

ACADEMIC INTERNAL MEDICINE

INSIGHT

AAIM IN ACTION

The New Alliance Meeting Experience Has Arrived!

Bergitta E. Cotroneo, FACMPE

COMMENTARY AND OPINION

Internal Medicine Specialists Treat the Whole Patient —The Right Thing to Do

Gailen D. Marshall, MD, PhD

UNDERGRADUATE MEDICAL EDUCATION

Why Are We Saving the Best for Last? “Boot Camps” Should Be Expanded beyond the Fourth Year

Steven E. Bishop, MD, Adam Garber, MD, Allison Phillips, Frank Fulco, MD, and Georgia McIntosh, MD

RESIDENCY EDUCATION

Elevate Wellness: Unlocking the Potential of Creative Problem Solving to Improve Wellness in Residency Programs

Bhavana Pathak, MD, Erin Parry, MD, PhD, Lauren Block, MD, and Sanjay V. Desai, MD

Training Internal Medicine Residents and Faculty to Deliver Culturally Competent Care and Eliminate Health Care Disparities: How Do We Meet the Challenge in Efficient and Effective Fashion?

Maria Maldonado, MD, and Ethan D. Fried, MD

FELLOW EDUCATION

Designing a New Subspecialty Training Fellowship: Education Theory and Work Redesign

Stephen Lanspa, MD, Adil Abdalia, MD, Benjamin Hall, MD, Robert Kizer, MD, Erin Jenkins Wessling, MD, and Savio Reddymasu, MD

FACULTY DEVELOPMENT

Promoting Yourself: The Role of Executive Presence, Coaching, Sponsorship, and Resilience in Leadership Development

Andrea Sikon, MD, Amy S. Gottlieb, MD, Sumita Khatri, MD, and Susan J. Rehm, MD

QUALITY, SAFETY, AND HIGH-VALUE CARE

An Effective Quality Improvement Curriculum in a Large Internal Medicine Residency

Gina Rossetti, MD, Seth Politano, DO, Patrick Sarte, MD, and Eric Hsieh, MD

ADMINISTRATION, FINANCE, AND REGULATORY ISSUES

From “I” to “We”: Defining Multidisciplinary Teams at an Academic Cancer Hospital

Salimah Velji, Naralys Sinanis, Kerin Adelson, MD, Anne Chiang, MD, Benjamin Judson, MD, and Rogerio Lilenbaum, MD

By the Numbers

2

>90%

4

Possible compliance with ACGME Resident Survey question about QI participation

6

Page 20

9

14%

Programs that report a mechanism to evaluate resident non-English language competence

Page 12

12

90%

Accounting for success attributed to leadership behaviors

Page 17

15

17

20

22

AAIM Deputy Chief Executive Officer and EVP Update: The New Alliance Meeting Experience Has Arrived!



Over the past eight years, I've used this column to share many triumphs with you—the merger and integration of the Alliance founding members, now five years past; the successful transition to the single invoice system, which opened the doors and almost doubled our membership; the phenomenal success of educational and research programs and initiatives promulgated by you, the members—all things both the volunteer leaders and staff are proud to have been part of.

These collaborative efforts (and myriad others) have helped to grow and strengthen AAIM. Internally, our volunteer leaders work closely with staff and each other to monitor progress, promote change, and contribute to the redesign of products and service lines to better meet your ever evolving needs.

But Everything Was Fine...

There's an old R&B song with lyrics that say "make it like it was...it was easier for me!" The idea of change is often like that. Too much work, uncertainty about the efficacy, and the nagging fear that the change won't really improve anything—a tremendous amount of work and upheaval, but not much to show for it.

Our traditional meetings and conference schedule work. Each is designed to meet the needs of the founding member group's constituency, and generate a significant amount of revenue for AAIM. The networking, learning opportunities, and ability to attract key stakeholders are also a major win. General members get the chance to meet with colleagues, expand their networks, and be exposed to the best and brightest academic internal medicine has to offer—in terms of both best practices and professional development.

It would be wonderful if we could leave things "like they were," but that would mean our organization is not growing in ways that would continue to make it such a wonderful professional home and our meetings and conference such valuable events.

Can't You Grow the Meetings Without Moving My Meeting?

Well, in a word, no. Let's explore why.

In fiscal year 2015, the AAIM Board of Directors convened a task force led by Dominick Tammaro, MD, to develop a new meetings structure to support growth, networking, and professional development for Alliance members.

Our old conference schedule (the APM Winter Meeting in February; APDIM Spring Conference in April; Academic Internal Medicine Week in October, which included annual meetings for AIM, CDIM, and APDIM plus preconference programming for ASP and APM) really would not allow us to convene a full annual conference that would attract a substantive number of the potential Alliance attendees.

I think you'll agree all the existing meetings offer excellent learning and networking opportunities. Post-meeting evaluations continue to reflect a high level of satisfaction with the program content, speakers, and venues. Registrations remain strong, and in some cases are growing.

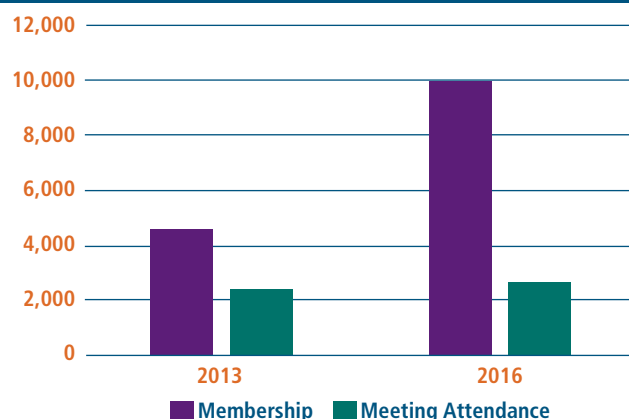
In the past eight years, our membership has grown from approximately 4,400 members to more than 10,000. While meeting attendance is strong, we still don't attract nearly as many of the newer members as we should (**Figure 1**). Even if attendance grew by 10–15%, under the old structure, we would not have the capacity to accommodate that increased attendance in the conference space or hotels.

The results of our FY2015 member needs assessment told us that people enjoy the live meetings and find them highly valuable. It is very important that we make changes to attract (and connect) as many members as possible to the core founding member groups and the Alliance.

Even Better Together

You have likely heard this tagline by now. We have embedded it in lots of places. What's most important is that it emphasizes the fact that together we can achieve the strategic goals of the Alliance. One of those goals is to expand opportunities in education and professional development.

FIGURE 1. Why Are We Doing This?



I believe professional organizations should work hard to provide ways for their members to come together, learn, share, and develop professionally. Enter the idea of redesigning and redeploying the annual meetings.


What Should You Look For?

First up is the new Fall Skills Development Conference, scheduled for October 21-22, 2016, at the Gaylord National Resort and Convention Center at National Harbor, MD. There will be plenaries, precourses, and multiple sessions over the two-day period. APDIM members will be thrilled to know that the tradition of a fall meeting will continue! Kelley Skeff, MD, PhD, will be a featured plenary speaker. You can see the more than 60 workshop offerings in seven tracks on the conference website at www.im.org. Registration opens June 24!

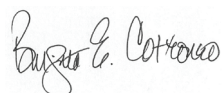
Next, the five founding member groups will convene in Baltimore, MD, in March 2017 for the new Academic Internal Medicine Week. Here's what's in store:

- APM Winter Meeting
- APDIM Spring Meeting
- ASP Accreditation Seminar
- CDIM National Meeting
- APDIM Program Administrators Meeting
- AIM Educational Conference
- APDIM Chief Residents Meeting

Attendees will be able to register for Academic Internal Medicine Week and cross-walk all the educational content and most networking opportunities. Several hotels have been contracted to provide multiple lodging choices. Sessions will be held at the Baltimore Convention Center as well as at the selected hotels.

You will have a chance to meet members from all the Alliance groups. Baltimore offers wonderful social amenities, easy access via air and rail, and a terrific place to launch our new conference model. I hope you will plan to join us in Charm City! 

Sincerely,



Bergitta E. Cotroneo, FACMPE
Deputy Chief Executive Officer and EVP



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AAIM is a consortium of five academically focused specialty organizations representing departments of internal medicine at medical schools and teaching hospitals in the United States and Canada. AAIM consists of the Association of Professors of Medicine (APM), the Association of Program Directors in Internal Medicine (APDIM), the Association of Specialty Professors (ASP), the Clerkship Directors in Internal Medicine (CDIM), and the Administrators of Internal Medicine (AIM). Through these organizations, AAIM represents department chairs and chiefs; clerkship, residency, and fellowship program directors; division chiefs; and academic and business administrators as well as other faculty and staff in departments of internal medicine.

