

APPD GRASSROOTS SIG – SUMMARY REPORT

April 30th, 2008

INTRO

Jerry Rushton, Roni Vasan, Brian Youth led the April 29th session of the APPD Grassroots meeting for PDs and Fellowship Directors. Approximately 150 attended the session with great interaction as a lead off for the APPD meeting.

We started the session with a brief introduction to the process, pre-meeting survey of 35 members, and an overview of our goals. Please see the attached survey and power point slides for additional introduction. The following is a summary of the discussions as compiled by the Grassroots SIG leaders. This is our best attempt to capture most of the discussion, apologies to any omissions. The main topic themes were organized around

- Resident and Faculty engagement and buy-in
- Program future planning and curricular balance
- PD personal/professional development

We presented the summary to APPD Board and have posted slides and summary on the website. Thanks to everyone who participated. We will review the evaluations and comments to see how to continue to improve the use of small group break outs, or consider other methods to balance individual participation and large group sharing. The new follow up session will also be reviewed to consider how this fits together.

I. Small Group Session 1: Resident and Faculty engagement and buy-in **Brian Youth**

A. Resident Buy-In

- Overall theme from this discussion is that although it is easier to get residents to buy-in to the multitude of requirements, it would be helpful to have an overview of RRC programmatic requirements so that they understand the “big picture” of residency training.
- Develop of “resident dashboards” so that residents can see what their colleagues are doing to help motivate themselves (ie- QI projects, research, patients seen in clinic etc..)

B. Faculty Buy-In

- Groups were more focused on this topic and identified the following needs:
 - Need to incentivize faculty to recognize that having a resident can actually help them, not hinder them (challenge in the era of clinical production needs)
 - Need for Program Directors to have “clout” with faculty- ie to help them become better teachers, do faculty development activities and make them meaningful for

the faculty (incorporate into grand rounds, division meetings so as not to monopolize more time)

- Need to recognize “perks” for faculty
 - Not necessarily financial, can be recognition of contributions, featured faculty in a dept. newsletter for example
 - Create “educational appointments” through the medical school or university as a way to recognize the dedicated teachers
 - Support the goal of having Dept. Chairs support “educational rvu’s” for faculty that may be less productive because they teach more
- Departments may consider requiring a set number of “Educational CME’s” to encourage faculty to attend FD sessions put on by program.
- Engage the complainers
- Help the faculty better understand RRC needs such that NICU for example will understand why continuity clinic is important.

General sense was that APPD could help be perhaps developing a powerpoint on RRC requirements that can be used to help both residents and faculty understand the big picture needs in training. Additionally, the APPD could be a place where ideas such as educational “carrots” (titles, CME credit etc) can be suggested and utilized by interested programs.

II. Small Group Session 2: Program future planning & curricular balance **Jerry Rushton**

A. “Blow up the RRC” a sort of joking theory of what next steps would be if we built from scratch (a.k.a. the volcano theory of Pelee – how to consider what would emerge out of a new paradigm if we started from scratch vs. chipping away at an existing construct)

- Consideration of what the core requirements should be as our foundation, to then expand outward to individual goals and flexible tracks.
- Idea of the PD as supervisor of local institutional individualized programs which should be entrusted more by the RRC.
- Truly consider competency in terms of more focused training for those advanced/ahead of schedule and additional time/training for those not meeting competencies with PD as the arbitrator.
- Consider if PD credentialing or addl. Training/formalization would help RRC entrust PDs in this role
- What is the APPD role in this process—with ABP, with RRC, with R3P?

B. How to consider potential future changes in GME and pediatrics

- Is this a moving target and subject to sig. changes if duty hours are further restricted, if training needs lengthened, if funding is less? (some discussion of IOM review and possible implications if further reductions of training)
- Can we develop any consensus on what is our outcome of residency, how to measure?
- Can we provide data to show the value of core training, or compare different models?
- What are the unique needs of different individuals/programs (small, rural, military, research, etc.)

C. Tracks and flexibility of training

- Interest in some common core, then allow different PGY3/addl. Training in individual needs— hospitalist, community peds, academic, fellowship, researcher pathways
- Other areas of emphasis/tracks— community/advocacy, intl. medicine, etc.
- How would ABP approve these, how would PD have latitude to experiment
- How to develop tracks across the medical ed. Continuum from what is now already done in some schools with primary care tracks, etc. in med. School and fellowship emphasis.
- Continuity clinics as more flexible option in other primary care arenas (behav.peds, adolescent, clinics, etc.) for addl. Clinics or a 2nd clinic per week, or some other specialty clinic experience in a longitudinal fashion.
- Some notion of moving fellowship apps. Back closer to PL3 year and allow less forced early choice.

D. How to keep balance of service and education

- Consider specific caps on teams as numbers of pts change, or resident slots are limited
- Similar to Internal medicine
- Consider role of hospitalists and effects
- Some mentions of Chair, institutional support/how to preserve for education

III. Small Group Session 3: PD personal/professional development **Roni Vasani**

E. Meeting New RRC Requirements – “new requirements leading to burnout”

1. Not enough protected time for PD (even with changes in the current requirements) - increasing documentation requirements - too labor intensive.

2. ACGME requirements are directed to the PD's – PD is held accountable for full compliance. Program implementation should be an institutional responsibility like JCAHO - The entire Institution should be held accountable.

Suggest:

- Adding a PIF section for completion by the chair and hospital administration.
- More Inst /DIO accountability
 - For overall Program support /resources/staffing
 - Assisting programs with implementing the competencies
 - Faculty development

3. Need shorter PIF – too many redundant questions. Lose faculty / resident buy – in when requirements / PIF makes “no sense”. Sometimes site visitors differ from RRC. Need accurate interpretation.

4. Enhance communication of PIF changes to Programs – especially when site survey schedule is announced. Last year saw many changes.

5. Limited faculty time for required competency assessments

Suggest: Recruit community faculty to help with competency assessments such as direct observation in continuity clinic.

6. Need to enhance opportunities to promote Innovation, new ideas and collaboration. Support at institutional level and the APPD.

7. Focus on Outcomes Project - Why are we still doing process? Documenting numbers, patient logs etc. Accurate reflection of resident learning? PIF accuracy?

Suggest:

- Enhance PD collaboration – share and learn best practices at institution /regional and national levels.
- Moving outside the box to organizations - learn the Disney model for Professionalism and Communication.
- Need RRC to move outcomes forward

F. Professional Development / Educational Scholarship / Promotion

1. Need more opportunities for professional development - APPD interactive workshops, sponsoring educational seminars. Promote scholarly activities for young faculty.

PD skill sets include:

- Effective communication, negotiation / collaboration with other PD's - Institution, regional and national levels
- Leadership – providing the motivation to foster resident enthusiasm in their own education; serving as mentor; managing change effectively; developing /communicating vision
- Administration - financial / personnel management
- Educational Scholarship – writing grants; developing / sharing new ideas dissemination; collaboration; publications

2. Institutional support for personal development - developing career goals, professional portfolios

Contact: Brian Youth, Grassroots SIG leader for 2009 Baltimore meeting for any comments on the format or other suggestions for the future: youthb@mmc.org