number of physicians employed by hospitals grew by 46,000 nationwide.
- Physician employment grew in each of the six-month periods analyzed.
- In the six months from July 2014 to January 2015 alone, nearly 20,000 physicians shifted into employment models.

Avalere analysis of SK&A hospital/health system ownership of physician practice locations data with Medicare 5% Standard Analytic Files

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Advancing Quality

Patient Safety is Our Top Priority

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AQI's Key Focus Areas in 2016

- July 1 successfully marked the successful transition of NACOR to ArborMetrix's cloud-based software platform
- Arbormetrix will manage: ARBORMETRIX
  - Technical operations; data intake & hosting
- ArborMetrix improvements allow:
  - Scalability to manage growth
  - Reporting capability
  - Data integrity
- AQI will continue to manage NACOR's registry business operations and support ASA members conducting clinical research.

AQI: Successes

- Arbor Metrix agreement is executed
- Governance structure is in place
- Procedures implemented to improve data integrity
  - Data Dictionary
  - Standardized Formatting
  - Minimum Data Set
- Improved reporting underway
- Additional quality reporting options for 2016
  - QCDR and Qualified Registry

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Advancing the Perioperative Surgical Home

Leaders in Perioperative Care for the Next Generation

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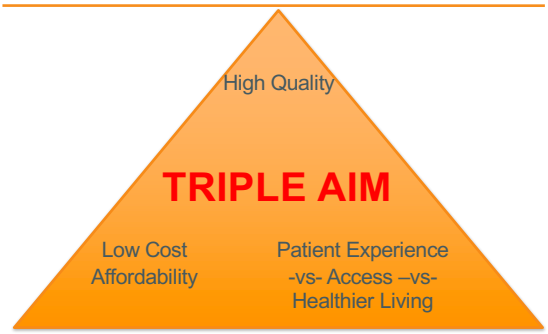
The Triple Aim?



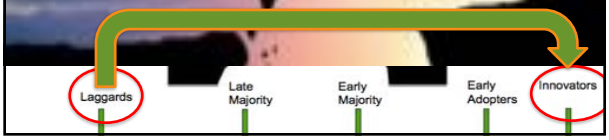
The Missing Aim

VOLUME

1. Fragmented Care
2. Fee for Service
3. Treating Sickness
4. Adversarial Payors
5. Little HIT
6. Lack of Outcome Based Measures
7. Duplication and Waste

VALUE

1. Accountable Care
2. Coordinated Care across the continuum
3. Global Payment
4. Fostering Wellness
5. Payor Partner
6. Fully Wired Systems
7. Right Care, Right Setting, Right Time
8. Triple Aim Metrics



Where are we now with PSH?

- What is the Perioperative Surgical Home (PSH)
- Progress Report on the PSH
  - PSH Learning Collaborative 1.0
  - PSH Learning Collaborative 2.0
  - PSH Summit 2016

Aligned with the Ongoing Shift from Volume to Value

The PSH is a care delivery model with outcomes that are aligned with the goals of a variety of value-based payment models, including:

- CMS' Bundled Payment for Care Improvement (BPCI) Program
- CMS' Comprehensive Care for Joint Replacement (CJR) Program
- CMS' Medicare Shared Savings Program (MSSP)
- Medicaid Bundled Payment Programs
- Commercial Accountable Care Organizations (ACOs)
- Commercial Bundled Payment Programs

25

PSH Learning Collaborative 1.0 Members

PSH 2.0 Members – 59 Organizations

39 in the Core Collaborative and 20 in the Advanced Cohort

27

PSH Learning Collaborative 1.0 - Pilots Launched

- 32 of 44 organizations (73%) successfully launched one or more pilots
- Collectively, members launched a total of 64 pilots
- The number of PSH cases completed by each pilot ranged from 14 to 2,700+
- The most common pilots include:
  - Orthopedics (20)
  - Colorectal (6)
  - Urology (5)
  - General Surgery (4)
  - ENT (3)
  - Neurosurgery/Neurovascular (3)
  - Spine (3)

28

PSH Learning Collaborative 1.0 - Sample Outcomes

A children's hospital implemented the PSH for **adenoidectomy** procedures in early 2015. Some of their preliminary results include:

- **32% decrease in pharmacy costs**
- **53% decrease in overall costs**
- Savings to the hospital of nearly **$50,000** across the first 19 cases

An academic medical center implemented the PSH for **joint replacement** procedures in 2014. Key results include:

- **28% reduction in average length of stay**
- **Increased percentage of patients going home rather than to a skilled nursing facility from 17.6% to 32.9%**

29

PSH Learning Collaborative 1.0 - Sample Outcomes (*continued*)

A community hospital implemented the PSH for total hip and knee joint replacements between 2013 and 2015. Some of the preliminary results include:

- Decrease from 11.9% to 1.9% in **readmission** rates for total hips
- Decrease from 6.3% to 3.7% in **readmission** rates for total knees
- Estimated savings of **$7,655** over target for each BPCI total joint episode
- **Decrease from 25% of patients discharged to SNF or inpatient rehab to 7%**
- **Increase in patients going home without home health to 67%**

30

PSH Learning Collaborative 2.0

Two membership levels, depending on implementation readiness, timeline, and support needs, both with an emphasis on creating opportunities for peer-to-peer networking and sharing

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 a PSH Community on PremierConnect (an online collaboration platform)
- Biweekly Community Digest and other communications

31

Ongoing Outreach Efforts

American College of Surgeons
Inspiring Quality: Highest Standards, Better Outcomes

American Urological Association

American Hospital Association

AAOS
American Academy of Orthopaedic Surgeons

shm
Society of Hospital Medicine

32

PSH-Why

Quality & Safety

- Decrease complications
- Decrease readmissions
- Decrease mortality

Improve Operational Efficiency

- Cost

Strategically Positions our Specialty

Aligns with Alternative Models of Payment

American Society of Anesthesiologists®

Brain Health Summit

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Special Thanks…

35

Up to 70%

Morbidity/Mortality

Poorer function

Cost

40% preventable

45 Stakeholders

American Society of Anesthesiologists®

NATIONAL QUALITY FORUM

Institute for Healthcare Improvement

NATIONAL INSTITUTES OF HEALTH

AARP®

The Joint Commission

AAOS American Academy of Orthopaedic Surgeons

American College of Surgeons
Inspiring Quality: Highest Standards, Better Outcomes
100+years

Multi Year Three Tiered Approach

- Dissemination of evidence regarding medications to avoid in at-risk patients through the development of a toolbox and working with electronic medical record companies to implement alerts.
- Development of an awareness campaign for those at risk and their families regarding the incidence, signs and symptoms of delirium and other cognitive disorders to inform preoperative decision-making, perioperative education to inform providers of changes in family members, and postoperative planning
- Development of an advocacy campaign for policymakers and funders to help develop a request for proposals to solicit the best scientists to address these problems

American Society of Anesthesiologists®

Research Summit

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Research Summit for the Specialty of Anesthesiology

- May 6-7, 2016 at ASA headquarters. Organized by: Alex S. Evers, M.D., Emery N. Brown, M.D., Ph.D. and James C. Eisenach, M.D.
- 36 attendees, most from Universities and Academic Medical Centers (includes 2 international attendees and 1 NIH staff)
- Co-sponsored by the ASA, IARS and FAER
- Agenda:
  - Day 1: Overview and 2 Breakout Sessions
  - Day 2: Report Out, Prioritization and Discussion of Research Priorities with ASA Advocacy Team

Research Summit for the Specialty of Anesthesiology

Goals:

- Generate a list of problems and opportunities to advance the specialty of anesthesiology and improve public health & clinical care over the next 10 years.
- Focus on: (1) clinical & patient care; (2) healthcare organization & delivery; (3) technology & drugs; and (4) basic science, neuroscience & Blue Sky areas.
- Recommend a list of highest priority potential problems and opportunities to address based on impact to the field and ability to make significant progress.
- Provide input to the organizing committee to generate a white paper on advancing the anesthesiology specialty through research.

Research Summit for the Specialty of Anesthesiology

Outcomes:

- Identification of 16 problem/opportunity areas within the 4 major topic areas discussed.
- Recognition of need for additional education in research fields.
- Identification of opportunities to work with other specialties and international organizations.
- Outline for a Whitepaper about research and anesthesiology.

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Advocacy

VHA Nursing Handbook

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Proposed Rule/Regulation:
Advanced Practice Registered Nurses Proposed Rule

- Comment period ran from May 25 – July 25
- Over 220,000 comments submitted
- Over 90,00[illegible] including [illegible] and [illegible], via ASA's [illegible]aVACare.org

THANK YOU!!!

ASA's Formal Comment Letter

- Current policy assures high quality anesthesia care
- No shortage of physician anesthesiologists in VA
- Veterans population is unique
- 47 states require physician involvement in anesthesia
- No independent data to support safety of proposed model
- Potential legal issues

Our campaign has been strong…

- Engagement of VA Leadership – 5 meetings (last June 7)
- Congressional Oversight – over 135 House and Senate members including key legislators from the VA committees and VA appropriations committees.
- Veteran Stakeholders –
  - Association of the U.S. Navy (AUSN)
  - AMVETS (recently reaffirmed at Annual Meeting)
  - National Guard Association of the United States (NGAUS)
  - National Association of VA Physicians and Dentists
  - Association of VA Anesthesiologists (AVAA)
  - VA Chiefs of Anesthesiology

Public Relations Efforts

Secured 401 media placements reaching an audience of more than 330 million in ASA's PR campaign May through July 2016.

401 Total number of media placements

330 M Audience reach/ Total Impressions

The Washington Post · FOX NEWS · FOX NEWS RADIO · McClatchyDC · San Francisco Chronicle · ajc The Atlanta Journal-Constitution

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Medicare Payment Reform and Anesthesiology Changes in the Sustainable Growth Rate

asahq.org

MACRA Mambo #5 – The Dance You Cannot Avoid 1:45 pm

Medicare Access & CHIP Reauthorization Act (MACRA) of 2015

Replaces the 1997 SGR formula, which capped Medicare physician per beneficiary spending growth at GDP growth rate

- Overwhelming bipartisan support
- Provides new tools in implementing payment reforms
- Applies to MD, DO, PA, NP, Clinical nurse specialist, CRNAs
- 2021 includes therapists, psychologists, social workers, audiologists, and dieticians.
- Creates clear timetable/benchmarks.
- Two options for physicians/providers
  - Merit Based Incentive Payment System (MIPS)
  - Alternative Payment Models (APMs)

On 3/26, the House passed H.R. 2 by 392-37 vote.

On 4/14, the Senate passed the House bill by a vote of 92-8, and the President signed the bill.

Medicare Program Targets

- 30% Medicare payments via APMs by 12/31/16
- 50% Medicare payments via APMs by 12/31/18
- 85% FFS tied to quality/value by 2016
- 90% FFS tied to quality/value by 2018

HHS Secretary Sylvia M. Burwell
January 26, 2015

MACRA in Brief

Timeline

Physicians must move quickly toward one of the two tracks.
Performance Year 1 starts January 1, 2017 for FY 2019 payment

	2015 and earlier	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026 and later
FEE (Fee Schedule Updates)		.5%	.5%	.5%	.5%	0%	0%	0%	0%	0%	0%	0.75% APMs 0.25% MIPS
MIPS (Quality, Resource Use, Clinical Practice Improvement Activities, Meaningful Use of Certified EHR Technology; PQRS, Value Modifier, EHR Incentives)					±4 %	±5 %	±7 %	± 9% MIPS Maximum Bonus or Penalty (+/-)				
Certain APMs					Qualifying APM Participant Medicare Payment Threshold Excluded from MIPS			5% Incentive Payment Excluded from MIPS				

Source: Centers for Medicare & Medicaid Services : www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

MIPS and APMS begin operating

MIPS Payments

EP performance assessment based on composite scores from 4 categories - 0-100

Threshold score determined by Secretary

Physician scores must be made publicly available on the Physician Compare website.

EP composite score compared to threshold score

- EP below threshold– negative MIPS payment adj
- EP at threshold – zero MIPS payment adj
- EP above threshold – positive MIPS payment adj

Challenges for Anesthesiologists

+ Patient attribution remains a challenge—primarily focused on primary care physicians
  - Similar to Value-Based Modifier under current performance programs
+ CMS requests comment on:
  - Allowing facility-based physicians to be measured based on the performance of their facility rather than their own performance
  - How to use measures designed for the inpatient and outpatient hospital settings for certain physicians (specifically mentioning anesthesiologists)
  - Alternative options for "non-patient-facing" physicians

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Advocacy

State Issues

Medicare OPT OUT

Inadequate Networks

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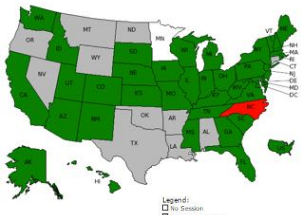
2016 Primary Topic Areas

- **Patient-centered, physician-led care**
  - Opt-out
  - Supervision
    - Alaska, Florida, Missouri, Ohio, Oregon, Virginia and West Virginia
  - Pain medicine
  - Certified anesthesiologist assistants
    - Iowa, Maryland and Oregon
  - Truth in advertising
- **Payment**
  - Out-of-Network Payment
    - Arizona, Florida, Hawaii, Missouri, New Hampshire and Tennessee



As of February 1, 2016

State Net @ available at https://sn.lexisnexis.com/secure/pe/start_page.cgi

In 2015, State Affairs reviewed more than 6,000 pieces of legislation and nearly 1,500 proposed regulations to assist state component societies in their important mission to protect patient safety in each state.

 56

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Advocacy

Inadequate Networks

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Keeping Ahead of the Curve: Out-of-Network Payment

Recognizing the evolving impact out-of-network payment has on the advocacy and public relations efforts of state component societies, the Executive Committee approved an Ad Hoc Committee on Out-of-Network Payment (AHCONP).

AHCONP's mission

- Conduct an assessment of the problem; ASA needs a comprehensive understanding via real data on how the issue impacts ASA physician leaders.
- Recommend appropriate Society policy, if needed.
- Develop a tool kit and advocacy resources to support federal and state lobbying.
- Develop messaging and resources for Society engagement with nonmedical organizations such as the National Association of Insurance Commissioners, the Consumers Union, etc.
- Serve as an authorized resource for stakeholders engaged in advocacy efforts requiring expert guidance.

The Ad Hoc Committee will report its progress at the August BOD meeting.

 58

American Society of Anesthesiologists®

Advocacy

Public Relations

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Research Told Us…

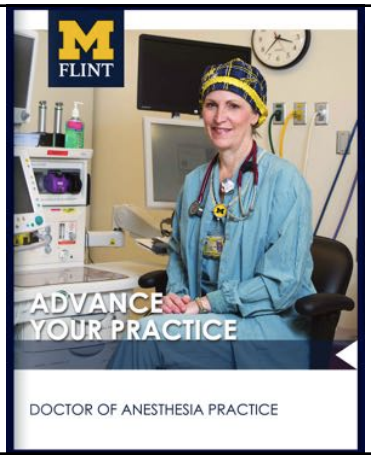
- Majority of the public and many policymakers unaware that anesthesiologists are physicians.
- Even fewer know how physician anesthesiologists save lives when emergencies occur.
- Quality of care is the No. 1 concern of Americans and policymakers.
- On issues of quality of care, physicians have almost unimpeachable levels of credibility.
- People want a physician in case of an emergency.

 60

Research Told Us…

- Majority of the public and many policymakers unaware that **anesthesiologists are physicians**
- Quality of care is the No. 1 concern of Americans **and policymakers**
- On issues of quality of care, **physicians** have almost unimpeachable levels of **credibility**
- **People want a physician in case of an emergency**

62



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Foundation Support

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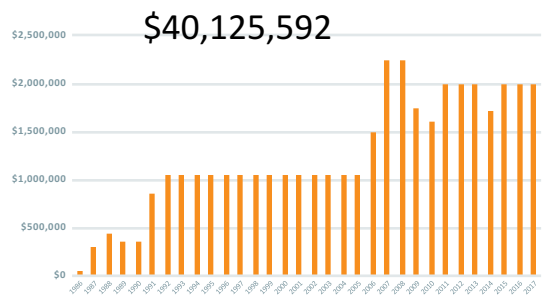
Contributions from ASA to FAER



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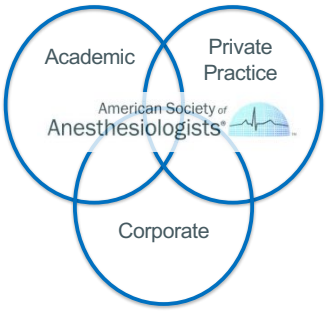
What brings these three together?



American Society of Anesthesiologists®

ASA PAC

American Society of Anesthesiologists

Political Action Committee

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Why each anesthesiologist should be giving always

- Patient safety and quality of care
- Assure physician-led team-based care
- The power of unity and amount

 69

What does ASA PAC advocate for?

- Safety and Quality Healthcare
- Patients
- Physician Anesthesiologists
- Appropriate Scope of Practice
- Increased GME funding
- Increased NIH dollars
- Fair payment for anesthesiologists

 70

American Society of Anesthesiologists Political Action Committee (ASAPAC)

Nation's top physician PAC

94% success rate in the November 2016 elections

Provides ASA members a powerful voice in the political process

Helped Elect Physician Lawmakers -

- Rep. Andy Harris, M.D. (R-MD)
- Rep. Larry Bucshon, M.D. (R-IN)
- Rep. Ami Bera, M.D. (D-CA)
- Rep. Raul Ruiz, M.D. (D-CA)

Three Members of the 115th Congress

Tom Price (R-GA) | Raja Krishnamoothi (D-IL) | Larry Buchon (R-IN)

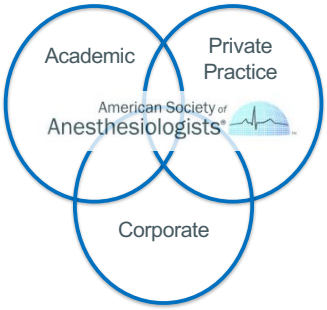
 72

Thank you….residency programs at 100% PAC participation…leading by example

- Beaumont Health
- Brigham and Women's
- Emory University
- Georgetown University
- Mayo Clinic Arizona
- Mayo Clinic Florida
- Michigan State University
- Mount Sinai – Miami Beach
- Northwestern University
- Ochsner Clinic
- Tulane University
- University of Alabama Birmingham
- University of Arizona
- University of Arkansas
- University of Chicago
- University of Colorado
- University of Connecticut
- University of Florida – Jacksonville
- University of Illinois – Chicago
- University of Kansas – Kansas City
- University of Kansas – Wichita
- University of Miami
- University of Mississippi
- University of Nebraska
- University of Pittsburgh
- University of Tennessee – Knoxville
- University of Texas – San Antonio
- University of Texas – Southwestern
- West Virginia University

 73

What brings these three together?



Better at the table than on the menu…..

AMA AMERICAN MEDICAL ASSOCIATION

 75

IF WE OPEN A QUARREL BETWEEN PAST AND PRESENT, WE SHALL FIND THAT WE HAVE LOST THE FUTURE

Winston Churchill

American Society of Anesthesiologists®

Thank You!

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American Society of Anesthesiologists®

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HANDOUT

RRC Update

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

11/12/2016
7:30am – 7:50am

Anesthesiology RC Update

Robert Gaiser, MD
Chair, Anesthesiology Review Committee
Anne Gravel Sullivan, PhD
Executive Director, Anesthesiology Review Committee

Disclosures

Dr. Gaiser has no conflicts of interest

Dr. Gravel Sullivan works for the ACGME

Objectives

- Introduce new RC members
- Summarize specialty 2015 Annual Program Review
- Provide update on Regional Anesthesiology and Acute Pain Medicine subspecialty
- Provide update on Single GME Accreditation System
- Review ACGME and RC Initiatives in 2017
- Answer questions

New RC Members and Leadership

Chair: Robert Gaiser, MD, MSEd

Vice Chair: Cynthia Wong, MD

New RC Members:

Aditee Ambardekar, MD, MSEd
Dept. of Anesthesiology and Pain Management
University of Texas Southwestern Medical Center

Andrew D. Rosenberg, MD
Chair, Dept. of Anesthesiology
New York University School of Medicine

New RC Members

Meghan Brennan, MD, MS (2016)
Resident member
University of Florida-Gainesville

Santhanam Suresh MD, FAAP (2016)
Chair, Dept. of Pediatric Anesthesiology
Director, Pain Management Team
Lurie Children's Hospital of Chicago

Mark Stafford Smith, MD, CM, FRCP(C) (2017)
Vice Chair of Education, Director of Fellowship Education
Duke University

2015-16 Annual Program Review

379 Programs Reviewed

368 Continued Accreditation

7 CA with Warning

1 Probation

3 Initial Accreditation

Common Citations

Faculty and Resident Scholarly Activity

Faculty Credentials (subspecialty)

New Program Director Credentials

Evaluation—PEC & CCC

Failure to Provide Accurate/Complete information

Regional Anesthesiology and Acute Pain Medicine

- Program Requirements approved at September 23-25, 2016 Board of Directors meeting
- Applications online October 7th
  - Common Application in ADS must be initiated by DIO
  - Sub-specialty Application on specialty page (Word format)

Video on how to complete an effective applications at: https://www.acgme.org/Program-Directors-and-Coordinators/Resources-for-New-Program-Directors

Regional Anesthesiology and Acute Pain Medicine

New Application Deadlines:

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

September 2017 RC meeting -- June 2, 2017 (approx.)

American Society of Regional Anesthesiology and Pain Medicine currently has 70 programs

Contact Anne Gravel Sullivan or Sonia Sangha with any questions.

Single Accreditation System

- Programs are permitted to accept AOA-trained applicants from programs in process of application (i.e. pre-accreditation)
- Three of 13 AOA Anesthesiology Programs have been given Initial Accreditation
- One has merged with an existing ACGME-accredited program
- Three applications up for review at January 26-27th meeting, two at March 30-31st meeting
- Outreach to AOA Programs

Upcoming RC Activities

Major revisions to Multidisciplinary Pain Medicine

Minor revisions to Core Anesthesiology Requirements

- ASA recommendations: perioperative and TTE requirements

Innovative Programs

- AIRE Applications coming soon

RC Presentations & Outreach

Annual Education Conference - February 2016

American Osteopathic Colleges of Anesthesiology Meetings - March & September 2016

New Program Coordinator Workshop - August 2016

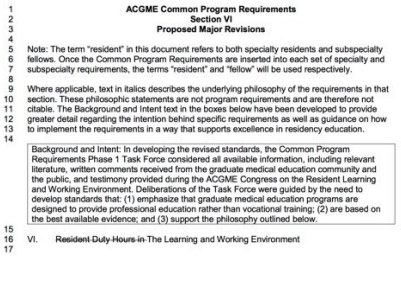
ACGME Initiatives

New Common Program Requirements

- Open for Review and Comment until December 19, 2016

Second Milestones Summit-Dec 15-16

- Research and Best Practices for V2.0



ACGME Common Program Requirements
Section VI
Proposed Major Revisions

Note: The term "resident" in this document refers to both specialty residents and subspecialty fellows. Once the Common Program Requirements are inserted into each set of specialty and subspecialty requirements, the terms "resident" and "fellow" will be used respectively.

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable. The Background and Intent text in the boxes below have been developed to provide greater detail regarding the intention behind specific requirements as well as guidance on how to implement the requirements in a way that supports excellence in residency education.

Background and Intent: In developing the revised standards, the Common Program Requirements Phase 1 Task Force considered all available information, including relevant literature, written comments received from the graduate medical education community and the public, and testimony provided during the ACGME Congress on the Resident Learning and Working Environment. Deliberations of the Task Force were guided by the need to develop standards that: (1) emphasize that graduate medical education programs are designed to provide professional education rather than vocational training; (2) are based on the best available evidence; and (3) support the philosophy outlined below.

VI. ~~Resident Duty Hours in~~ The Learning and Working Environment

ACGME Initiatives

Moved to 401 N. Michigan Avenue

- More meeting space
- All RC meetings in Chicago 2017 onwards

Program Coordinator Advisory Council

- 13 Members, 3-year terms
- First meeting Sept 2016

Questions?

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Sonia Sangha, MPH
Accreditation Administrator
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ssangha@acgme.org

HANDOUT

ABA Update

James P. Rathmell, M.D.

