Tom Nasca: “We have no idea,
but we must prepare”

Predicting the Future of Medical Education

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MEDICINE *of* THE HIGHEST ORDER

UR MEDICINE

Goals

1. Understand the models attempting to predict the future of Medicine and GME

2. What this means we need to be teaching in our programs

Agenda

1. Present and synthesize 3 national models predicting the future of Medicine
   - ACGME's Sponsoring Institution 2025
   - AAIM's Internal Medicine 2035
   - ACGME Pursuing Excellence Initiative

2. Discuss the skills necessary for you, your Med-Peds program and your trainees to succeed in the most likely version(s) of the future
   - Leadership Skills
   - Teamwork Skills
   - Diversity and Inclusion Skills

ACGME: Sponsoring Institution 2025

June 2015, ACGME Board appointed 19 member task force

- Health Executives
- Education Leaders
- Public Representatives

National Listening Tour

- Standardized and open-ended questions
- Over 1000 interviews in 7 locations
- Very diverse and heterogeneous respondents

ACGME

SI 2025: Key Findings

1. *Democratization*: Medical advice and information widely available without a physician involved, posted for all to see

2. Commoditization of health care will continue and accelerate

- Increasing standardization of price-driven services
- Patient choice of if/when/how to enter health care
- Increased use of telehealth and technology

3. *Corporatization*: Large health systems (e.g. 100 hospitals)

AAIM: IM 2035

Background Context:

1. ACGME revised and approved the Common Program Requirements
   - Specialty RC chairs, board members worked for 18 months on a draft
   - Out for public comment period, then finalized
   - Purposefully leave flexibility for each specialty RC to tailor
   - Sections 1-5: nuts and bolts
   - Section 6: Clinical Learning Environment

2. Each individual specialty review committee inserts their specific language in the allowed areas in the common program requirements

AAIM: IM 2035

In preparation for these IM RC additions to the common program requirements the IM community (including the IM RC):

- Held conversations over 2 separate workshops in 2017
- Used SI 2025 as starting place
- Participated in “scenario-based planning” to “to rigorously and creatively think about what the specialty of medicine and the internist of the future could look like”
- Today’s IM graduates will practice until ~2050, career midpoint is 2035

AAIM
Alliance for Academic Internal Medicine

IM 2035: Key Findings

1. Medical education will need to become increasingly flexible
   - Improved efficiency of educational process
   - Modularized into discrete units
   - Competency-based rather than purely time-based training
2. Information and knowledge
   - Ubiquitous, including big data/artificial intelligence, patient-wearable technology
3. The Future Internist as Team Leader

ACGME Pursuing Excellence Initiative

1. Clinical Learning Environment
   - Imprints clinical outcomes on our trainees for up to 20 years
   - Site visits: no one was providing a good (let alone optimal) learning environment in the 6 CLER areas
   - Quality/Disparities, Patient Safety, Professionalism, Well-being, Supervision, Care Transitions (now *Teamwork*)

2. Response: Pursuing Excellence Initiative (PEI)
   - Pathway Innovators Collaborative

Pursuing Excellence: Key Findings

1. Align GME with hospital, university and community

2. Faculty must have skills in quality, safety, leadership and teamwork

3. The quadruple aim is realized when silos are broken down and the standard of working and learning is collaborative and interprofessional

SI 2025, IM 2035, PEI
Synthesizing the 3 models

1. Increasing need to possess strong *leadership* skills
   - Collaborative, diverse, inclusive
   - Data management
   - Communication skills
   - Emotional Intelligence

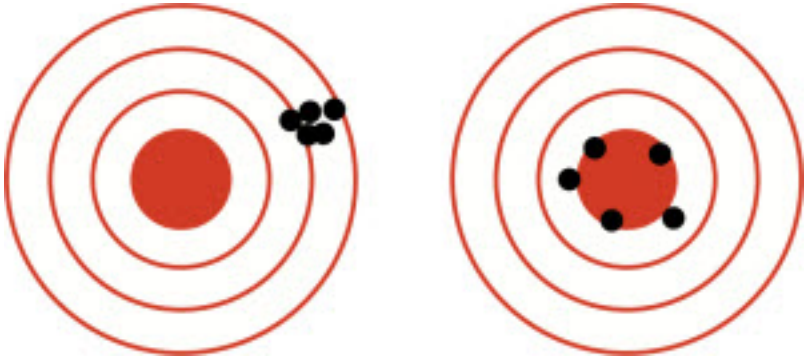
2. Increasing need to possess strong *teamwork* skills
   - Inter-professional
   - Team dynamics, diversity, inclusion
   - Change management
   - Personal and team well-being

