APPD Spring 2019
Program Director Grassroots Forum

Moderators:
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Agenda

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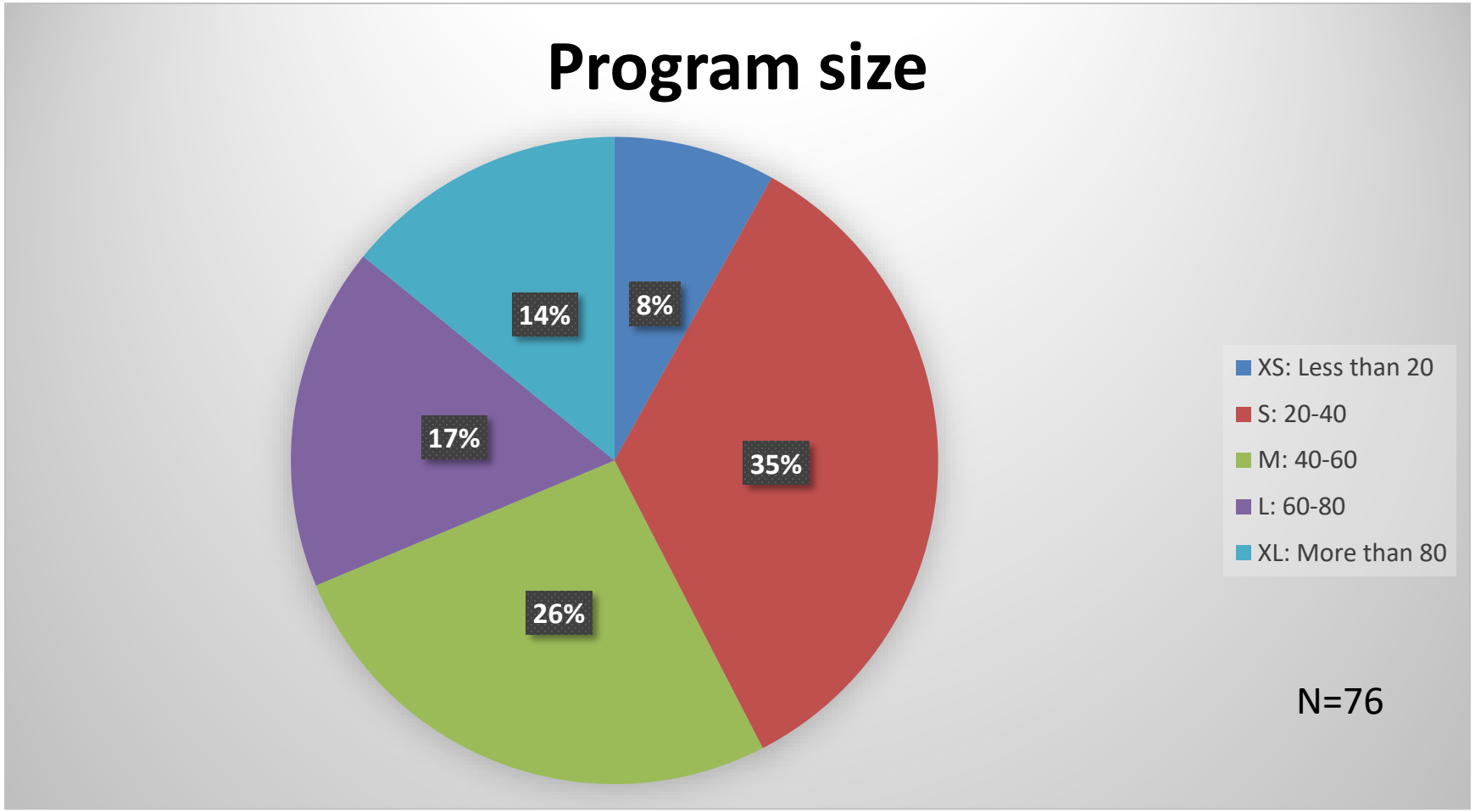
1. PD Demographics
2. Discussion of 3 “Hot Topics”
3. Follow-up from 2018 Grassroots session
   - Frontiers in Science and Pediatric Scientist Development Program – Dr. Wade Clapp
   - ABP Roadmap Project to support Resilience, Emotional, and Mental Health – Dr. Carole Lannon
4. Open forum

Demographics



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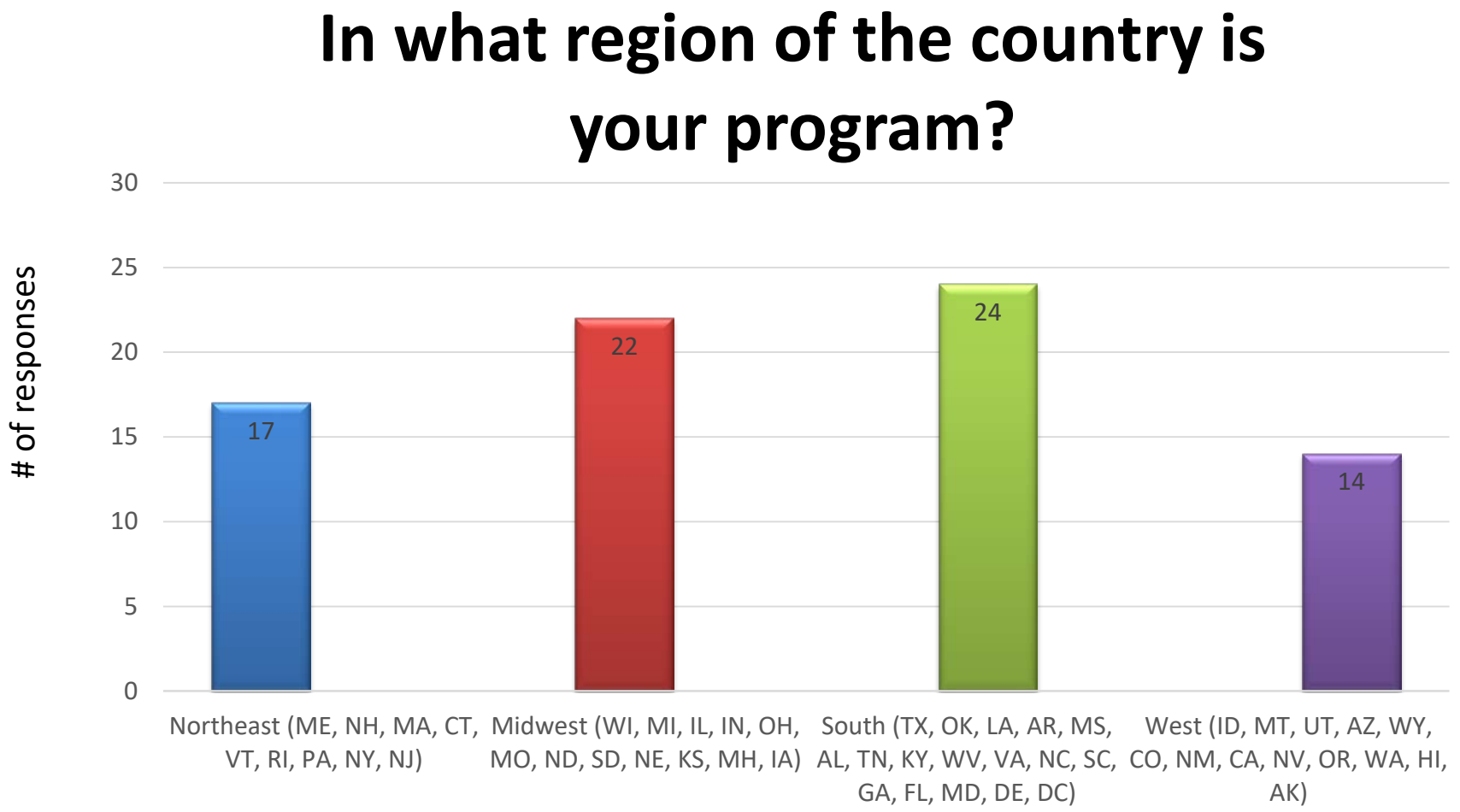