Internal Medicine Specialists Treat the Whole Patient—The Right Thing to Do

After I graduated from medical school in the early 1980s, I did my first year of residency training in internal medicine at an outstanding Midwestern academic health center. I vividly remember the ward rounds, the call nights when very sick individuals were placed in my care, and how—more often than I wanted to admit at the time—I had difficulty interpreting conflicting history, physical exam, and laboratory findings to come up with a diagnosis (certain I would be demeaned on work rounds the next day if I didn't have a proper one) and a sound, rational treatment plan. Many sleepless nights were spent looking up antibiotic doses, ventilator settings, and drug-drug interactions in patients with compromised renal or hepatic function. Yet, even with the depth of my angst over feeling like I knew virtually nothing about proper patient care, I can still, to this day, remember specific patients (some by name) and their families who were afraid, angry, anxious, worried, or despondent. I also remember that taking just a few minutes to sit by their beds to show compassion and try to help them understand what was happening and what was going to happen made such a difference to them—and ultimately to me.

For in those moments, I began to realize that the art of medicine can often have the same healing power as the science of medicine. As I progressed through my training and then my academic career, I saw the incredible advances in medical science play out in positive ways for patients with acute (and some chronic) problems amenable to these new pharmaceutical, procedure, or device based interventions. Yet, the chronically ill patients keep coming to the hospital or the clinic and are still afraid, angry, anxious, worried, or despondent. Too often, these patients are still marginalized, ignored, and, sadly neglected. For example, the patient presents with vague, sometimes protean complaints. A good internist would take a good history, do a thorough physical exam, and order appropriate labs and/or procedures. If no abnormalities were found, too often the provider would go to the patient and say “Good news! There’s nothing wrong!” Yet, the patient’s symptoms persist or worsen, and he or she may turn to non-evidence-based providers who offer ineffective and sometimes dangerous interventions (typically secretive and expensive). Traditional providers may opt to dismiss any complementary or alternative medicine (CAM) treatments without any search for evidence to support or refute such an approach, even if the patient insists that it is working for him or her. Compound it with financial constraints that significantly limit the time that providers (both primary care and subspecialty) have to spend with individual patients in the hospital or office. Osler famously

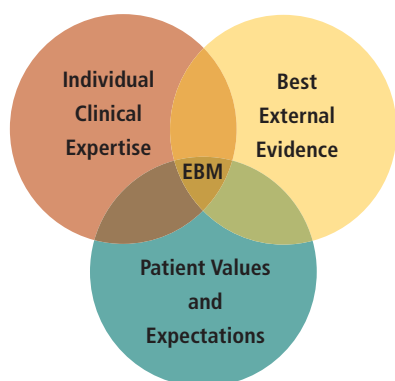
The modern expression of integrative medicine puts the patient at the center and addresses the full range of physical, emotional, mental, social, spiritual, and environmental influences that affect a person’s health.

said, “It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has” (1). The result can be a myopic focus on the science with neglect of the art. How can such a conundrum be resolved?

A fundamental function of the academic internal medicine specialist is to serve as a role model for learners. This role includes patient advocacy. While spending 30 minutes with each patient every time he or she comes for a visit or on hospital rounds might be attractive and satisfying, it is neither practical nor necessary. Ten minutes of undivided attention to the patient can make a world of difference in clinical outcomes (2). Be cognizant that a patient not only has a diseased body, but that he or she also has a mind and a spirit (some people use the term “soul”) affected by that disease, which can directly affect the disease if there is significant psychological or spiritual dysfunction (3). Indeed, in several studies looking at all cause mortalities, optimistic people live longer than pessimistic ones (4). Patients with a sense of spirituality respond better to therapies such as chemotherapy, organ transplantation, and hemodialysis (5-7). Is this just a statistical aberration or an indication of a deeper truth regarding the relationships of body, mind, and spirit?

Integrative medicine is a fairly recently described approach to patient care that can trace its roots to ancient medicine. Hippocrates wrote about the importance of diet, exercise, and outlook (optimism) on general health and response to therapeutic interventions (8). The modern expression of integrative medicine puts the patient at the center and addresses the full range of physical, emotional, mental, social, spiritual, and environmental influences that affect a person’s health. The therapeutic goal is treating the whole patient, using whatever evidence-based medicine (EBM) therapy (conventional or CAM) that addresses the patient’s specific needs. Although few of us would challenge

FIGURE 1. The EBM Triad (18)



this concept, operationalizing it in a practice setting can be daunting. Even in academic venues designed for education, time with an individual patient is increasingly limited. The reasons can be multifold—a class to teach, a meeting to attend, an experiment to perform, or, perhaps most commonly, an RVU target to achieve. We are increasingly called on to see more patients in a shorter period of time, and it makes discussions about anxiety, depression, psychological stress perception, lifestyles, and existential concerns a luxury that often seems unaffordable.

Yet data are increasingly persuasive regarding the health benefits of positive, optimistic attitudes; good dietary intake such as that found in the Mediterranean diet; exercise programs that provide cardiovascular conditioning, weight loss, and relaxation; mindfulness-based stress reduction; and spiritual behaviors ranging from religious practices to increased self-awareness (9-13). Additionally, in patients with established diseases, various modalities that address diet, exercise, stress management, and spirituality have been described for cardiovascular disease, diabetes, obstructive lung diseases, and malignancies (14-17). The effects may vary from increased longevity to improved therapeutic responses to higher quality (if not quantity) of life.

Finally, one of the major intellectual impairments to an integrative approach to patient care is that some of the practices (particularly the ones that involve CAM) are not as “evidence-based” as we might like. Yet, as described by the Cochrane initiative (Figure 1), true EBM has three parts: well-designed, controlled studies (best external evidence); our individual clinical expertise (still valued as a major component); and (too often minimized or forgotten) consideration of and respect for patient values and expectations. We as clinicians are willing to fulfill the first dictum of medicine: “primum non nocere”—first, do no harm. If we follow a philosophy of (a) keeping the patient safe, (b) not automatically prescribing a therapy because it is the “conventional” treatment, and (c) not automatically discarding any therapy (even CAM-based) that is evidence based, we will be treating the whole patient—not

just the disease. In the final analysis, isn’t that the right thing to do? ☺

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Why Are We Saving the Best for Last? “Boot Camps” Should Be Expanded beyond the Fourth Year

Medical students often graduate without all the knowledge and skills to succeed on the first day of internship (1). The advent of the core entrustable professional activities (EPAs) for entering residency renews the focus on ensuring medical schools graduate students who are competent to be residents (2). The most critical EPAs expected of a capable day one intern include “gather a history and perform a physical exam” (EPA 1), “recognize a patient requiring urgent or emergent care” (EPA 10), “perform the general procedures of a physician” (EPA 12), “give or receive a patient handover to transition care responsibility” (EPA 8), and “identify system failures and contribute to a culture of safety and improvement” (EPA 13). While some of these skills are explicitly taught in the traditional undergraduate medical education (UME) curriculum, many students do not receive structured pedagogical attention and even fewer are assessed before graduation.

As a result, program directors have long recognized that many interns begin residency without these critical skills and created intensive, hands-on “boot camp” experiences to bring new interns up to speed before starting in the clinical environment (1,3). Subsequently, UME programs began to create similar experiences (4). We created a boot camp at our institution, using the core EPAs to guide curriculum development and sought to understand how students perceived the benefits of these experiences.

Description

We built a three-day curriculum, with themes designed to correspond with several graduating EPAs (Figure 1).

Day 1: Patients and Processes (EPAs 1 and 13)

We divided students into groups of five or six. A portion of the groups spent the first half-day rotating in our simulation center through five stations focused on teaching and practicing critical physical examination (PE) skills. Each station lasted 45 minutes and was designed to ensure everyone

was able to perform the relevant PE maneuvers. The stations included were splenomegaly, ascites and hepatomegaly, pleural effusions, volume status, and heart sounds.

The remaining groups spent the first half-day developing and critiquing a quality improvement (QI) project using interactive case-based learning with an expert faculty facilitator. For this session, the facilitator instructed the students on the basic concepts of a plan-do-study-act cycle. Students chose a QI problem, determined the aims for the project, selected the process measures, brainstormed possible interventions, and reviewed simulated data points to draw conclusions about the success or failure of the intervention.

The groups switched sessions for the second half-day, allowing all participants to experience both the PE and QI sessions.

Day 2: Procedures and Protocols (EPAs 10 and 12)

Some groups spent the morning in the simulation center practicing procedures commonly encountered in the inpatient environment. Faculty from general medicine and emergency medicine as well as rapid response nursing staff facilitated the procedure training for arterial blood gas, peripheral IV placement, central line placement, lumbar puncture, thoracentesis, and paracentesis. Facilitators discussed the indications/contraindications and risks of each procedure before demonstrating techniques and allowing students to practice. Facilitators included ultrasound training when appropriate.

The remaining groups attended an interactive session with critical-care faculty on how to recognize unstable patients and provide stabilizing treatment for dyspnea, chest pain, altered mental status, sepsis, acid-base disorders, and acute kidney injury. Facilitators emphasized stabilizing therapies, methods of escalating to senior providers, and how to access hospital resources to manage emergencies.

Groups switched sessions for the second half-day.