Skills crucial to success

1. Leadership
   - Emotional Intelligence: *the ability to identify and manage one's own emotions, as well as the emotions of others.*
   - Know yourself and your team members
   - Don't take yourself so seriously you can't improve
   - Be an equally good team member as team leader

2. Teamwork, Diversity and Inclusion
   - More diverse teams make the accurate decision ***twice as often*** as homogeneous teams
   - Homogeneous teams are ***twice as confident*** in their ***half as accurate*** decisions

Precision Vs Accuracy



Homogeneous

BOWGSAT

Diverse

Inclusive

Take Home Points

1. The future state of medicine (although unknown for sure)
   - Democratized: ubiquitously available information
   - Commoditized: choice
   - Corporatized: large systems with safe processes and pathways
2. Crucial skills for us and our trainees
   - Collaborative emotionally intelligent leadership
   - Diverse, inclusive and change-agile interprofessional teamwork
3. How do I do this?
   - Make leadership, teamwork, diversity and inclusion explicit and robust portions of your own self-development and your program's curriculum and optimally your clinical learning environment

MPPDA Congratulates

Natasha Piracha, MD
Med-Peds Chief Resident
Rutgers New Jersey Medical School

Recipient of the 2019 MPPDA Walter W. Tunnessen, Jr., MD, Award

MPPDA Congratulates

Colleen A. Monaghan, MD
Associate Med-Peds Program Director
Harvard Medical School
Brigham and Women's Hospital

Recipient of the 2019 MPPDA Brendan P. Kelly, MD, Award

Recruitment

Outreach to schools without MedPeds programs?

Recruiting to primary care. This year, Family Medicine generated an outreach tool "Strolling through the Match" for medical students. It highlighted FM as a residency of choice for anyone with primary care interests. Would like to see us join with FM, and involve Peds and IM to create a more balanced info option and use it to promote primary care residency training more broadly.

How to continue to focus on recruiting top candidates to Med Peds?

Beyond board scores, how do you choose the resident for 2024?

Best Practices?

- Interview day structure: 1 vs. 2 days?
- how many interviews?
- Structure of the day? Meet with categorical PDs or just MPs, pay for applicant hotel, etc.

Diversity and Inclusion

Strategies to support diversity, equity and inclusion in GME training programs

Diversity initiatives. What works and what doesn't work at the med school and residency levels?

What are programs doing to broaden the scope of their applicant pool?

How are programs/GME communities measuring/monitoring and fostering a culture of inclusivity?

Pediatric Hospital Medicine

MPPDA Annual Survey: **PHM Edition!**

Research Committee

New Orleans, LA

MPPDA Annual Program Directory Survey 2019

Survey launched and completed over 3 weeks in Feb. 2019

70-some questions, took on average 10-15 minutes.

Core:

- Program Characteristics
- Program Assessment/Accreditation
- Ambulatory Education
- Chief Resident and Graduates

Modules:

- Pediatric Hospital Medicine
- Transition

MPPDA Survey 2019 – Who completed the survey?

67 out of 77 programs

87% of programs!

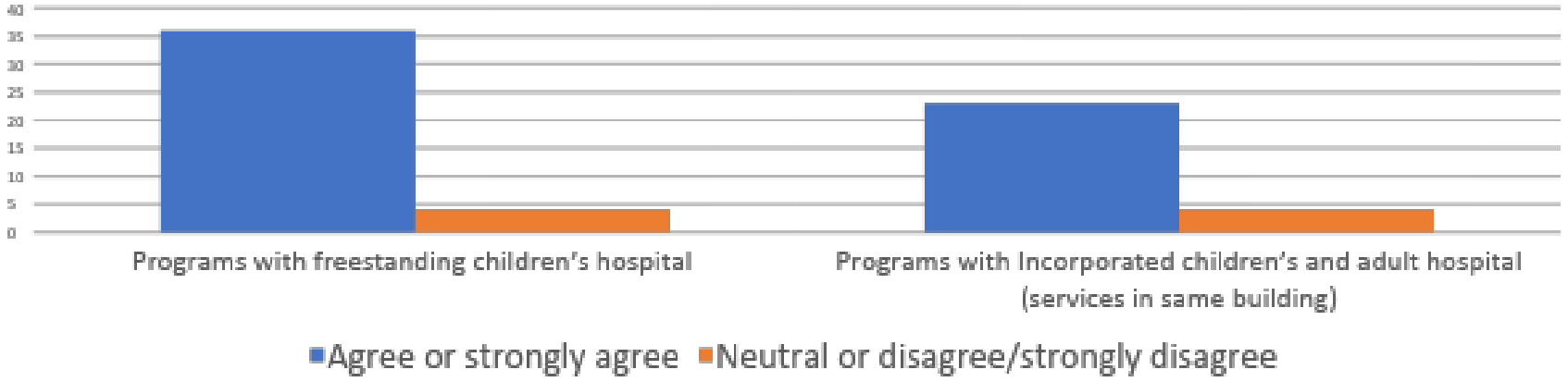
Female: 36 (53%)