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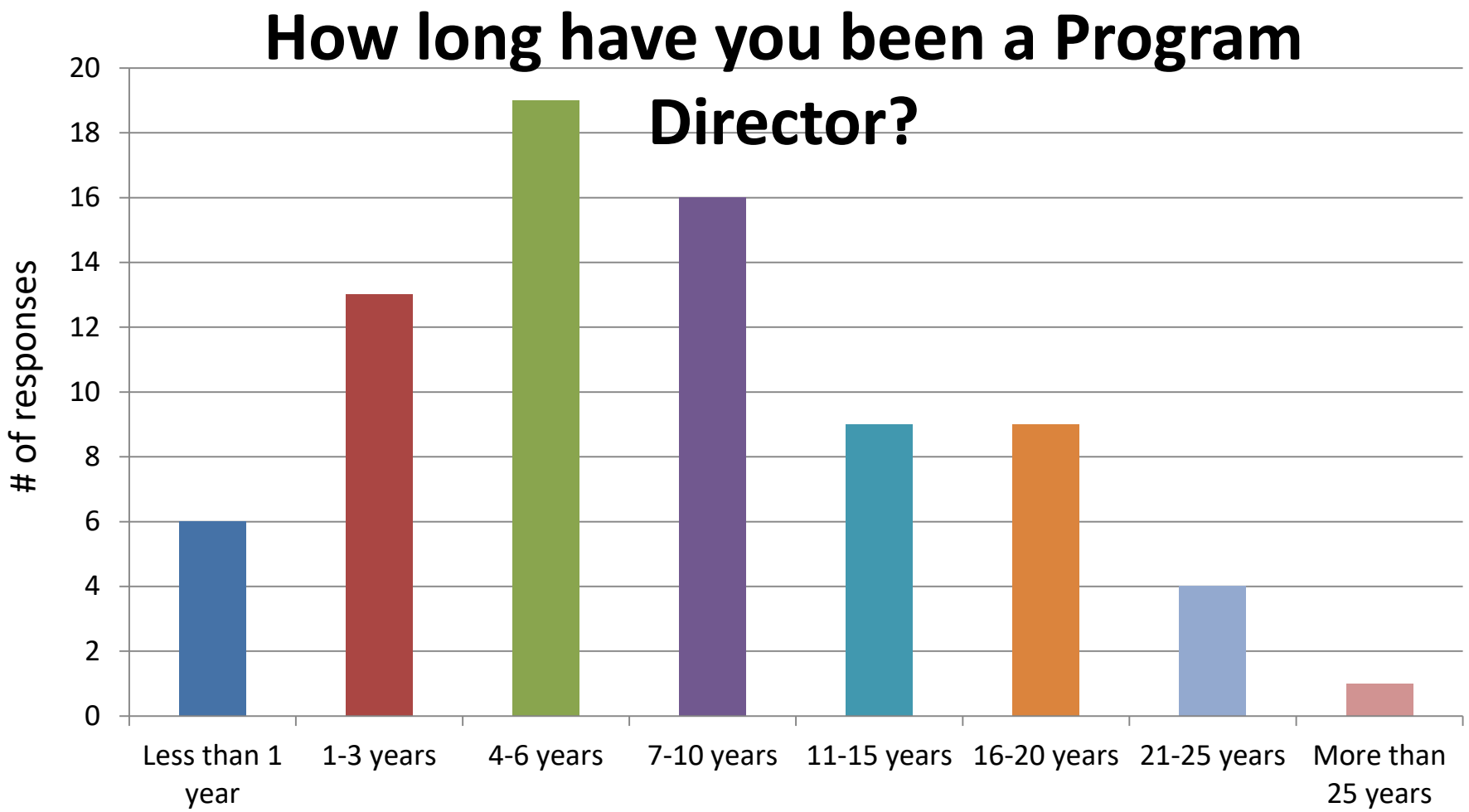
Demographics