Day 3: Communication (EPAs 8 and 13)

On the final day, students rotated among three large-group sessions: sign-out and principles of cross-cover, escalation and feedback, and code status/end-of-life care. Faculty members crafted learning objectives for these sessions and facilitated each session, along with senior residents. Each large group included breakout sessions, role play, and other methods of interactive learning.

Evaluation

At the end of each day, students completed a retrospective pre-post survey on their knowledge, skills, and attitudes related to the daily topic(s). Forty students completed the voluntary, anonymous survey on day 1, 36 on day 2, and 21 on day 3.

FIGURE 1. Curriculum Schema

	First Section	Second Section	Third Section
Day 1	Physical exam skills	Quality improvement workshop	
Day 2	Procedure training	Recognizing the unstable patient	
Day 3	Escalation	End-of-life communication	Handoffs

Results

On day 1, we detected increases in PE skill confidence ($p < 0.0001$). Students reported gains in feeling “moderately” or “extremely” comfortable in all surveyed QI domains. Day 2 yielded increases in procedure confidence ($p < 0.0001$), ability to recognize a “sick” patient ($p = 0.0039$), and confidence in initiating the care of decompensating patients (multiple patient types, all p -values < 0.0040). On day 3, we identified increases in comfort with communication skills, including those related to hospice and palliative care ($p < 0.0001$), notifying an attending of a change in patient status ($p < 0.0001$), and performing a handoff ($p < 0.0001$).

Figure 2 summarizes the 10 domains with the lowest percentage of students reporting “high confidence” in their pre-assessment. **Figure 3** summarizes the 10 domains with the greatest increase in the percentage of students reporting “high confidence” in their post-assessment.

Discussion and Conclusions

Our boot camp was unique in that it was developed with the EPAs in mind. Survey data indicate this experience significantly improved student self-assessed knowledge and skills in several domains important for new interns. Distressingly, we found many of our students entered the boot camp with significant confidence deficiencies in critical areas of practice for new interns. Finding ways to assess and address these deficits earlier in the medical education curriculum continues to pose a challenge and reinforces the need for the

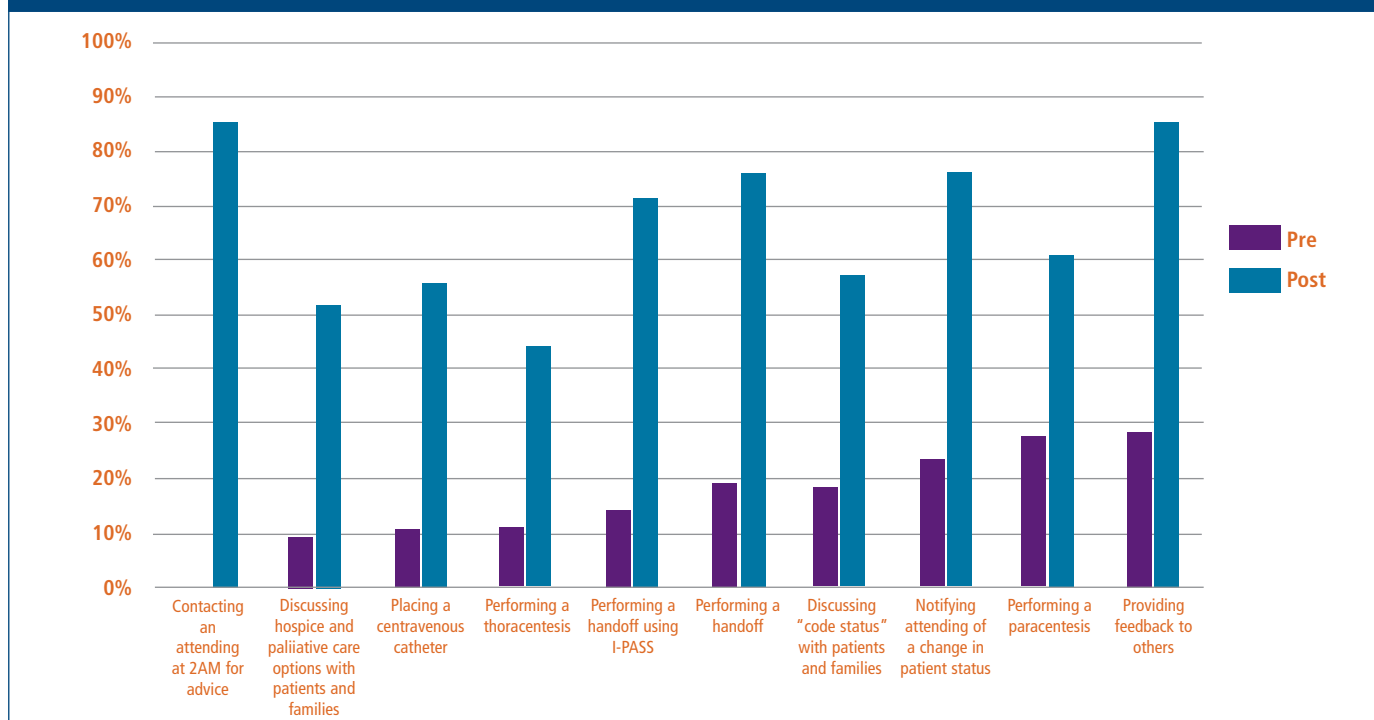
EPAs, both as a guidepost to prospectively develop curricula that enhance the skills of graduating students and to create appropriate assessments for those skills.

Faculty at our institution and others have been encouraged by the perceived efficacy of boot camps. This enthusiasm is understandable, given students seem to enjoy the experiences and achieve positive, measurable outcomes. Additionally, boot camps appear to achieve these results over just a few short days. Unfortunately, as seen in our data, the skills in which students are least confident do not always improve the most over short periods of time. Additionally, the positive outcomes are likely transient, given the limited opportunity for practice before graduation, and implementing boot camp curricula can be exceptionally labor-intensive for faculty.

To decompress the required faculty time and enable more student exposure to EPA-related skills, we believe these skill-based experiences with focused feedback should be delivered before or during most clinical clerkship rotations—and not relegated to the weeks before graduation. Ideally, each clinical rotation would create a “mini boot camp” or “EPA workout” experience for a subset of skills most relevant to that rotation. The pre-graduation boot camp could then become a final “booster” as part of an overall EPA-focused curriculum.

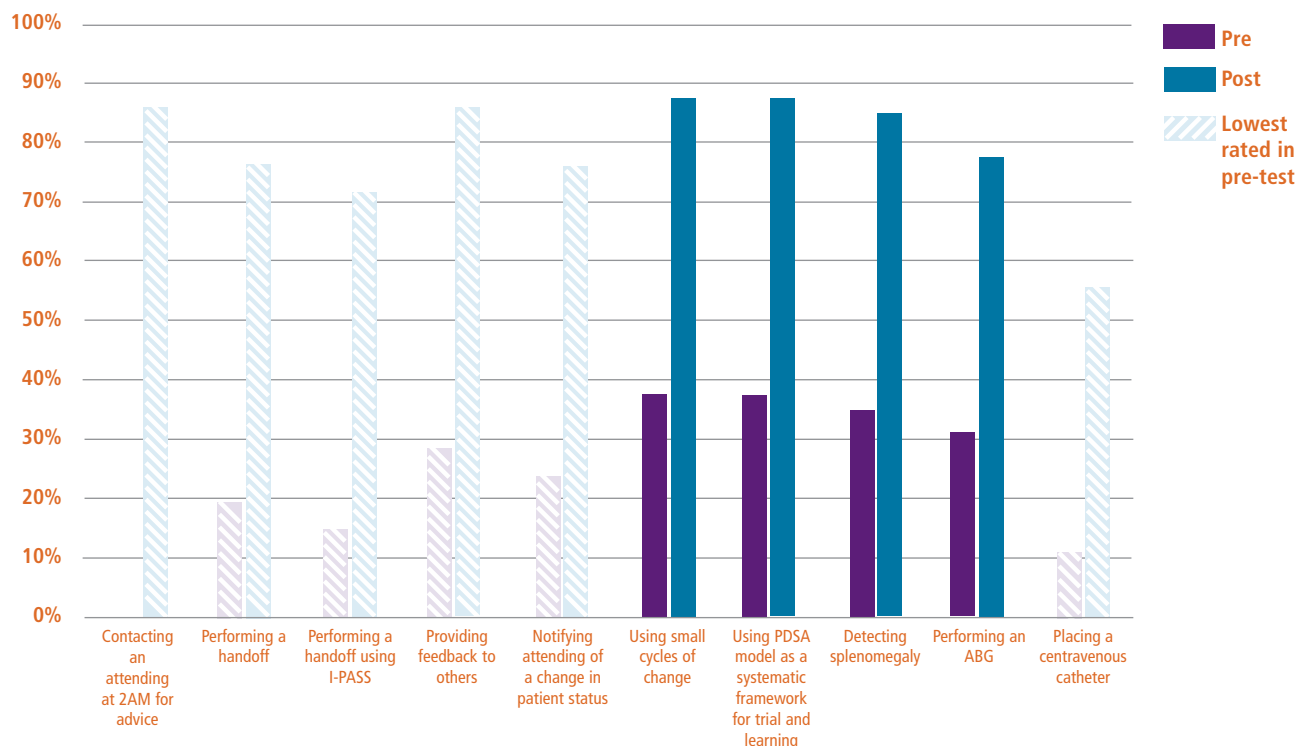
Waiting until spring of the fourth year to focus on either acquiring these skills or assessing them leaves little time for students to achieve reasonable levels of competency or to remediate deficiencies that may affect their ability to perform