11/12/2016
8:00am – 8:35am

The American Board of Anesthesiology

2016 ABA Report

Society of Academic Anesthesiology Associations

James P. Rathmell, M.D.
President, American Board of Anesthesiology

Brigham and Women's Hospital
Boston

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Andrew J. Patterson, M.D., Ph.D.
University of Nebraska Medical Center

Santhanam Suresh, M.D.
Lurie Children's Hospital of Chicago

David O. Warner, M.D.
Mayo Clinic

Discussion Overview

- RTID Milestones Reporting Update
- Primary Certification Updates
- Subspecialty Certifications
- Program Directors' Meetings
- Combined Training Programs
- Alternate Entry Pathway (AEP)
- MOCA 2.0®

RTID Reporting Update

RTID Reporting Requirements

- Programs should complete the following activities every six months (**Jan. 31** and **July 31**):
  - Resident Enrollment Forms
  - Clinical competency assessments
  - Program Director Reference Forms
- Assess at end of training whether resident can independently practice in the specialty without accommodation or with reasonable accommodation

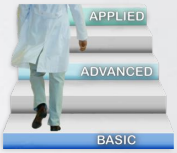
Certificate of Clinical Competency (CCC) Report

- Core tool for evaluating residents' training and performance
- Required for each resident who has spent any portion of six-month reporting period in training
- Programs now only report milestones to ACGME
  - Will not report milestones to the ABA for this reporting period (July 1 – Dec. 31, 2016)

Primary Certification

Staged Examinations

- Staged examinations
  - Complement ACGME movement toward competency-based training and promotion
  - Encourages residents to engage in more sustained study over the course of residency training

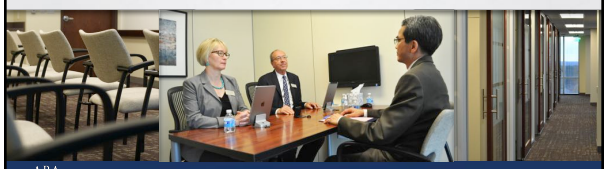


- In 2017, we will launch the APPLIED Exam, the last exam in the staged exam series
- In 2018, we will add the Objective Structured Clinical Examination (OSCE) component to the APPLIED Exam

2016 Part 2 Examinations

ABA Assessment Center

- More than 1,900 candidates participated in their Part 2 Examination in the ABA Assessment Center
- ABA Director David Warner, M.D., will share more information about the Part 2 and other exams during his presentation



2017 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

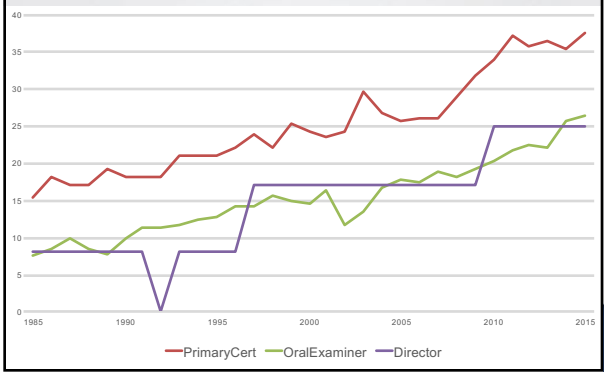
Examiner Recruitment

- The ABA had **250** active examiners at the start of 2015
- In preparation for the APPLIED Examination, the ABA recruited **118** more in 2015 and is pursuing another **78** this year

GOAL: 405 Examiners by 2019

Female Anesthesiologist

Percentages 1985-2015



Subspecialty Certification

Subspecialty Certification

- The ABA currently offers subspecialty certification in:
  - Critical Care Medicine
  - Pain Medicine
  - Hospice & Palliative Medicine
  - Sleep Medicine
  - Pediatric Anesthesiology
- No more "grandfathering" criteria accepted
  - Must have completed an ACGME-accredited fellowship program

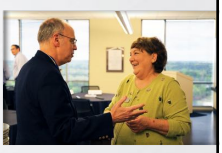
Subspecialty Exam Registration

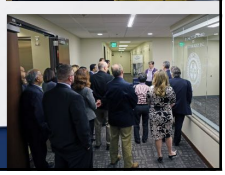
- Physicians who wish to take subspecialty certification exams must:
  - Hold an unexpired license
  - Be certified by the ABA
- Fellows must take and pass the Part 2 Exam prior to registering for a subspecialty exam
  - They should register for a spring Part 2 Exam if they wish to take the subspecialty exam in the same year

Program Directors' Meetings

Program Directors' Meetings

- The ABA will host Program Directors' meetings in 2017 to share updates on the APPLIED Exam launch with OSCEs in 2018
- Topics for discussion include:
  - Rationale for OSCEs
  - OSCE Content Outline and exam structure
  - Tour OSCE rooms
  - Pilot test of OSCE scenarios





Combined Training Proggrams

Combined Training Programs

- Collaborate with other boards to provide combined training in
  - Pediatrics
  - Internal Medicine
  - Emergency Medicine **(NEW)**
- Physicians can complete training requirements in both specialties in five years (instead of six)
- Graduates may qualify for dual certification

Combined Training Programs

- Programs must be approved by both boards
  - Pediatrics (7 programs)
  - Internal Medicine (5 programs)
  - Emergency Medicine (1 program)
- Residents complete 60 months of education
  - **Emergency Medicine may have some 4-year programs (72 training months)**
- Certifying exams can be taken once all training has been completed

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

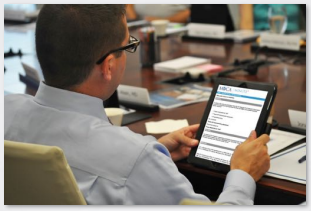
AEP Statistics

- Anesthesiology departments may now enroll **as many as four** international medical graduates in the AEP program

July 2007 – June 2016	
# of Programs Approved	37
# of Individuals Now Certified	33

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.

Evolution to MOCA 2.0®
Background

- 2011: Developed strategic plan
- 2012: Hosted technology summit
- 2013: Conceptualized MOCA 2.0 and MOCA Minute®
- 2014: Facilitated collaborative concept development
- 2016: Launched MOCA 2.0 and expanded MOCA Minute pilot

MOCA 2.0®: 2016

- MOCA Minute® pilot replaced once-every-10-years MOCA Exam
- More options for Part 4: Improvements in Medical Practice; Simulation no longer a requirement
- Nearly 21,000 program participants

MOCA 2.0®: 2017

- MOCA 2.0® launches for diplomates with subspecialty certifications on **Jan. 9**
- Diplomates with more than one certificate will:
  - Complete a **single set** of MOCA 2.0 requirements for all certificates
  - Answer just 30 MOCA Minute questions per quarter (120/year)
  - Pay $210 for the first certificate, $100 for each additional one

MOCA 2.0®: 2017

- Launching new features mid-2017, including:
  - **Personal Portfolio** to store ABA certification records, medical licenses and other documents
  - **Search and Explore** function in physician portal to easily find CMEs to fill knowledge gaps diplomates identify via MOCA Minute

ABA The American Board of Anesthesiology

Questions?

Communications Center:
Phone: (866) 999-7501
Fax: (866) 999-7503
Email: coms@theABA.org

Mail Correspondence:
ABA Secretary
4208 Six Forks Rd, Suite 1500
Raleigh, NC 27609-5765

HANDOUT

ABA Exams Report

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

11/12/2016
8:45am – 9:05am

The American Board of Anesthesiology

2016 ABA Exams Report

Society of Academic Anesthesiology Associations

Santhanam Suresh, M.D.
Director, American Board of Anesthesiology
Chair, ABA Pediatric Anesthesiology Examination Committee

Ann & Robert H. Lurie Children's Hospital
Chicago

Question Editors

ITE/BASIC/ADVANCED/Part 1Exams

75 Junior Editors
9 were selected in 2015
Write questions (18/year)
Revise questions based on feedback

42 Senior Editors & Committee Members
Edit questions
Mentor junior editors

Question Development

- Question generation for the ABA Examinations: BASIC, ADVANCED, Part 1 and ITE
  - Approximately **1,400** questions generated
  - Three senior editors meetings and 8 webinars to review items
  - ITE and BASIC Exam forms reviewed by exams committees in August and September 2016
  - ADVANCED form to be reviewed in January 2017

2017 In-Training Exam

- Internet-based exam delivered via vendor
  - Exam may be delivered any time from **12 a.m. EST on Thursday, Feb. 16,** to **11:59 p.m. EST on Tuesday, Feb. 21,** 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

ITE Results Reporting

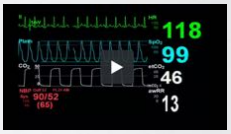
- **Personal Performance Reports** include information about individual performance on BASIC and ADVANCED items
  - Scaled score based on the whole exam
  - Percent Correct Scores based on BASIC and ADVANCED items, respectively
  - Performance within content/category areas
  - Keywords associated with 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

ITE: Reported Categories

- Basic Sciences
- Clinical Sciences: Anesthesia Procedures, Methods and Techniques
- Clinical Subspecialties
- Organ-Based Basic and Clinical Sciences
- Special Problems or Issues in Anesthesiology

ITE, ADVANCED & Part 1 Exams 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
  - **Beginning in 2017, we will no longer use videos on ITE**

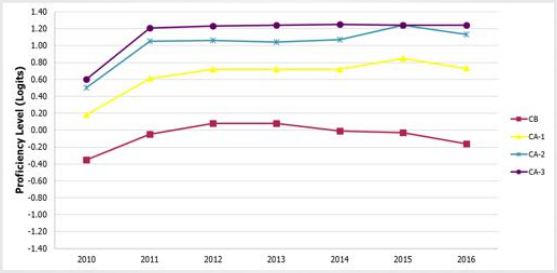


ITE-Pain Medicine (ITE-PM)

- In 2016, 80 programs administered the exam to nearly 300 fellows
- 2017 ITE-PM will be administered at fellowship program sites on **Friday, March 24**
- Additional subspecialty ITEs will likely be added in the future as our item banks grow

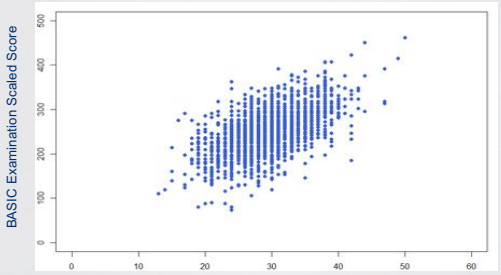
In-Training Exam Performance

by Training Level & Exam Year



Relation of Scores

ITE to the BASIC Examination



The correlation between the 2016 ITE scaled scores and 2016 June BASIC Exam scaled Scores is 0.569, $p < 0.001$

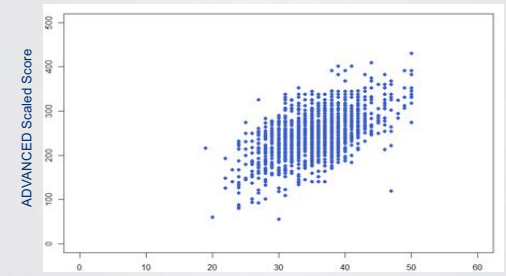
Relation of Scores

ITE to the BASIC Exam

Scaled Score	N	2016 June BASIC Scaled Score Mean (S.D.)	BASIC Pass Rate
≤25	364	214 (46)	75%
26-30	614	239 (41)	91%
31-35	456	266 (41)	98%
36-40	191	297 (40)	100%
41-45	23	320 (58)	100%
≥46	5	380 (64)	100%

Relation of Scores

2016 ITE to 2016 advanced Examination



The correlation between the 2016 ITE scaled scores and 2016 ADVANCED Exam scaled Scores is 0.557, $p < 0.001$.

Relation of Scores

ITE to First Attempt on ADVANCED Exam

Scaled Score	N	2016 ADVANCED Scaled Score Mean (S.D.)	ADVANCED Pass Rate
≤25	34	171 (54)	47%
26-30	184	208 (44)	81%
31-35	547	239 (41)	95%
36-40	542	259 (42)	99%
41-45	159	287 (38)	100%
≥46	51	319 (51)	98%

Examination Scoring

- Standard-setting study conducted every five years
- Following exam administration, preliminary item analysis conducted (difficulty & discrimination)
- Key validation for items
  - negative discrimination
  - no clear correct answer

Standard-Setting Process

BASIC and ADVANCED Exams

- Third BASIC Exam standard-setting study was conducted in June with a panel of program directors
- The ADVANCED Exam standard-setting study was conducted in August
- The Hofstee Method
  - Combined panel member judgments about an **appropriate passing score** and an **appropriate pass rate**

2016 June BASIC Exam

Results

- Candidates were assigned to examine on Friday or Saturday
- Key validation eliminated 7 items and rekeyed 2 items
- 90.7% of candidates passed

N	Mean Scaled Score	Standard Deviation	Pass Rate	Reliability
1,661	249.62	50.53	90.7%	0.76

2016 BASIC Exam

Top 10% Letters

- The ABA sent congratulatory letters to examinees who scored in the top 10% on the June BASIC Examination
  - Program directors also received copies of these letters
- All November 2016 BASIC Exam top 10% letters will go out in December
  - Program directors will receive copies

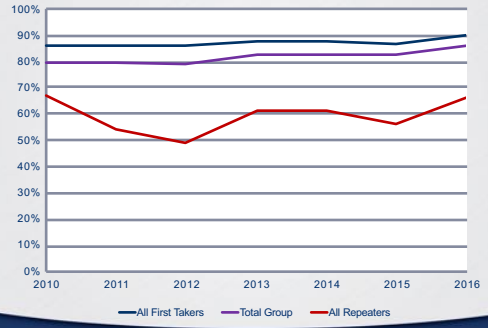
2016 July ADVANCED Exam

Results

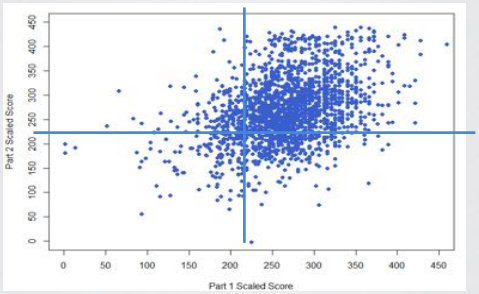
- Candidates were assigned to examine on Friday or Saturday
- Key validation eliminated 6 items
- 94.4% of candidates passed

N	Mean Scaled Score	Standard Deviation	Pass Rate	Reliability
1,560	248.95	50.11	94.4%	0.75

Part 2 Examination
Success Rates



Relation of Scores
2016 Part 2 Exam to First Attempt on Part 1 Exam



The correlation between the 2016 Part 2 Exam scaled scores and First Attempt Part 1 Exam scaled scores is 0.409, $p < 0.001$

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 on subspecialty based practice and complex clinical issues, but includes content from entire BASIC /ADVANCED Exam content outline
- Offered the first time in July; **Next administration is Jan. 27-28, 2017**

APPLIED Examination
- Will replace the Part 2 (Oral) Examination in 2017, and include both the oral exam and Objective Structured Clinical Examinations (OSCEs) **beginning in 2018**

Who Takes Staged Exams?

- **Traditional Part 1 and Part 2 Exams**
  Residents who completed training before June 30, 2016
- **Staged Exams**
  Residents who began their four-year training in anesthesiology on or after July 1, 2012, and will complete training on or after June 30, 2016

Duration of Candidate Status

- Candidates who completed residency training **prior to Jan. 1, 2012**, have until Dec. 31, 2018 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

2017 BASIC Examination

- BASIC Exam administered at Prometric testing centers:
  - **June 2017:** Friday, June 9, and Saturday, June 10
  - **November 2017:** Friday, Nov. 17, and Saturday, Nov. 18
- Residents are assigned an exam day
- They must register for exam with ABA, then schedule seat with Prometric
  - Registration opens **March 1** for June exam, **Aug. 1** for November exam

If a Resident Fails the BASIC Exam…

- They can take it 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

Why Add OSCEs?

- Intended to assess domains that are difficult to assess in written or oral exam formats, such as
  - Communication and Professionalism
  - Technical skills
- Evidence that these domains are important in physician performance after training
- Role of exams in driving training priorities

OSCE Timeline

2015: OSCE Task Force established to draft and test scenarios (11 members)

2016: Content outline created and expanded to provide additional details; OSCE overview video created; further scenario development

2017: Scenarios tested/viewed at program director meetings in Raleigh; extensive validation of delivery and scoring

2018: OSCEs launch

The OSCEs

- OSCE component of the APPLIED Exam will take **84 minutes** from start to finish
  - Seven-station circuit to evaluate proficiency in seven of the nine OSCE Content Outline skills
  - Each scenario will be eight minutes long
  - Four minutes between stations to review the next scenario
- Candidates will interact with a **standardized patient actor** in some rooms, directly with examiners in others
  - Examiners will not be in most exam rooms
  - Sessions will be recorded for grading purposes

The OSCEs

- Expanded content outline now available online
  - **Communication and Professionalism (Six skills)**
    Informed consent, Treatment options, Peri-procedural complications, Ethical issues, Communication with other professionals, Practice-based learning and improvement
  - **Technical skills (Three skills)**
    Interpretation of monitors, Interpretation of echocardiograms, Application of ultrasonography (TEE)
- Designed to provide as much information as possible regarding format and expectations

The OSCEs

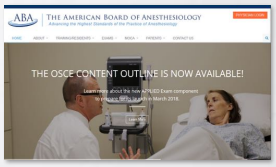
- OSCEs will be administered to candidates in the Assessment Center in Raleigh on the same day they take the SOE component
  - If candidates fail one component (OSCE or SOE), they will only retake that component
- APPLIED Exam registration fee will remain the same with the addition of the OSCE component in 2018

Who Will Take the OSCEs?

- Candidates who complete residency training **on or after Oct. 1, 2016**, will take both the SOE and the OSCE of the APPLIED Exam
- Candidates who completed residency training **between June 30 and Sept. 30, 2016**, will not take the OSCE component of the APPLIED Exam
  - Only required to pass the SOE component

www.theABA.org

- Sample questions, content outlines, blueprints, administration schedules and videos are available
- Blueprint information for all exams includes:
  - Exam purpose
  - Exam content
  - Exam specifications
  - Exam administration information
  - Number and relative percentage of questions in content categories



OSCE Overview Video

www.theaba.org/ABOUT/Videos

The American Board of Anesthesiology

Questions?

Communications Center:
Phone: (866) 999-7501
Fax: (866) 999-7503
Email: coms@theABA.org

Mail Correspondence:
ABA Secretary
4208 Six Forks Rd, Suite 1500
Raleigh, NC 27609-5765

HANDOUT

Academic Caucus Update

Jeffrey R. Kirsch, M.D.
Peter Rock, M.D., M.B.A., FCCM

11/12/2016
9:45am – 9:55am

HANDOUT

Diversity: Strategy for Improving Diversity Within Anesthesiology

William A. McDade, M.D., Ph.D.

11/12/2016
10:00am – 10:20am

Strategy for Improving Diversity Within Anesthesiology Residencies Panel

William McDade, MD, PhD
Executive Vice President/Chief Academic Officer
Ochsner Health System
New Orleans, LA

Ochsner Health System

When you think of what a doctor looks like…

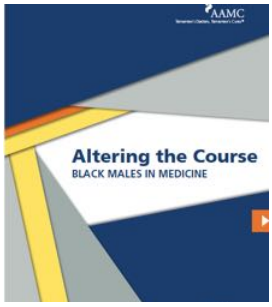
What comes to mind?

What do you think of when you think of a doctor?

Dr. Tamika Cross
Meharry 2013
UT Houston PGY3 OB/GYN Resident

Ochsner Health System

Who's Missing?



Ochsner Health System

Minimal Growth in Black Candidates

AAMC Data Book

AAMC

B3. Archive of U.S. Medical School Applicants and Accepted Applicants by Race and Ethnicity, 2002-03 Through 2012-13

	Race Alone or in Combination, Non-Hispanic											
	American Indian or Alaska Native		Asian		Black/ African American		Native Hawaiian or OPI		White		U.S. Non-Hispanic*	
Year	Apps	Accepted	Apps	Accepted	Apps	Accepted	Apps	Accepted	Apps	Accepted	Apps	Accepted
2002-03	344	163	6,500	3,511	2,858	1,284	95	37	20,446	11,152	30,202	16,124
2003-04	342	168	6,834	3,562	2,963	1,228	98	38	21,330	11,332	31,342	16,132
2004-05	383	176	7,464	3,585	3,004	1,264	103	37	22,007	11,443	32,163	16,148
2005-06	383	171	8,089	3,862	3,013	1,228	102	41	22,801	11,471	33,454	16,330
2006-07	332	149	8,257	3,830	3,073	1,280	180	67	23,567	11,672	34,852	16,716
2007-08	349	148	9,134	4,113	3,322	1,282	182	58	25,071	11,755	37,502	17,105
2008-09	333	154	8,971	4,089	3,168	1,265	187	57	24,717	11,715	37,343	17,274
2009-10	312	140	9,219	4,226	3,313	1,293	180	62	24,426	11,709	37,569	17,527
2010-11	362	178	9,473	4,322	3,264	1,319	164	56	24,408	11,704	37,764	17,651
2011-12	308	135	9,818	4,472	3,407	1,332	139	48	25,074	12,145	38,813	18,165
2012-13	340	150	10,373	4,704	3,551	1,347	149	50	25,556	12,135	39,852	18,334

Ochsner Health System

There were only 556 Black men who matriculated nationally

Table A-9: Matriculants to U.S. Medical Schools by Race, Selected Combinations of Race/Ethnicity and Sex, 2013-2014 through 2015-2016

Matriculants	2013-2014			2014-2015			2015-2016		
Selected Combinations of Race/Ethnicity	Women	Men	Total	Women	Men	Total	Women	Men	Total
American Indian or Alaska Native Only	17	26	43	23	30	53	24	31	55
American Indian or Alaska Native, Black or African American	4	3	7	9	3	12	4	4	8
American Indian or Alaska Native, White	46	41	87	49	53	102	48	50	98
Asian Only	1,845	1,868	3,713	1,918	1,899	3,817	2,029	2,066	4,095
Asian, Black or African American	9	10	19	16	14	30	13	14	27
Asian, White	151	152	303	184	151	335	195	153	348
Black or African American Only	734	500	1,234	712	515	1,227	793	556	1,349
Black or African American, White	24	28	52	28	25	53	35	32	67
Hispanic or Latino Only	583	667	1,250	574	656	1,230	625	695	1,320
Hispanic or Latino, Black or African American	26	22	48	25	20	45	39	26	65
Hispanic or Latino, White	193	206	399	222	244	466	222	248	470
Native Hawaiian or Other Pacific Islander Only	15	14	29	12	15	27	7	10	17
White Only	4,645	5,729	10,374	4,831	5,778	10,609	4,793	5,775	10,568
White, Other	49	62	111	47	80	127	56	62	118
Other	239	283	522	238	285	523	232	265	497
Multiple Race/Ethnicity Not Listed Above	119	98	217	127	109	236	140	119	259
Unknown Race/Ethnicity	656	727	1,383	550	601	1,151	438	499	937
Non-U.S. Citizen and Non-Permanent Resident	112	152	264	153	147	300	165	164	329
Total Matriculants	*9,467*	*10,588*	*20,055*	*9,718*	*10,625*	*20,343*	*9,861*	*10,766*	*20,627*

Ochsner Health System

What difference does it make if we don't accept the challenge to increase diversity in medicine?

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Underrepresented Minority Population

- Producing a physician workforce that reflects the diversity of the American population has been a goal of medical schools, teaching hospitals, policy makers, and the health care professions for many years
- Strong evidence exists to show that racial, ethnic, and linguistic diversity among health care providers is correlated with better access to and quality of care for underserved populations

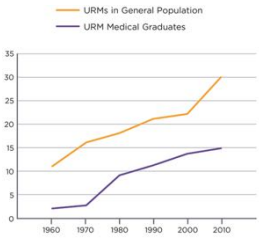

FIGURE 2-2 Trends in the proportion of underrepresented racial minorities (URMs) among medical school graduates and the U.S. general population

SOURCE: Sullivan, 2010 (AAMC).