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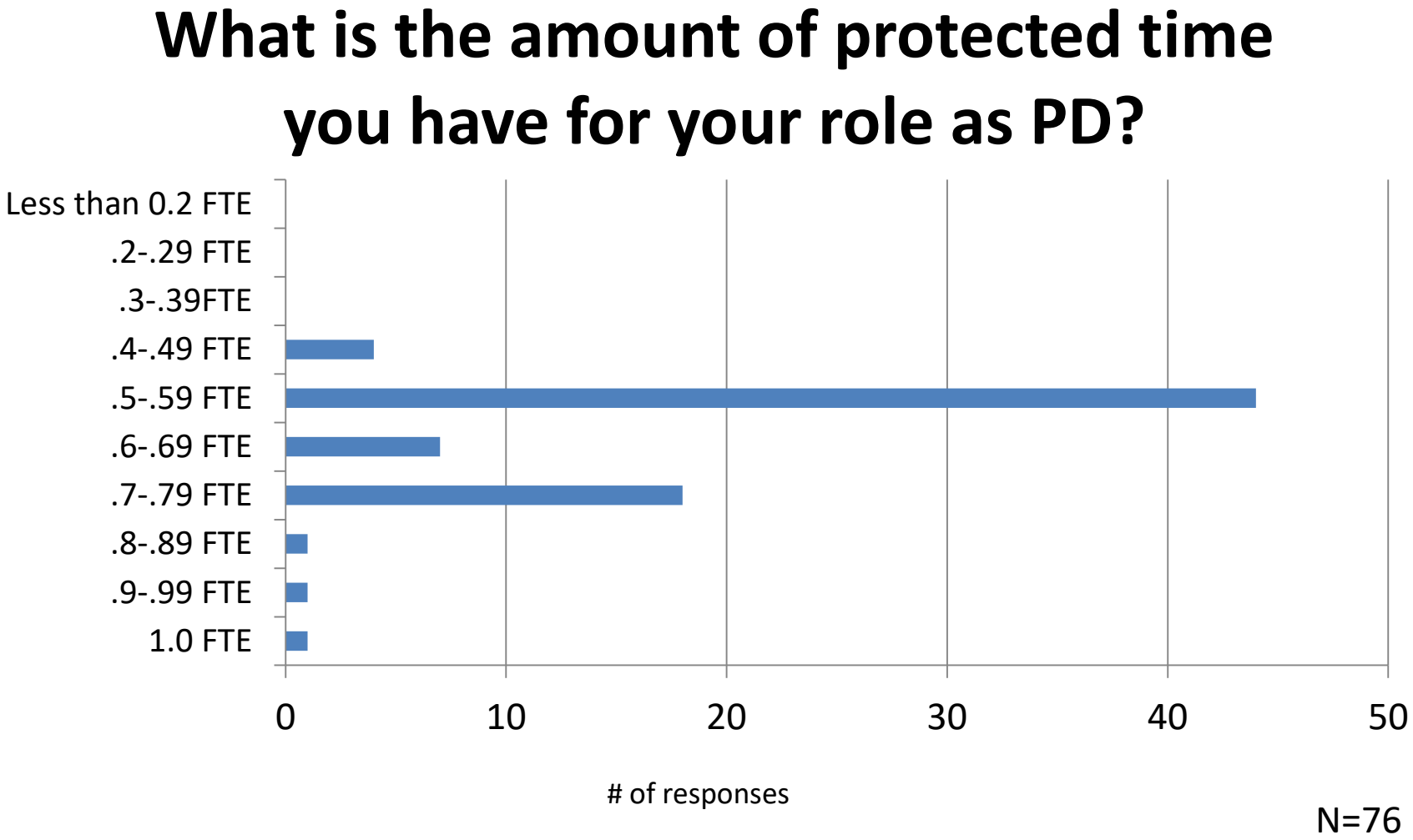
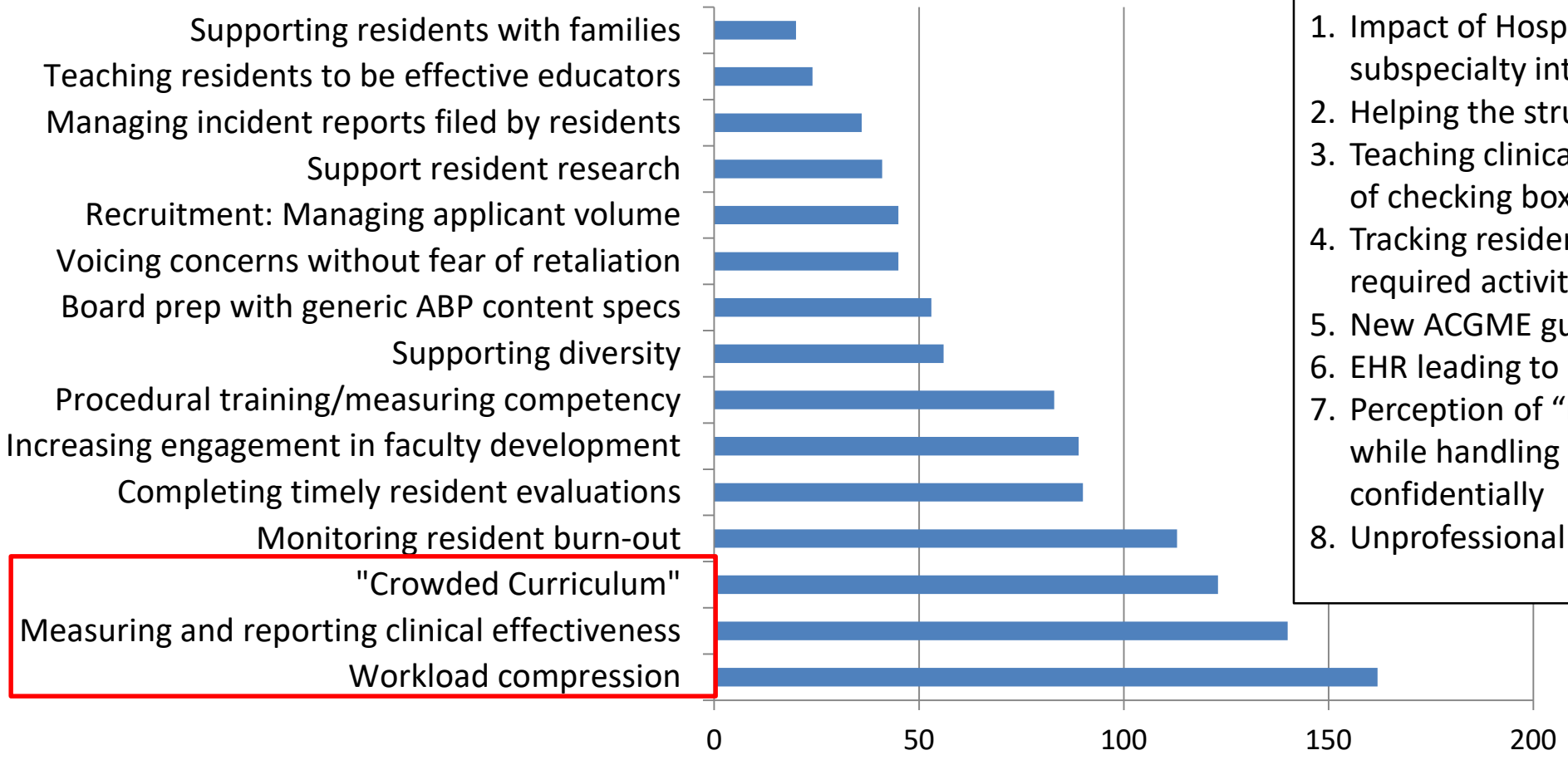


What are the most pressing issues you are facing as a PD?



OTHER:

1. Impact of Hospitalist Fellowship on subspecialty interest
2. Helping the struggling resident
3. Teaching clinical reasoning in the era of checking boxes on order sets
4. Tracking resident compliance with required activities
5. New ACGME guidelines
6. EHR leading to burn-out
7. Perception of “not doing anything” while handling problems confidentially
8. Unprofessional teaching faculty

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What are the most pressing issues you are facing as a PD?

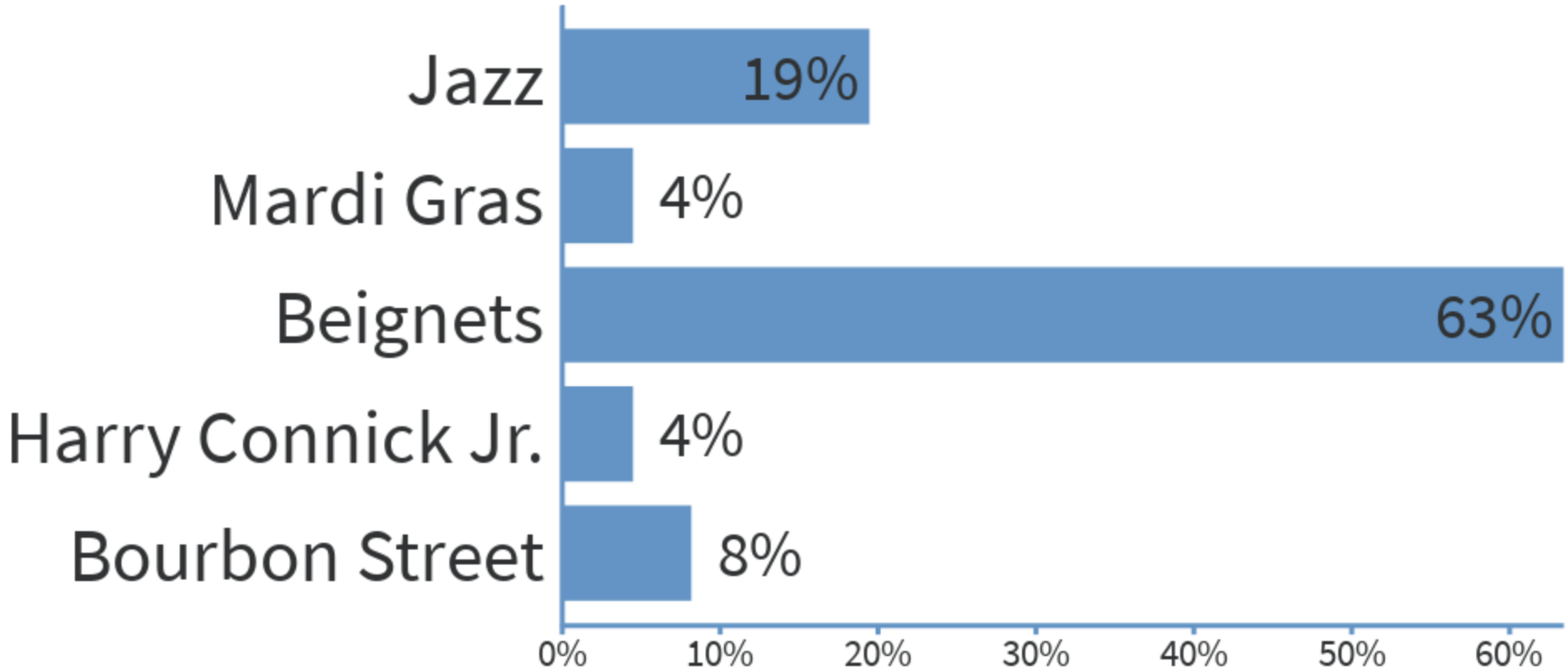
1. Workload compression - optimizing resident efficiency with restricted work hours

2. Measuring and reporting clinical effectiveness in residents

3. "Crowded Curriculum" - finding time to fit in non-core topics

What is your favorite thing about New Orleans?