FIGURE 2. Competencies with Lowest Percentage of Students Reporting “High Confidence” in Pre-Test Assessment



continued on page 8

continued from page 7

FIGURE 3. Competencies with Greatest Increase in Percentage of Students Reporting “High Confidence” in Post-Test Assessment

as an intern. By frequently and systematically demonstrating the skills and competencies we want students to develop, we can expect a higher level of performance during clinical rotations, at the time of assessment, and most important, by graduation. 🔄

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Elevate Wellness: Unlocking the Potential of Creative Problem Solving to Improve Wellness in Residency Programs

Wellness is a popular buzzword in need of practical implementation. Workplace wellness, in particular, has long been a part of human resources in non-health care industries, yet has been slow to pick up in the health care industry itself (1,2). For physicians and learners, wellness programs can serve as a proactive and integrative solution to burnout in the residency learning environment.

The data on burnout is clear: 25–75% of residents are burnt out at any given time, depending on specialty. Burnout leads to poorer patient care, along with increased medical errors, rates of substance abuse, suicide, and intent to leave practice (3,4). This issue has reached national attention. In 2014, American Medical Association President Robert M. Wah, MD, declared physician wellness a global issue at the International Physicians Health Conference, calling for systematic and cultural changes in medicine to support the physical, mental, and emotional health of physicians (5). As educational leaders, our ultimate goal is to cultivate training programs that foster healthy lifelong practices of being a physician in medicine.

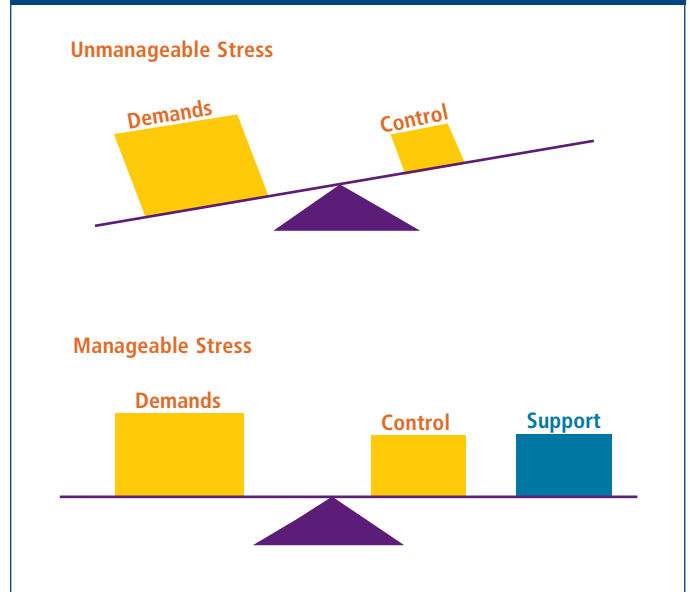
While representing a valuable effort towards addressing resident wellness, duty hour reforms have had their limitations. A growing body of data suggests limited actual efficacy in thwarting patient safety errors and reducing burnout (6,7). Duty hour reforms approach physician stress through the single axis of time. The multivariable Karasek demand-control model is a useful framework to understand physician stress as a state of equilibrium, as described by Mark Linzer, between demands (work hours) and control (flexibility) (Figure 1). In this balanced state, it is possible to achieve a state of eustress or beneficial stress. Eustress, in contrast to distress, allows residents to view clinical and professional challenges as opportunities for achievement and progress (8,9).

Formalized wellness programs provide added support and control to the demands of residency and balance stress and burnout. Some advantages include that they are communal, individualized to programs, and do not conflict with patient care. Rather than propagating a “hidden curriculum” of foregoing self-care during training, formalized wellness programs promote a transparent and lifelong curriculum of personal wellness.

The Osler Wellness Program Model

The creation of the Osler Wellness Program was prompted by the unexpected passing of a bright senior resident in the Osler Internal Medicine Residency Program. Through her family’s generosity and interest in promoting excellence through

FIGURE 1. Unmanageable Stress v. Manageable Stress



wellness, the program was able to work with the Daylight Consulting Group to learn how to use “design thinking” to create an effective and implementable wellness initiative.

Design Thinking

Design thinking is a problem solving methodology that has long been used in the engineering, architecture, and business worlds as a formal method to creatively, collectively, and iteratively solve problems. This approach differs from the analytical scientific method in that it starts with the solution rather than the problem (10,11).

The Stanford Design School has created a prototype of the Design Thinking Process (Figure 2).

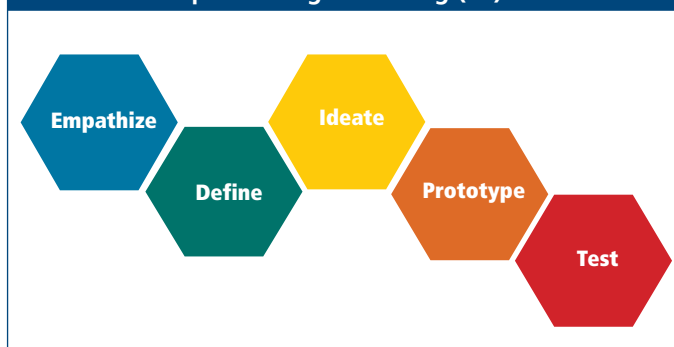
Our program utilized the design process to create the Osler Wellness Program in three simple steps: assess needs, brainstorm ideas, and conduct trials.

Step One: Assess Wellness Needs

In the Osler Wellness Program, a wellness needs assessment was conducted via interviews with residents, involved faculty, administrators, chief residents, and alumni. Maslow’s Hierarchy of Needs (Figure 3) stratifies human needs into physiologic (food, water), safety (shelter), belonging (family, friends), self-esteem (achievement), and self-actualization (creativity

continued on page 10

Continued from page 9

FIGURE 2. Steps in Design Thinking (12)

and fulfillment). Interestingly, physicians often meet their higher order needs such as financial security or meaning of work and they poorly rate their more basic needs such as food, sleep, or protection (13,14). Based on this initial needs assessment, the Osler Wellness Program identified overwhelming support for the need for water availability, fresh and healthy snack choices, errand support, and psychospiritual support.

Step Two: Brainstorm Wellness Ideas

The creation of a wellness committee enables sharing and spreading wellness ideas. The ideas need not be costly, since low resource, high-impact interventions often work the best. We conducted online polls to determine which interventions would be the most popular, with the resulting interventions chosen:

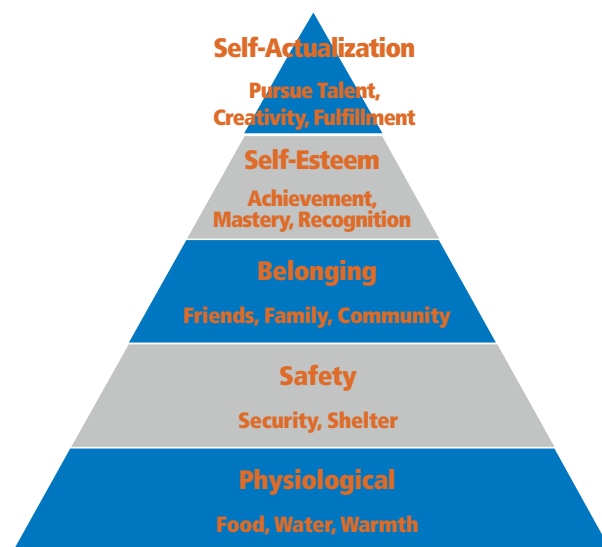
- Fuel the Firm: bimonthly delivery of healthy snacks
- Rethink Noon Lunch: healthy revamped local catering options
- Aquanimitas: Accessible water options (bottle, fountain)
- Easy Chores: Cleaning services with negotiated discount rates
- Osler's Hope: Psychospiritual support group

Step Three: Conduct Wellness Trials

Prototype trials were conducted to see which programs were successful and which needed modulation. The Aquanimitas Water initiative was the most well received intervention. Initially, the Aquanimitas intervention supplied water coolers to every resident office. Upon move to a newly renovated clinical facility, this model could no longer thrive within current building code regulations. The core of design thinking is using even failure as opportunities to brainstorm and launch initiatives back again. Instead of individual water coolers, the Wellness Committee brainstormed to bring water bottle packs to each office, in addition to disseminating information about the availability of water dispensers on each floor.