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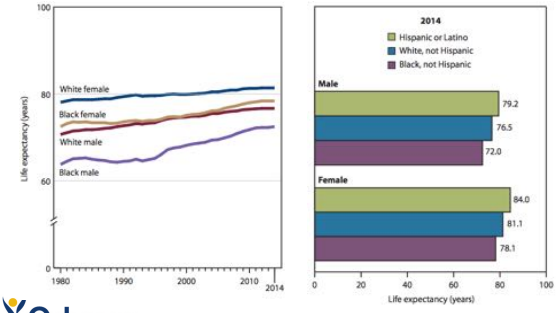
Life Expectancy 2014



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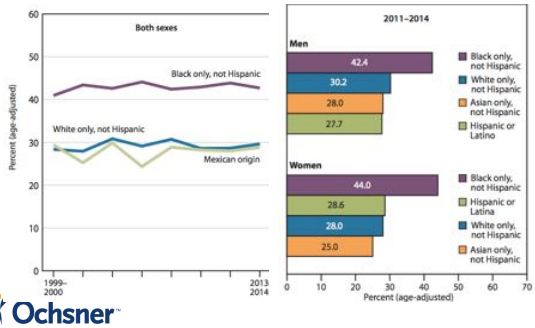
SOURCE: CDC/NCHS, National Vital Statistics System (NVSS)

Hypertension 2014



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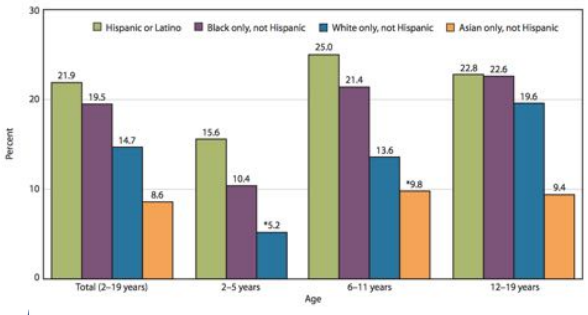
Childhood and Adolescent Obesity 2014



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Racial/Ethnic Health Disparities

Since 1988, there have been about 200,000 papers published dealing with documentation of racial and ethnic health disparities

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Institute of Medicine Report 2002

- 584 pages detailing the extent of racial and ethnic differences in healthcare that are not otherwise attributable to known factors such as access to care
- Evaluated potential sources of racial and ethnic disparities in healthcare, including the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health system levels
- Recommendations to eliminate health disparities

Ochsner Health System

A central goal of the physician workforce of tomorrow must be to eliminate health disparities

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."
Martin Luther King, jr - Medical Committee for Human Rights, 1966

- Multiple touch-points exist to effect change in medical education to accomplish this. Two approaches include:
  - Recognizing that all physicians, in any future scenario, will have to learn about cultural and social determinants of health and be trained accordingly
  - Enrich the workforce with individuals who are more likely to positively impact the elimination of health disparities

Ochsner Health System

Can Cultural Competency Reduce Racial And Ethnic Health Disparities?

- Interpreter services
- Recruitment and retention
- Training
- Coordinating with traditional healers.
- Use of community health workers
- Culturally competent health promotion
- Including family and/or community members
- Immersion into another culture
- Administrative and organizational accommodations.

Can Cultural Competency Reduce Racial And Ethnic Health Disparities? A Review And Conceptual Model

Cindy Brach
Irene Fraserirector
Agency for Healthcare Research and Quality

This article develops a conceptual model of cultural competency's potential to reduce racial and ethnic health disparities, using the cultural competency and disparities literature to lay the foundation for the model and inform assessments of its validity. The authors identify nine major cultural competency techniques: interpreter services, recruitment and retention policies, training, coordinating with traditional healers, use of community health workers, culturally competent health promotion, including family/community members, immersion into another culture, and administrative and organizational accommodations. The conceptual model shows how these techniques could theoretically improve the ability of health systems and their clinicians to deliver appropriate services to diverse populations, thereby improving outcomes and reducing disparities. The authors conclude that while there is substantial research evidence to suggest that cultural competency should in fact work, health systems have little evidence about which cultural competency techniques are effective and less evidence on when and how to implement them properly.

Medical Care Research and Review, Vol. 57 Supplement 1, (November 2000) 181-217

Case for Diversity

- Advancing cultural competency
  - *Adequate representation among students and faculty of the diversity in our society is indispensable for quality medical education*
- Increasing access to high-quality health care services
- Strengthening the medical research agenda
- Ensuring optimal management of the health care system

HEALTH CARE WORKFORCE

The Case For Diversity In The Health Care Workforce

Interventions to improve the racial and ethnic diversity of the U.S. medical workforce should begin well before medical school.

by Jordan J. Cohen, Barbara A. Gabriel, and Charles Terrell

PROLOGUE: The notion that substantial improvements in the health indicators of U.S. racial and ethnic minority populations have been achieved over the past fifty years is relatively uncontroversial. By way of example, David Mechanic recently reported in *Health Affairs* (Mar/Apr 02) that infant mortality among African Americans fell from 43.9 deaths per thousand in 1950 to 13.8 in 1998. However, as Mechanic also noted, the troubling fact that infant mortality among African Americans remained 130 percent higher than that among whites as recently as 1998 dramatically illustrates that despite improvements in absolute numbers, the issue of health disparities is an independent question that retains much contemporary salience.

HEALTH AFFAIRS (2002) Volume 21(5): (0-102

Ochsner Health System

Minority Physicians Disproportionately Dedicate their Careers to the Underserved

- Kington R, Tisnado D, Carlisle DM. Increasing racial and ethnic diversity among physicians: an intervention to address health disparities? In: Smedley BD, Colburn L, Evans CH, eds. *The Right Thing to Do, the Smart Thing to Do: Enhancing Diversity in the Health Professions*. Washington, DC: National Academy Press; 2001;64:68.
- Cantor JC, Miles EL, Baker LC, Barker DC. Physician service to the uninsured: implications for affirmative action in medical education. *Inquiry.*1996;33:167-180.
- Komaromy M, Grumbach K, Drake M. et al.. The role of Black and Hispanic physicians in providing health care for underserved populations. *N Engl J Med.*1996;334:1305-1310.
- Moy E, Bartman BA. Physician race and care of minority and medically indigent patients. *JAMA*. 1995;273(19):1515-1520.

Ochsner Health System

Premature Abandonment of Affirmative Action in Medical Education

- Affirmative action challenges decreased the progress being made to increase the pipeline of URM medical students

The Consequences of Premature Abandonment of Affirmative Action in Medical School Admissions

Jordan J. Cohen, MD

The US Supreme Court recently accepted on appeal 2 cases from the University of Michigan regarding the constitutionality of race-conscious decision making in higher education admissions. The consequences of the Court's decision will directly affect the future of medicine in the United States. Medical schools have a societal obligation to select and educate the physician workforce of the future. To outlaw the use of affirmative action in the admissions process would cripple the profession's ability to achieve racial and ethnic diversity. Preserving this diversity in medical school admissions programs is important for 4 major reasons: (1) adequate representation among students and faculty of the diversity in US society is indispensable for quality medical education; (2) increasing the diversity of the physician workforce will improve access to health care for underserved populations; (3) increasing the diversity of the research workforce can accelerate advances in medical and public health research; and (4) diversity among managers of health care organizations makes good business sense. This article explores these reasons in detail, reviews the history and effectiveness of affirmative action in medical school admissions programs, and explains why alternatives to affirmative action are unworkable.

www.jama.com

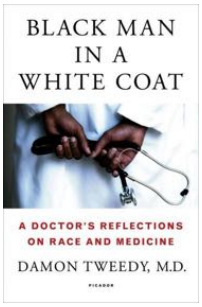
Table. Underrepresented Minority Matriculants to US Medical Schools, 1995 and 2001

State	1995	2001	Numerical Change, 1995-2001	% Change, 1995-2001
California	179	126	–53	–29.6
Texas	218	181	–37	–17.0
Mississippi	14	5	–9	–64.3
Louisiana	46	35	–11	–23.9
Washington	14	6	–8	–57.1
All other states	1554	1433	–121	–7.8
Total	**2025**	**1786**	**–239**	**–11.8**

JAMA 2003 289(9) 1143-1149

Affirmative Action Issues

- Concerns about lack of adequate preparation and mismatch
- Concerns of the learners regarding inferiority and stigma
  - "the quality that earns us preferential treatment is an implied inferiority..- Shelby Steele
- Class-based affirmative action may be a better fit?
- Concerns from society that lowering standards may lead to poorer health care delivery
- Are "qualified", "deserving" students being denied a fair chance to become doctors?



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A Research Agenda to Assess Affirmative Action

- Are the primary measures used in the residency selection process valid and reliable for making selection decisions?
- Do tests used in the residency selection process display racial bias?
- Do between-group differences in performance on cognitive tests explain the current under representation of minority groups in U.S. medical education?
- Are there viable selection models that promote diversity while maintaining validity?
- Does an increase in racial diversity within medical education result in improved educational outcomes?
- Can alternate pre-selection measures remediate the underrepresentation of minority groups in residency training?
- Is it possible to attain racial diversity and proportional representation without large declines in general performance?
- Do holistic methods represent a psychometrically valuable alternative to formulaic methods?
- Do affirmative action initiatives succeed in graduating competent underrepresented minority physicians?
- Do underrepresented minority physicians' practice choices lead to increased access to care for underserved communities?

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Modified from C. Kreiter Med Educ Online (2013) 18: 20531

Minority Physicians' Role in the Care of Underserved Patients

- Nonwhite physicians cared for 53.5% of minority and 70.4% of non–English-speaking patients
- Patients from underserved groups (except uninsured patients) were significantly more likely to see nonwhite physicians than White physicians.
- Patients of Black, Hispanic, and Asian physicians were more likely to have Medicaid; patients of Hispanic physicians were more likely to be uninsured.
- Increasing the racial and ethnic diversity of the physician workforce may be key to meeting national goals to eliminate health disparities

Ochsner Health System

Marrast LM, Zallman L, Woolhandler S, Bor DH, McCormick D. Minority Physicians' Role in the Care of Underserved Patients: Diversifying the Physician Workforce May Be Key in Addressing Health Disparities. *JAMA Intern Med.* 2014;174(2):289-291.

Merits of Increasing Minority Representation in Medicine

- Studies of service commitment, however, have shown that, compared with race, SES is a relatively weak predictor of medical students' going on to serve the underserved.
- URM students from the highest SES categories serve the underserved at greater rates than do white students from the lowest SES groups
- One possible reason for this finding is that SES changes over time, while race does not. In becoming a physician, a student from a poor or working-class upbringing moves quickly into a higher social tier and is no longer a member of a disadvantaged class. Race, however, confers more durable disadvantage.

Ochsner Health System

Saha S, Shipman SA. Race-neutral versus race-conscious workforce policy to improve access to care. Health Aff (Millwood). 2008;27(1):234-245.

Table 1. Unadjusted Association Between Disadvantaged Population and Receipt of Care From White vs Black, Hispanic, and Asian Physicians, Medical Expenditure Panel Survey, 2010

Patient Characteristic	No. (%)							
	Millions of Patients With a White Physician	Millions of Patients With a Black Physician	Unadjusted Odds Ratio (95% CI)[a]	Millions of Patients With a Hispanic Physician, No. (%)	Unadjusted Odds Ratio (95% CI)[b]	Millions of Patients With an Asian Physician, No. (%)	Unadjusted Odds Ratio (95% CI)[c]
All patients	62.2 (100.0)	3.3 (100.0)		5.9 (100.0)		9.8 (100.0)	
Non-Hispanic whites	53.2 (86.8)	1.1 (34.7)	1 [Reference]	2.4 (41.5)	1 [Reference]	5.2 (53.7)	1 [Reference]
Minorities	9.0 (13.2)	2.2 (65.3)	12.30 (8.30-18.00)	3.5 (58.5)	8.20 (5.98-11.23)	4.6 (46.3)	5.40 (4.16-6.99)
Black, non-Hispanic	4.1 (7.1)	1.9 (63.9)	23.24 (16.28-33.17)	0.5 (16.8)	2.65 (1.81-3.87)	1.0 (16.3)	2.56 (1.90-3.44)
Hispanic	3.1 (5.5)	0.1 (5.1)	0.96 (0.49-1.88)	2.7 (52.6)	19.04 (13.47-26.93)	1.1 (17.7)	3.68 (2.62-5.18)
Asian	0.9 (1.7)	0.1 (5.1)	3.06 (1.15-8.17)	0.3 (9.0)	5.63 (2.67-11.86)	2.3 (31.2)	25.73 (16.92-39.13)
Other	0.9 (1.7)	0.1 (7.4)	4.60 (1.78-11.94)	0.02 (0.6)	0.61 (0.17-2.15)	0.2 (3.8)	2.25 (1.19-4.25)
Income							
High/middle	48.9 (78.5)	2.1 (64.5)	1 [Reference]	3.9 (65.5)	1 [Reference]	7.0 (70.9)	1 [Reference]
Low	13.4 (21.5)	1.2 (35.5)	2.03 (1.46-2.75)	2.1 (34.5)	1.92 (1.44-2.55)	2.8 (29.1)	1.49 (1.23-1.81)
Medicaid							
None	54.8 (93.2)	2.5 (78.4)	1 [Reference]	4.4 (81.8)	1 [Reference]	7.9 (85.2)	1 [Reference]
Medicaid	4.0 (6.8)	0.7 (21.6)	3.75 (2.72-5.18)	1.0 (18.2)	3.04 (2.29-4.04)	1.4 (14.8)	2.38 (1.85-3.06)
Any health insurance	58.8 (94.3)	3.1 (95.2)	1 [Reference]	5.4 (90.1)	1 [Reference]	9.3 (94.0)	1 [Reference]
Uninsured	3.5 (5.7)	0.1 (4.8)	0.83 (0.49-1.41)	0.6 (9.9)	1.83 (1.30-2.57)	0.6 (6.0)	1.07 (0.78-1.47)
English home language	60.6 (97.3)	3.2 (96.8)	1 [Reference]	3.9 (66.7)	1 [Reference]	7.9 (80.4)	1 [Reference]
Non-English home language	1.7 (2.7)	0.1 (3.2)	1.18 (0.51-2.69)	2.1 (33.4)	17.83 (12.80-24.82)	1.9 (19.6)	8.69 (6.19-12.19)

[a] Odds of patients in a demographic group reporting a black physician relative to non-Hispanic white patients reporting a black physician.
[b] Odds of patients in a demographic group reporting a Hispanic physician relative to non-Hispanic white patients reporting a Hispanic physician.
[c] Odds of patients in a demographic group reporting an Asian physician relative to non-Hispanic white patients reporting an Asian physician.

Marrast LM, et al. *JAMA Intern Med.* 2014;174(2):289-291.

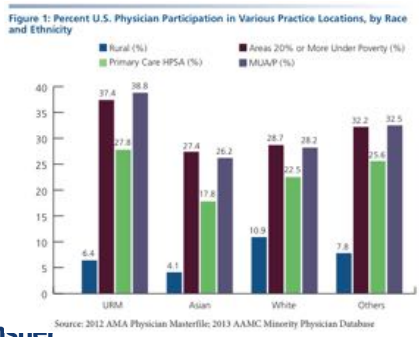
Table 1. Practice Specialty by Medically Underserved Areas (MUAP) and by Race and Ethnicity, 2013

Race and Ethnicity	Practice Specialty	N/A	No	Yes	Total
Asian	Specialist	160	29,205	10,693	40,058
	Primary Care	91	19,195	7,426	26,712
	subtotal	251	48,400	18,119	66,770
Black or African American	Specialist	38	9,775	5,246	15,057
	Primary Care	32	7,455	4,995	12,482
	subtotal	70	17,228	10,241	27,539
American Indian or Alaska Native	Specialist	5	939	401	1,345
	Primary Care	1	660	466	1,127
	subtotal	6	1,599	867	2,472
Hispanic or Latino	Specialist	29	9,550	6,585	16,164
	Primary Care	30	6,745	5,214	11,987
	subtotal	59	16,295	11,799	28,151
White	Specialist	933	164,250	65,899	231,082
	Primary Care	570	95,933	26,985	122,596
	subtotal	1,503	250,183	101,992	353,678
Others	Specialist	6	844	374	1,224
	Primary Care	2	566	291	861
	subtotal	8	1,412	665	2,085
Unknown	Specialist	1,754	105,718	47,246	154,718
	Primary Care	813	56,161	28,230	85,906
	subtotal	2,569	162,559	75,496	240,624
Total		4,466	497,674	219,179	721,319

Source: AAMC Data Warehouse: Minority Physician Database, 2013 AMA MASTERFILE, AAMC other data sources, and 2013 HRSA Geospatial Data Warehouse (05/14/2013).

Castillo-Page, et al.. "Diversity in Undergraduate Medical Education: An Examination of Organizational." *Developing Workforce Diversity Programs, Curriculum, and Degrees in Higher Education* (2016): 304.

Practice Distribution of Physicians by Race



IM Xierali et al., AAMC Analysis in Brief Volume 14(9) Aug 2014

It's not our fault….We don't control the pipeline…

Anesthesiology Residency and Fellowships 2014

Table 2. Resident Physicians on Duty in ACGME-Accredited and Combined Specialty GME Programs December 31, 2014

	Total No. of Programs[a]	No. (%) of Resident Physicians[b]					
		Total	Female	USMDs	IMGs	Canadians	Osteopathic
Specialty/Subspecialty							
Allergy and immunology	75	301 (0.3)	190 (63.1)	224 (74.4)	53 (17.6)	1 (0.3)	23 (7.6)
Anesthesiology	133	5686 (4.8)	2015 (35.4)	4423 (77.8)	675 (11.9)	3 (0.1)	585 (10.3)
Adult cardiothoracic anesthesiology	61	172 (0.1)	57 (33.1)	135 (78.5)	25 (14.5)	1 (0.6)	11 (6.4)
Critical care medicine	55	148 (0.1)	43 (29.1)	121 (81.8)	21 (14.2)	0	6 (4.1)
Obstetric anesthesiology	27	30 (<0.1)	18 (60.0)	23 (76.7)	5 (16.7)	0	2 (6.7)
Pediatric anesthesiology	53	191 (0.2)	114 (59.7)	149 (78.0)	27 (14.1)	1 (0.5)	14 (7.3)

Table 8. Race and Ethnic Origin of Resident Physicians in ACGME-Accredited and Combined Specialty Graduate Medical Education (GME) Programs on Duty December 31, 2014, by Specialty

	No. of Resident Physicians[a,b]								
	Black	American Indian/ Alaskan Native	White	Asian	Native Hawaiian/ Pacific Islander	Multiracial[c]	Other/ Unknown	Hispanic Origin[d]	Total
Specialty/Subspecialty									
Allergy and immunology	11	0	169	89	1	5	26	24	301
Anesthesiology	352	12	3509	1430	18	136	229	332	5686
Adult cardiothoracic anesthesiology	3	0	122	37	1	1	8	10	172
Critical care medicine	5	1	94	34	0	3	11	7	148
Obstetric anesthesiology	3	0	18	7	0	0	2	4	30
Pediatric anesthesiology	11	0	108	58	1	1	12	9	191

Brotherton SE, Etzel SI. Graduate Medical Education, 2014-2015. *JAMA*. 2015;314(22):2436-2454

Why Are Some Specialties Less Diverse?

- Overreliance on USMLE STEP 1 scores for screening candidates for interviews
  - Pressure from ACGME to achieve a first-time pass rate on Board examination of > 80-90%
  - Correlation between STEP1 performance, in-training examinations and Board pass rate
- Lack of advocacy for URM candidates among program directors

Other Factors?

"There is little doubt that women, African Americans, and Hispanics, have fewer opportunities to enter, or once in, to become contributing members of orthopaedic programs in the United States. The expressed reasons for this by faculty members sometimes sound reasonable, but on analysis all are spurious. It is the responsibility of the chief of service and the faculty members to change this pattern and offer all individuals equal opportunity and treat them identically to anyone in the program or on the faculty."

Mankin, HL *Diversity in Orthopedics* Clinical Orthopedics and Related Research 1999 362:85-87

Mankin's Examples of Spurious Explanations

- Women are not strong enough to do a man's job
- Working closely with women in the operating room makes a male orthopaedic surgeon nervous; touching a woman orthopaedic surgeon is distracting
- Some orthopaedic surgeons are more comfortable and therefore feel that they are better able to practice and teach more effectively when they are with their own people
- Their values (people of diversity) are different than ours and may be not as good for our patients and fellow faculty members
- People like to work with people they can take home, who speak the same language, and who have the same religious beliefs; they are more comfortable with them
- As much as one would like to do it, one does not want to be the first service in their hospital to break the barrier; one may be sympathetic but there is much peer pressure here

Mankin, HL Clinical Orthopedics and Related Research 1999 362:85

Mankin's Solution

- Believe in people as people and in their abilities as separate and unrelated to gender, color, race, creed, language, religion, or country of origin.
- A scientist is a scientist, not an African American person who does science. A surgeon is a surgeon, not a woman from Honduras who speaks the language with an accent and also does hand surgery. Judge them only on what they are and are in fact, put on earth to do: care for patients, teach, and do research
- Maintain a true belief that not only are people different from one another, but they must be different from one another to make the world a better place.

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Mankin, HL Clinical Orthopedics and Related Research 1999 362:85-87

Mankin's Solution

- Everyone regardless of origin, creed, and gender has something to contribute; often their contribution is more important as a result of their ethnic or gender diversity
- Allow those precious differences that make people who they are, to not only come out, but to be emphasized to improve quality and productivity and make the hospital and the caretaking system a better one.

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Mankin, HL Clinical Orthopedics and Related Research 1999 362:85-87

Residency Selection Practices

- Despite its intended purpose, many residency program directors continue to use applicants' USMLE Step 1 scores as a sole or primary filter for selecting candidates to interview, often disregarding the statistical characteristics of the score scale
- In general, the more competitive the residency discipline (e.g., orthopedic surgery, radiation oncology, dermatology, ophthalmology, and otolaryngology), the higher the USMLE Step 1 score needed to pass through the filter.

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Charles G. Prober, MD, Joseph C. Kolars, MD, Lewis R. First, MD, and Donald E. Melnick, MD (2015) *Academic Medicine* 90(10): 1-3

Does USMLE Performance Predict Physician Quality?

- The validity argument about using USMLE Step 1 and 2 scores for postgraduate residency selection decisions is neither structured, coherent, nor evidence based.
- …scores are not associated with measures of clinical skill acquisition among advanced medical students, residents, and subspecialty fellows.


ACADEMIC MEDICINE AAMC

Are United States Medical Licensing Exam Step 1 and 2 Scores Valid Measures for Postgraduate Medical Residency Selection Decisions?

Abstract

WC McGaghi, ER Cohen, and DB. Wayne (2011) Acad Med. 86:48–52

Ochsner Health System

ACADEMIC MEDICINE AAMC

A Plea to Reassess the Role of United States Medical Licensing Examination Step 1 Scores in Residency Selection

Charles G. Prober, MD, Joseph C. Kolars, MD, Lewis R. First, MD, and Donald E. Melnick, MD (2015) *Academic Medicine* 90(10): 1-3

- "We do not believe that USMLE Step 1 scores should continue to be the major determining factor in the selection of graduating medical students for interview for graduate medical education positions."
- "These scores (USMLE STEP1) do not measure many clinical aptitudes and skills, qualities of professionalism, or competencies specific to the planned training program."
- "Although using numbers as a filter is a convenient way to screen large numbers of applications, USMLE Step 1 scores do not come close to reflecting the totality of attributes critically relevant to a candidate's potential performance during residency training."

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Lack of Advocacy

- Resident Selection is done by faculty
- A more diverse admissions committee leads to more diversity in medical school, the same may be true for residency selection committees
- Paucity of URM faculty (only 2.9% are Black) makes this difficult and places unfair burden on those who serve
- Very few residency program directors are URMs

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Barriers to Underrepresented in Medicine Resident Recruitment

- Lack of racial diversity within a residency program, department, and/or institution
- Limited visibility of existing underrepresented in medicine faculty within a residency training program and/or during applicant recruitment.
- Perceived lack of residency program or institutional commitment to supporting diversity-related outcomes
- Incomplete understanding of how underrepresented in medicine applicants select and rank residency programs
- Limited post-interview contact with applicants
- Limited coordination between residency program and medical school diversity efforts
- Opportunities to work with underserved patient populations unavailable or not readily apparent to applicants

Ochsner Health System

Pierre, Joseph M., et al. *Academic psychiatry* (2016)

Transition to Residency

ACADEMIC MEDICINE AAMC

- Does your residency recruitment committee have URM faculty members?
- Does the department train the recruitment committee to play a vital role in URM recruitment?
- Does your department ask URM faculty to review (and potentially reverse) each offer to refuse an interview to an URM candidate?
- Has your department appointed a committee member to separately review URM applications and advocate for them at final committee meetings?
- Has your department begun a dialogue between URM residents and department leadership regarding how "URM-friendly" the program is?
- Does your department send representatives to national meetings of minority students (e.g., Student National Medical Association, Latino Medical Student Association)?
- Has your department created (and widely advertised) elective rotations for URM medical students?
- Do URM residents call each URM candidate to help establish personal contact, dispel misperceptions, and offer personal advice?
- Are there opportunities for URM residents to meet as a group and discuss the program?