When poll is active, respond at **PollEv.com/pchmeded** Text **PCHMEDED** to **22333** once to join



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Work Compression

"doing the same amount of work in less time"

Programs must consider the *impact* of work compression on *well- being* and take steps to *minimize* work compression

What is the Impact of High Workload and Work Compression?

- Reduced empathy
- Higher mortality and readmission rates in elderly pts
- Lower patient satisfaction
- Greater use of diagnostic testing
- Shifting from active care to monitoring
- Reduced educational participation
- Decreased perception of quality of education
- Decreased perception of one's own professionalism

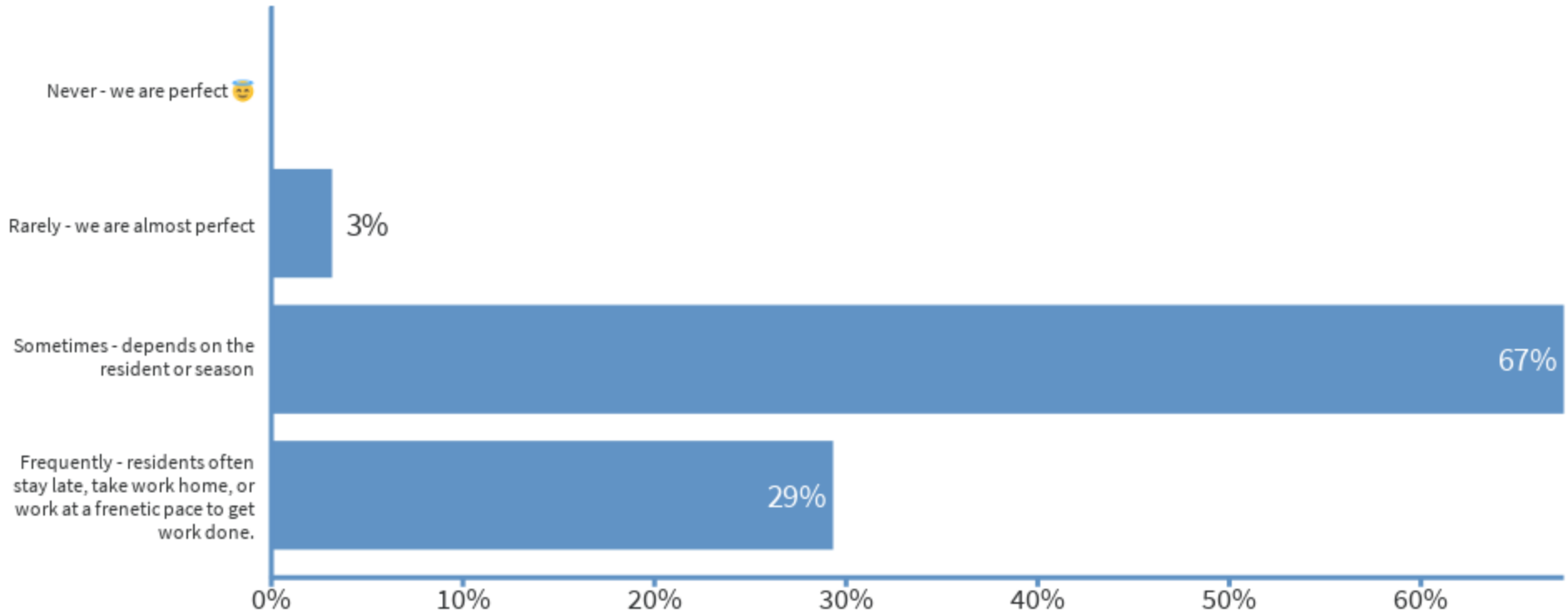
ACGME Common Program Requirements FAQs, page 18

How Has Workload Intensity Changed Over Time?

- More conditions being managed as outpatients
- Higher acuity/complexity of patients being admitted to hospitals
- More time spent on EMR (data review and entry)
- Duty hour limitations were implemented

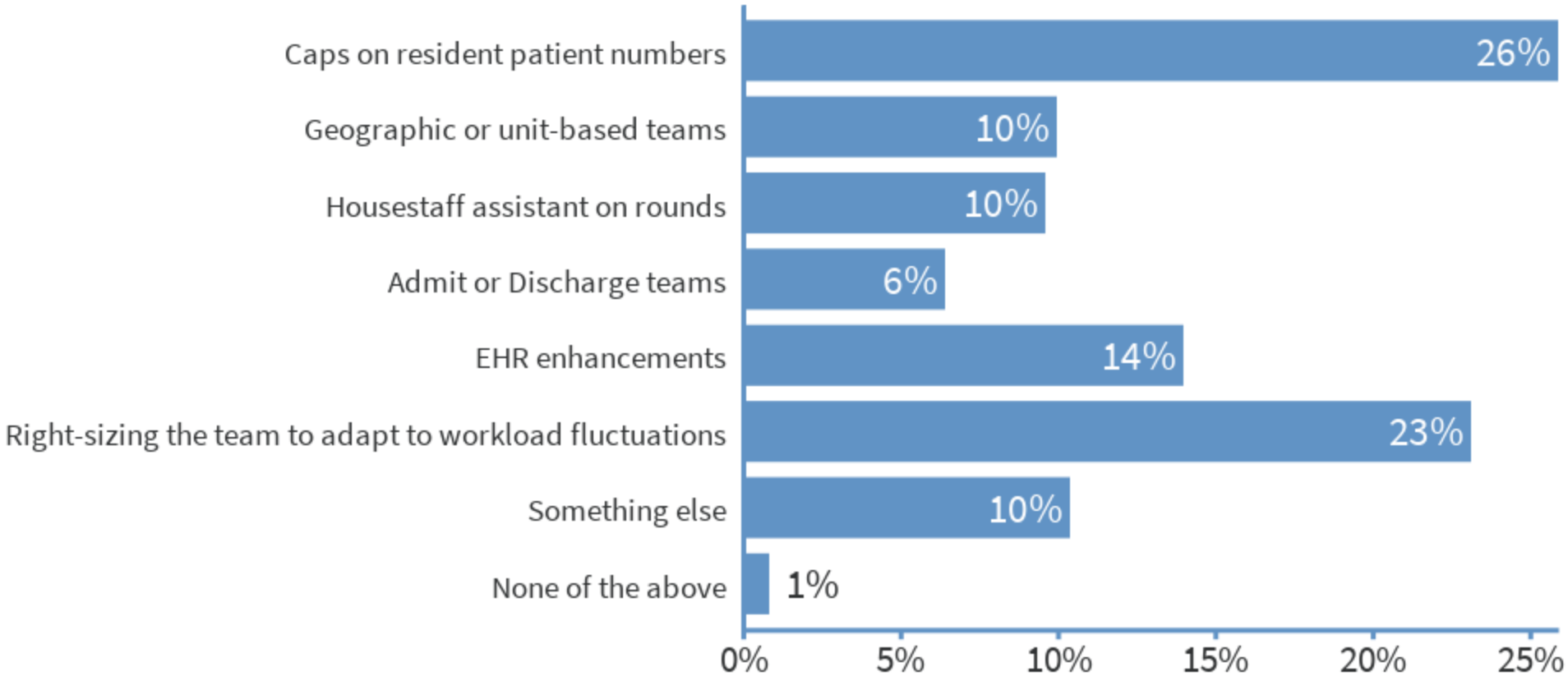
Clark et al, “Trends in inpatient admission comorbidity and electronic health data: implications for resident workload intensity” Journal of Hospital Medicine, Aug 2018

How often do residents in your program have difficulty completing their work in the time allotted during an *inpatient* rotation?