Males: 31 (46%)

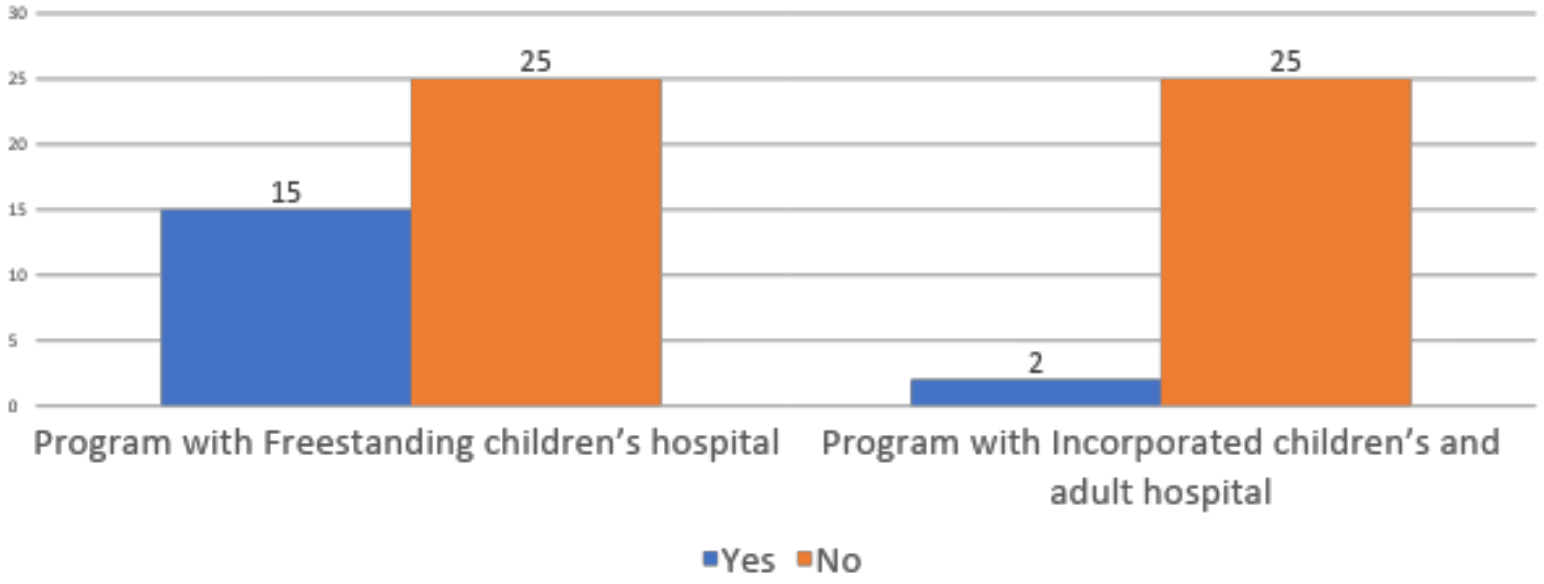
PHM Module

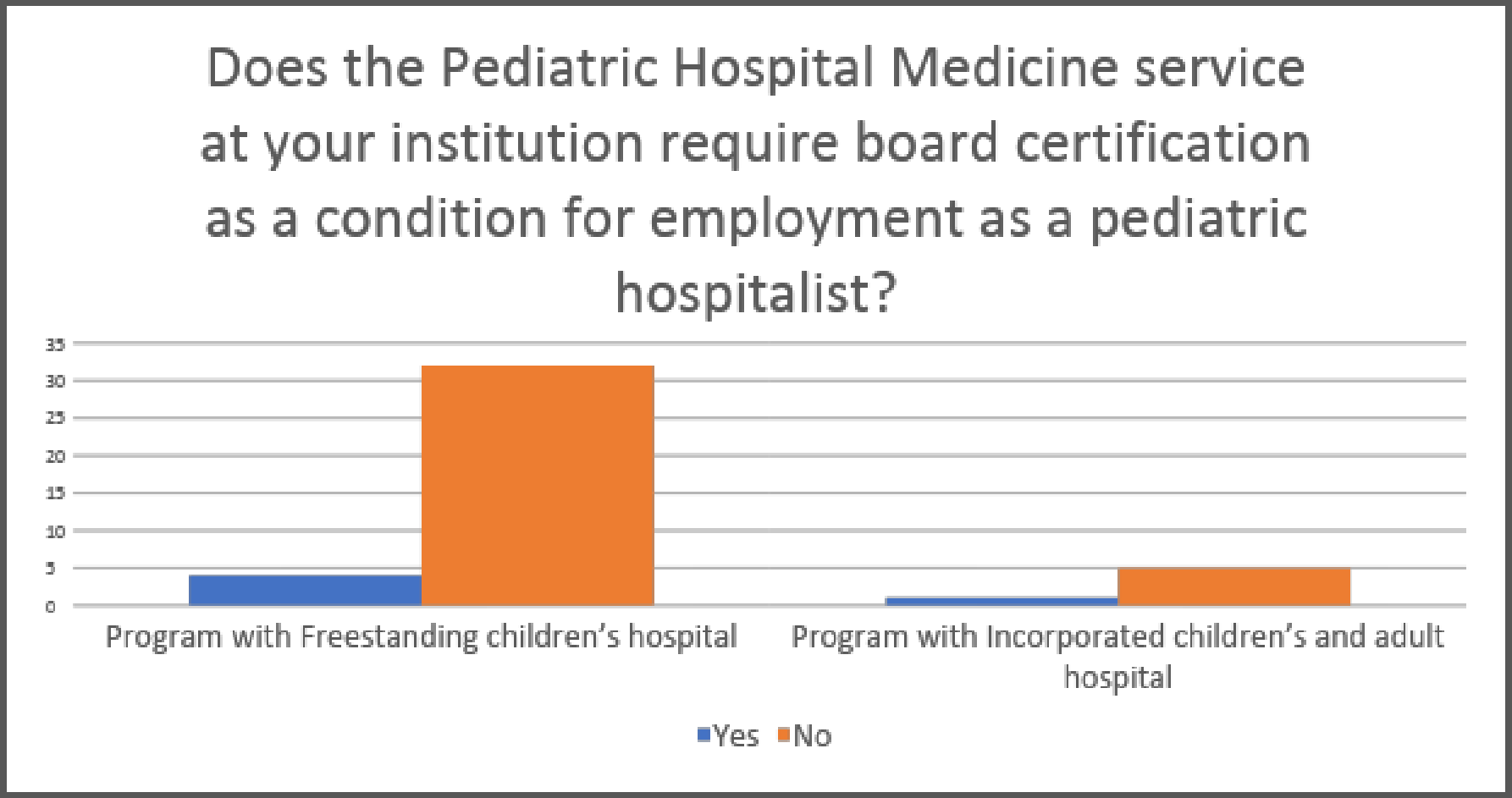
- Lead group: PHM fellowship directors led by Tony Tarachichi, MD at UPMC
- Collaborated with MPPDA Research Committee to design PHM module for Program Director Survey
- Priniciple aim: to assess MP PD perspectives on PHM fellowship and impact on how residents are being advised

What is your level of agreement with the statement: PHM now being an ABP sub-specialty has affected how I advise Med-Peds residents interested in pursuing a career as a Pediatric or Med-Peds hospitalist.