Ochsner Health System

M Peek et al. URM Candidates Are Encouraged to Apply": A National Study to Identify Effective Strategies to Enhance Racial and Ethnic Faculty Diversity in Academic Departments of Medicine. Academic Medicine. 88(3):405-412, March 2013

Transition to Fellowship

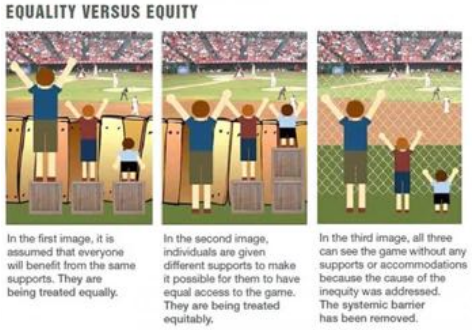
ACADEMIC MEDICINE AAMC

- Does your department require section/division chiefs and fellowship directors to prominently mention the department's increasing commitment to URM representation?
- Does your department link legitimate diversity enhancement efforts to annual evaluations/financial incentives within the sections?
- Does your department require program directors and search committees to examine (at least annually) the fairness of the selection process and results in achieving diversity?
- Is information about funding opportunities available to URM fellows (and junior faculty) widely disseminated?
- Does your department sponsor an annual social affair with key URM and non-URM faculty, department leaders, and URM residents/fellows?
- Does your department use visiting professorships to showcase research accomplishments of nationally known URM physician scientists?

Ochsner Health System

M Peek et al. URM Candidates Are Encouraged to Apply": A National Study to Identify Effective Strategies to Enhance Racial and Ethnic Faculty Diversity in Academic Departments of Medicine. Academic Medicine. 88(3):405-412, March 2013

william.mcdade@ochsner.org



Ochsner Health System

HANDOUT

Diversity: Strategy for Improving Diversity Within Anesthesiology

Abiona V. Berkeley, M.D., J.D.

11/12/2016
10:20am – 10:40am

Creating The Diverse Workplace:
Social, Economic, and Legal Implications

Abiona V. Berkeley, MD, JD
Society for Academic Anesthesiology
November 12, 2016

Objectives

1. Review the changing demographics within the United States.
2. Examine the factors motivating businesses to invest in diversity.
3. Investigate some of the strategies used in the business arena to promote diversity within their rank.
4. Analyze the legal issues facing employers related to diversity within the workplace.

Disclosures

Disclosures

Disclosures

- I do not have a financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation

The Changing U.S. Demographics (Between 2014 and 2060)

- Projected ↑ from 319 million to 417 million
- ⅕ of that growth will be foreign born
- Current majority: non-Hispanic white population; 2044: Majority-minority crossover; 2060: 44% of population
- Fastest growing group in US – "Two or More" races population

Diversity Investment: Motivating Factor

- Globalization
- Diverse/Inclusive Teams = Better Company Decisions
- Positive Perceptions = ↑ Interactions

Diversity Investment: The Comfort of Sameness

- The Similarity Organizational Theory
- The Social Categorization Model
- The Similarity-Attraction and Self-Categorization Theories

Innovation with Diversity

- Diverse groups (race, ethnicity, gender, sexual orientation) more innovative than homogeneous groups
- Finding hidden power in our biases

Gender Research

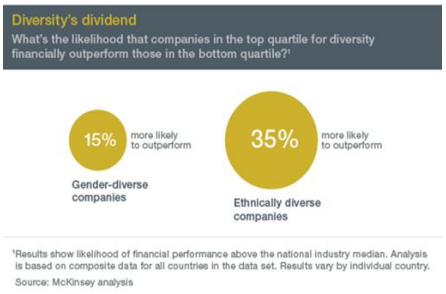
- Review of top firms from S&P Composite 1500 list 1992-2006 - Companies that prioritized innovation saw greater financial gains when women were part of the top leadership ranks
- Other research found companies with one or more women on board had higher than average return on equity, net debt to equity and better that average growth

Race Research

- A 2003 study based on 177 national US bank executives surveys comparing financial performance and racial diversity with the emphasis the executives placed on innovation

Results:

The innovation-focused banks with increased racial diversity demonstrated enhanced financial performance



Tying Diversity to Innovation

- A 2004 study with 350 students from 3 universities examining the influence of racial and opinion composition in small group discussions
- Dissenting opinions were written, having both black and white members deliver them to their respective groups

Results:

When a black person presented the dissenting opinions to a white audience, the perspective was perceived as novel and led to more introspective thinking than when a white person presented the identical information to the white audience

Powerful Motivating Factor: Difference

- 186 people identified as Democrat or Republican partnered with another individual and asked to prepare an essay communicating their perspective.

Result:
Those making the argument with a member of their own party were less prepared than those from a different party.

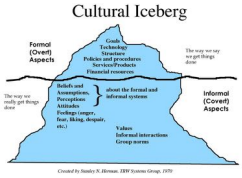
The Tincture of Time: The Millennials

- A 2014 study looked at the effects of supervisor demographics and the relational differences within the supervisor-subordinate relationship on employee satisfaction.

Results:
- Older white supervisors positively affected Millennials job satisfaction
- No preference noted with respect to gender

Recruitment and Retention Strategies that Fail

- Diversity Training
- Hiring Tests
- Performance Ratings
- Grievance Systems



Poor Returns on the Usual Diversity Programs

The three most popular interventions make firms less diverse, not more, because managers resist strong-arming. For instance, testing job applicants hurts women and minorities—but not because they perform poorly. Hiring managers don't always test everyone (white men often get a pass) and don't interpret results consistently.

% CHANGE OVER FIVE YEARS IN REPRESENTATION AMONG MANAGERS

	White		Black		Hispanic		Asian	
Type of program	Men	Women	Men	Women	Men	Women	Men	Women
Mandatory diversity training				-9.2			-4.5	-5.4
Job tests		-3.8	-10.2	-9.1	-6.7	-8.8		-9.3
Grievance systems		-2.7	-7.3	-4.8		-4.7	-11.3	-4.1

NOTE GRAY INDICATES NO STATISTICAL CERTAINTY OF A PROGRAM'S EFFECT.
SOURCE AUTHORS' STUDY OF 829 MIDSIZE AND LARGE U.S. FIRMS. THE ANALYSIS ISOLATED THE EFFECTS OF DIVERSITY PROGRAMS FROM EVERYTHING ELSE GOING ON IN THE COMPANIES AND IN THE ECONOMY.
FROM "WHY DIVERSITY PROGRAMS FAIL," BY FRANK DOBBIN AND ALEXANDRA KALEV, JULY–AUGUST 2016 © HBR.ORG

Recruitment and Retention Strategies

- Blind Auditions (Business and Music Industries
- Recruitment Fairs
- Mentoring
- Institutional Diversity Exposure
- Social Accountability

Diversity Programs That Get Results

Companies do a better job of increasing diversity when they forgo the control tactics and frame their efforts more positively. The most effective programs spark engagement, increase contact among different groups, or draw on people's strong desire to look good to others.

% CHANGE OVER FIVE YEARS IN REPRESENTATION AMONG MANAGERS

Type of program	White Men	White Women	Black Men	Black Women	Hispanic Men	Hispanic Women	Asian Men	Asian Women
Voluntary training			+13.3		+9.1		+9.3	+12.6
Self-managed teams	−2.8	+5.6	+3.4	+3.9				+3.6
Cross-training	−1.4	+3.0	+2.7	+3.0	−3.9		+6.5	+4.1
College recruitment: women*	−2.0	+10.2	+7.9	+8.7		+10.0	+18.3	+8.6
College recruitment: minorities**			+7.7	+8.9				
Mentoring				+18.0	+9.1	+23.7	+18.0	+24.0
Diversity task forces	−3.3	+11.6	+8.7	+22.7	+12.0	+16.2	+30.2	+24.2
Diversity managers		+7.5	+17.0	+11.1		+18.2	+10.9	+13.6

*College recruitment targeting women turns recruiting managers into diversity champions, so it also helps boost the numbers for black and Asian-American men.

**College recruitment targeting minorities often focuses on historically black schools, which lifts the numbers of African-American men and women.

NOTE GRAY INDICATES NO STATISTICAL CERTAINTY OF A PROGRAM'S EFFECT.
SOURCE AUTHORS' STUDY OF 829 MIDSIZE AND LARGE U.S. FIRMS. THE ANALYSIS ISOLATED THE EFFECTS OF DIVERSITY PROGRAMS FROM EVERYTHING ELSE GOING ON IN THE COMPANIES AND IN THE ECONOMY.
FROM "WHY DIVERSITY PROGRAMS FAIL," BY FRANK DOBBIN AND ALEXANDRA KALEV, JULY–AUGUST 2016

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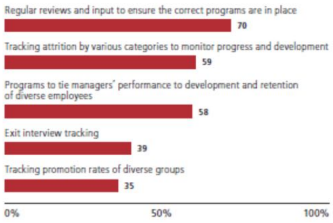
Effects of Diversity Programs: Monitoring

- Demonstrates commitment, productivity, and advancement
- Efficacy tracked by employee reviews, company policy feedback, attrition rates, and manager's performance tied to development goals
- Examples of accountability metrics: productivity, employee morale, employee turnover

Globally Senior Executives Report on Programs to Retain Diverse Talent



Legal Issues in Creating a Diverse Program: QUESTIONS

- Can you pursue diversity within the bounds of our legal system?
- Does Bakke permit you to work towards a more level playing field?
- Does the pursuit of diversity ultimately mean discrimination against white males?

Review of Diversity based Caselaw

- Pro se Caucasian woman files age and race discrimination case.
- Caucasian attorney files racial harassment suit.
- Caucasian teacher won a reverse discrimination case stemming from his termination.

Review of Diversity Case Law

- Bakke.
- Grutter v Bollinger.
- Fisher v. University of Texas at Austin.

Recent events

YAHOO!

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HANDOUT

Diversity: Strategy for Improving Diversity Within Anesthesiology

Demicha D. Rankin, M.D.

11/12/2016
10:40am – 11:00am

Strategy for Improving Diversity Within Anesthesiology

Demicha D. Rankin, MD
Assistant Professor-Clinical
Anesthesiology Residency Program Director
The Ohio State University Wexner Medical Center

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Disclosures

I have no disclosures to report.

Objectives

- Objective 1: Review literature that recognizes bias which may contribute to an underrepresentation of minorities and women in leadership positions in Academic Anesthesiology.
- Objective 2: Identify opportunities to reduce individual and institutional bias to improve diversity in gender, race, and ethnicity within Academic Anesthesiology.

Sex Roles (2016) 75:95–109
DOI 10.1007/s11199-016-0586-1

ORIGINAL ARTICLE

Published online: 5 February 2016

But You Don't Look Like A Scientist!: Women Scientists with Feminine Appearance are Deemed Less Likely to be Scientists

Sarah Banchefsky[1] · Jacob Westfall[2] · Bernadette Park[1] · Charles M. Judd[2]

[1] Department of Psychology and Neuroscience, University of Colorado Boulder, Muenzinger D244, Boulder, CO 80309-0345, USA

[2] Department of Psychology, The University of Texas at Austin, SEA 4.208, 108 E. Dean Keeton Stop A8000, Austin, TX 78712-1043, USA

Abstract Two studies examined whether subtle variations in feminine appearance erroneously convey a woman's likelihood of being a scientist. Eighty photos (half women) of tenured/tenure-track science, technology, engineering, and math (STEM) faculty at elite research universities were selected from the Internet. Participants, naïve to the targets' occupations, rated the photos on femininity and likelihood of being a scientist and an early childhood educator. Linear mixed model analysis treated both participants and stimuli as random factors, enabling generalization to other samples of participants and other samples of stimuli. Feminine appearance affected career judgments for female scientists (with increasing femininity decreasing the perceived likelihood of being a scientist and increasing the perceived likelihood of being an early childhood educator), but had no effect on judgments of male scientists. Study 2 replicated these findings with several key procedural modifications: the presentation of the stimuli was manipulated to either be blocked by gender or completely randomized, questions pertaining to the stimuli's appearance were removed, and a third career judgment likelihood rating was added (i.e., early childhood educator). In both studies, results suggest that for women pursuing STEM, feminine appearance may erroneously signal that they are not well suited for science.

Orchestrating Impartiality: The Impact of "Blind" Auditions on Female Musicians

By Claudia Goldin and Cecilia Rouse*

A change in the audition procedures of symphony orchestras—adoption of "blind" auditions with a "screen" to conceal the candidate's identity from the jury—provides a test for sex-biased hiring. Using data from actual auditions, in an individual fixed-effects framework, we find that the screen increases the probability a woman will be advanced and hired. Although some of our estimates have large standard errors and there is one persistent effect in the opposite direction, the weight of the evidence suggests that the blind audition procedure fostered impartiality in hiring and increased the proportion women in symphony orchestras. (JEL J7, J16)

Source: *The American Economic Review*, Vol. 90, No. 4 (Sep., 2000), pp. 715-741
Published by: American Economic Association
Stable URL: http://www.jstor.org/stable/117305

JSTOR

Project Implicit®

"Project Implicit is a non-profit organization and international collaborative network of researchers investigating implicit social cognition - thoughts and feelings outside of conscious awareness and control. Project Implicit is the product of a team of scientists whose research produced new ways of understanding attitudes, stereotypes and other hidden biases that influence perception, judgment, and action."

What is the impact of implicit association in healthcare?

Implicit bias vs explicit bias

Implicit Bias among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients

Alexander R. Green, MD, MPH[1], Dana R. Carney, PhD[2], Daniel J. Pallin, MD, MPH[3], Long H. Ngo, PhD[4], Kristal L. Raymond, MPH[5], Lisa I. Iezzoni, MD, MSc[6], and Mahzarin R. Banaji, PhD[2]

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ORIGINAL RESEARCH

Do Physicians' Implicit Views of African Americans Affect Clinical Decision Making?

M. Norman Oliver, MD, MA, Kristen M. Wells, MPH, PhD, Jennifer A. Joy-Gaba, PhD, Carlee Beth Hawkins, MA, and Brian A. Nosek, PhD

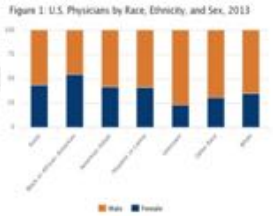
Background: Total knee replacement (TKR) is a cost-effective treatment option for severe osteoarthritis (OA). While prevalence of OA is higher among blacks than whites, TKR rates are lower among blacks. Physicians' implicit preferences might explain racial differences in TKR recommendation. The objective of this study was to evaluate whether the magnitude of implicit racial bias predicts physician recommendation of TKR for black and white patients with OA and to assess the effectiveness of a web-based instrument as an intervention to decrease the effect of implicit racial bias on physician recommendation of TKR.

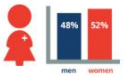
Conclusions: **Physicians possessed explicit and implicit racial biases, but those biases did not predict treatment recommendations. Clinicians' biases about the medical cooperativeness of blacks versus whites, however, may have influenced treatment decisions. (J Am Board Fam Med 2014;27:177–188.)**

AAMC data

AAMC Physician

Figure 1: U.S. Physicians by Race, Ethnicity, and Sex, 2013





Among all younger non-white physicians, women make up a greater percentage of the workforce.

Blacks and African-Americans comprise only 4 percent of the physician workforce.

Race and Ethnicity	Women	Men
Asian (n=119,355)	52006	67349
Black or African-American (n=40,499)	22146	18353
American Indians or Alaska Native (n=3,475)	1455	2020
Hispanic or Latino (n=43,685)	17917	25768
Unknown (n=281,346)	65096	216250
Other Race (n=3,861)	1180	2681
White (=464,302)	161402	302900

Race and Ethnicity	% of Women	% of Men
Asian (n=119,355)	43.60%	56.40%
Black or African-American (n=40,499)	54.70%	45.30%
American Indians or Alaska Native (n=3,475)	41.90%	58.10%
Hispanic or Latino (n=43,685)	41.00%	59.00%
Unknown (n=281,346)	23.10%	76.90%
Other Race (n=3,861)	30.60%	69.40%
White (=464,302)	34.80%	65.20%

Note: These data exclude missing sex and inactive physicians.

Source: AAMC Data Warehouse: Minority Physician Database, AMA Masterfile, and other AAMC data sources, as of 1/22/2014.http://aamcdiversityfactsandfigures.org/section-ii-current-status-of-us-physician-workforce/

Figure 10: U.S. Physicians by Graduation Year, Race, Ethnicity, and Sex, 1980–2012

Source: AAMC Data Warehouse: Minority Physician Database, AMA Masterfile, and other AAMC data sources, as of 1/22/2014.

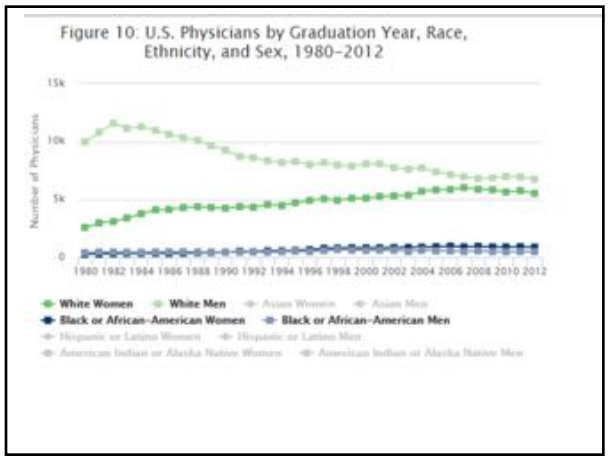


Figure 10: U.S. Physicians by Graduation Year, Race, Ethnicity, and Sex, 1980-2012
Number of Physicians
15k
10k
5k
0
1980 1982 1984 1986 1988 1990 1992 1994 1996 1998 2000 2002 2004 2006 2008 2010 2012
White Women
White Men
Asian Women
Asian Men
Black or African-American Women
Black or African-American Men
Hispanic or Latino Women
Hispanic or Latino Men
American Indian or Alaska Native Women
American Indian or Alaska Native Men

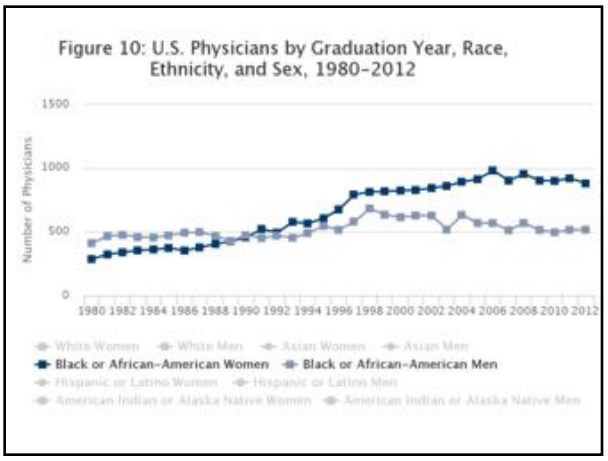
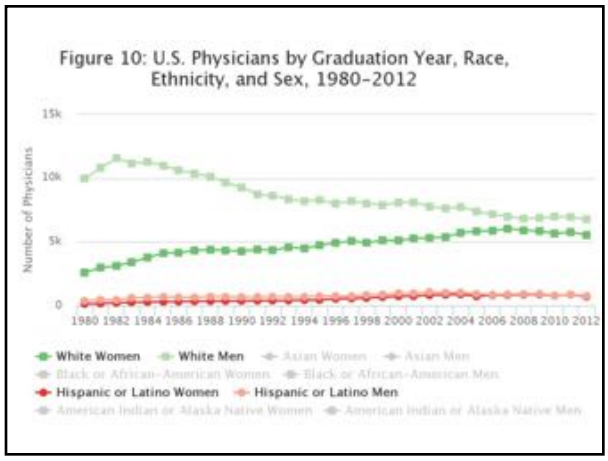


Figure 10: U.S. Physicians by Graduation Year, Race, Ethnicity, and Sex, 1980-2012
Number of Physicians
1500
1000
500
0
1980 1982 1984 1986 1988 1990 1992 1994 1996 1998 2000 2002 2004 2006 2008 2010 2012
White Women
White Men
Asian Women
Asian Men
Black or African-American Women
Black or African-American Men
Hispanic or Latino Women
Hispanic or Latino Men
American Indian or Alaska Native Women
American Indian or Alaska Native Men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Number of Physicians
15k
10k
5k
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1980 1982 1984 1986 1988 1990 1992 1994 1996 1998 2000 2002 2004 2006 2008 2010 2012
White Women
White Men
Asian Women
Asian Men
Black or African-American Women
Black or African-American Men
Hispanic or Latino Women
Hispanic or Latino Men
American Indian or Alaska Native Women
American Indian or Alaska Native Men

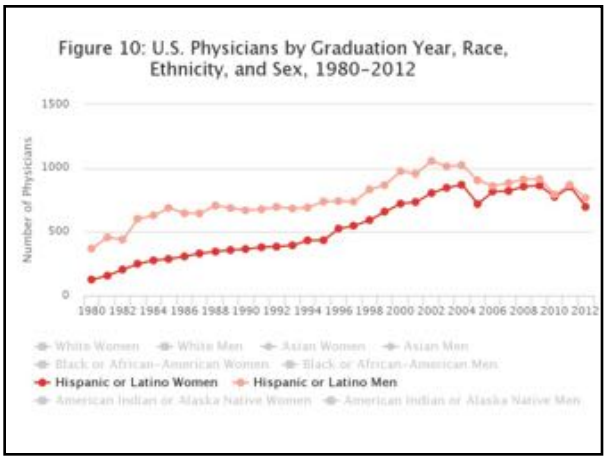
Figure 10: U.S. Physicians by Graduation Year, Race, Ethnicity, and Sex, 1980-2012
Number of Physicians
1500
1000
500
0
1980 1982 1984 1986 1988 1990 1992 1994 1996 1998 2000 2002 2004 2006 2008 2010 2012
White Women
White Men
Asian Women
Asian Men
Black or African-American Women
Black or African-American Men
Hispanic or Latino Women
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American Indian or Alaska Native Women
American Indian or Alaska Native Men

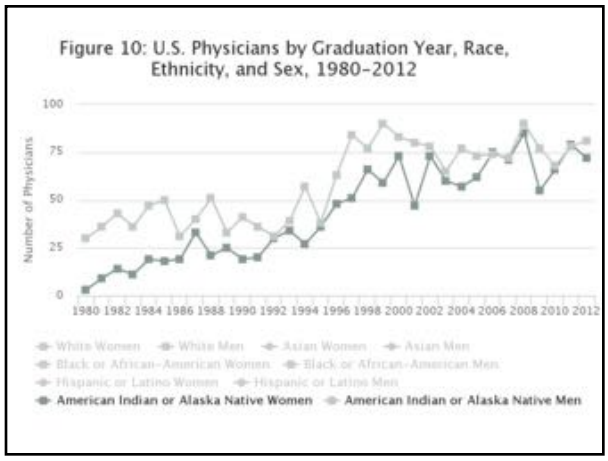
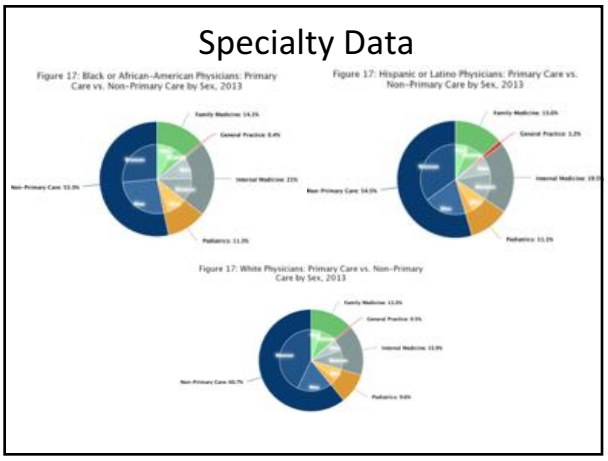
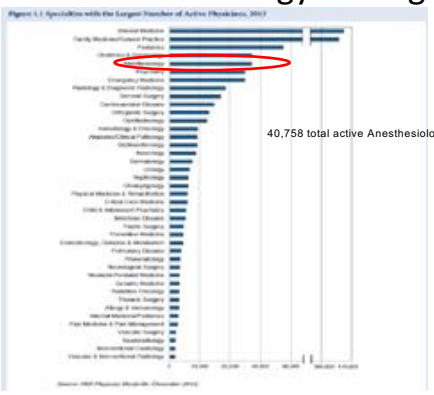


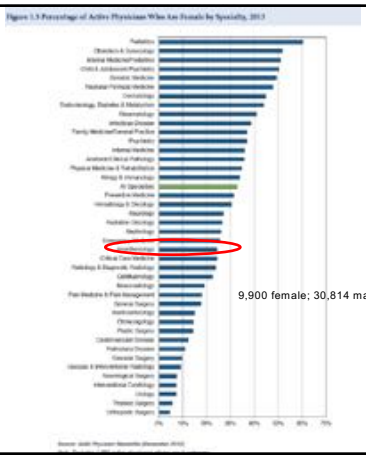
Figure 10: U.S. Physicians by Graduation Year, Race, Ethnicity, and Sex, 1980-2012
Number of Physicians
100
75
50
25
0
1980 1982 1984 1986 1988 1990 1992 1994 1996 1998 2000 2002 2004 2006 2008 2010 2012
White Women
White Men
Asian Women
Asian Men
Black or African-American Women
Black or African-American Men
Hispanic or Latino Women
Hispanic or Latino Men
American Indian or Alaska Native Women
American Indian or Alaska Native Men


Specialty Data
Figure 17: Black or African-American Physicians: Primary Care vs. Non-Primary Care by Sex, 2013
Figure 17: Hispanic or Latino Physicians: Primary Care vs. Non-Primary Care by Sex, 2013
Figure 17: White Physicians: Primary Care vs. Non-Primary Care by Sex, 2013

Anesthesiology demographics



40,758 total active Anesthesiologists (2013)



9,900 female; 30,814 male Anesthesiologists (2013)

ORIGINAL COMMUNICATION

The Association Among Specialty, Race, Ethnicity, and Practice Location Among California Physicians in Diverse Specialties

Kara Odom Walker, MD, MPH; Gerardo Moreno, MD, MSHS; Kevin Grumbach, MD

Table 2. Percent of Racial and Ethnic Groups by Specialty Practicing in Designated Service Areas in California[a]

	Practice Location Shortage Designation	
Characteristic	**Medically Underserved Area, %**	**Health Professional Shortage Area, %**
Facility-based specialties[c]		
White	15.1 (13.8-16.3)	11.1 (10.0-12.2)
African American	19.8 (12.7-27.0)	16.5 (9.9-23.2)
Latino	18.4 (12.4-24.4)	16.0 (10.3-21.6)
Asian	17.7 (15.6-19.8)	11.9 (10.1-13.7)
Pacific Islander	22.4 (15.1-29.7)	17.6 (10.9-24.3)
Other	14.4 (9.1-19.6)	13.8 (8.7-18.9)
P value	.06	.04

[a] *P* values assessed by χ^2 tests.
[b] Primary care = family medicine, internal medicine, and pediatrics.
[c] Facility-based = anesthesiology, emergency medicine, and radiology.