What strategies have you implemented to decrease work compression?

Select all that apply



Total Results: 251

Work compression - Discussion

- What impact is work compression having on your residents and/or faculty?
- What strategies have you found helpful to address workload or work compression?
- What barriers are you facing?

Work compression - Discussion Points

- Boston children's has faculty writing notes to avoid redundant documentation. The majority of the faculty will do this.
- Discussion about implementation of Patient Numbers
- Geisinger- Patients to a certain number for interns (10) then the residents are responsible
- Floor based teams- discussed that this can be easier with overflow seen by the hospitalist
- Some disagreement about compression and discussion that maybe the problem is with the increased complexity of patients, as residents have more efficient and available information at their fingertips
- Moonlighting- in peak season some residents are allowed to moonlight, and these are supported by the hospital
- Suggestion of capping a 8 to 9 patients, checking census daily, if census exceeds it, hospitalists will take the surplus
- A jeopardy service used for overflow. Residents comprimise subspecialty experience
- Mount Sinai has a double hospitalist service but recognize this is a financial hit to the hospitalist because they of smaller teams, therefore fewer patients, and if this is used for salary, it can be a detriment to faculty
- Cincinnati has a resource team during rounding time with resident extenders "assistants" and there are caps during weekends
- Concerns and fragmented signout if more teams and extenders are involved. In protecting the residents, how are they prepared to become faculty?
- Case management partnership, discharge coordination, pre-authorizations scheduling. All this is done by resident assistants and the hospital pays this, and "sell" to hospitalist decreased length of stay
- House staff scribes in the ED, initially only for faculty, but were able to facilitate this for residents also
- Suggestion to partner with information technology and find ways to make more efficient
- Converting to a scheduled intern admission team (1/2 day) and discharge team (1/2 day)
- Conversation that signout is taking too long and an intervention can be to have a more efficient signout
- Non-faculty mentor (faculty may not have the expertise) with IT to make more efficient.

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Measuring and Reporting Clinical Effectiveness in Residents

Clinical Effectiveness and Metrics

- Clinical Effectiveness: The application of the evidence-based knowledge, clinical experience and patient preferences to achieve optimum processes and outcomes for patients.

- Clinical Metrics: A measurable element of practice performance, for which there is evidence or consensus, and that can be used to assess the quality of care that is provided.

From the ACGME

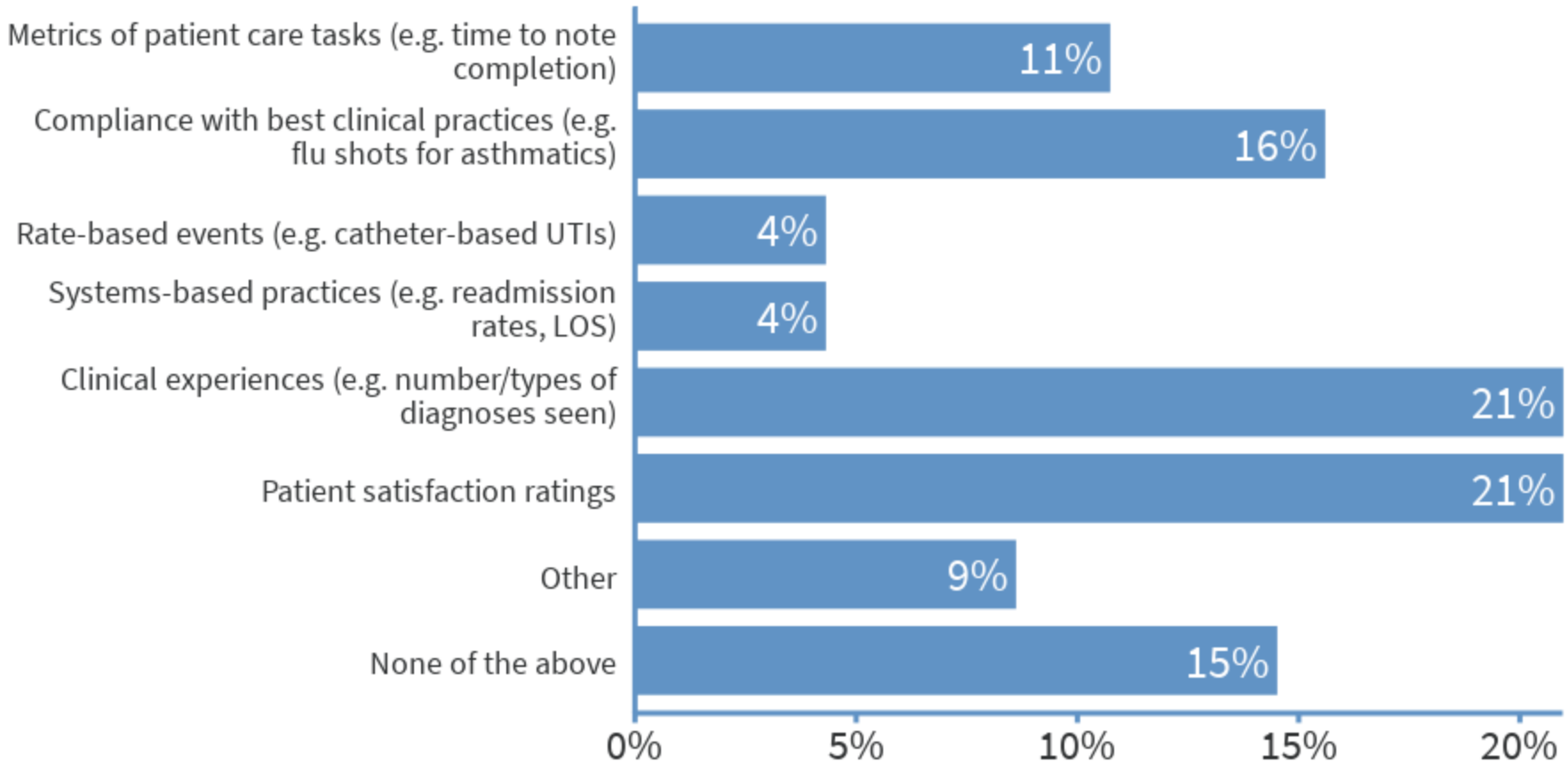
- Pediatric Program Requirements:
  - Access to data is essential to prioritize activities for care improvement and evaluating success of improvement efforts.
  - Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.