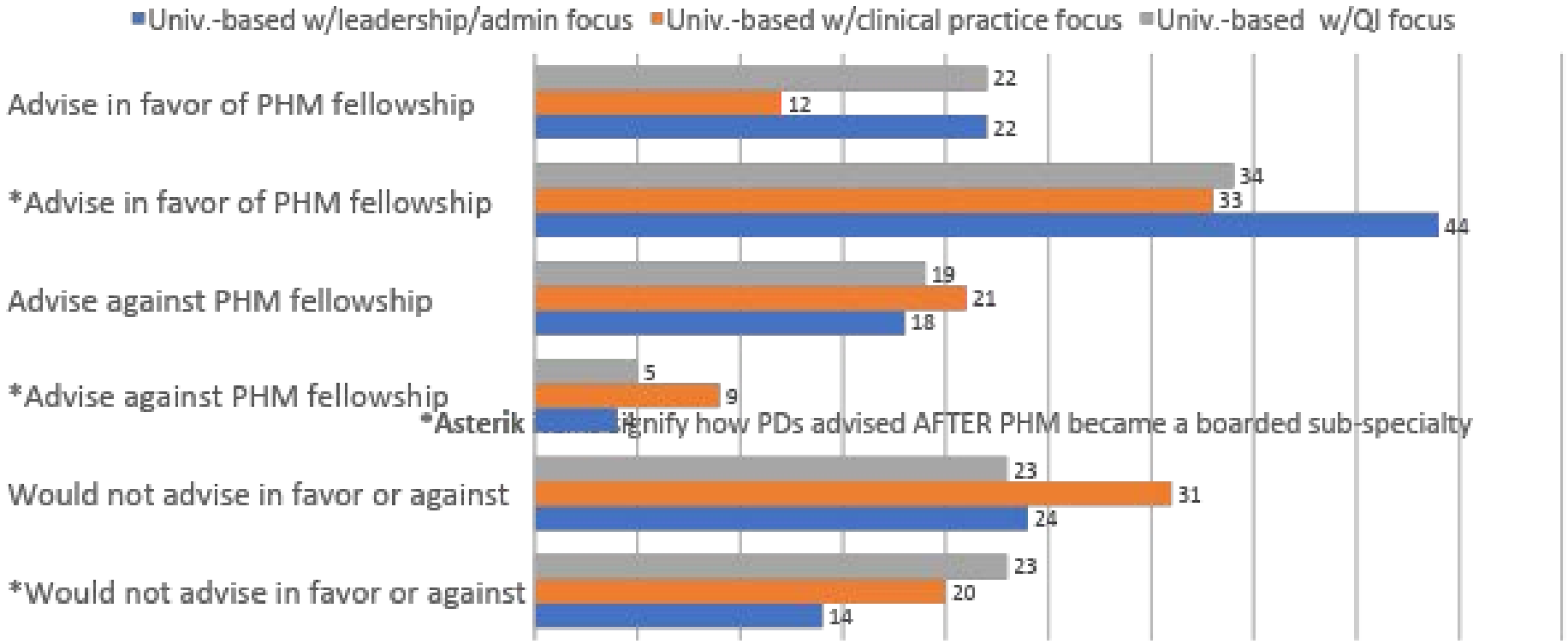


Does your institution have a Pediatric Hospital Medicine fellowship?