Lessons Learned

Almost anyone can create a wellness program. The key is in identifying what is important to your individual

FIGURE 3. Maslow's Hierarchy of Needs

program and what wellness needs are optimal to address. It is important to have people invested, preferably in the form of a wellness committee, with leaders within each class to engender class support. The interventions brainstormed need not require many resources but do require creativity and the desire to make a meaningful difference in a resident's life. Branding the interventions highlights the intention of having a wellness program, linking big and small efforts.

Initially conducted as a quality improvement project, the wellness program used the Maslach Burnout Inventory survey to understand burnout rates of residents (15). Pre-wellness intervention, it was found that 96% of 66 internal medicine residents reported burnout in 2011 versus 90% of 47 residents reporting burnout in 2014 ($p=0.35$). In 2011, 55% reported high burnout compared with 48% reporting high burnout in 2014 ($p=0.53$). Despite the implementation of a wellness program, the studies did not show a statistically significant difference. Certainly more studies within our own institution and across institutions need to be conducted to demonstrate any effect formalized wellness programs may have.

The establishment of formalized wellness programs in residency is a potential step in providing residents the resources they need to manage the challenges and rewards of the practice of medicine. Elevating wellness is an adaptable and communal response to the need for balance, positivity, and meaning in the lives of physicians and learners. 

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Training Internal Medicine Residents and Faculty to Deliver Culturally Competent Care and Eliminate Health Care Disparities: How Do We Meet the Challenge in Efficient and Effective Fashion?

The Accreditation Council for Graduate Medical Education (ACGME) has explicit expectations that residency programs train residents and faculty to deliver and evaluate culturally competent care and that residents are engaged in clinical site initiatives to address health care disparities (1,2).

In an effort to understand the current state of internal medicine's efforts to meet accreditation requirements for cultural competency and health care disparities and to determine the needs of the graduate medical education (GME) community, the AAIM Diversity and Inclusion Committee disseminated a confidential survey to internal medicine residency program directors. A 2007 survey of internal medicine program directors revealed barriers to teaching effectively about cultural competency due to shortages of qualified faculty and a lack of standardized curricula. The 2014 survey sought to establish what had changed and what the community required to help support their efforts (3). Early findings of the CLER site visits implemented as part of the Next Accreditation System revealed variable focus on cultural competency and that reducing health disparities was largely not part of the an institutional strategic quality improvement plan, generally developed on an annual basis (4).

Results

We surveyed 391 program directors (PDs) with a 45% (177) response rate (5). Responding programs reflected adequate geographic diversity and adequate university and community hospital representation. While 76% of responding PDs stated that residents received training in cultural competency and 71% stated that they received training in recognizing health care disparities, only 35% felt that there were sufficient faculty members competent to train residents on health care disparities and cultural competence. Only 24% of PDs stated that faculty development on cultural competency and health care disparities was provided and about 25% stated that their faculty could evaluate residents on their ability to practice culturally competent care. Only 18% were satisfied with the tools available to evaluate residents on their ability to provide culturally competent care. While the majority of PDs (70%) surveyed agreed that their institutions had an explicit commitment to identifying and reducing health care disparities, less than 20% reported that data on ethnicity/racial/language specific differences at their institutions were disseminated. Reported barriers to implementing curricula on

cultural competency and health care disparities were lack of faculty expertise (68%), not enough institutional resources (62%), and not enough time (67%). Interestingly, only 14% of PDs reported a mechanism in place to evaluate language competence in a language other than English in their residents.

These data reflect a need to ensure adequate faculty and resident development to care for what is an increasingly diverse patient population. There is clearly a need for valid and effective assessment tools in this area. Finally, there may be a need to assess resident self-declared linguistic ability in a language other than English prior to allowing the resident

FIGURE 1. Kern's Six Steps for Curricular Development (6)

1. Problem Identification and General Needs Assessment

Whom does it affect?
What does it affect?
How is it currently being addressed and what is the ideal approach?
What factors affect the problem?
Who are your stakeholders?

2. Needs Assessment for Targeted Learners

Who are the targeted learners?
What are their current characteristics (training, proficiencies/performance, learning styles)?
What are their ideal characteristics?

3. Goals and Objectives

Goal Statement: Who? What? Where? Why? When?

4. Educational Strategies

Methods

5. Implementation

Resources
Time
Facilities
Funding
Support
Barriers
Introduce curriculum (pilot, phase-in, full)

6. Evaluation and Feedback

Formative
Summative

to communicate with patients with limited English proficiency (LEP) to ensure adequate patient-physician communication.

At Stamford Hospital, a multi-disciplinary process was implemented to engage with institutional leadership on the issues of cultural competency and health care disparities and address the need to assure faculty and resident development in this area. Stamford Hospital is a “Planetree-designated institution,” which requires that participants in that health care delivery system provide access to understandable health information to empower individuals to participate in their care. Demographics of Stamford, CT, reveal a large LEP population. Residents from all residency programs [n=65] at

the hospital were surveyed on their experiences with patients with LEP; we found that the majority of residents surveyed deferred using an interpreter for a patient not fluent in English at least 25% of the time and only informed patients of their right to interpretation services when a family member/friend was present 38% of the time. The results indicated a need to educate residents (and likely faculty) about the rights of patients with LEP and provide additional training in cultural competency.

The PDs of all residency programs at Stamford Hospital applied for and won a patient safety grant to implement an online curriculum in cross-cultural care sponsored by the Disparities Solutions Center to be delivered to all residents and core faculty. The objectives of the curriculum “Quality Interactions on Cross Cultural Care: A Person Centered Approach” are to summarize how cultural competence is important to the delivery of high-quality health care, define the social and cultural issues that are most relevant in the care of diverse populations, communicate effectively across cultures, and develop appropriate management strategies that take cultural perspectives and preferences into account. The multiple benefits of applying for the grant include that it demonstrated an interdisciplinary process, heightened institutional awareness, identified adequate formal interpretation as a patient safety issue, and promoted faculty development efficiently. Additionally, the curriculum led to an assessment tool that allows direct observation of residents practicing culturally competent care and evaluates ability to negotiate complicated transactions with patients from diverse backgrounds. This tool additionally allows the learner to engage in self-reflection about what their expectations were when they first encountered the patient.

At Lenox Hill Hospital in New York, patient self-reported ethnicity is included on a panel management database that will eventually allow primary care clinic physicians to determine health care disparities in preventive care and performance measures in chronic disease management. This data was previously unavailable due to the rise of “color blindness” as a strategy to eliminate bias in the care of diverse groups.

Faculty who need to develop a robust curriculum in cultural competency and health care disparities can utilize Kern’s six steps for curricular development (Figure 1) (6). As part of that process, they should aim to develop a shared mental model about what constitutes a culturally competent physician in training. Performing a needs assessment of the patient population at the institution where the residency program is seated is essential to focus efforts in ensuring culturally competent faculty and residents and mitigating health care disparities in an environment of limited resources and time. Suggested curricular resources that can be reviewed for applicability for a specific patient population and institution are in Figure 2.

During a seminar presented as part of a recent APDIM meeting, participants agreed that an independently practicing

FIGURE 2. Curricular Resources on Cultural Competency

Expert Panel on Cultural Competence Education for Students in Medicine and Public Health (2012). Cultural competence education for students in medicine and public health: Report of an expert panel. Washington, DC: Association of American Medical Colleges and Association of Schools of Public Health. Online.
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Stanford University Center for Biomedical Ethics. *Worlds Apart: A Facilitator’s Guide. A Four Part Series on Cross Cultural Health Care*. Online.
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DiversityRx. *Cultural Competence Training*. Online.
<http://www.diversityrx.org/topic-areas/cultural-competence-training>.

Continued on page 14

continued from page 13

physician should be able to consistently use professional translation services with LEP patients, actively work to reduce health care disparities by making unbiased management decisions, and utilize data to identify disparities and implement interventions to address them. Additionally, the group felt that physicians should elicit patient illness and treatment belief systems by utilizing Kleiman's explanatory model (7) or other principles of cross-cultural communication (Figure 2).

Accreditation requirements provide a unique opportunity for the GME community to advocate on behalf of their patients by underscoring the need for access for data across race, ethnicity, language, gender identification, sexual orientation, and religion. Faculty development in cultural competency must occur, and should occur concomitantly with resident education. An assessment of faculty expertise in delivering culturally competent care should become part of resident evaluations of faculty. Finally, tools to assess resident competence in this fundamental area of patient care are needed and should be shared among the GME community. 

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Designing a New Subspecialty Training Fellowship: Education Theory and Work Redesign

In July 2016, Creighton University and Catholic Health Initiatives Health will welcome the first cohort of fellows for gastroenterology subspecialty training. Our number of accomplished faculty, training sites, clinical volume, and level of funding are similar to other institutions. Keeping up momentum for new projects today when such clinical and academic missions face so much competition for resources is difficult. Instead, the real issues to address in designing a fellowship are educational theory and work redesign for faculty.