- Resident Survey: How often are you provided data about your practice habits?
  - Question with lowest national compliance past 5 years (59%-70%)

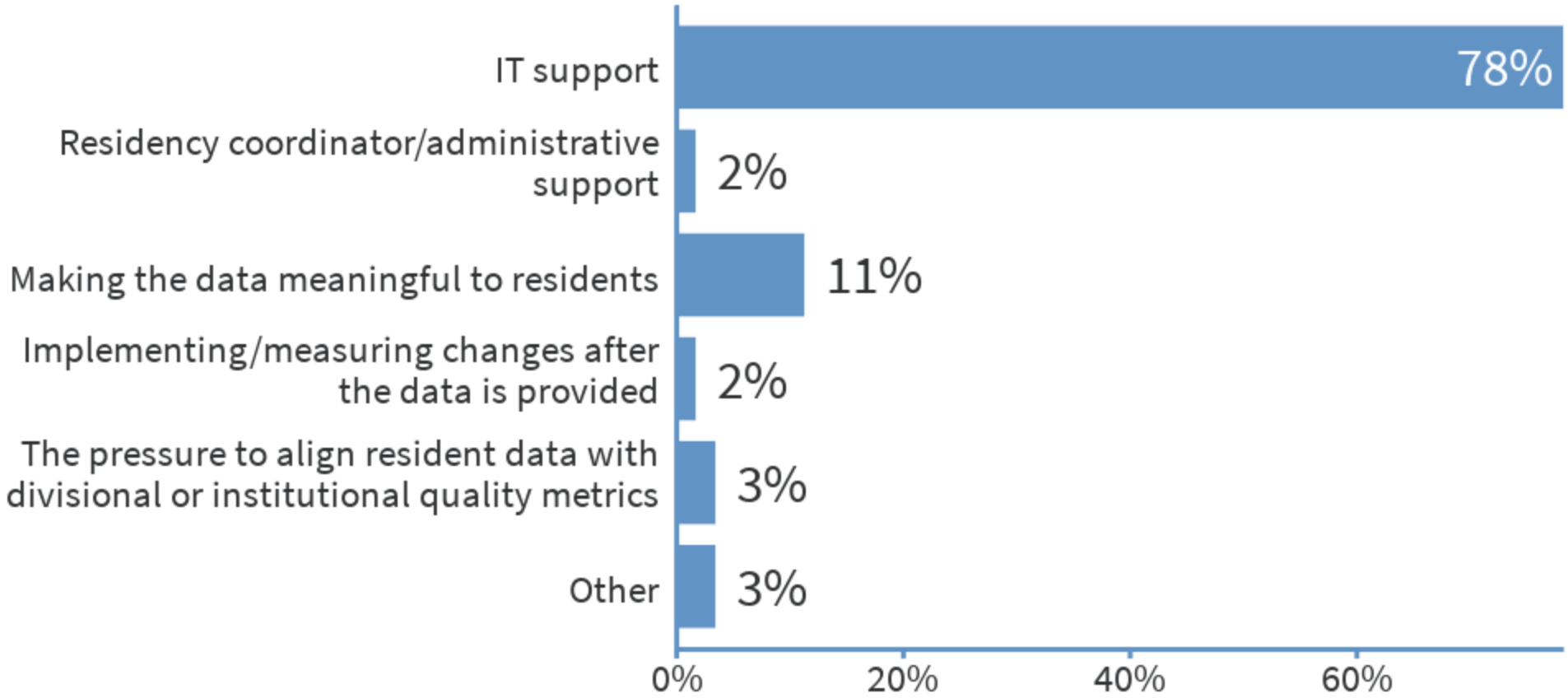
ACGME Pediatric Program Requirements 2017

What practice data have you provided *individually* to your residents?

Select all that apply



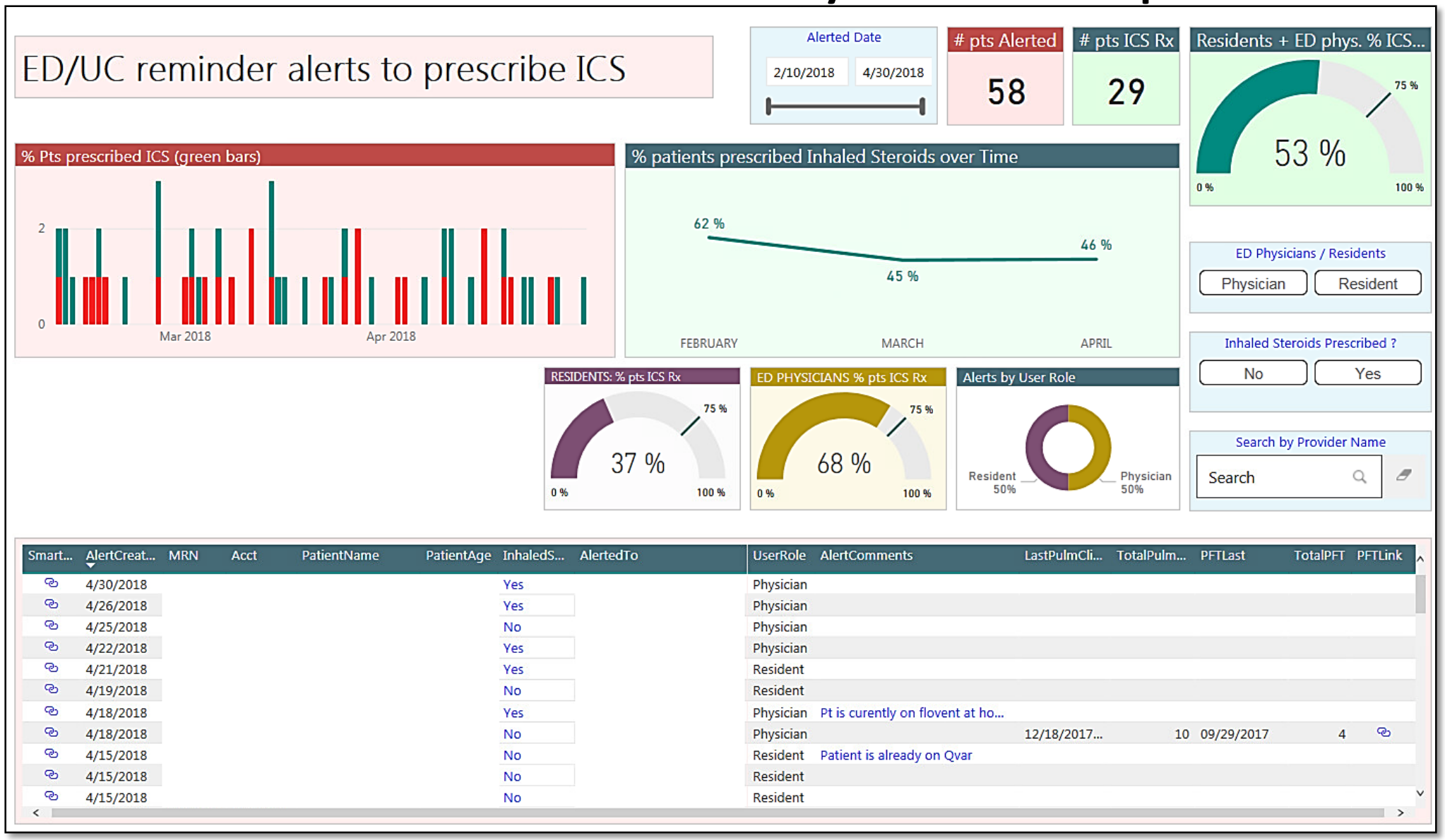
What is the *biggest* barrier to providing data about your residents' practice habits?