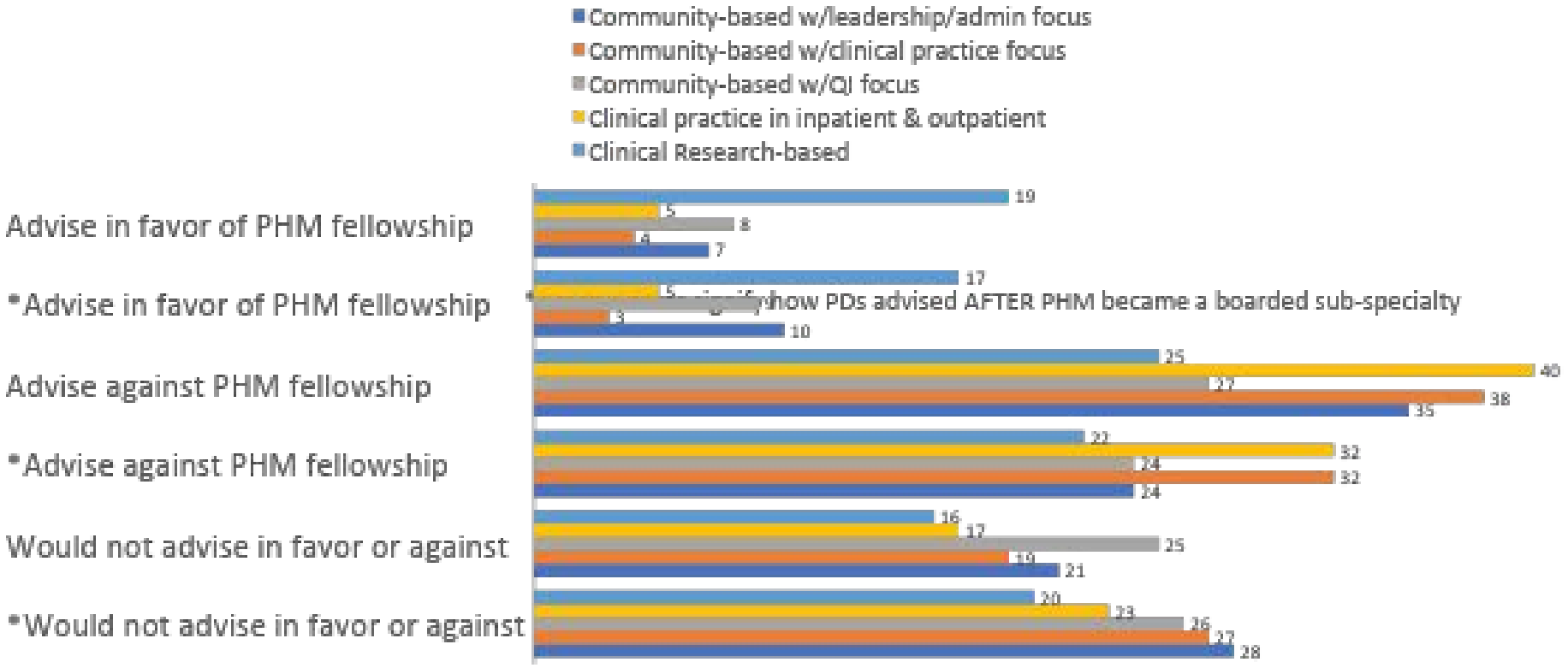



Does the Pediatric Hospital Medicine service at your institution require board certification as a condition for employment as a pediatric hospitalist?
35
30
25
20
15
10
5
0
Program with Freestanding children's hospital
Program with Incorporated children's and adult hospital
Yes
No

How program directors advise Med-Peds residents pursuing university based careers before and *after PHM became a boarded sub-specialty