Journal of Vascular Surgery®

April Supplement 2010

Minorities in academic medicine: Review of the literature

Marc A. Nivet, Ed.D., *New York, NY*

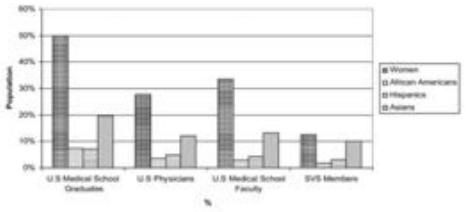


Fig. Proportion of women and minorities in medicine.

Physician path to leadership roles

Minorities struggle to advance in academic medicine: A 12-y review of diversity at the highest levels of America's teaching institutions

Peter T. Yu, MD,[a,*] Pouria V. Parsa, MD,[b] Omer Hassanein, MD,[a] Selwyn O. Rogers, MD, MPH,[b] and David C. Chang, PhD, MPH, MBA[a]

[a]Department of Surgery, University of California, San Diego, San Diego, CA, USA
[b]Department of Surgery, Harvard Medical School, Boston, Massachusetts

ORIGINAL CONTRIBUTION

JAMA The Journal of the American Medical Association

Racial and Ethnic Disparities in Faculty Promotion in Academic Medicine

Di Fang, PhD
Ernest Moy, MD, MPH
Lois Colburn, MA
Jeanne Hurley

JOURNAL OF WOMEN'S HEALTH
Volume 17, Number 8, 2008
© Mary Ann Liebert, Inc.
DOI: 10.1089/jwh.2007.0708

Model of Excellence in Leadership Development

Fixing the System, Not the Women: An Innovative Approach to Faculty Advancement

Abstract

Women in academic medicine are approaching parity without power. Although the number of women choosing careers in medicine has grown substantially over the last 35 years, there has not been a commensurate increase in the percentage of women in senior leadership positions. To redress this situation at the University of Illinois College of Medicine (UICM), the Faculty Academic Advancement Committee (FAAC) was established in January 2003. FAAC's long-term goals are to create an institution whose faculty, department leaders, and deans reflect the gender and ethnic profile of the college's student body and to enable excellence in research, teaching, and patient care while promoting work/life balance. Commissioned as a Dean's Committee, FAAC brings together a diverse group of faculty and academic professionals from inside and outside the college to learn, reflect, and act. FAAC has committed to increasing the percentage of tenured women faculty and advancing women into leadership positions by carrying out an ambitious evidence-based institutional transformation effort. FAAC's initiatives—data gathering, constituency building, department transformation, policy reform, and advocacy—have helped to create an enabling environment for change at UICM. This case study outlines the history, conceptual approach, structure, initiatives, and initial outcomes of FAAC's efforts.

JOURNAL OF WOMEN'S HEALTH
Volume 20, Number 12, 2011
© Mary Ann Liebert, Inc.
DOI: 10.1089/jwh.2011.2906

Resident and Program Director Gender Distribution by Specialty

Timothy R. Long, M.D., Beth A. Elliott, M.D., Mary Ellen Warner, M.D., Michael J. Brown, M.D., and Steven H. Rose, M.D.

Results: Specialties with higher percentages of female PDs had a higher percentage of female residents enrolled ($r = 0.83$, $p = 0.005$). The number of female PDs appointed from July 1, 2006, through June 30, 2010, was greater than the number appointed before July 1, 2006, in emergency medicine ($p < 0.001$), family medicine ($p = 0.02$), and for all PDs ($p = 0.005$). Female PDs were fewer than expected based on the gender distribution of medical school faculty in 7 of the 10 specialties.

Conclusions: Women remain underrepresented in PD appointments relative to the proportion of female medical school faculty and female residents. Mechanisms to address gender-based barriers to advancement should be considered.

Table 2.2 Number and Percentage of ACGME Residents/Fellows by Sex and Specialty, 2013

Specialty	Total Residents and Fellows	Male		Female	
		Number	Percent	Number	Percent
All Specialties	116,675	62,925	53.9	53,750	46.1
Allergy & Immunology	305	104	34.1	201	65.9
Anatomic/Clinical Pathology	2,289	1,052	46.0	1,237	54.0
Anesthesiology	5,630	3,603	63.9	2,036	36.1
Cardiovascular Disease	2,596	2,037	78.5	559	21.5
Child & Adolescent Psychiatry	907	353	38.9	554	61.1
Critical Care Medicine	1,848	1,237	66.9	611	33.1
Dermatology	1,190	427	35.9	763	64.1
Emergency Medicine	5,599	3,502	62.5	2,097	37.5

AAMC

Moving Forward

Implicit Racial Bias in Medical School Admissions

Quinn Capers IV, MD, Daniel Clinchot, MD, Leon McDougle, MD, and Anthony G. Greenwald, PhD

Abstract

Problem
Implicit white race preference has been associated with discrimination in the education, criminal justice, and health care systems and underrepresentation of African Americans into the medical profession, where they and other minorities remain underrepresented. Little is known about implicit racial bias in medical school admissions committees.

Approach
To measure implicit racial bias, all 140 members of the Ohio State University College of Medicine (OSUCOM) admissions committee took the black-white implicit association test (IAT) prior to the 2012–2013 cycle. Results were collated by gender and student versus faculty status. To ensure that committee members took the IAT on the admissions process, members took a survey at the end of the cycle, which 100 (71%) completed.

Outcomes
All groups (men, women, students, faculty) displayed significant levels of implicit white preference; men ($d = 0.693$) and faculty ($d = 0.820$) had the largest bias measures ($P < .001$). Most survey respondents (61%) thought the IAT might be helpful in reducing bias; 48% were conscious of their individual results when interviewing candidates in the next cycle, and 21% reported knowledge of their IAT results influenced their admissions decisions in the subsequent cycle. The class that matriculated following the IAT exercise was the most diverse in OSUCOM's history at that time.

Next Steps
Future directions include preceding and following the IAT with more robust reflection and education on unconscious bias. The authors join others in calling for an examination of bias at all levels of academic medicine.

Research

Original Investigation

Minority Faculty Development Programs and Underrepresented Minority Faculty Representation at US Medical Schools

James P. Garvin, MD, MPH, Emem Adonga, BA, Elorm Asikame, BS, Margo Brooks Carthon, PhD

Mentoring Programs for Underrepresented Minority Faculty in Academic Medical Centers: A Systematic Review of the Literature

Dr. Kathleen M. Busch, DrPH [Professor],
Department of Social Sciences and Health Policy, and codirector, Maya Angelou Center for Health Equity, Wake Forest School of Medicine, Winston-Salem, North Carolina

Dr. Jorge Calles-Escandon, MD [Formerly professor],
Department of Internal Medicine, Wake Forest School of Medicine, Winston-Salem, North Carolina, and is currently, chair, Division of Endocrinology, Wake Health Medical Center, Cleveland, Ohio

Dr. Kristen G. Kenton, MD [Assistant professor],
Department of Internal Medicine, Wake Forest School of Medicine, Winston-Salem, North Carolina

Ms. Sarah E. Langdon [Project manager],
Maya Angelou Center for Health Equity, Wake Forest School of Medicine, Winston-Salem, North Carolina

Dr. Brenda A. Latham-Sadler, MD [Assistant dean for student services], and
Wake Forest School of Medicine, Winston-Salem, North Carolina

Dr. Nancy A. Bell, PhD [Professor],
Department of Epidemiology, and codirector, Maya Angelou Center for Health Equity, Wake Forest School of Medicine, Winston-Salem, North Carolina

Abstract

Published in final edited form as:
Acad Med. 2011 October ; 86(10): 1211–1220. doi:10.1097/ACM.0b013e31823ab044.

Faculty Diversity Programs in U.S. Medical Schools and Characteristics Associated with Higher Faculty Diversity

Kathleen Raquel Page, MD [assistant professor],
Department of Medicine, the Johns Hopkins University School of Medicine, Baltimore, Maryland

Laura Castillo-Page, PhD [senior director], and
Diversity Policy and Programs, Association of American Medical Colleges, Washington, D.C.

Scott M. Wright, MD [professor]
Department of Medicine, the Johns Hopkins University School of Medicine, Baltimore, Maryland

Action Plan

Individual level

- Acknowledge and address stereotypes, bias, and privilege
  - Personal reflection and consultation with other physicians
- Consider taking the Implicit Association Test (IAT)
  - https://implicit.harvard.edu/implicit/takeatest.html
- Conscious effort to negate stereotypes; visualize positive images
  - Engage in immersion experiences to facilitate development of more accurate perceptions of marginalized groups

Plan

Institutional level

- Make it a priority: clear goals, held accountable, integrated into evaluation criteria
- Workshops, faculty development
  - Begin with leadership
  - Make education ongoing
- Holistic reviews of faculty candidates
- Structured interviews
  - Exclude discussion or evaluation of criteria that is not related to the position
- Commit to predetermined credentials; gender neutral titles
- Decide whom to include not who to exclude

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Thank you
Questions, comments?

HANDOUT

Diversity Presentation

Tyronne Stoudemire

11/12/2016
11:15am – 11:45am

MAKING THE BUSINESS CASE FOR THE IMPORTANCE OF DIVERSITY

Tyronne Stoudemire

Vice President Global Diversity & Inclusion, Hyatt Hotels

ABOUT Tyronne Stoudemire

Vice President Global Diversity and Inclusion
Hyatt Hotels Corporation

- Responsible for the development and implementation of inclusion and diversity strategies for Hyatt's colleagues in more than 100 countries.
- His charge is to leverage diversity and inclusion as an engine for growth and foster a corporate culture that champions all of its colleagues.
- Has built a remarkable career in Diversity and Inclusion leadership and is always seeking to empower others through education and mentorship.

Diversity is the Mix…

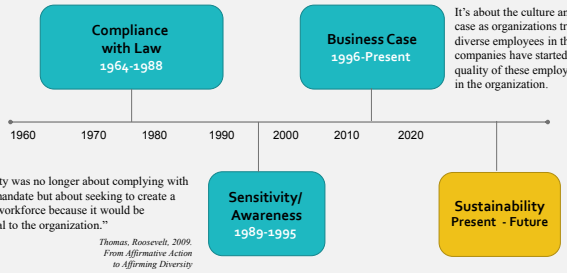
When an employee perceives that a company and its leadership are committed to a diverse and fair workplace, they are:

- More likely to stay with that company
- More likely to outperform the competition
- More likely to recommend their company to others
- Less likely to have experienced discrimination
- Less likely to have missed days at work
- More engaged in their work

From Civil Rights in the Workplace 2005 Survey, Conducted by the Gallup Organization

…and the Mix Matters

EVOLUTION of Diversity & Inclusion

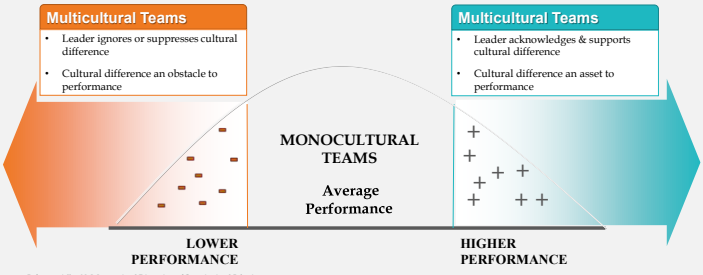


It's about the culture and the business case as organizations try to retain diverse employees in their workforce, companies have started looking at the quality of these employees' experience in the organization.

"Diversity was no longer about complying with a legal mandate but about seeking to create a diverse workforce because it would be beneficial to the organization."

Thomas, Roosevelt, 2009. From Affirmative Action to Affirming Diversity

IMPACT of Diversity and Inclusion on Team Performance



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C. Milton J. Bennett 2008

INFLUENCEpower

Are you listening to everyone's idea? Are you influenced by power? Are you truly working in an inclusive workplace?

5 GENERATIONS in the Workforce

- The workforce will be more diverse than ever, with multiple generations, cultures and ethnicities working side by side.
- The workforce will be increasingly diverse in terms of people with disabilities, across country borders, and flexible work schedules.
- Across the globe, the working-age population (ages 20 to 64) will continue to diminish in numbers up through 2050.

Traditionalists (1930-1943)	Baby Boomers (1943-1964)	Generation X (1965-1977)	Generation Y/Milenials (1977-1997)	Digital Natives (1998-2010)

According to the Workforce Crisis: How to Beat the Coming Shortage of Skills and Talent, Harvard Business Review:

THE NewAFFLUENT

Are you really listening to what your client say? Are you paying attention to what matters to them?

Diversity: Why We Care?

By embedding the Diversity & Inclusion strategy into the global business strategy, we continue to leverage and maintain strong leadership support, a compelling business relevance and action plans that lead to attraction, engagement, retention and advancement for colleagues.

With continued efforts of Diversity & Inclusion embed into talent acquisition, benefits, communications, leadership, performance management, workforce planning, and other ongoing HR processes. Through this, we create a sustainable strategy that points the way for Diversity & Inclusion to add value to the business, talent, operational strategies and objectives.

EXAMPLE the Impact on Business

$100 Million Lawsuit

EXAMPLE the Impact on Business

Why were African & Japanese consumers horrified by Gerber's product packaging?

$$ Millions of Dollars in Advertising, Branding, and Shelf Restocking Costs

Adapted from Harvard Business Review (1984)

EXAMPLE the Impact on Business

Why did this not appeal to the Hispanic/Latino/a community?

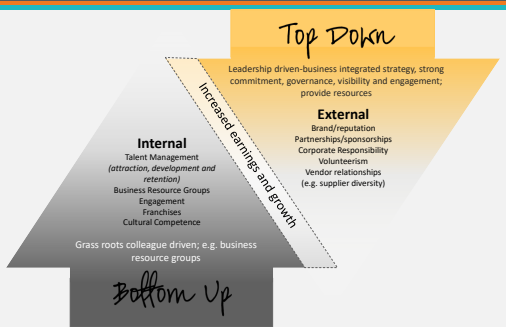
Chevy Nova (in Spanish, *no va* means "**won't go**"), car renamed **$$ Millions of Dollars in Advertising and Branding**

Adapted from Harvard Business Review (1984)

EXAMPLE the Impact on Business

Does this seem all too familiar? How can our communities flex?

DRIVING The Change

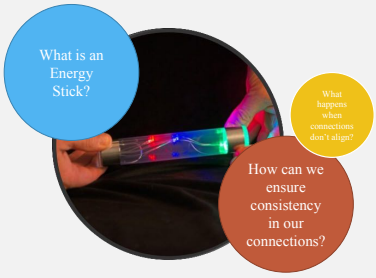


Path to CULTURAL COMPETENCE

Diversity without inclusion leads to conflict. Inclusion without diversity may create harmony, but since everyone is alike, the organization will not be able to reach its full creative or innovative potential.

Inclusion creates a work environment in which all **associates feel valued and cared for** because of the different attributes they bring. Therefore, each associate is more **motivated** and **engaged** to reach their fullest potential toward achieving business goals.

Energy STICK



ABOUT Bias

- UNCONSCIOUS bias works behind the scenes, subversively undermining equality efforts
- Traditional thinking has generally assumed that patterns of discriminatory behavior in organizations are CONSCIOUS
- The COLLECTIVE phenomena listed above can make the group take some control on individual minds and limit their independence of decisions and actions.

TRY This….

What are 4 things that you value the most, that are *MOST* important to you?

1. 2. 3. 4.

Unconscious BIAS

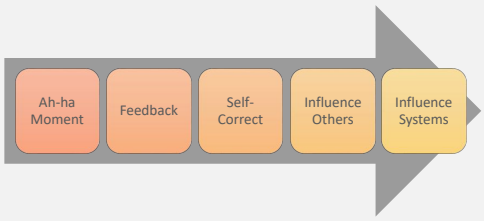
Studies have proven:

- Brain produces 'shortcuts' to what is right, wrong or important
- Different = "unsafe"
- Also rooted in cultural environment
- Our "perceptual lens" acts as filter
- Biases impact decision-making

Sources: "Proven Strategies for Addressing Unconscious Bias in the Workplace", CDO Insights Aug 2008 Vol 2, Issue 5.
Photo from Scientific American, LeDoux, J. The Emotional Brain: The Mysterious Underpinnings of Emotional Life, New York: Simon and Schuster

SELF-CORRECTION

ah-Ha! Moment



TRY This….

Google

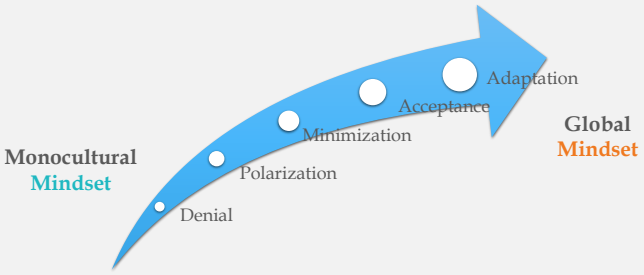
Cross Cultural Competence

The ability to discern and take into account one's own and others' world views to be able to seize opportunities, make decisions, and resolve conflicts in ways that optimize cultural differences for better, longer lasting, and more creative solutions and outperform the competition.

From ***Tolerance and Sensitivity***

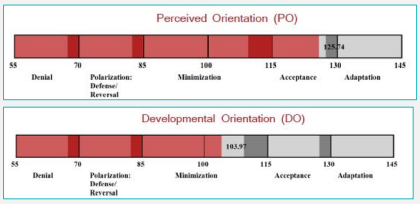
To ***Cross Cultural Competence***

Intercultural Development Inventory (IDI)



Perceived VS. Developmental

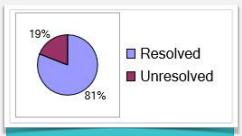
SAMPLE



The **Orientation Gap** between your Perceived Orientation score and Developmental Orientation score is 21.77 points. A gap score of 7 points or higher can be considered a meaningful difference between where you perceive "you are" on the developmental continuum and where the IDI places your level of intercultural competence.

CULTURAL disengagement

SAMPLE



NOTE: The degree of cultural disengagement one experiences is not directly related to the level of one's intercultural expertise.

What Do You SEE…

What Do You SEE…

D.I.N. Model

First describe the behaviors and actions you see. Be careful not to let your personal judgments influence what you observe. The behaviors and actions that you see.

In a cross cultural situation, be aware of culturally influenced interpretations of the behaviors that take place in another culture. Try to interpret the behaviors and actions from two perspectives:

- From your perspective, based on your cultural background and values.
- From the perspective on the culture you are observing. You can do this by finding out more about the other culture and what motivates their behavior.

Once you feel you have a pretty good understanding of the behaviors and actions you just observed, begin to think through ways to navigate the situation effectively!

Dialogue: Think about…

1. What forums or memberships do organization or company have that create a space for colleagues and supports the mission/vision of cross cultural competence?
2. What additional challenges might an organization or company face when thinking about changing behaviors on the concept of cross cultural competence?
3. What strengths and weaknesses might help to create opportunities for cross cultural learning, recruitment and communication planning?
4. Have you thought about the implication for diversity and inclusion within the services or products that are offered within that organization or company?
5. Where are opportunities that you may be overlooking to incorporate diversity and inclusion?

Learning Stage

**Other learnings for each stage are located in the appendix.*

HANDOUT

Choosing Successful Residents: Do We Have a Gambling Problem?

Keith H. Baker, M.D., Ph.D.
Amy Miller Juve, Ed.D., M.Ed.

11/12/2016
1:00pm – 1:35pm

Choosing Successful Residents:
Do We Have a Gambling Problem?

Keith Baker, M.D., Ph.D.
Vice Chair for Education
Program Director
MGH, Boston, MA

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Director for Education
Program Improvement Specialist
OHSU, Portland, OR

Society of Academic Anesthesiology Associations (SAAA)

November 12, 2016
Chicago, IL

1

Disclosures: **None**
Conflicts of Interest: **None**

2

Objectives

- Define what we know about predictors of success in residency training, including predictor strength, interdependence and independence.
- Articulate how personality inventories have been used to screen applicants for medical training programs.
- Discuss how the uncertainty in our selection criteria impacts our ability to predict future performance.
- Evaluate whether we have a gambling problem when it comes to trainee recruitment.

3

Defining success* AFTER residency?
Conventional

- Academic output, peer-reviewed publications
- Awards
- Board Certification
- Fellowship positions
- Independent research funding
- Innovation and Intellectual Property
- Leadership positions
  - Departmental, Hospital or University level
  - SCCM, ABA, AMA, ASA, etc.
- Master clinician
- Master educator
- etc.

4

Defining success* AFTER residency?
Additional

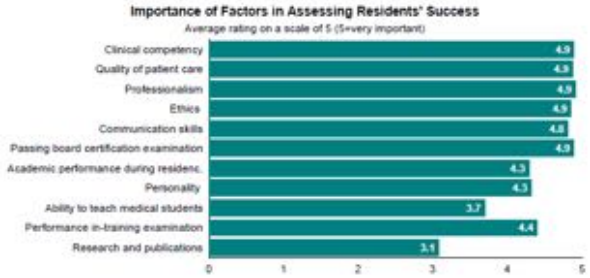
The ACGME, Program Requirements (Int. B, 2016)

Full spectrum of patient care related to anesthesiology
Conduct, interpret, and apply the results of medical research
Leadership of health services delivery,
Prudent fiscal resource stewardship,
Quality improvement,
Supervision, education, and evaluation of the performance of personnel, both medical and paramedical, involved in peri-operative and peri-procedural care

5

How do 'we' define success* DURING residency?

2016 NRMP Survey of Anesthesiology Program Directors
N = 51 or 40%



http://www.nrmp.org/wp-content/uploads/2016/09/NRMP-2016-Program-Director-Survey.pdf

6

The definition of success varies widely and also depends on who is doing the defining:

Chair
Program Director
Trainee
Faculty Member
Patient
ACGME
ABA
Hospital
Partners in a group
etc.