Measuring Clinical Effectiveness - Discussion

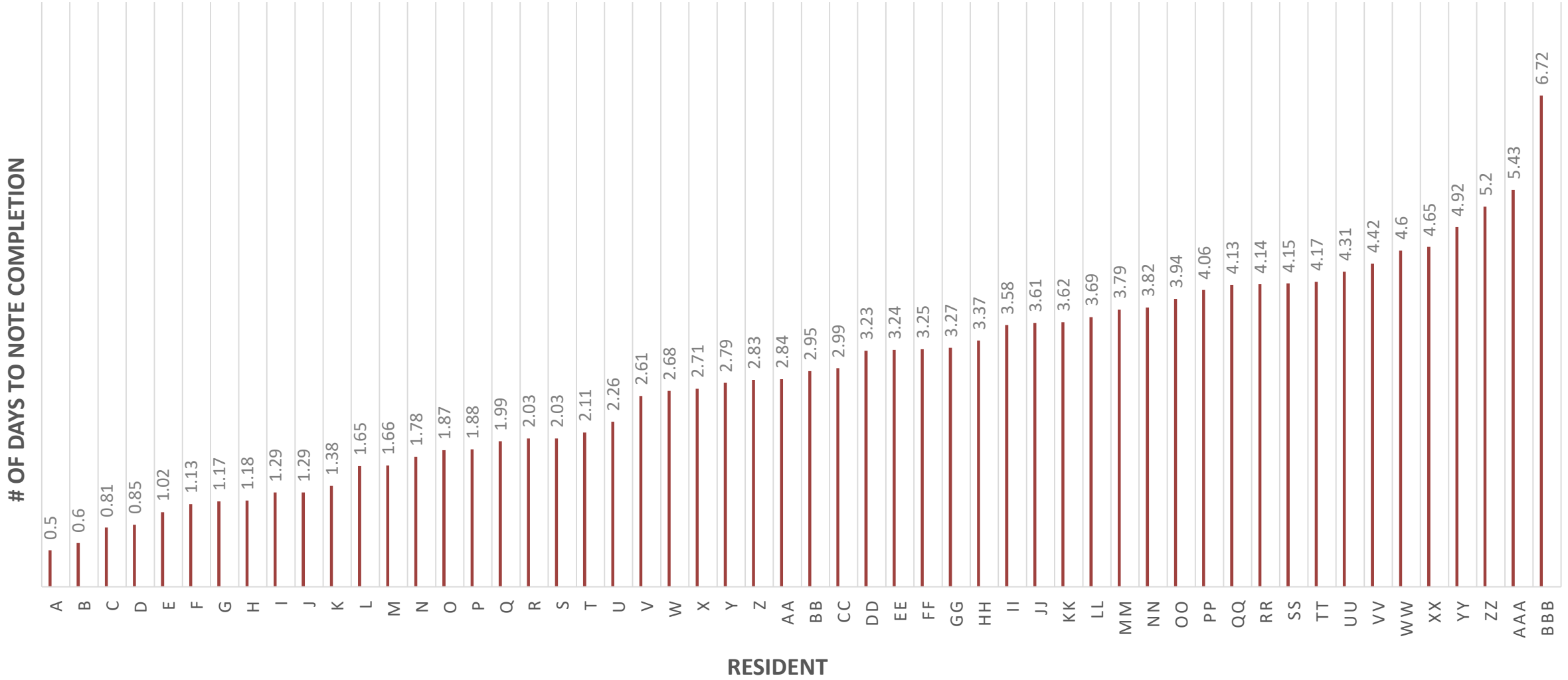
- What unique methods does your program use to provide residents with data about their practice habits?
- How do you make this data meaningful initially and in follow-up?
- How do you overcome barriers such as IT?

Example: Dashboard of prescribed inhaled corticosteroids in the ED by resident providers



Smart...	AlertCreat...	MRN	Acct	PatientName	PatientAge	InhaledS...	AlertedTo	UserRole	AlertComments	LastPulmCli...	TotalPulm...	PFTLast	TotalPFT	PFTLink
	4/30/2018					Yes		Physician						
	4/26/2018					Yes		Physician						
	4/25/2018					No		Physician						
	4/22/2018					Yes		Physician						
	4/21/2018					Yes		Resident						
	4/19/2018					No		Resident						
	4/18/2018					Yes		Physician	Pt is curently on flovent at ho...					
	4/18/2018					No		Physician		12/18/2017...	10	09/29/2017	4	
	4/15/2018					No		Resident	Patient is already on Qvar					
	4/15/2018					No		Resident						
	4/15/2018					No		Resident						

Example: Time to note completion for residents in continuity clinic



Measuring Clinical Effectiveness – Discussion Points

- Conversation that it does not have to be individual data per the ACGME, and that we can teach people to look at data in general
- EPIC system: IT can report personal reports when using the EHR, data including time to completion of note, review medications, medication reconciliation completed. These were reviewed individually by residents by the continuity clinic preceptor
- Chart audits two times per year, five patients can answer the questions and focus on practice habits
- Dashboards on desktop, showing patients seen per day and RVU generated
- Provide median RVU per encounter, radiology cost per encounter, and show benchmark to their peers twice a year
- Discussion about ACGME and the resident survey preparation- Alliance for Academic Internal Medicine can be used as a prep for preparing for this specific survey question about data habits
- Divisional data, some discussion about how we can apply that to individual residents
- Groups data quarterly: patient safety, quality improvement, and has a grand rounds that describes departmental data such as line infections and comparing to similar hospitals
- EQUIPP through AAP, one set up can have a team leader and can look at own data
- EPIC system can give lots of data including quality data repository, as long as you have clear goals and outcomes it is easy to show how others posted reach each, and can allow the program director to evaluate every resident’s performances

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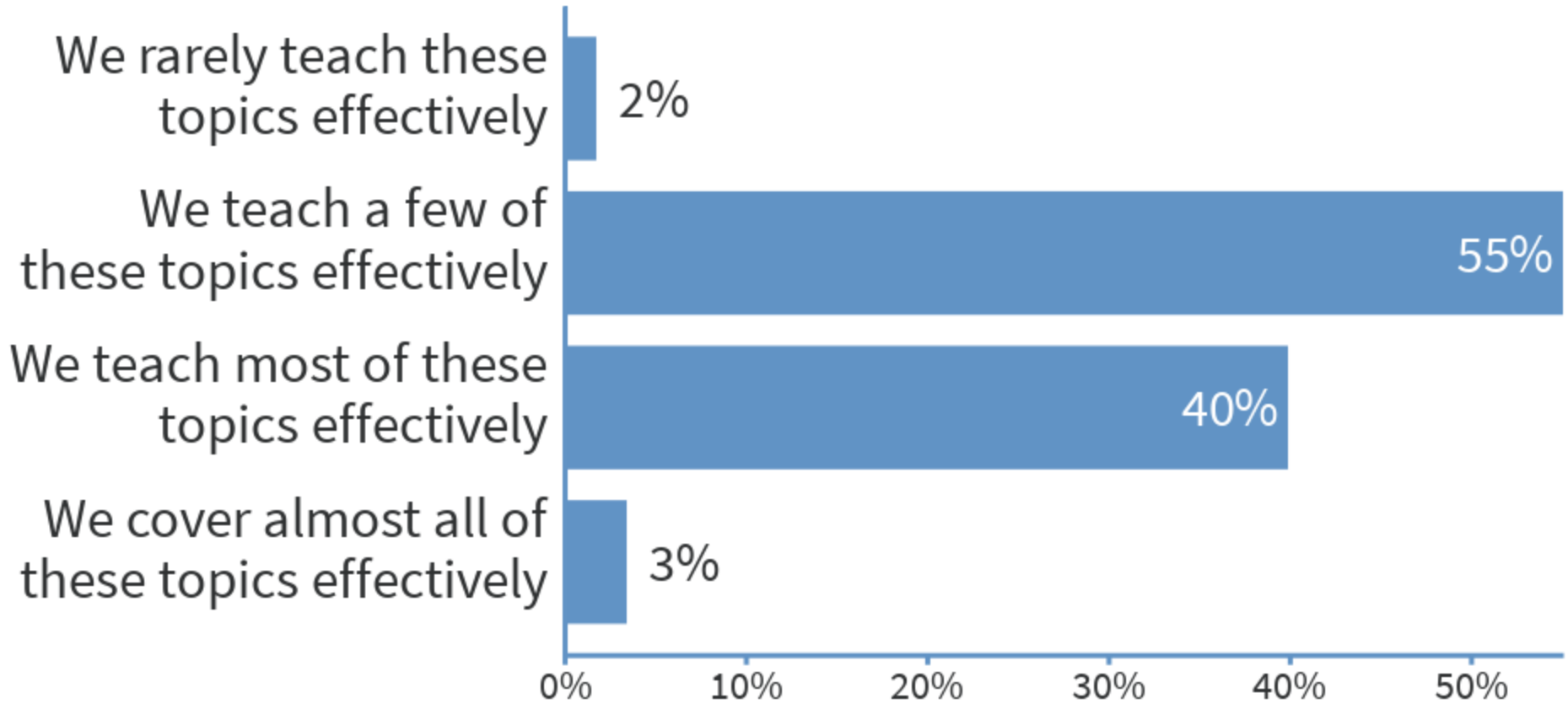
The “Crowded Curriculum”: How do we effectively teach “non-core” topics?