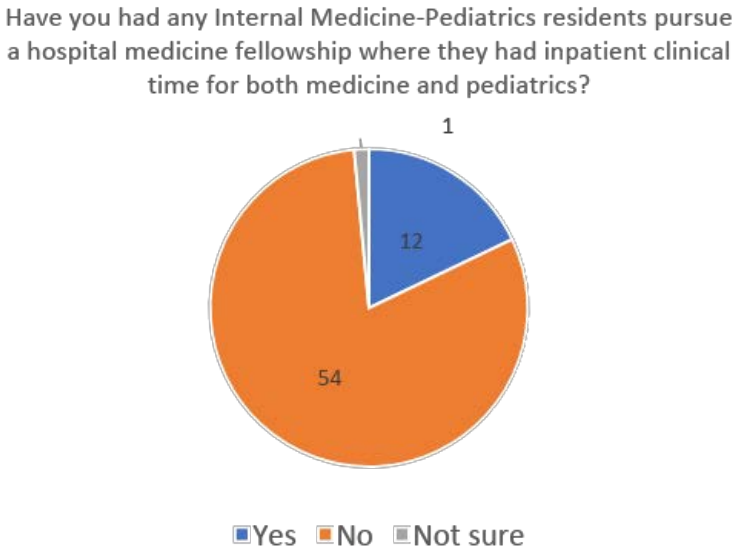


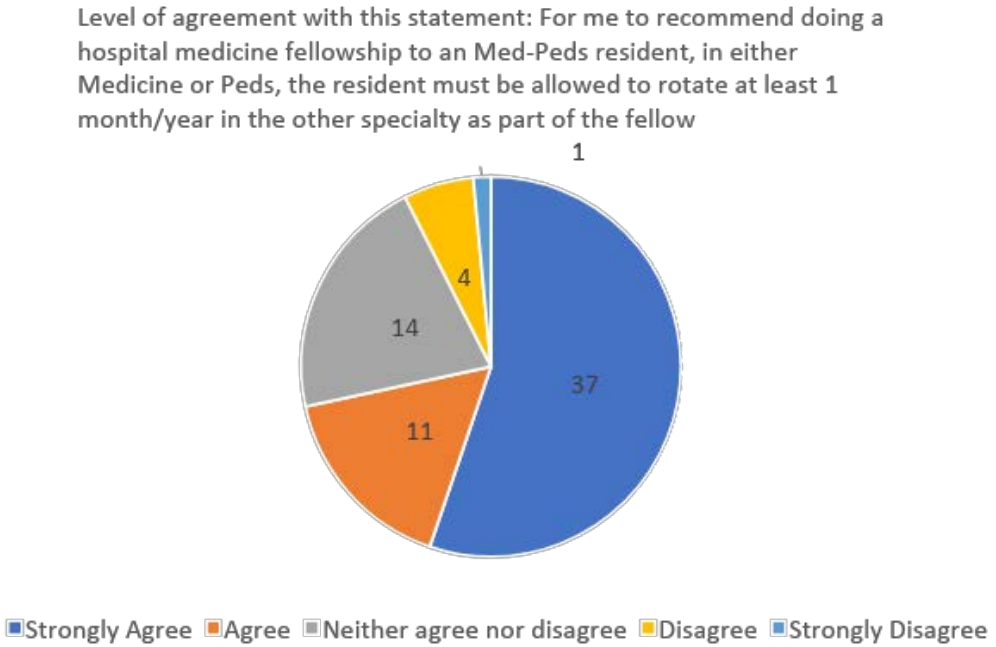
How program directors advise Med-Peds residents pursuing community based careers before and *after PHM became a boarded sub-specialty



Hospitalist Fellowships

- Three institutions reported having a combined Med-Peds hospitalist fellowship
- 18% of current PGY-4 Med-Peds residents are planning a career as a Med-Peds Hospitalist





To be eligible, an individual must:
Hold a current ABP certification in general pediatrics.
Possess a current (active), unrestricted medical license in the US or Canada.
Satisfactorily meet requirements for pediatric hospital medicine via the training pathway, the practice pathway, or the combined pathway

Training Pathway	Combined Pathway
2-year PHM fellowship in a program supervised by a director who is certified in PHM or who possesses appropriate educational qualifications.	Individuals completing less than 2 years of fellowship may qualify with an additional 2 years of practice experience that meets the requirements of the practice pathway.
2-year fellowship in general academic pediatrics may be considered if the clinical training during the fellowship focused on the care of hospitalized children… comparable to that offered in a PHM fellowship training program.	The 2 years of practice experience may be completed at any time either before or after training within the four years prior to the examination
Training may be completed on a part-time basis if the required two years of fellowship is completed over no more than a four-year period.	
Temporary period (2019, 2021 and 2023) for those who have completed 2 years of non-accredited PHM training within the previous 7 years	

Practice Pathway

The most recent 4 years of full-time practice (prior to 2023) must have consisted of at least 50% time spent engaging in professional activities (clinical care, teaching, quality improvement, patient safety, research, administration, etc.) related to the care of hospitalized children.

At least half of that time must be devoted to direct patient care of children, i.e., 25% of full-time professional practice.

Professional activities must be sufficient to substitute for the breadth of experience one would encounter during formal subspecialty fellowship training.

Direct care of patients should average no less than 10 hours per week (450-500 hours per year) over the most recent four years caring for children whose diagnoses encompass the breadth of the discipline

Between 900-1000 hours per year over the most recent four years should be spent overall in the practice of PHM.

If not clinically engaged in PHM for at least 50% time, but do meet the requirement for 25% clinical time, then required to engage in other HM activities for an additional 25% of time.

These "other HM" activities
- Include: administrative, QI, patient safety, research, or teaching activities related to the care of hospitalized children.
- DO NOT include: administrative time as a residency or fellowship program that do not directly relate to the care of hospitalized children.

Practice experience must be accrued in the US or Canada.

Practice Pathway for Med-Peds Hospitalists

Med-Peds physician must spend at least 25% of their full-time, professional activity in the direct clinical care of hospitalized children.

If less than 50% of practice activity is direct clinical care of hospitalized children: the additional, required 25% of professional activity must include administrative, quality improvement, patient safety, research, or teaching activities related to the care of hospitalized children AND/OR ADULTS.

Advising:

- Medical Students
- Current Residents

Advocating for Med-Peds Hospital Medicine fellowships at your program.

Peds Hospitalist Fellowship approaches for IM time during fellowship.

What kinds of jobs that would qualify as PHM?