7

In all cases, we want Performance

Performance is what you actually do *in everyday practice* (***typical*** *performance)*

Competence is what you can do *under optimal conditions* (***maximum*** *performance)*

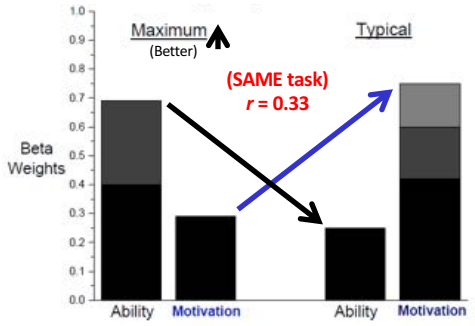
In most cases medical school measures ***competence***.
Presentation on rounds
Shelf exam, USMLE exam
Interview day

Performance and *competence* are different

Rethans JJ, et al., Fam. Pract. **7** 168 (1990)
Rethans JJ,et al., Med. Educ. **36** 901 (2002)

8

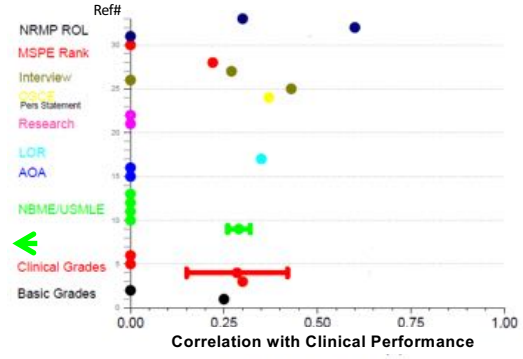
What predicts performance under different conditions?
Maximum vs. Typical Situations (Same Task!)



Klehe et al., J. Appl. Psych. **92** 978 (2007) – after Table 3 and Table 4
Beus et al. Human Perf. **25** 355 (2012)

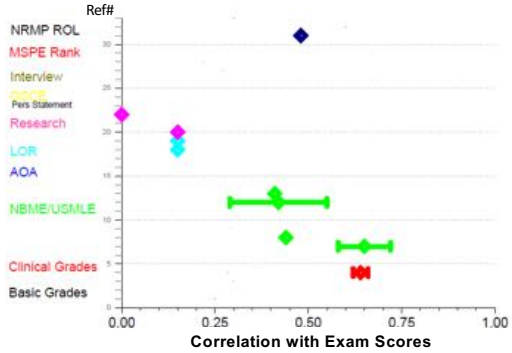
9

Representative **correlations** of medical school metrics and **resident clinical performance** (various specialties & times)



10

Representative **correlations** of medical school metrics and **resident exam scores** (various specialties & times)



11

A word about correlation
What can you conclude with a correlation of 0.25?

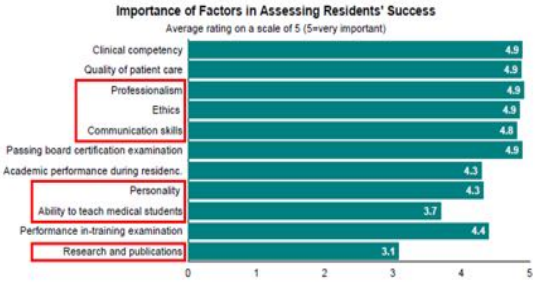
If
X correlates with Y and $r = 0.25$
$R^2 = 0.25 \times 0.25 = 0.063$

Then
X explains 6.3% of the variance in Y

Example:
If **USMLEs** correlate with **clinical performance** at ***r* = 0.28** that means you can use USMLE scores to explain less than **8 %** of the variation in clinical performance scores.

12

Should we gamble on inventories



http://www.nrmp.org/wp-content/uploads/2016/09/NRMP-2016-Program-Director-Survey.pdf

Should we gamble on inventories

Importance of factors cited for ranking applicants

http://www.nrmp.org/wp-content/uploads/2016/09/NRMP-2016-Program-Director-Survey.pdf

Inventories: betting "max lines"

Inventories: Anesthesia

- California Personality Inventory
- State-trait anxiety inventory
- The Vigil
- Strong Interest Inventory
- Cattell's Sixteen Personality Factor Questionnaire
- International Personality Item Pool Representation (NEO PI-R) Revised as"Big Five"
- Myers-Briggs Type Indicator

Merlo et al. Med. Teach. 31, e551 (2009)
Reich et al., Anesth. & Analg. 88(5), 1092 (1999)
Schnell et al. J. Clin. Anesth. 24(7), 566 (2012)

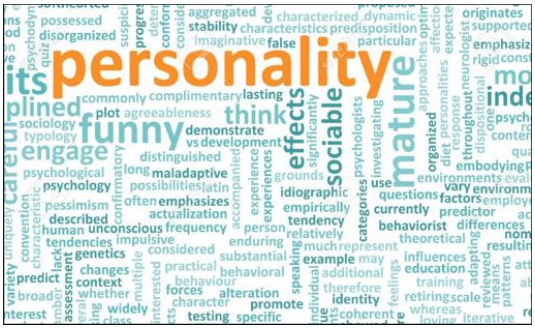
Correlations and significance

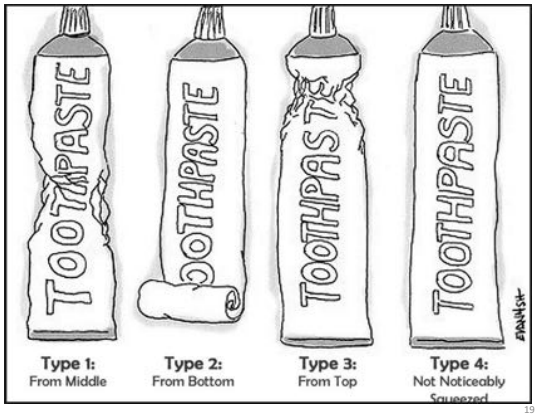
high performers - anesthesiology

- Very limited data = not generalizable
- CPI Correlation (.20 to .26):
  - Independence, empathy, socialization, well-being, achievement via conformance
- IPIP NEO Statistical significance (*p<.05 to **p<.0.01)
  - *Scored higher on cooperation, self-efficacy, adventurousness, neuroticism
  - **Scored lower on neuroticism, anxiety, anger, assessing vulnerability

Merlo et al. Med. Teach. 31, e551 (2009)
Reich et al., Anesth. & Analg. 88.5, 1092 (1999)

So many inventories!





19

20

Challenges with inventories

The Most Effective Method to Pass a Personality...
www.youtube.com/watch?v=zX0HGlxfLp4
Jul 27, 2015 ... The screening will detect if the probable employee... ... The Most Effective Method **to Pass a Personality Test** during **Employment** Screening ... Up next. **How To Pass A Pre-Employment Personality Test Part 1** - Duration: 9:48. ... **How to** Use **a Pre Employment Test**.

Cornell HR Review. http://www.cornellhrreview.org/personality-tests-in-employment-selection-use-with-caution
Duckworth et. al., Edu. Res. 44(4), 237 (2015)

21

Moving from slots to table games

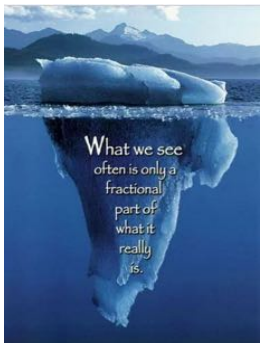
can we increase our odds

- Deficits in professionalism
- Academic difficulties
- Communication
- Teamwork
- MSPE = read for the negative or lack of the positive
- Examine the outliers

Baker. Acad. Med. 88, 1206 (2013)

22

Tip of the Iceberg



23

The consequence of **independent** traits

We want residents that have:

High IQ
High Grit (i.e. high conscientiousness) Duckworth
High Rationality quotient (RQ) (unbiased thinking) Stanovich

But, It turns out that these are independent traits!

Example:
Let's be choosey and try to pick an applicant who is in the top 30% for EACH trait (top 30% for IQ, Grit and RQ).

Unfortunately, less than 3 in 100 applicants will have all 3 traits in this top range (top 30%). *calc*: 0.3 x 0.3 x 0.3 = 0.027 = 2.7% of the applicant pool (which is 0.027 x 1771 = 48 people).

Duckworth et al. J. Pers. Soc. Psych. **92** 1087(2007)
Stanovich et al. Curr. Dir. Psych. S ci. **22** 259 (2014))

24

We appear to have a gambling problem

1) The predictors are **weak** (USMLEs, Class Rank, LoRs, AOA, Clinical grades, Research, Interviews, etc.). This is made worse by using maximum performance metrics to predict typical or everyday performance.

2) Some important **traits** are **independent** of each other

The combination of **weak independent predictors** means that our decisions contain a high degree of **uncertainty** when it comes to determining which applicants will become highly successful residents. This is like rolling the dice and hoping for snake eyes! (which does happen but only 1/6 x 1/6 ≈ 3% of the time)

25

When it comes to selecting anesthesia residents
It's a zero-sum game:

If you recruit the best, then someone else can't

Table 1 Number of Applicants and Positions in the 2016 Main Residency Match *by Preferred Specialty**

Preferred Specialty	Total Positions Offered	Total Number of All Applicants	Number of All Applicants Per Position	Number of U.S. Seniors			Number of U.S. Seniors Per Position
				Matched	Not Matched	Total	
Anesthesiology	1,696	1,771	1.04	1,048	28	1076	0.63

http://www.nrmp.org/wp-content/uploads/2016/09/Charting-Outcomes-US-Allopathic-Seniors-2016.pdf

26

Hoping for X but getting Y

What to do? → Manage, Manage, Manage

Set expectations at the outset
Teach them, **show** them, **council** them, **coach/mentor** them

If issues arise, **PROMPTLY intervene**!
Consider these resources:

- Clinical Competency Committee (CCC)
- Occupational Health (Fitness for Duty)
- Mental Health consultation
- Physician Health Services (PHS)
- Office of General Council (OGC)
- Graduate Medical Education (GME) office
- Leave of Absence (LOA)

27

Thanks for your attention

Questions?

28

References: Slides 10 & 11 (correlations)

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HANDOUT

MACRA Mambo #5: The Dance You Can't Avoid

Joseph W. Szokol, M.D., J.D., M.B.A.

11/12/2016
1:45pm – 2:05pm

Society of Academic Anesthesiology Associations
MACRA Mambo #5: The Dance You Can't Avoid
11/12/2016
1:45pm – 2:05pm
Joseph W. Szokol, M.D., JD, MBA

Background

In 1997 congress passed the Balanced Budget Act (BBA) of 1997, which replaced the Medicare Volume Performance Standard (MVPS), to rein in the growth in physician expenditure and healthcare costs. The BBA was designed to ensure that the annual increase in expense per Medicare beneficiary did not exceed the growth in Gross Domestic Product, and tied physician reimbursement to GDP. Each year CMS would send a report to the Medicare Payment Advisory Commission, and include a conversion factor that would either increase or decrease physician reimbursement based on whether targeted expenditures. Unfortunately, almost all the potential adjustments were downward and each Spring Congress would have to suspend or adjust the Sustained Growth Rate (SGR) formula ("doc fix"). This situation led to the passage of the Medicare Access and CHIP Reauthorization Act (MACRA)[1] of 2015, which President Obama signed into law on April 16, 2015 and went into effect in July of 2015.

Center for Medicare and Medicaid Services (CMS) Goals

In January of 2015, Secretary of Health and Human Services, Sylvia Burwell, stated that the goal of CMS was to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018. Even more striking was the goal to have 30% of all Medicare payments tied through either quality or value through an alternative payment model by 2016, and 50% of those payments by the end of 2018.

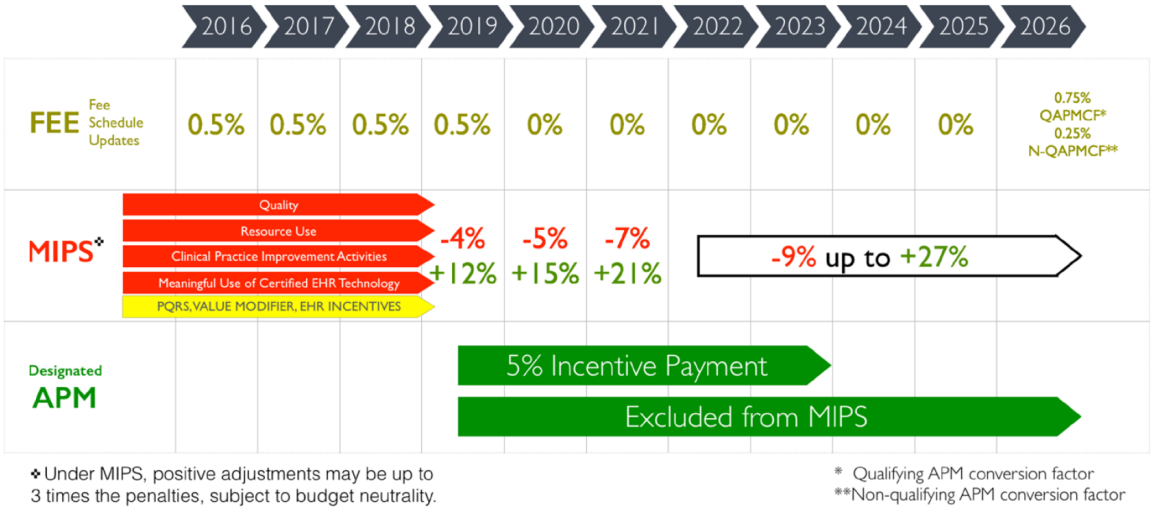
New Payment System Options (MIPS vs. APMs)

Physicians and other Eligible Providers (physician assistants, nurse practitioners, CRNAs, etc.) will now be paid through systems set up via MACRA. Payment will be through the Quality Payment Program, which will have two pathways for participation. These are the Merit-based Incentive Payment System (MIPS)[2] or the Advanced Payment Model (APM). About 5% of all physicians are initially expected to participate in the APM, which provides a 5% bonus for participation for the first six years of the program but also places some of those payments within a risk model. MIPS applies to all Eligible Providers except for those new to Medicare, have less than or equal to $10,000 in Medicare charges, and less than or equal to 100 Medicare patients.

Beginning in 2019, 4 percent of an Eligible Professional's revenue generated through Medicare fee-for-service payments will be distributed under MIPS and will grow to 9 percent by 2022 and remain at that level for an indeterminate time. Under the previous PQRS programs physicians in small practices were liable to penalties as

much as 6 percent or bonuses of up to 2 percent; practices with 8 or more physicians were subject to maximum penalties of 8 percent and a bonus of 4 percent.[3]

Payment Adjustment Under MACRA

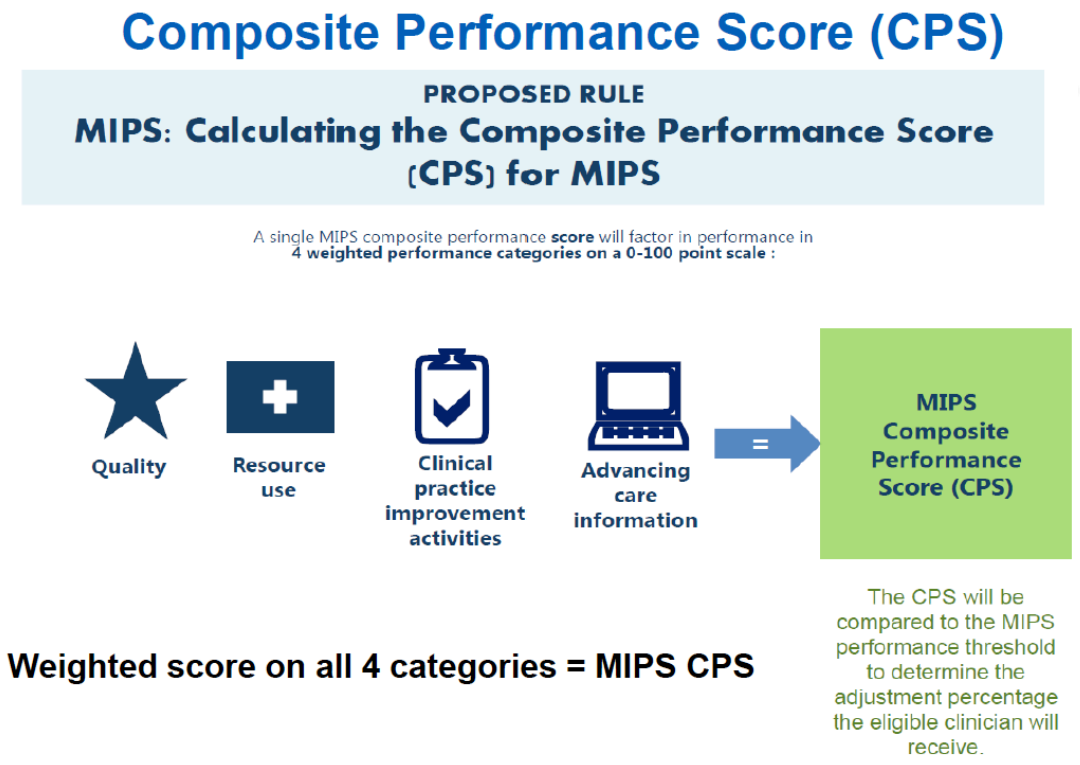


MACRA includes a 0.5% upward adjustment to the Medicare conversion factor for the first five years of the program, followed by no upward adjustment for the subsequent five years. From year 11 onward, Eligible Providers will receive either a 0.25% increase under the MIPS program or a 0.75% increase under the APM model. To be eligible for the APM providers must be part of current APMs that measure up to the "advanced" threshold." These include the Medicare Shared Savings Program (MSSP) ACOs, Tracks 2 and 3; Medicare Next Generation ACOs; Comprehensive Primary Care Plus (CPC+) Model; Oncology Care Model (two-sided risk); and, Comprehensive End-Stage Renal Disease Care Model. Absent from the proposed APM rules are Track 1 MSSP ACOs and other bundled payment models. There will also be rewards or penalties under the new Quality Payment Program, with incentives ranging from 4% to 9%, and penalties starting at 4% and increasing to 9% of Medicare reimbursement. Overall the program is budget neutral ("Hunger Games" strategy). However, the program does provide for an additional $500 million in funding that is separate from budget neutrality and can be awarded for those exceeding targets within the first five years. The bonuses would be awarded on a sliding scale with those bonuses reaching a maximum 10% additional amount above the base MIPS bonus. Bonuses within the APM model are not required to be budget neutral.

Composite Performance Score (CPS)

Under MACRA, the current separate programs of quality and cost (Value-based Modifier), Physician Quality Reporting System (PQRS), and Meaningful Use will all

be combined under MACRA. There will now be four components (quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology) comprising payment and Eligible Providers will be scored, and those scores will be weighted and combined into a composite score. The weight of each of the four components will shift over time, with initial benchmark of quality at 50%, cost at 10%, Clinical Practice Improvement Activities (CPIA) at 15%, and advancing care information at 25%. Most anesthesiologists are exempt under the current standard of Meaningful Use and may continue to be exempt under the new Advancing Care Information program as a "non-patient facing" specialty, as long as the anesthesia provider reported 25 or fewer codes during the given reporting year. Under Clinical Practice Improvement Activities, Eligible Providers must report on three high-weighted activities or six medium-weighted activities (out of a total of 90 listed activities).



Current Quality Reporting System

Under the Physician Quality Reporting System (PQRS) over 70% of anesthesiologists reported on quality measures with over 30% receiving a payment adjustment in 2016. This rate of participation is much higher than other specialties such as cardiology (26.7%), emergency medicine (28.3%), and radiology (25.7%). MACRA will fundamentally alter how the Centers for Medicare & Medicaid Services (CMS) pays physicians and other medical professionals as the shift from quantity to

quality occurs and emphasis will be on pay-for-value rather than pay-for-reporting or pay-for-performance. The reporting period begins January 1, 2017.

Quality Under MACRA[4]

Under the new quality program, Eligible Providers only need to report on six measures versus the previous 9 measures under PQRS. One measure must be an outcome measure and one measure must be a cross-cutting measure. Clinicians may still continue to report quality measures via claims (80%) of Medicare patients, or 90% of all patients if reporting through a Qualified Clinical Data Registry (QCDR).

The trend by CMS to emphasize non-process measures will continue in the areas of patient outcomes, patient experience and satisfaction, and patient perception of coordination of care by multiple eligible professionals (EPs).
CMS in its release of the 2016 Measure Development Plan (MDP) and the MACRA proposed rule emphasized measures that follow the patient across the continuum of care including patient-reported outcome measures such as functional status, measures that accountability among multiple levels of care, etc.

Quality Measures for Anesthesiologists:

CMS has proposed an Anesthesiology Specialty-Specific Measure Set for eligible anesthesiologists. Those are:

- MIPS #44: CABG: Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
- MIPS #76: Prevention of CVC-Related Bloodstream Infections*
- MIPS #404 Anesthesiology Smoking Abstinence*
- MIPS #424: Perioperative Temperature Management*
- MIPS #426: Post-Anesthetic Transfer of Care Measure: Procedure Room to PACU*
- MIPS #427" Post-Anesthetic Transfer of Care Measure: Procedure Room to ICU*
- MIPS #430: Prevention of PONV-Combination Therapy*

* Indicates a proposed "high priority measure"

Different Options for Inclusion in MACRA in 2017

On September 8, the Acting Administrator at CMS, Andy Slavitt, published a blog[5] post outlining different options that eligible clinicians might follow for inclusion in MACRA in 2017. This occurred after comments by many professional organizations over concern regarding the relative short timeline for implementation of quality reporting measures. The proposal was to allow up to four options to avoid negative payment adjustments under MACRA in 2019. The new plan allows eligible providers

to pick the pace of participation for the first performance period that begins January 1, 2017.

- Option #1: As long as eligible providers submit some data to the Quality Payment Program, the negative payment adjustment will be avoided.
- Option #2: Allows the eligible provider to submit date to the Quality Payment Program for a reduced number of days. In practicality this means that one's first performance period could begin after January 1, 2017. The EP could qualify for a small positive payment adjustment
- Option #3: Eligible Providers may opt to submit Quality Payment Program information for a full calendar year beginning on January 1, 2017. The Eligible Providers then could qualify for a modest positive payment adjustment
- Option #4: Instead of reporting quality data and other information, MACRA allows the EP to participate in the Quality Payment Program by joining an Advanced Alternative Payment Model (APM), such as Medicare Shared Savings Track 2 or 3 in 2017. The EP could then qualify for a 5 percent payment incentive in 2019.

Conclusion

MACRA will fundamentally change how physicians are judged on quality, cost, and practice improvement projects. Both CMS and the American Society of Anesthesiologists have excellent resources for understanding the nuances of this new program.

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HANDOUT

Are We Teaching Anesthesiology Residents The Skills That They Will Need to Be Successful in The Future?

Cynthia A. Wong, M.D.

11/12/2016
2:45pm – 3:00pm

Are We Teaching Anesthesiology Residents The Skills That They Will Need to Be Successful in The Future?

Cynthia A. Wong, MD

July 12, 2016

The University of Iowa

Disclosures

- ACGME: Anesthesiology RC, Vice Chair
- ABA: Basic Exam Senior Editor
- ABA: MOCA Minute Senior Editor
- ABA/ASA Perioperative GME Workgroup (ABA representative), 2015-2016

The University of Iowa

Objectives

Upon completing this learning activity, participants will be able to…

- Discuss the rationale for teaching new technical skills, e.g. perioperative ultrasound, in anesthesiology training.
- Discuss the rationale for teaching quality improvement, management, and leadership skills in anesthesiology training.

The University of Iowa

The University of Iowa

Case #1

38-year-old G_1P_0 with preeclampsia with severe features is undergoing induction of labor.

18 hours into the induction, she is is oliguric.

?DDx

The University of Iowa

Case #2

38-year-old G_1P_0 with preeclampsia with severe features had cesarean delivery for nonreassuring fetal status with spinal anesthesia.

In the PACU, her BP is 105/55 mmHg.

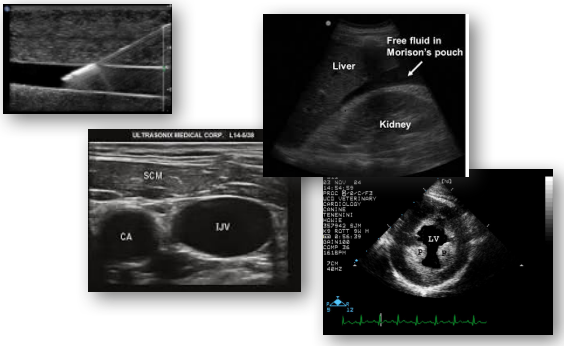
?DDX

The University of Iowa

Case #3

38-year-old G_1P_0 presents to the ED with vaginal bleeding. She is hypertensive. The presumed diagnosis is preeclampsia with severe features and placental abruption. Both fetus and mother are unstable and a stat CD is scheduled. The patient is very edematous and has no IV access.

THE UNIVERSITY OF IOWA



THE UNIVERSITY OF IOWA

ACGME

Accreditation Council for Graduate Medical Education

ACGME Program Requirements for Graduate Medical Education in Anesthesiology

THE UNIVERSITY OF IOWA

Definition and Scope of the Specialty

The Review Committee representing the medical specialty of anesthesiology exists in order to foster and maintain the highest standards of education and educational facilities in anesthesiology, which the Review Committee defines as the practice of medicine dealing with the peri-operative management of patients. This includes the peri-operative/peri-procedural management of patients during surgical and other therapeutic and diagnostic procedures. This management encompasses the pre-operative preparation of the patient and their peri-operative maintenance of normal physiology, as well as the post-operative relief and prevention of pain. An anesthesiologist is skilled in the management and diagnosis of critically-ill patients, including those experiencing cardiac arrest, and in the diagnosis and management of acute, chronic, and cancer-related pain.