We began work on the fellowship four years ago with recruitment of faculty with a specific paradigm in mind. No education is value free. Every academic discipline transmits its assumptions about the human person and human society. We follow the Ignatian pedagogical paradigm (context, experience, reflection, action, evaluation) (1) and chose our faculty accordingly.

Pedagogy

Context requires that the teacher become conversant with the life experience of the learner, understanding student life and culture. Additionally, the teacher must be attuned to the actual environment in which the teaching and learning are to take place. For instance, our hospitals across Omaha care for different patient populations and therefore are different learning environments. It is important to acknowledge when learners are dealing with socioeconomic issues that are likely to evoke strong feelings.

Experience means that the teacher creates the conditions in which learners gather and recollect the material—in addition to helping them gain a cognitive grasp of the lesson, some affective engagement is registered by the learner.

Later, the teacher guides the learner in assimilating the new information. The opportunity for reflection is an important part of the paradigm. Reflection allows the learner to capture the actual meaning for self and others of what is being studied. Helping the learner develop an ongoing habit of reflection helps him or her maintain clinical excellence but is also a critical factor in helping the learner grow more into his or her identity as a professional who also practices the art of medicine. Further, a well-developed habit of reflection can assist the learner in becoming more resilient and in maintaining a healthy work-life balance.

Action is the external expression of learned content. Teachers foster decision-making and commitment among the learners. Evaluation of learner growth is a step all teachers know. But in addition to academic mastery, we evaluate learner growth as a professional. Proper evaluation requires that teachers be alert to the uniqueness of each learner, which might then call for alternative methods of instruction. Proper

evaluation should sharpen the understanding of the context in which learning takes place. Context, experience, reflection, action, and evaluation become an ongoing pattern. The aim of this Ignatian pedagogy is the fullest possible development of the learner, both for her or his own sake but especially for the greatest possible benefit for the learner's future patients (and their future students).

A consistent educational theory is the first hurdle in designing a new fellowship program, before funding, curriculum design, and service sites. Because of the educational theory we follow, we select faculty who in addition to being bright and accomplished are engaging and reflective as well as have a diverse range of outside interests. All current faculty—not just the chair and division chief—are involved in the interview and selection process for new faculty members. Candidates must fit the culture. They must be comfortable conversing about the moral dimensions of the practice of medicine and demonstrate a persuasive personality. We consciously try to discern how a potential teacher relates to students, and how he or she conceives of learning. We use the same criteria in selecting gastroenterology fellows. Again, all faculty interview and evaluate each candidate for fellowship training. We expect that these learners will all be potential faculty.


Design to Motivate

The next hurdle is work redesign. Today, all clinical faculty are stressed and overcommitted with routine work. Introducing a new training program significantly increases the demands on everyone in the division. Protected time and appropriate compensation are built into the planning. However, alone it is insufficient to convince the division to undertake the increased demands of a fellowship. Compensation motivates people, but diminished teamwork, a focus on short-term goals, and political behavior are potential risks. To attract and retain gifted faculty, institutional leaders must engage in work redesign. They must give faculty challenging, interesting, and meaningful work.

Hackman and Oldman suggest ways to design a job to motivate people (2). The principles are similar to the ones we used to design our new fellowship. Allow faculty to tap into a range of skills and abilities and they will be much more motivated than with focusing on one skill. Faculty should have the opportunity to work on a whole task, start to finish, rather than piecemeal. We used this format to plan our application for fellowship. If faculty understand the significance of the undertaking and the benefit to the organization as a whole, they can see the great impact that their actions will have. Though working as a team, faculty must have some level of autonomy and division leaders must give clear and immediate

continued on page 16

continued from page 15

feedback. A consistent educational philosophy and generating intrinsic motivation do not create funding sources or clinical volume. However, those tangible resources alone will not be sufficient to move an organization to create a new training program. 

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Promoting Yourself: The Role of Executive Presence, Coaching, Sponsorship, and Resilience in Leadership Development

Most academic health care institutions in this country are undergoing rapid and significant change. As these systems become consolidated and increasingly corporate, it is critical that physicians aspiring to leadership roles enhance their personal attributes and develop professional connections that will help them advance within these organizations. The pace and magnitude of change within the health care industry necessitates greater resilience among physicians trying to thrive and advance in these new environments. Strategies such as executive presence, coaching, and sponsorship in career development originate in corporate America but apply to professional advancement within academic health care institutions. Recognition that resilience is inherent to and built from participation in career development activities provides insights useful for emerging leaders.

Executive Presence

Presence, commonly referred to as “executive presence,” involves presenting your best self, highlighting strengths and attributes in a consistent and authentic manner. Importantly, personal brand comes not from first impressions alone but more from impressions made over time (1). Presence can be honed with intentional effort. Remaining mindful of how you are perceived can lead to positions that resonate with strengths (2). The ability of others to assess an individual’s skills and potential may facilitate mutually satisfying mentoring and sponsoring relationships.

Presenting an authentic self does require a degree of emotional intelligence (EI) and involves awareness in various realms. EI includes self-awareness, self-management, social awareness, and relationship management (3). Self-awareness can more effectively allow you to prepare for any circumstance, from meeting with a supervisor to appearing in front of a crowd. Confidence attained from adequate practice to refine how your message is conveyed through appearance, actions, and words cannot be overestimated. Common desirable qualities that promote connection with others are approachability, humility, sincerity, having a sense of humor, being engaging, and taking risks. In contrast, common detractors include being self-absorbed, over-rehearsed, playacting, overly technical, insecure, and pessimistic. In addition, how you move, such as having an open stance and smiling can convey friendliness, openness, and mutual understanding. Your tone of voice, with the appropriate pace, pitch, and projection, when bolstering a choice of language that is clear, concise, and compelling can

Studies have demonstrated that in highly effective organizations, leadership behaviors accounting for approximately 90% of success are being supportive, operating with strong results orientation, seeking different perspectives, and solving problems effectively

more strongly convey your passion for a topic or cause (1). These skills can open doors regardless of seniority or status in an organization. Preparing for important encounters ahead of time (including the oft-feared “elevator speech”) will maximize the outcomes of spontaneous inflection points in your career and personal life.

Individuals who demonstrate consistency between their intentions and behaviors are viewed as stronger leaders. Studies have demonstrated that in highly effective organizations, leadership behaviors accounting for approximately 90% of success are being supportive, operating with strong results orientation, seeking different perspectives, and solving problems effectively (4). It is easy to understand how polishing your personal brand to enhance the connecting qualities would lead to such results.

Coaching

Promoting self-awareness and processing feedback into actionable behavior change still true to yourself can be daunting but can be facilitated by using a “thinking partner” or coach. Distinct from traditional mentoring, coaching serves to enhance awareness and promote coachee-generated goals rather than providing prescriptive advisement from an expert viewpoint (5). Many organizations across the country in the corporate world are increasingly using coaching and believe that it is associated with higher performance, both individual and organizationally (6).

Various coaching frameworks exist. The ones founded in positive psychology may be of particular benefit to physicians but the approach is radically different from traditional clinical

continued on page 18

continued from page 17

Working with a coach can help an individual to feel empowered to create the future and may facilitate resilience, driving the ability to advance and succeed.

training. Positive psychology is “the scientific study of what enables individuals and communities to thrive” and is an important underpinning of resilience (7). Clinical training is problem-focused and leads us to be deficit thinkers. When physicians approach a patient, they focus on what their clinical problem is and explore all facets related to that problem to diagnose the underlying cause and then devise a plan to intervene. As physicians become expert, it becomes natural to employ this same method to all contexts in which we live, including professional development and leadership skills. The limitations lie in the constraints it imposes on openness to alternate perspectives, feedback, and exploration of possibilities.

A deficit-based approach to development or leadership orients the brainstorming around failures and barriers and often on factors outside of our own control, limiting options and innovation. Coaching from an asset based perspective can help a coachee to re-frame the view of a circumstance to a future orientation and to envision success, creating positive internal emotion that helps to build confidence around factors within their control to change and expand options (8).

Working with a coach can help an individual to feel empowered to create the desired future and may facilitate resilience, driving the ability to advance and succeed. Coaching provides a framework for asset-based thinking. It requires a unique skillset based on deep listening and asking questions that stimulate reflection rather than giving advice. Coaching is available historically through external contracting and increasingly through developing internal programs.

Sponsorship

Sponsorship, i.e., having a highly placed person in the organization that spotlights and opens doors for a highly talented individual, is another activity that has been shown to significantly impact growth and advancement. Sponsorship is a mainstay of leadership development in the corporate community and may be a critical component to career success within a large academic health care organization. Sponsorship differs from traditional mentorship by focusing on active endorsement rather than passive advisement. In corporate America, it has been shown to enhance promotion, facilitate stretch assignments, create upward pressure in pay, and improve gender parity in career advancement (9-11).