What?

- Well-being/resilience/burnout
- Fatigue management
- Humanism in medicine
- Promoting life-long learning
- Clinical effectiveness
- Transitions of care
- Professional duty and accountability
- Professional boundaries
- Sensitivity to diverse populations
- Advocacy
- Substance abuse
- Residents as educators
- EHR Efficiency
- Medical ethical stewardship
- Patient safety
- Quality Improvement
- Basic principles of research
- Dealing with challenging patients
- Responsible social media use
- Documentation
- Career planning
- Business of medicine
- Practice management
- High-value care

How effective is your program at teaching these non-core topics?



Why?

"…not so much a particular segment of the curriculum as a defining dimension of medical education as a whole"

Sullivan WM (2009) quoted in Teaching Professionalism-Why, What and How
Cruess SR and Cruess RL Facts Views Vis Obgyn; 2012 4(4): 259-265

How?

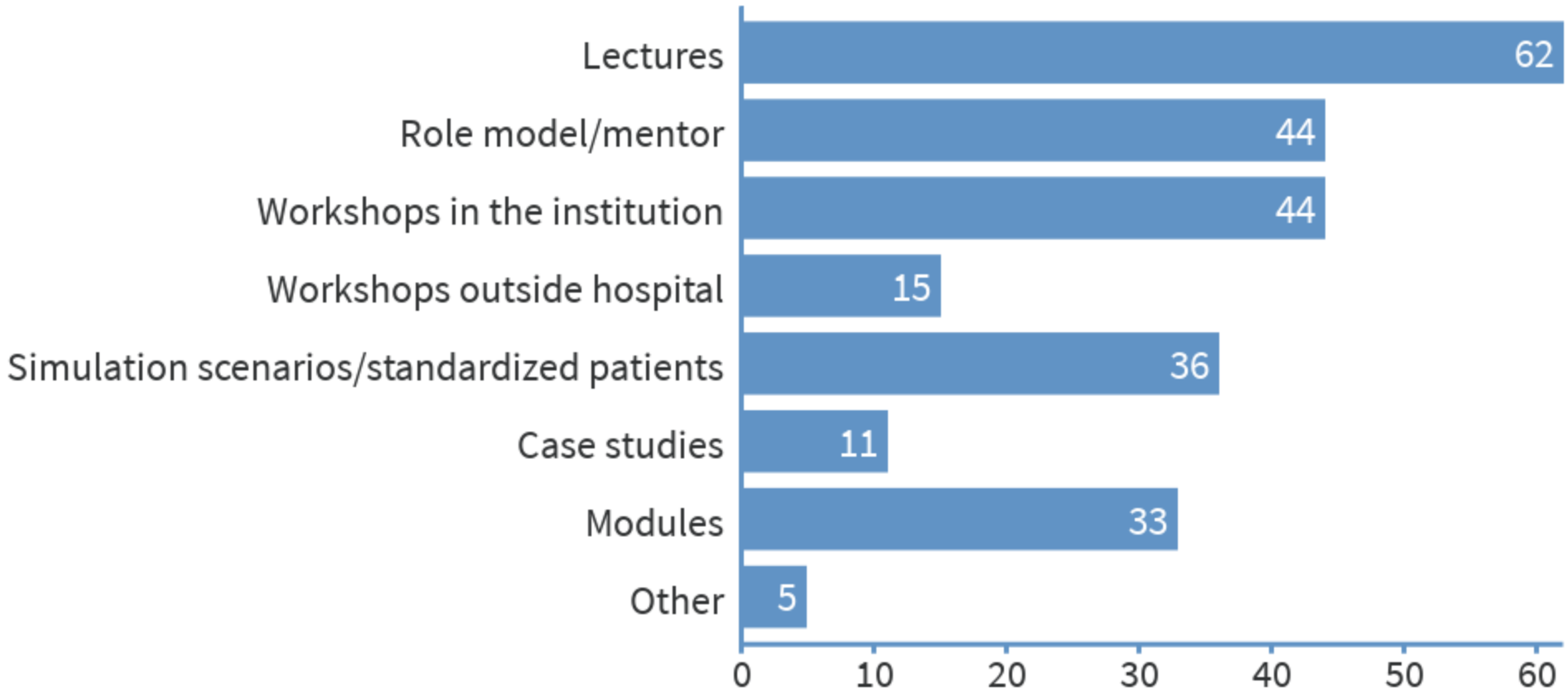
True or False?

- “Finding time for lecture is easier than extensive work to change actual practice behaviors of trainees and physician role-models”

Understanding Medical Professionalism Chapter 8: The Hidden Curriculum and Professionalism, Wendy Levinson et al. Lange 2014

How do you teach non-core topics in your program?

Select all that apply



Crowded Curriculum - Discussion

- In what creative ways have you added ONE non-core topic to your resident curriculum?

- In what unique ways have you “squeezed” non-core topics into your curriculum?

Crowded Curriculum – Discussion Points

- One time-saving suggestion regarding I pass: Instead of a three hour workshop , this training has been converted to a 30 minute online module in Boston - they also observe handoffs using an app on the phone to reinforce and sustain appropriate “hand off” behaviors.
- Regarding QI and patient safety- IHI modules can be used and incorporated into rotations
- “Resilience rounds” once a month as a case based discussion
- Two week block for PGY two‘s and which a lot of these topics are covered via workshops.
- Several participants suggested leveraging GME to require and/or provide some of this curriculum; for example the “residents as teacher” curriculum could be provided/ funded by the institution.
- “Asynchronous committee” that evaluates and implements curriculum (they decide what to keep or toss, what and where to add new curriculum)
- At UCSF they teach QI using first a didactic and then applying at cont clinic. The data is reviewed quarterly in cont clinic (during protected time) and the residents present this information and a Grand Rounds annually.
- The “wellness champion” sends inspirational messages and memes on “Motivational Mondays” , give special thanks and kudos on “Wellness Wednesday” and suggestions for nutrition and exercise on “Fitness Fridays”. You Never know when one of these small efforts may make a big impact on one or more individuals. Same program offers “examples of excellence“ in which a survey monkey is used to identify areas of excellence and a certificate for s given to residents who have been “Caught being excellent”.
- One program (that utilizes academic half days) sets aside the fourth session of each month to cover some of these “non-core topics”. They break into small groups and use facilitated discussions to review these Topics in a collegial atmosphere.
- Suggestion that we need to prioritize which topics to cover each year. They focus on a “theme for the year”. Another program echoed the need to prioritize stating that we need to focus on “providing the material when the resident is most ready to learn it.” Ex: They provide a third-year retreat focusing on financial planning lifelong learning and MOC. These same topics would not be very appealing for interns.
- One program mentioned a linking with national institutions and taking advantage of their curriculum specifically to AAP and advocacy or high value care and John Hopkins. They also suggested getting a resident involved in a project and having the president teach the others.
- One program also advocated using the state AAP to assist with teaching about career planning and business of medicine. They may be able to provide a good source of expert speakers as well as funding.

THANK YOU - SEE YOU IN 2020!