THE UNIVERSITY OF IOWA

IV.A.5.	**ACGME Competencies**
	The program must integrate the following ACGME competencies into the curriculum: (Core)
IV.A.5.a)	**Patient Care and Procedural Skills**
IV.A.5.a).(2)	**Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Residents:** (Outcome)

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IV.A.5.a).(2).(l)	patients whose peri-operative care requires specialized techniques, including: (Outcome)
IV.A.5.a).(2).(l).(i)	a broad spectrum of airway management techniques, to include laryngeal masks, fiberoptic intubation, and lung isolation techniques, such as double lumen endotracheal tube placement and endobronchial blockers; (Outcome)
IV.A.5.a).(2).(l).(ii)	central vein and pulmonary artery catheter placement, and the use of transesophageal echocardiography and evoked potentials; and, (Outcome)
IV.A.5.a).(2).(l).(iii)	use of electroencephalography (EEG) or processed EEG monitoring as part of the procedure, or adequate didactic instruction to ensure familiarity with EEG use and interpretation. (Outcome)

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Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

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Content Outline for

Primary Certification in Anesthesiology

This content outline covers the In-Training, Part 1, BASIC, and ADVANCED Examinations

AMERICAN BOARD OF ANESTHESIOLOGY

Revised – May 2016

I. Basic Topics
  A. Basic Sciences
    1. Anatomy
      a. Radiologic Anatomy
        1) Neck (Including Doppler Ultrasound for Central Venous Access)
    2. Physics, Monitoring, and Anesthesia Delivery Systems
      a. Mechanics
        3) Principles of Ultrasound: Obtaining an image, resolutions, depth, frequency, resonance
      b. Flow Velocity
        3) Principles of Doppler Ultrasound

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II. Advanced Topics
  A. Basic Sciences
    1. Physics…
      b. Instrumentation
        4) Ultrasound-Guided Placement of Invasive Catheters (Arterial, Central Venous) and Nerve Blocks

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ABA

APPLIED EXAMINATION

Objective Structured Clinical Examination

THE UNIVERSITY OF IOWA

B. Technical Skills

1. Interpretation of monitors

2. Interpretation of echocardiograms *(Interpret basic transesophageal echocardiographic images relevant to anesthesia practice)*

3. Application of ultrasonography *(Identify relevant normal anatomy using ultrasonography)*

The successful candidate will identify the relevant anatomy using an ultrasound probe with a simulated patient and may be asked to demonstrate simulated needle placement technique for scenarios chosen from among the following procedures:

a. Vascular cannulation
   i. Internal jugular vein
   ii. Cubital fossa vessels
   iii. Radial artery
   iv. Femoral vessels
b. Nerve blocks
   i. Interscalene
   ii. Supraclavicular
   iii. Transversus abdominis plane (TAP)
   iv. Femoral
   v. Adductor canal (saphenous)
   vi. Popliteal

ACGME Program Requirements for Graduate Medical Education in Emergency Medicine

IV.A.5.a).(2).(c).(viii) emergency department bedside ultrasound; (Outcome)

IV.A.5.a).(2).(c).(viii).(a) Residents must use ultrasound for the bedside diagnostic evaluation of emergency medical conditions and diagnoses, resuscitation of the acutely ill or injured patient, and procedural guidance. (Outcome)

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Accreditation Council for Graduate Medical Education

- ~~Transitional year~~
- ~~Surgery~~
- ~~Pediatrics~~
- ~~Internal medicine~~

The University of Iowa

Options

- Just add as general procedural skill (such as central lines, evoked potentials)
- Add an ultrasound rotation
  - Clinical base year
  - Clinical anesthesia years

The University of Iowa

Ultrasound

- Vascular access (arterial and venous)
- Diagnose cardiac pathology
- Diagnose pulmonary pathology
- Intra-abdominal process (hemorrhage)
- Assessment of gastric contents
- Emergency airway management

The University of Iowa

The University of Iowa

HANDOUT

Are We Teaching Anesthesiology Residents The Skills That They Will Need to Be Successful in The Future?

James P. Rathmell, M.D.

11/12/2016
3:00pm – 3:15pm

Are We Teaching Anesthesiology Residents The Skills That They Will Need to Be Successful in The Future?

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

Director, American Board of Anesthesiology

The ABA oversees preparation and administration of the physician specialty board certification examination in Anesthesiology

Objectives

- Discuss the rationale for teaching new technical skills, e.g. perioperative ultrasound, in anesthesiology training
- Discuss the rationale for teaching quality improvement, management, and leadership skills in anesthesiology training

Training the Next Generation of Anesthesiologists

QUALITY AND SAFETY

PPR - PHYSICIAN PRACTICE ROUNDTABLE

Advisory.com

Enhancing Anesthesiologists' Value to Hospitals

Original Inquiry Brief • June 24, 2011

RESEARCH IN BRIEF

With looming changes in payment structures and overall health care delivery model, anesthesia providers are seeking opportunities to heighten their visibility across the continuum of patient care. In particular, administrators interviewed for this research brief indicate that anesthesia providers at their respective institutions play an increasingly vital role in driving efficiency and improving quality of care from the point of patient admission through discharge. Keeping this in mind, anesthesiologists are taking on additional roles and responsibilities within the perioperative arena, such as prescreening patients and overseeing staffing and scheduling in the OR. At the same time, many anesthesia providers and practices continue to focus their expertise and targeted purview of services provided outside of the operating room in order to ensure that their value is recognized across the continuum of care.

Anesthesiologists, Quality and Patient Safety

"[Anesthesia providers] are leaders in creating a culture of safety in any procedural area."

Perioperative Administrators Notice Results from Anesthesiologists' Efforts

Decrease in:
- Complications
- Length of stay
- Side effects

Increase in:
- Patient safety
- Patient and surgeon satisfaction
- Throughput

Anesthesiologists, Quality and Patient Safety

Why anesthesiologists?

- Understand all elements of OR safety
- Understand management of OR distractions
- Able to apply closed claim findings
- Familiar with QA/QI process, root cause analysis
- Set quality measurement, metrics, benchmarks
- Proven success in building a culture of safety

Anesthesiologists, Quality and Patient Safety

Other Quality and Safety elements to consider in improving the education of anesthesiology trainees

- Developing fatigue awareness
- Knowledge of "never" events
- Understanding what the value equation is for anesthesia (value = outcomes divided by cost)
- Patient centered care
- Professionalism
- Individual physician vs. team performance

Training the Next Generation of Anesthesiologists

MANAGEMENT

Anesthesiologists as Managers

Management is part of what anesthesiologists do every day

- Case management – understanding the patient
- Daily OR management (OR & Non-OR locations)
- Human Resources/Personnel Management
- Patient Flow
- Compliance/Risk Management

Anesthesiologists as Managers

Other Management elements to consider in improving the education of anesthesiology trainees

- Licensure/Credentialing/MOCA
- Financial
  - Billing and coding
  - Cost accounting/hospital & professional/technical
  - Changing environment
  - Compensation Models

Anesthesiologists, Efficiency and Process Improvement

Efficiency and Process Improvement elements to consider in improving the education of anesthesiology trainees

- What and how efficiency is measured
- Define and understand the metrics
- Define and understand the processes

  Patient flow – Drug accounting
- Understand how to design process improvement projects and include them in the culture

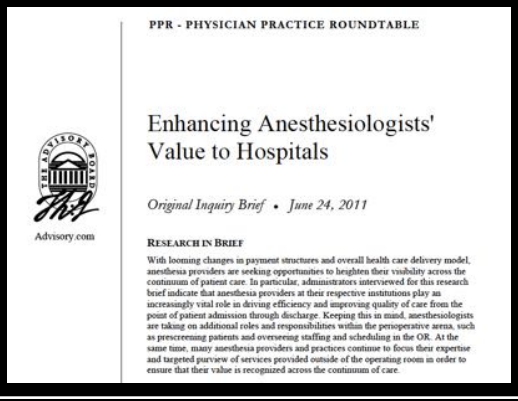
Anesthesiologists, Efficiency and Process Improvement

Efficiency and Process Improvement *elements to consider in improving the education of anesthesiology trainees*

- Effective use of the EMR
- Understanding of the supply chain
- Implementation of change
- Efficient utilization personnel

Training the Next Generation of Anesthesiologists

LEADERSHIP



PPR - PHYSICIAN PRACTICE ROUNDTABLE

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Enhancing Anesthesiologists' Value to Hospitals

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Anesthesiologists Value to Hospitals

Observation #1

Administrators rely on anesthesia providers to drive efficiency, patient satisfaction and throughput

Anesthesiologists Value to Hospitals

Observation #2

Anesthesiologists' role in providing care in out-of-OR ambulatory setting likely to expand moving forward

Anesthesiologists Value to Hospitals

Observation #3

Administrators envision broader involvement of anesthesia providers in response to shifting payment structures

Anesthesiologists Value to Hospitals

Observation #4

Role of anesthesiologists in conjunction with EMR based performance tracking system is critical in improving quality of care

THE AMERICAN BOARD OF ANESTHESIOLOGY, INC.

4208 Six Forks Road, Suite 900 | Raleigh, NC 27609-5735 | Phone: (866) 999-7501 | Fax: (866) 999-7503 | Website: www.theABA.org

CA3 LEADERSHIP TRAINING TO IMPROVE HEALTHCARE

DATE: Friday, January 13, 2012
TIME: 10:00am – 2:00pm (Eastern)
LOCATION: Massachusetts General Hospital – Davison Lecture Hall (Gray/Jackson 412)

PURPOSE: The American Board of Anesthesiology would like to incorporate formal training in leadership, performance improvement, patient safety and practice management into the latter part of residency training in anesthesiology. The purpose of this meeting is to discuss the value of adding this as a required component in all U.S. training programs and to prepare a more detailed proposal for this training.

Summary

Anesthesiologists are increasingly recognized by hospitals and health care systems for their roles in:

- Quality and Safety
- Management
- Leadership

These emerging aspects of the practice of anesthesiology should become an integral part of our training.

The Etherdome *Boston, Massachusetts, 2014*

HANDOUT

Departmental Strategic Plans and Retreats: Are They Important or a Waste of Time? (Pro)

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

11/12/2016
3:25pm – 3:45pm

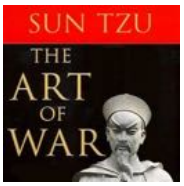
Departmental Strategic Plans and Retreats: Are They Important Or A Waste of Time?

Ronald Pearl, MD, PhD
Professor and Chair
Department of Anesthesia
Stanford University
Rpearl@stanford.edu

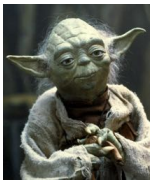
No financial disclosures

What is Strategic Planning?

- The word strategy comes from the Greek στρατηγία (strategos), which means "art of the general"



"Every battle is won before it is fought"



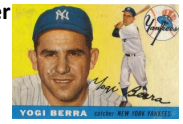
"The dark side clouds everything. Impossible to see the future is."

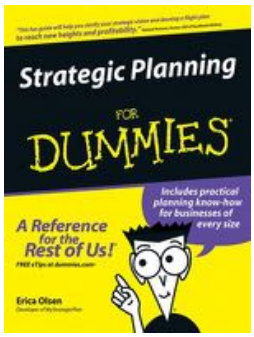
Are Strategic Plans of Value?

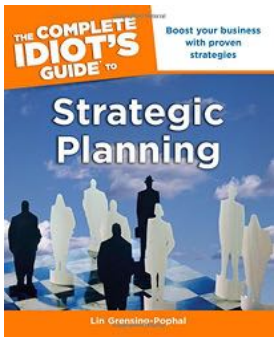
- Strategic planning is the most widely used management tool among businesses
  - Higher utilization in high performing organizations
- CEOs spend 50-90% of their time in strategic planning

Value of Strategic Planning

- "By failing to prepare, you are preparing to fail."
  — Benjamin Franklin
- "If you don't know where you are going, you'll end up someplace else."
  — Yogi Berra"
- In preparing for battle I have always found that plans are useless, but planning is indispensable."
  — Dwight D. Eisenhower







What Is A Strategic Plan?

- Roadmap to get from an initial state to a goal state effectively and efficiently
  - Where are we now, where are we going, how will we get there?

Value of an Anesthesia Plan

- Where are we now?
  - Preoperative assessment
- Where are we going?
  - Patient outcome
- How will we get there?
  - Anesthetic goals (hemodynamic stability)
  - Action plans (regional block)
  - Metrics (urine output)
- Response to dynamic changes

Why the Controversy?

- Bad plans
  - 60% of organizations do not link strategy to budgeting
- Bad execution
  - 90% of organizations fail to execute their strategies
  - 95% of workforce does not understand the organization's strategy

Balanced Scorecard Collaborative

Why Strategic Plans Fail

- Lack of ownership of the plan
- Lack of communication
- Not viewed as relevant to daily operations
- Viewed as an annual event
- Created without an implementation plan
- No clear, realistic goals
- No action plans
- Metrics not followed
- Employees not empowered

Why Create Strategic Plans?

- Reflect your values
- Inspire change
- Define the culture for achieving success
- Assist in daily decision making
- Strategic planning as a learning process

Elements of a Strategic Plan

- Mission and vision statement
- Long-term goals and objectives
- Strategies to achieve these goals
- Action plan to implement the strategies
- Strategic plan must be dynamic and change when conditions change

Steps in Strategic Planning

- Assess current state (SWOT analysis)
- Design strategic plan
  - Mission, vision, values, strategy
- Build out the plan
  - Specific objectives, goals, and metrics
- Execute the plan

SWOT Analysis

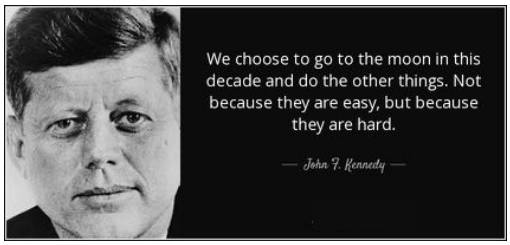
	Strengths	Weaknesses
Opportunities	Use strengths to take advantage of opportunities	Overcome weaknesses by taking advantage of opportunities
Threats	Use strengths to avoid threats	Minimize weaknesses and avoid threats

Mission, Vision, and Values

- Mission: Why you are doing what your are doing
- Vision: Where you are trying to go
- Values: How you are going to get there

Vision

- Your future state (big hairy audacious goals)
  - JFK: Put a man on the moon within a decade



Mission and Vision Statements

- Facebook
  - Mission: "to give people the power to share and make the world more open and connected."
  - Vision: "People use Facebook to stay connected with friends and family, to discover what's going on in the world, and to share and express what matters to them."
- Burger King
  - Mission: "offer reasonably priced quality food, served quickly, in attractive, clean surroundings."
  - Vision: "to be the most profitable QSR business, through a strong franchise system and great people, serving the best burgers in the world."
- Walmart
  - Mission: "Saving people money so they can live better."
  - Vision: "To be the best retailer in the hearts and minds of consumers and employees."

University of Wisconsin School of Medicine

- Mission
  - Advancing health without compromise through service, scholarship, science, and social responsibility.
- Vision
  - Working together, UW Health will be a national leader in health care, advancing the well-being of the people of Wisconsin and beyond.
- Values
  - Integrity
  - Compassion
  - Accountability
  - Respect
  - Excellence
  - Diversity

School of Medicine and Public Health
UNIVERSITY OF WISCONSIN-MADISON

Elements of a Strategic Plan

- Mission statement
  - What is our purpose? Why do we exist? Should unify the department.
- Vision statement
  - What do we want to be or achieve?
- Values (principles)
  - What do we believe? What are we not willing to compromise?
- SWOT analysis
  - Internal strengths and weakness
  - External opportunities and threats
- Plan
  - Long-term strategic objectives (3-5 years)
  - Short-term goals (1 year)
    - SMART: specific, measurable, attainable, responsible person, time specific
  - Action plans (90 days) for each goal
  - Metrics (key performance indicators)

Elements for Success

- People
- Resources
- Structure
- Culture
- Systems to assess success

Ten Keys to Successful Strategic Planning

- A clear and comprehensive grasp of external opportunities and challenges
- A realistic and comprehensive assessment of the organization's strengths and limitations
- An inclusive approach
- An empowered planning committee
- Involvement of senior leadership
- Sharing of responsibility by board and staff members
- Learning from best practices
- Clear priorities and an implementation plan
- Patience
- A commitment to change

http://www.tccgrp.com/pdfs/per_brief_tenkeys.pdf

Are Retreats Of Value?

- Retreats are powerful when they bring the right people together at the right time for the right reasons with the right process. Retreats allow us to step away from our daily responsibilities and see each other, our assumptions and our work with a wider lens and a different perspective. Retreats can enable us to access different parts of our hearts and minds, create new curiosity, generate momentum and good will, and move our work forward in powerful ways.

https://www.just-works.com/img/Retreats_Ora_Grodsky_and_Jeremy_Phillips.pd

Ineffective Retreats

- Too broad
- Too narrow
- No clear purpose (annual ritual)
- Leader (chair) is not involved
- One-off events
- Avoid addressing tough issues

"an act or process of withdrawing especially from what is difficult, dangerous, or disagreeable"

"a place of privacy or safety"

Ways Retreat Can Add Value

- Make important decisions
- Create a major plan
- Build community and teamwork
- Provide training
- Resolve conflict
- Extra time to solve issues
- Share information and get feedback
- Create strategic plan
- Think deep thoughts
- Out of the box thinking

Retreats That Add Value

- Identify the intended outcome before setting the agenda
- Review progress on plans from last retreat
- Allow time for both long-term and short-term action planning
- Allow time for collegial interaction
- Effective meeting leadership/facilitator
- Identify next steps and accountability

http://www.integralstrategy.com/PDF_articles/ArtHaines_PlanningRetreats.pdf

Strategic Planning and Retreats

- Need to be free of the daily workload to plan

Summary

- Departmental strategic planning and retreats are valuable for success

HANDOUT

Solving the Prescription Opioid Crisis: An Anesthesiology Chair's Perspective

James P. Rathmell, M.D.

11/12/2016
4:15pm – 4:30pm

Solving the Prescription Opioid Crisis: An Anesthesiology Chair's Perspective

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

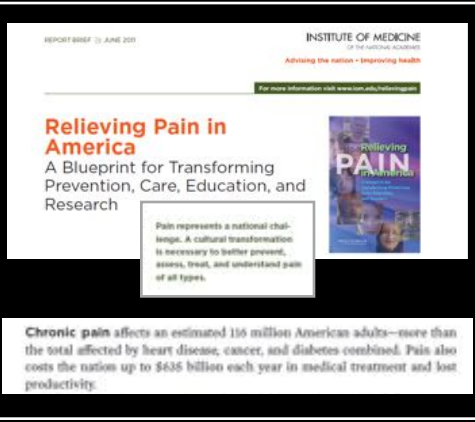
Objectives

- Explain the evolution of increased use of opioids for the treatment of chronic pain
- Outline recent trends in the pharmacological management of pain, including the evolving role for opioid analgesics
- Describe the (potential) impact of this epidemic on academic anesthesiology departments

An Unmet Need

THE BURDEN OF PAIN

2011: Relieving Pain in America



The Universal Antidote

THE OPIATES & OPIOIDS

10,000 B.C. – 2016

Acute Pain and Opioids

- Opioid analgesics are used to effectively treat acute pain in the postoperative period and following trauma
- Opioid analgesics are an integral part of treating pain and minimizing suffering in those with advanced illness

Chronic Pain and Opioids

- Until recent years, use of opioids for treating chronic pain was limited
- The potential for adverse effects, including addiction and death due to overdose, has been known for as long as opium has been in use

Chronic Pain and Addiction

- While the likelihood of patients progressing from taking legitimately prescribed opioids for pain to opioid addiction is low, pain in the context of pre-existing opioid addiction is extremely high
- Individuals with severe pain and opioid addiction have over five times higher relapse rate compared with their counterparts with opioid addiction but no pain

Wachholtz A et al. Subst Abuse Rehabil 2011; 2:145–162.

A Newfound Panacea

OPIOIDS FOR CHRONIC PAIN

1988 - 2001

Opioids for Chronic Pain

"…these papers represent a phenomenon akin to 'breaking the sound barrier.' Our attitudes to narcotics are influenced by unfounded prejudice based on street addicts…"

Melzack R. *The tragedy of needless pain: a call for social action.* IASP President's Address, Vth World Congress on Pain, 1988.

Opioids for Chronic Pain

New Pharmacologic Preparations

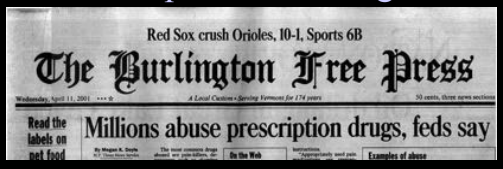
1987: Extended-release morphine (MS-Contin®)
1990: Transdermal fentanyl (Duragesic®)
1996: Extended-release oxycodone (OxyContin®)
1998: Oral transmucosal fentanyl (Actiq ®)
2006: Oral buccal fantanyl (Fentora®)
2010: Extended-release hydropmorphone (Exalgo ®)
2013: Extended-release hydrocodone (Zohydro ER ®)

Prescription Drug Abuse

AN EPIDEMIC EMERGES

2000 - 2012

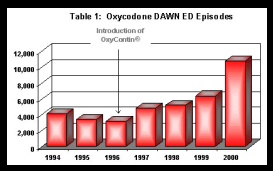
An Epidemic Emerges


Red Sox crush Orioles, 10-1, Sports 6B

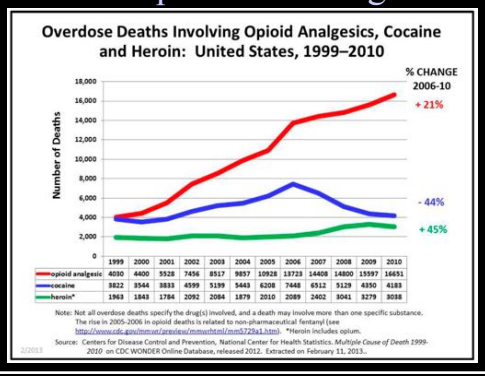
The Burlington Free Press

Read the labels on pet food

Millions abuse prescription drugs, feds say



An Epidemic Emerges



Recent Trends

PHARMACOLOGICAL PAIN MANAGEMENT

The Evolving Role for Opioid Analgesics

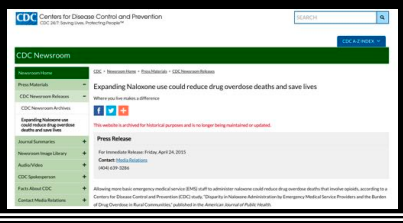
New Analgesics

- No novel analgesics
  - "Abuse-deterent" formulations of opioids
  - New extended-release formulations
  - New routes of delivery for some agents (topical, transmucosal)
  - Label extension to new indications
- Little impact on managing those with chronic pain

Onzetra Xsail (sumatriptan nasal powder)
Troxyca ER (oxycodone + naltrexone)
Belbuca (buprenorphine)
Vivlodex (meloxicam)
Dyloject (diclofenac sodium) Injection
Targiniq ER (oxycodone hydrochloride + naloxone hydrochloride) extended-release tablets
Tivorbex (indomethacin)
Xartemis XR (oxycodone hydrochloride and acetaminophen) extended release
Zohydro ER (hydrocodone bitartrate) Extended-Release Capsules
Zubsolv (buprenorphine and naloxone)
Lyrica (pregabalin)
Subsys (fentanyl sublingual spray)

Naloxone

- Narcan (naloxone hydrochloride); Adapt; For emergency treatment of known or suspected opioid overdose; Approved November 2015
- The effectiveness of naloxone in preventing opioid-related overdose deaths and who should receive this drug, particularly among those on chronic opioid therapy for pain, are unknown



Emphasis on Mimimizing use of Opioid Analgesics

Trends in the Pharmacological Management of Acute Pain

- Enhanced Recovery After Surgery (ERAS) protocols that combine multiple analgesics as part of comprehensive protocols have become commonplace
- Education for providers with emphasis on use of the smallest effective doses and shortest duration of analgesics after surgery have become common

Evaluating the Scientific Evidence

ARE OPIOIDS EFFECTIVE?

Twenty Years of Scientific Inquiry

Are Opioids Effective?