Sponsors, because of their senior position within organizations, have the opportunity to influence decisions about professional advancement and to offer public support and advocacy for unrecognized talent. Successful sponsors provide protégés with exposure to other leaders, ensure they are considered for promising assignments, actively advocate for their promotion, and provide protection when needed (9). Although initially fueled by the sponsor’s efforts, the sponsor-protégé relationship is not one-sided. Successful protégés should be trustworthy, loyal, and self-directed. They should also capitalize on their ability to keep sponsors apprised of critical developments and constituencies within the organization and recognize that their ascent within the institutional hierarchy also expands the impact of their sponsor (10).

Sponsorship activity, especially for women, is more likely to occur when formal programming is in place (9,11). To that end, academic programs should invest in sponsorship initiatives that are distinct from mentorship initiatives, match talented individuals with highly placed members of their organization, expect a targeted development plan, and have oversight and accountability (9,10).


Resilience

To optimally promote yourself and thrive in the rapidly changing health care environment, physicians need to be resilient: able to recover readily from adversity. Resilient people understand and accept reality, find meaning in difficult times, and make do with available resources (12). Resilience allows individuals to bounce back after facing challenges. The ability to accept reality is critical, as it frames the development of effective and innovative strategies within the local culture. For example, definitions of success within practices, programs, and systems are changing rapidly in the face of health care reform. Though it is painful to accept that past achievements may not be viewed as valuable in new formats, recognition of this reality must inform brainstorming about new approaches. Ties to personal and organizational values provide a bridge to a better future.

Resilient physicians learn to incorporate sustaining elements in their everyday professional and personal activities. Based on detailed analyses of structured interviews with physicians in a variety of practice settings, Zwack and her colleagues recognized that job-related gratification, like the physician-patient relationship and the ability to positively impact the health of patients, are sources of resilience (13). In addition, they identified resilience-building practices, routines, and attitudes, such as leisure time activities, spending time with family and friends, spirituality, and self-organization. Interestingly, daily practices that build self-awareness and professional relationships were also frequently cited by resilient physicians (13).

Emerging leaders have the opportunity to promote resilience in others through their attitudes and practices. Shanafelt and his collaborators found that physician

satisfaction was higher in departments whose leaders were attentive to physician personal and professional growth (14). As a bonus, activities that benefit others are renewing and reinforce resilience (15).

Executive presence, coaching, sponsorship, and resilience are all highly intertwined concepts essential for leadership development. EI provides the relationship focus for executive presence, coaching, and sponsorship. Coaching can help to raise that self-awareness and expand options, which builds resilience. Likewise, resilience is a foundational characteristic that enables leaders to sustain and thrive, which will be strengthened by participation in activities that build EI, facilitating personal and professional advancement. Strengthening familiarity and practice of these concepts can help to promote essential skills, personal growth, and a reputation of exceptional leadership. 

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An Effective Quality Improvement Curriculum in a Large Internal Medicine Residency

Quality improvement (QI) and patient safety (PS) curriculum has become an integral part of graduate medical education (GME) in the past decade. In the wake of the 1999 Institute of Medicine report on medical errors, along with its recent report on the need for GME reform, residency programs must develop innovative ways to insert QI principles into their program syllabus (1-3). Duty hour restrictions and the increasing number of program requirements mandated by the Accreditation Council for Graduate Medical Education

Our challenge was to create an effective intervention that would teach each resident the necessary skills to implement a successful QI initiative

(ACGME) make it increasingly difficult (4). Specifically, ACGME asks that housestaff not only learn QI and PS methods, but also directly participate in a QI initiative (5). It becomes even more difficult in large residency programs, where there are often more than 100 residents per class (6). The University of Southern California internal medicine residency is one of the largest programs in the nation, with a total of 165 categorical housestaff. Our challenge was to create an effective intervention that would teach each resident the necessary skills to implement a successful QI initiative.

Methods

The intervention began in 2013 and was planned with the expectation that all housestaff will complete the curriculum in three years. Each year, the duration of the curriculum was eight months. Subjects were divided into three groups and a core faculty member delivered two hours of QI education to each group. The first hour included an introduction to plan-do-study-act models and cause and effect (fishbone) diagrams, delivered in a problem-based learning format. The second hour included a root cause analysis using the three tiers of error model and an actual case example from the hospital. The didactic series occurred in August of each year. Prior to the instruction, each intern completed a pre-intervention survey assessing his or her knowledge of the above topics.

In September, the subjects were divided into eight groups based on their subspecialty or career goals. The groups met every four weeks from September through March to plan

and enact a QI project based on their career interest. Each group was led by a core faculty member and implemented one intervention. The faculty member gave a one-hour lecture during the first meeting to review didactics from August.

The interns were asked to complete a post-intervention survey in January during the project implementation phase to assess their knowledge and ability to implement a QI project. The survey was distributed electronically via email, with three reminders sent by the chief residents to complete the survey.

In addition, the ACGME resident survey data were reviewed to look for an improvement in the question assessing resident QI participation. The full intervention was completed with the intern classes of 2013 and 2014 to assess durability of ACGME resident survey improvement.

Results

Thirty-seven interns completed the full curriculum in the 2014-2015 academic year. Of those 37 housestaff, we obtained pre- and post-intervention survey data from 20 subjects. The survey response rate was 54%. The survey questions measured knowledge and comfort with QI topics. Using a two-tailed paired t-test, survey questions mean scores increased significantly from pre- to post-intervention, indicating an increase in resident self-assessment of knowledge and comfort with QI (Figure 1).

Prior to the intervention, three people reported being involved in a QI or PS project before residency. After the intervention, the number increased to seven people. The ACGME resident survey data assessing QI participation are reported pre- and post-intervention from 2013-2015 in Figure 2.

After the completion of the curriculum in March 2015, four projects were completed, had abstracts accepted at a

FIGURE 1. Pre- and Post-Intervention Survey Data

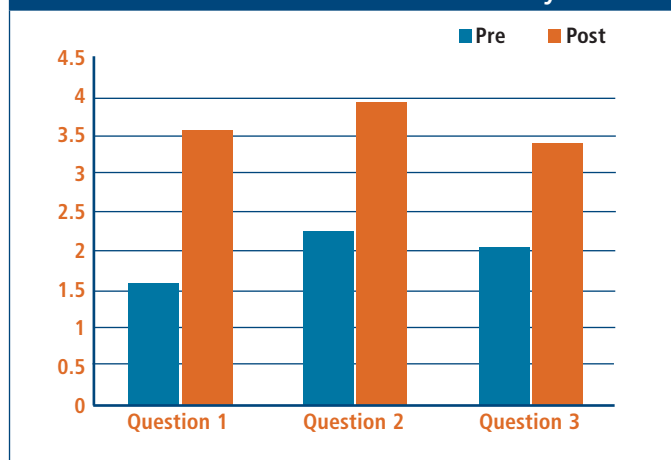
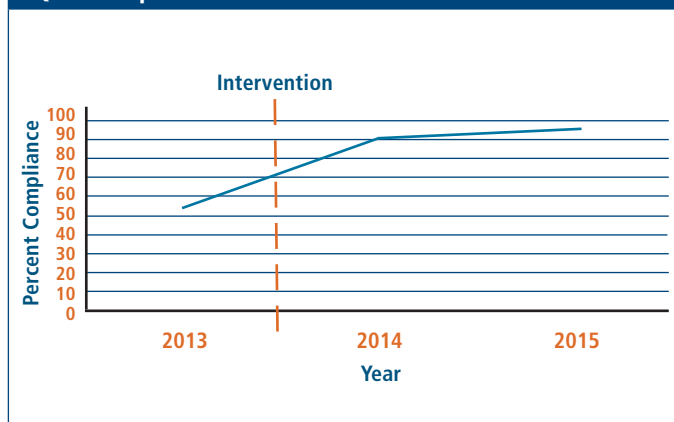


FIGURE 2. ACGME Resident Survey Data Assessing QI Participation



conference, and produced changes in policy at our institution. Two of the projects were in the data collection phase and the final two projects were in the pre-implementation/planning phase.

Discussion

Achievements

We were able to develop an effective QI curriculum with a high participation rate in a large internal medicine residency program. By using core faculty members and forming small groups, each subject was able to take an active role in his or her QI initiative. Resident buy-in was supported by making each group specific to individual career interests. Allowing one year to complete the planning and implementation phase permitted the residents to integrate the QI project into their busy schedules. The group size of seven to 10 people allowed for work to continue at an even pace throughout the year and gave the project different perspectives. The initial two hours of instruction was also given in small groups, which allowed for a problem-based learning format. This format has been shown to increase both initial and sustained learner retention (7). The QI concepts were reinforced a second time by core faculty members; therefore, the housestaff had repeated exposure to key theories.

Notably, the number of residents who indicated they were involved in a QI or PS project increased significantly on the post-intervention survey, which was attributed to increased knowledge of what constitutes a QI project and resident realization that they had participated in a project in the past. Additionally, the ACGME resident survey data showed that it is possible to have greater than 90% compliance with the QI participation question when the curriculum continued.

Challenges

The post-intervention survey response was at 54%. The survey was sent out anonymously by email and the investigators sent out the survey link three additional times to increase the

response rate, which may have created selection bias toward the housestaff who felt the curriculum was more worthwhile. However, the ACGME survey data show that the vast majority of each class felt they had directly participated in a QI project.