- A 2015 NIH workshop centered on the prescription drug abuse epidemic
- There is not one study long-term (>1 year) outcomes related to pain, function, quality of life, opioid abuse, or addiction
- Observational studies suggest that opioid therapy for chronic pain is associated with increased risk for overdose, opioid abuse, fractures, myocardial infarction, and markers of sexual dysfunction
- For some of these harms, higher dose was associated with increased risk

Chou R et al. Intern Med 2015;162:276-86.

Addressing the Epidemic

CHRONIC OPIOIDS TODAY

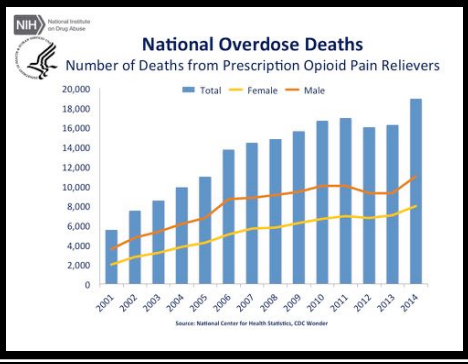
2016 and Beyond

Chronic Opioids Today

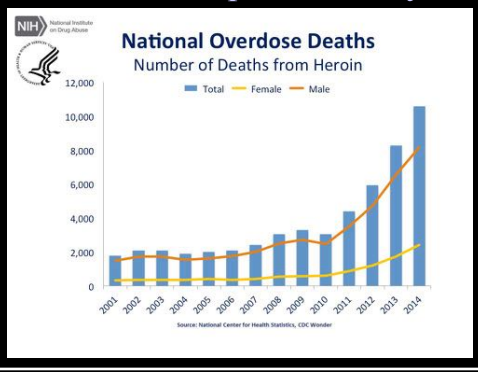
The 2011 White House plan calls for:

- Expanded education of patients and health care practitioners
- An urgent call for new research
- Expansion of existing Prescription Drug Monitoring Programs (PDMPs)
- Better means for disposing of unneeded prescription drugs
- Tougher enforcement of existing laws focused on identifying and prosecuting practitioners

Chronic Opioids Today



Chronic Opioids Today



Chronic Opioids Today

How do we appropriately select and manage patients with chronic non-cancer pain for chronic opioid therapy to treat only those with the greatest chance to benefit while minimizing the risk to the individual who is treated and our society?

Chronic Opioids Today

- Identify at-risk patients using validated screening tools
- Incorporate frequent monitoring, periodic urine screens, opioid therapy agreements, opioid checklists, and motivational counseling

Jamison RN, Mao J. Opioid analgesics. Mayo Clin Proc 2015; 90:957-968.

Chronic Opioids Today

How do we identify and best manage those patients receiving chronic opioid therapy who are not benefiting from this course of treatment?

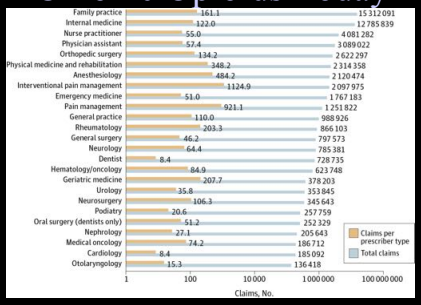
Chronic Opioids Today

Discontinuation and/or maintenance of chronic opioid therapy

- Guides for tapering opioids are non-existent
- Most studies are in those under treatment for substance use disorder
- Psychiatric co-morbidities and fears of medico-legal risk hinder treatment

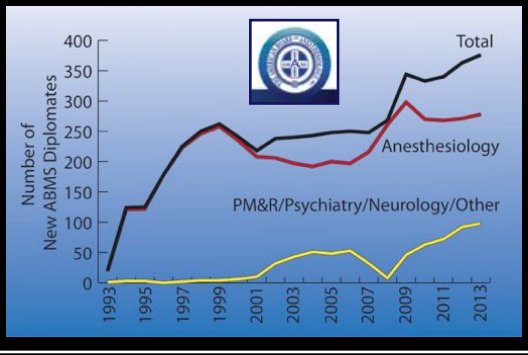
Berna C et al. Mayo Clin Proc 2015;90:828-42.

Chronic Opioids Today



JAMA Intern Med. 2016;176(2):259-261.

Physician Training in Pain Medicine



National Pain Strategy

A Comprehensive Population Health-Level Strategy for Pain

Contents

Solving the Prescription Opioid Crisis: An Anesthesiology Chair's Perspective

Conclusions

ACADEMIC ANESTHESIOLOGY MUST LEAD

- RESEARCH: Aimed at developing new analgesics that are more effective and less subject to abuse
- RESEARCH: Aimed at determining who will benefit most from chronic opioid therapy with an emphasis on measurable improvements in function
- RESEARCH: Aimed at identifying patients who are not benefiting from chronic opioid therapy and determining how best to discontinue opioids

Solving the Prescription Opioid Crisis: An Anesthesiology Chair's Perspective

Conclusions:

ACADEMIC ANESTHESIOLOGY MUST LEAD

- EDUCATION: Improving the education of all health care providers in the compassionate and evidence-based management of chronic pain is needed
- INNOVATION: The magnitude of this problem calls for the adoption of new models for collaborative care among primary care and specialty providers for managing patients with chronic pain with an emphasis on measurable improvement in function

Boston Public Library *Boston, Massachusetts, 2012*

HANDOUT

Solving the Prescription Opioid Crisis: A Pain Clinician's Perspective

Asokumar Buvanendran, M.D.

11/12/2016
4:30pm – 4:45pm

Solving the Prescription Opioid Crisis: A Pain Physicians' Perspective

Asokumar Buvanendran, MD

William Gottschalk endowed Chair of Anesthesiology
Vice Chair of Research & Director of Orthopedic Anesthesia
Professor, Department of Anesthesiology
Rush University Medical Center
Chicago, IL

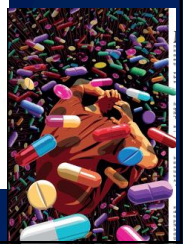
Follow me at Twitter on @Kumar_asra

Disclosures: ASRA President – Elect: 2015 - 2017
Research Funding: NIH, Independent Medical School grants from Pfizer
Consulting: Heron, St Jude Medical, Kimberly Clark, Axosome, Trevena

Objectives and Outline

1. Understand the epidemic of prescription opioids (5 min)
2. Pain Physicians perspective (5 min)
3. National strategies to control the opioid epidemic (5 min)

PAIN TREATMENT HISTORY OR HOW WE GOT WHERE WE ARE NOW

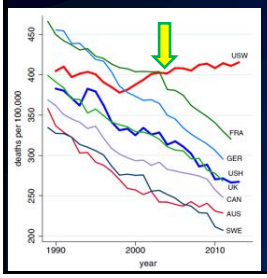


Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century

PNAS 2016

Anne Case[1] and Angus Deaton[1]
Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University, Princeton, NJ 08544
Contributed by Angus Deaton, September 17, 2015 (sent for review August 22, 2015; reviewed by David Cutler, Jon Skinner, and David Weir)

- Data from 1999-2013 comparisons



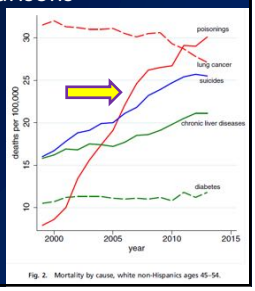


Fig. 2. Mortality by cause, white non-Hispanics ages 45–54.

2016 Feb

The NEW ENGLAND JOURNAL of MEDICINE

FDA

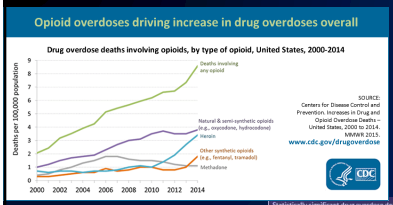
SPECIAL REPORT

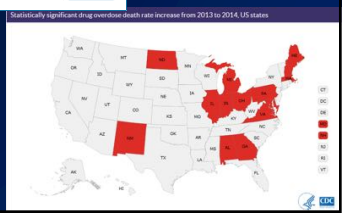
A Proactive Response to Prescription Opioid Abuse

Robert M. Califf, M.D., Janet Woodcock, M.D., and Stephen Ostroff, M.D.

- In 2012, health care providers wrote 259 million prescriptions for opioid pain medication, *enough for every adult in the United States to have a bottle of pills*[1] 1.http://www.cdc.gov/vitalsigns/opioid-prescribing/. Accessed August 2016
- Nationally, the annual number of deaths from opioid overdoses now exceeds the number of deaths caused by motor vehicle accidents.

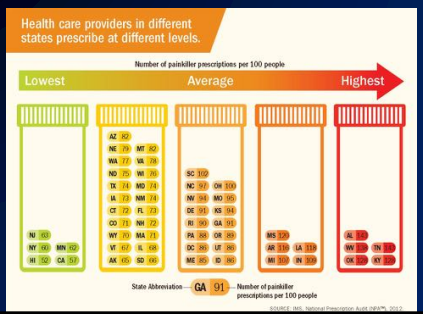
CDC Data from 2014 for USA





Opioid Epidemic

- An estimated **20%** of patients presenting to physician offices with non-cancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receive an opioid prescription.



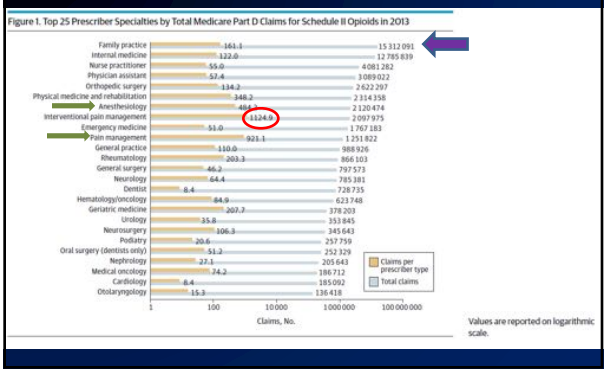
So Who are these Prescribers?

- Data from individual prescribers from 2013 Medicare Part D
- Focused on schedule II opioid prescriptions containing hydrocodone oxycodone, fentanyl, morphine,methadone, hydromorphone, oxymorphone, meperidine, codeine, opium, or levorphanol

- **Results:**
  - Opioid prescriptions are concentrated in specialty services such as Pain, Anesthesia, and Physical Medicine & Rehabilitation.
  - By sheer volume however, total prescriptions are dominated by general practitioners (family practice, internal medicine, nurse practitioners, and physician assistants).

Chen JH et al: JAMA Med 2016

So Who are these Prescribers?



The CDC Guidelines for opioids

- CDC developed this guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE). This method specifies the systematic review of scientific evidence and offers a transparent approach to grading quality of evidence and strength of recommendations.

- These include evidence types 1, 2, 3, and 4, and recommendation categories A and B.
- Long-term opioid therapy is defined as opioids on most days for >3 months.

- Relative to 1-19 MME (morphine milligram equivalent)/day, the adjusted hazard ratio for any **overdose event** (consisting of mostly nonfatal overdose) was:
  - Low risk: 1.44 for 20 to 49 MME/day,
  - Medium risk: 3.73 for 50-99 MME/day,
  - High risk: 8.87 for ≥100 MME/day.
  - A similar pattern was observed for serious overdose.

The CDC recommendations are grouped into three areas for consideration

1) Determining whether to initiate or continue opioids for chronic pain.

2) Opioid selection, dosage, duration, follow-up, and discontinuation.

3) Assessing risk and addressing harms of opioid use.

- There are **12 recommendations** .

Determining When to Initiate or Continue Opioids for Chronic Pain

1) Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

- Evidence review found that many nonpharmacologic therapies, including physica therapy, weight loss, psychological therapies such as CBT, and certain interventional procedures can ameliorate chronic pain.
- Multimodal therapies and multidisciplinary biopsychosocial rehabilitation-combining approaches can reduce long-term pain and disability compared with usual care and compared with physical treatments alone.
- Multimodal therapies are not always available or reimbursed by insurance and can be time-consuming and costly for patients.

- To guide patient-specific selection of therapy, clinicians should evaluate patients and establish or confirm the diagnosis. Evaluations should generally include a focused history, including history and physical exam, with imaging or other diagnostic testing only if indicated.
- For complex pain syndromes, pain specialty consultation can be considered to assist with diagnosis as well as management. Diagnosis can help identify disease-specific interventions to reverse or ameliorate pain; for example, improving glucose control to prevent progression of diabetic neuropathy; immune-modulating agents for rheumatoid arthritis; physical or occupational therapy to address posture, muscle weakness, or repetitive occupational motions that contribute to musculoskelatal pain; or surgical intervention to relieve mechanical/compressive pain.
- The underlying mechanism for most pain syndromes can be categorized as neuropathic or nociceptive.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

6) Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

- Several guidelines on opioid prescribing for acute pain from ER and other settings have recommended prescribing ≤3 days of opioids in most cases. Because physical dependence on opioids is an expected physiologic response in patients exposed to opioids for more than a few days, limiting days of opioids prescribed also should minimize the need to taper opioids to prevent distressing or unpleasant withdrawal symptoms.

Opioids, Surgery and Postop Pain

- N=147 were reached.
- 5 common outpatient surgery procedures performed at an academic medical center in 2015.
- Postoperative opioid prescriptions entered into the EMR, refill data, and patient outcomes were tabulated.
- Only opioid naïve patients included in the analysis.
- A phone survey was then conducted on all patients who were operated on and received an opioid prescription from June through December 2015.

Hill MV, et al. Wide Variation and Excessive Dosage of Opioid Prescriptions for Common Gener Surgical Procedures. Annals of Surgery. September 14, 2016

- Patients undergoing partial mastectomy were prescribed a range of 0- 50 pills while for partial mastectomy with sentinel node biopsy patients, range was 0 - 60

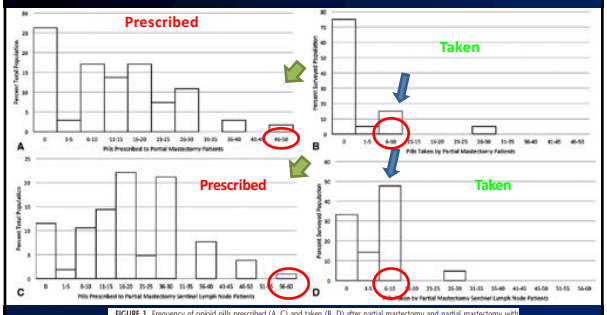
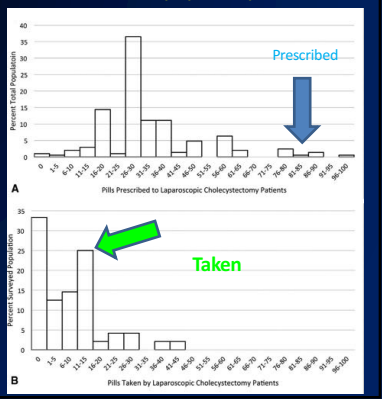


FIGURE 1. Frequency of opioid pills prescribed (A, C) and taken (B, D) after partial mastectomy and partial mastectomy with sentinel lymph node biopsy.

Hill MV, McMahon ML, Stucke RS, Barth RJ. Wide Variation and Excessive Dosage of Opioid Prescriptions for Common General Surgical Procedures. Annals of Surgery. September 14, 2016

Opioids & Lap Chol and Postop pain pills



Hill MV, McMahon ML, Stucke RS, Barth RJ. Wide Variation and Excessive Dosage of Opioid Prescriptions for Common General Surgical Procedures. Annals of Surgery. September 14, 2016.

Opioids Surgery and Postop pain pills

TABLE 2. Opioid Pills Taken

Operation	Partial Mastectomy	Partial Mastectomy With Sentinel Node Biopsy	Laparoscopic Cholecystectomy	Laparoscopic Inguinal Hernia Repair	Open Inguinal Hernia Repair	All Cases
Surveys completed	20	21	48	20	18	127
Pills prescribed	415	490	1450	650	540	3545
Pills taken	61 (14.7%)	126 (25.7%)	474 (32.7%)	189 (14.7%)	168 (31.1%)	1018 (28.7%)
Pills remaining	354 (85.3%)	364 (74.3%)	976 (67.3%)	461 (85.3%)	372 (69.9%)	2527 (71.3%)

An "ideal" number of pills to prescribe for each operation was calculated by determining the number of pills that would satisfy approximately 80% of patients' postoperative use.

For partial mastectomy this was calculated to be **5 pills**

For **partial mastectomy with sentinel node biopsy** this was **10 pills or less**

For **laparoscopic cholecystectomy** this was **15 pills**

For **laparoscopic inguinal hernia repair** this was **15 pills**

For **open inguinal hernia repair** this was calculated to be **15 pills**

Opioids and Surgery and Postop Medications

- A total of **17,167** pills were prescribed for the 642 patients. If these patients were prescribed the "ideal" number of pills for each operation, *7360 pills* (42.9% of the actual number prescribed) would have been prescribed.
- Of the 127 patients with completed phone survey data:
  - 117 had excess pills
  - 9% of these patients disposed of their excess opioids in an FDA approved fashion
  - 5% returned them to a DEA approved collection site
  - 4% flushed them down the toilet
  - > 50% of the patients didn't recall a disposal method or still had them in their possession

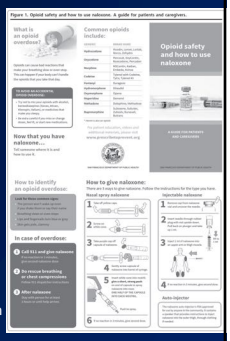
Hill MV, McMahon ML, Stucke RS, Barth RJ. Wide Variation and Excessive Dosage of Opioid Prescriptions for Common General Surgical Procedures. Annals of Surgery. Post Author Corrections September 14, 2016.

The Role for Perioperative Physician ?

- Should it be the perioperative physician to determine the optimal dose of opioids for postoperative pain?
- Should the perioperative physician be prescribing a multimodal analgesia at discharge?

Offering Naloxone to Patients When Factors That Increase Risk for Opioid-Related Harms Are Present

- Naloxone can be administration by lay persons, such as friends and family of persons who experience opioid overdose, can save lives.
- There is evidence for effectiveness of naloxone provision in preventing opioid-related overdose death at the community level through community-based distribution (e.g., through overdose education and naloxone distribution programs in community service agencies) to persons at risk for overdose (mostly due to illicit opiate use), and it is plausible that effectiveness would be observed when naloxone is provided in the clinical setting as well.



Assessing Risk and Addressing Harms of Opioid Use

10) When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11) Clinicians should avoid prescribing opioid pain medication and **benzodiazepines** concurrently whenever possible.

- Clinicians should avoid prescribing opioids and benzodiazepines concurrently whenever possible. Clinicians should communicate with others managing the patient to discuss the patient's needs, prioritize patient goals, weigh risks of concurrent benzodiazepine and opioid exposure, and coordinate care.

12) Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Medical Societies, Pharmacist and Pharmacy and DEA created document: Red Flags for Prescribing

- There were several parties (including ASA) involved with document and over 2 year period including the DEA.

- Red flags warning signs are screening tools that we should be considering before prescribing an opioid for patients.

Red Flag Signs

Initial Visit/Presentation

- Patients who travel to the prescriber's practice as a group and all request controlled substance prescriptions on the same day.
- Patient declines physical examination, or permission to obtain past records, or to undergo diagnostic tests.
- Patient statements and conduct suggest abuse of controlled substances, eg, appears sedated, confused, intoxicated, or exhibits withdrawal symptoms, or had physical signs of drug abuse.

Medication Taking/Supply

- Patient exhibits multiple unexplained dose escalations or other non-adherence to the treatment plan.
- Patient uses a route of drug administration other than the method prescribed, eg, injecting or inhaling oral formulations; ingesting transdermal formulations.
- Patient repeatedly seeks medications form non-coordinated sites of care; possible examples could include the emergency department, urgent care facilities, or walk-in clinics.
- Patient suffers and unintentional (or intentional) overdose.

Patient Behavior/Communication

- Patient behavior or PDMP report provides evidence that the patient is obtaining controlled substance prescriptions from multiple health care practitioners without the prescribers' knowledge of the other prescriptions.
- Patient was discharged from another physician practice for egregious behavior.
- Patient pressures physician to prescribe by implying or making direct threats to the prescriber or staff.

Treatment Plan Related

- Patient repeatedly resists changes in the treatment plan, despite clear evidence or adverse physical or psychological effects from the drug.
- Patient refuses to sign, or fails to comply with, an opioid pain care agreement governing their use of opioid analgesics.

Illicit/Illegal

- Prescriber is made aware that patient alters, forges, or rewrites prescriptions.
- Prescriber receives reliable information that patient is diverting or selling medication, or "borrowing" drugs from others.
- Patient indicates that drugs with be shared with others or sold.
- Patient requests controlled substance prescriptions written in the names of other people for whom the patient is not the designated caregiver.

What are some of the measures taken to Control the Opioid Epidemic

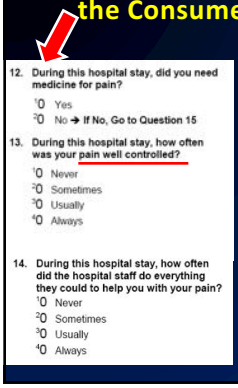
PHARMACY CORRESPONDING RESPONSIBILITY

- Pharmacists are accountable for improperly prescribed / dispensed medications.
- DEA mandates on pharmacists "include assessing whether prescriptions for controlled substances were written for a legitimate medical purpose in the usual course of professional practice."
- A pharmacist should not dispense a controlled substance unless he/she concludes that the prescription meets these criteria.

Naloxone access laws, physician co-prescribing on the rise

- In the second quarter of 2015, 4,291 prescriptions were dispensed, a 1,170 percent increase over prescriptions in the fourth quarter of 2013.
- ASA & AMA advocacy and widespread state medical society support has led to more than two dozen new state laws that increase access to naloxone—bringing the national total to more than 45 states with naloxone access laws.

Hospital Care Quality Information from the Consumer Perspective (HCAHPS)



12. During this hospital stay, did you need medicine for pain?
    - 1 Yes
    - 2 No → If No, Go to Question 15
13. During this hospital stay, how often was your pain well controlled?
    - 1 Never
    - 2 Sometimes
    - 3 Usually
    - 4 Always
14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
    - 1 Never
    - 2 Sometimes
    - 3 Usually
    - 4 Always

- The intent of the HCAHPS is to provide a standard survey for measuring patient's perspective on hospital care.
- CMS payment to hospital is going to be based on the percentile of the summed score.
- Pain Management for 2015:
  - Rush University: 73%
  - Average for the state: 72%
  - National average: 71%

http://www.hospitalcompare.hhs.gov/

CMS proposes eliminating pain management from HCAHPS payment score

- In an effort to combat the opioid addiction raging in the U.S., CMS has proposed removing pain management-related questions on the HCAHPS survey from the hospital payment scoring calculation.
- Many clinicians report feeling pressure to overprescribe opioids because scores on the HCAHPS survey pain management questions are tied to Medicare payments to hospitals.
- Under the proposal, the three pain management questions on the HCAHPS survey would no longer factor into the Hospital Value-Based Purchasing Program payments from Medicare, staring in fiscal year 2018. The questions would remain on the survey, however.

"Report Cards" for Physicians with Opioids Prescriptions: Pilot program in AZ

- Arizona's quarterly reports rate a doctor's prescribing of oxycodone and certain other drugs as normal, high, severe or extreme compared with the state's other doctors in his medical specialty.
- During a two-year pilot program, the number of opiate prescriptions fell 10% in five counties while rising in other counties.
- The report cards also contributed to a 4% drop in overdose deaths in the pilot counties.

Safely Disposing of Unneeded Prescription Opioids

- The DEA has announced it will hold its 12th National Prescription Drug take Back on Saturday, October 22, providing a safe, convenient, and responsible way of disposing of unneeded prescription drugs.
- More than 6.4 million pounds of medication have been collected over the last eleven Take Back Days.
- Local communities and some pharmacies are also establishing ongoing drug take-back programs.

ASA Action Plan on Opioid Crisis

- ASA believes a **multipronged strategy** is necessary to reduce the misuse, abuse, and diversion of prescription opioid medications that have led to unintended consequences, including deaths.
- ASA believes the solutions to this public health epidemic require **collaboration among multiple entities**, including federal and state policymakers and representatives from the judicial branch, physicians and other health care professionals, patients, educators, and public health officials.

ASA Initiatives on the Opioid Crisis

- ASA collaborated with the White House Office of National Drug Control Policy (ONDCP) to develop a wallet-sized card to help families identify the signs and symptoms of an overdose, as well as tips for responding to an overdose.
- ASA has partnered with the AMA and encourages more physicians to register and use state Prescription Drug Monitoring Programs (PDMP); enhance physician education on effective evidence based prescribing, reduce stigma, and enhance access to naloxone and also develop the online portal for CME resources for physician education.