It was also difficult to retain resident and faculty interest, and the participation rates did drop as the year progressed, likely due to burnout, lack of faculty buy-in, and time constraints. Perhaps more faculty instruction surrounding QI and PS implementation skills would help both faculty and resident retention. In the future, we plan to continually assess project completion rates and have a route to implementation on an institutional scale if residents are especially interested. Involving the hospital administration directly with the QI groups may help with global participation as well as move each project forward. Involving senior residents who have completed the curriculum may also help with faculty time constraints and burnout. 🌀

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From “I” to “We”: Defining Multidisciplinary Teams at an Academic Cancer Hospital

Health care organizations, and academic institutions in particular, face significant challenges to provide higher quality care in a time of diminishing resources. Given that labor accounts for an average of 50% of total operating revenues in US hospitals, it is not surprising that ideas are emerging about how to extract more value from our teams. Moreover, academic leadership teams struggle to balance the priorities of outstanding patient care, superb education and training, and cutting-edge research (1). On the care delivery aspect, integrated and multidisciplinary teams have been linked with superior-quality outcomes, including reduced mortality (2). The benefits of a team-based approach, in contrast to the more traditional individual physician-based model that has permeated the practice of medicine in the United States for more than a century, include a more efficient coordination of care, a decrease in redundant and unnecessary care, and a more rational utilization of resources, all leading to a better patient experience.

Breakthrough innovations in cancer medicine have resulted in more complex and expensive treatments, which require a higher degree of multidisciplinary care (3). The focus on treatment results is no longer sufficient. To optimize outcomes in a cost-efficient manner, a tightly orchestrated continuum of care is mandatory, from screening to diagnosis, active treatment, and end-of-life planning (2). While multidisciplinary care denotes the involvement of a variety of connected disciplines with different types of expertise, the risk of functioning in independent silos persists without proper coordination (4). The most common distinction between multidisciplinary and interdisciplinary care is that

interdisciplinary implies interdependency across the disciplines. Interdependency fosters intersecting lines of roles and responsibilities and a shared sense of ownership for the team's effectiveness—advanced multidisciplinary care teams achieve this level of interconnectedness (5). Advanced multidisciplinary care teams in oncology have substantial advantages; studies have demonstrated significant improvements in survival, quality of life, cost-effectiveness, patient satisfaction, and access (6).

Smilow Cancer Hospital (SCH) is the clinical facility of the Yale Cancer Center, one of 41 National Cancer Institute–designated comprehensive cancer centers and one of 26 National Comprehensive Cancer Network–designated institutions. In addition to serving as an academic tertiary center, SCH includes a large network of community oncology practices across the state of Connecticut. Clinical care at SCH is based on the disease team structure across 12 programs that cover various tumor sites (Figure 1). Each team has a clinical program and disease-aligned research team leader with clearly defined qualifications, responsibilities, and accountabilities within the academic and hospital contexts.

At SCH, we developed a disease team dashboard to help define the attributes of a successful multidisciplinary team, develop a transparent performance score, and assist the team leaders in setting specific goals. The dashboard development process was deliberately inclusive, ensuring clinical and administrative input and buy-in on the metrics that mattered most. Five strategic dimensions with three or four corresponding metrics each were selected: patient care/quality, research, education, business clinical effectiveness, and network integration (Figure 2). These dimensions currently reflect the

FIGURE 1. Smilow Patient Care Delivery Model (7)

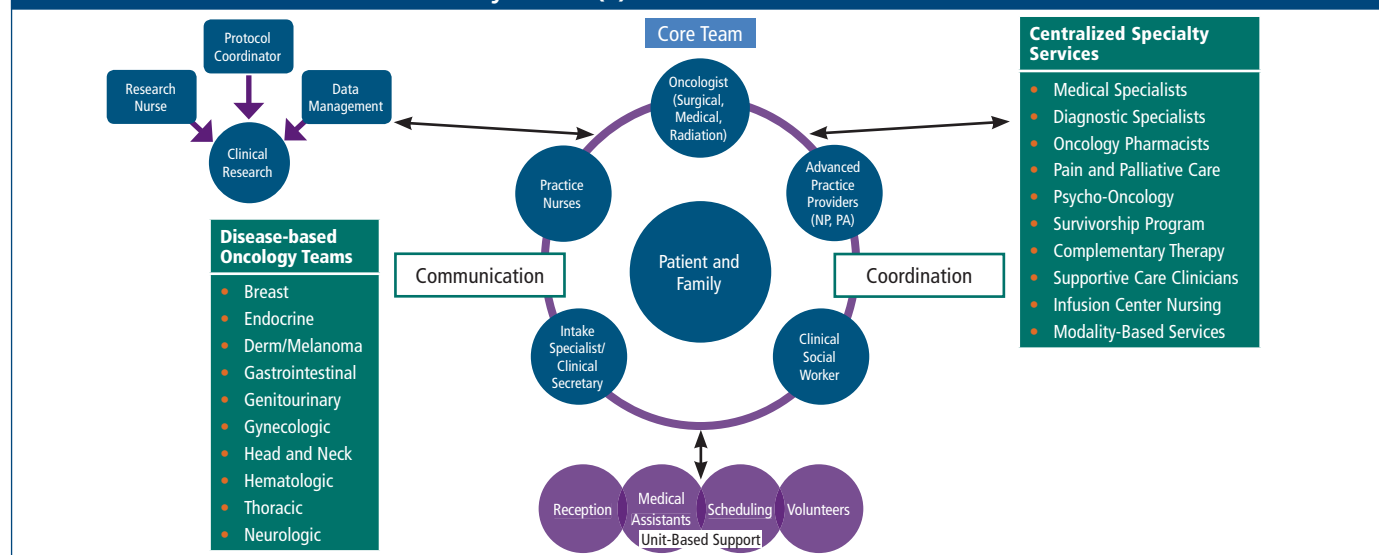
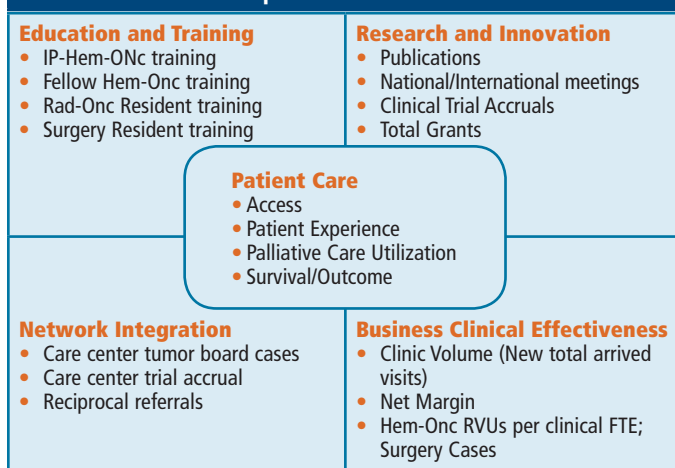


FIGURE 2. SCH Exemplary DT Dimensions

Patient Care	Provides outstanding, integrated, multidisciplinary clinical care in a supportive, patient-centered setting
Research and Innovation	Promotes a strong scientific base - make discoveries that advance the prevention and cure of cancer
Education and Training	Trains and mentors the next generation of world leaders in cancer research and cancer care
Clinical Business Effectiveness	Delivers efficient, comprehensive care based on sound cost and value principles
Network Integration	Expanded presence and improved access to patient care and research protocols

FIGURE 3. SCH Comprehensive DT Dashboard Model

intersection of our hospital mission and cancer center strategic objectives.

The final shortlist of selected metrics met what we called the M2R2 criteria: measurable, meaningful, reproducible, and reliable (Figure 3). Most metrics were trended to evaluate growth or benchmarked to industry and peer groups. In an attempt to maintain a balance between strategic and operational goals, metrics that could not be immediately sourced were kept in a pipeline document for future reference.

The dashboard served as a platform to spotlight teams as opposed to individual academic clinicians. The disease team leaders subsequently used the dashboard as a tool to develop short- and long-term strategic planning, update the clinical leadership on their performance, and justify requests for additional resources. In selected cases, metrics appropriate for comparison across teams led to best-practice sharing and a competitive spirit among the team leaders.

At SCH, we learned that driving individual contributors to function in the context of a team is best done by making team-based performance measures readily accessible, comparable, and rewarded. Academic programs are under increasing pressure to learn from other industries that have long employed cross-knowledge teams in a transparent, competitive landscape.

In the setting of health care delivery, and cancer care in particular, a disease team dashboard promotes the connection of a broader organizational mission to programmatic objectives and day-to-day clinical operations. Future steps include providing our team leaders with formal training to develop systems-level thinking and leadership skills to further enhance team performance. Shifting from individual evaluation to team performance measurement is one intuitive and practical way to promote team-based work in the traditional provider setting. At SCH, we are persistent in our efforts to transform the quintessential “I” in medicine to the higher-yield “we.”

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