President’s Corner – Making Gratitude the “G” in GME

Frederick M. Schiavone, MD, FACEP

As I write this, it’s Labor Day weekend and, in Florida, that can only mean one thing. We are preparing for the first major hurricane and Dorian has reached Category 5 status. Working for HCA Healthcare means we are preparing like FEMA prepares—actually better I think.

This weekend we also closed the books on a large percentage of our WebADS updates, meaning we are officially embedded in the new academic year and our programs were charged with answering 26 questions that were new to the WebADS updates, as compared to prior years. If we were in a room together, I would ask you how you constructed your program mission/aims/diversity responses and what you learned from reviewing the responses offered by your programs. What encouraged you? What inspired you? What sounded like an immediate best practice?

In thinking about this, consider was it about your wellness efforts and successes? Or was it an insightful response to a citation that acknowledged the program’s learning curve on a particular answer? Were the five areas of faculty development impressive and inclusive? Did the new faculty scholarly activity grid elicit broader thinking about important topics? Was your interprofessional learning environment emphasized and celebrated? I ask these questions because I reviewed multiple submissions and was impressed with several factors: by the variety of responses offered by our programs, by the opportunities to provide consistency where appropriate, by the conversations that we had around the topics addressed in the WebADS questions.

In many meetings and/or organizations, we are fond of asking, “What keeps you up at night?” Instead, I like to ask, “For what are you grateful?” In the context of GME, I’m grateful to the ACGME for adding dimension to the requirements we used to know. We have opportunities for new conversations between our programs and our leaders about our GME mission, about our purpose in each and every GME program.

Expressing gratitude is a natural state of being and reminds us that we are all connected. —Valerie Elster

We are grateful to focus on initiatives to ensure well-being for our residents and our faculty and that we, as a community, take care of each other. We are able to look at the Clinical Learning Environment and the integration and involvement of residents in the programs in which they train. I’m grateful that we now place value on collaborative interprofessional care. I am grateful that AHME plays a role in the National Collaborative for the Clinical Learning Environment (NCICLE) and that we are able to represent all that AHME does to fulfill our mission: “Improving Health Care through Medical Education.” With a focus on Medical Education – as it occurs in all venues, all specialties, in large and small sponsoring institutions,
in community-based programs and national health care systems – we are able to change the conversation. Largely, I am grateful for the impact we all have at our institutions by demonstrating mutual respect that AHME prioritizes. I am personally grateful for the opportunities Medical Education has given me – to try to have a meaningful impact on so many areas about which I care so deeply. I’m especially grateful to be helping areas about which I care so deeply.

This academic year has sent us some grave tragedies here in the West Florida Tampa Bay area. We had a lightning strike that took the life of a loved one of one of our residents; we suffered the death of a 29-year old resident in another of our programs, who died suddenly of natural causes; and we lost a truly beloved faculty member, a victim of a murder-suicide in her home. We have only one approach to dealing with these terrible events – and that is that we stand closer together, we hold onto each other more tightly and we offer each other all of our strength.

I’m grateful for each of you. I’m grateful for everything I continue to learn in GME. I’m grateful for all that we can teach each other. And I remain grateful for our unbreakable AHME connections to each other.

**Letter to the New DIO**

Maggie Hadinger, EdD, MS, ACC
ACGME Designated Institutional Official and Director, Graduate Medical Education & Student Programs, Department of Education Lehigh Valley Health Network

ACGME Institutional Requirements require that each Sponsoring Institution has a Designated Institutional Official (DIO). As such, at last count, there are 846 DIOs across the U.S. (ACGME, 2019); a survey conducted in 2016 showed that 61% of DIOs have served in the DIO role less than 5 years (McDougal, L. et al., 2016). As others have found, the DIO role is complex and evolving (Bellini, Hartmann & Opas, 2010; Riesenberg, Rosenbaum & Stick, 2006). Further, by definition, the DIO role is a unique role, with only one named individual serving at a given institution at any one time – possibly with the support of an Associate or Assistant DIO, or the collegial support of other DIOs at sister institutions. It can also be a lonely role, with no one else within an institution truly understanding the nuances, varied expertise, unique stakeholders, and challenges encountered. Thus, support from others in the same role – albeit at other institutions – can be critical to the success of a DIO, particularly in the first pivotal months.

I started my tenure as DIO at a large academic community health network as I came back to work after a maternity leave. In my first few months, I encountered, weathered, and led through both personal and professional tragedy, the departure of a long-time staff member, and the closure of a nearby large academic center – learning quickly that beginning a new position means facing any number of unanticipated challenges, because life doesn’t stop just because you got a new job.

A handy book that has served me well as a guide to starting new roles throughout my career is The First 90 Days (Watkins, 2013). The recommendations suggested would serve any new leader, but are particularly useful for a new DIO charting his/her course in the world of GME.

There is great wisdom to be learned from veteran DIOs – likewise, there can be valuable perspective to be gained from DIOs new to the position. So from one new DIO to another, what follows are some tips on how to make the first months of your new role as impactful as possible:

- Make new connections and re-engage with connections. Even if you’ve worked with them before, this is the time to meet with your program directors, coordinators, and other stakeholders. Connect (or re-connect) with your institutional coordinator. These are key experts, and they are specifically knowledgeable about...
GME at your institution. Introduce yourself. Ask lots of questions. Find out what their pain points are. Find out what motivates them. Find out what you can do to support them.

- **Engage with leadership and other key stakeholders.** Meet with your boss and your boss’ boss. Meet with the VP of nursing. Meet with the director of facilities. Find out what’s important to them, and how you can help them meet their goals, before you seek their help to meet yours.

- **Meet with your trainees.** Go program-by-program or convene small groups over lunch. Host a DIO Town Hall. Meet with your elected resident representatives. Ask what they find excellent in their training experiences and what they find lacking.

- **Over-communicate.** This is the time to be clear with your goals. Present to your GMEC and share with them what you value. Let them learn who you are before learning what you might want to change.

- **Secure early wins.** Do your residents want a coffee machine in their lounge? Get one. It may take time for you to secure larger wins that take a heavier lift, but small early wins speak volumes about how well you listen to concerns and about your commitment to taking action and making change.

- **Wait to make big changes but capitalize on pivotal moments.** Big changes take time, and most should wait until you’ve completed a thorough assessment of your environment. But don’t let a pivotal moment pass. For example, after a sudden/unexpected resident death in one of our programs less than a month after I became DIO – and just before the start of the new academic year– I worked with our GMEC to set the expectation that all new/first-year trainees would have a wellness check-in in their first few months of training, and I asked our program leaders to join me in facilitating making this happen. The moment to do this was important, and this moment counterbalanced the risk taken in making a change so early in my tenure.

- **Build a support system.** Because the DIO role can be a lonely one, it's critical that you create a support system. Think outside your institution, as well as inside. Seek out support groups. I was fortunate to have a number of experienced DIOs reach out to me. Does your region have a regional DIO group? If so, get involved, and if not – why not start one? Similarly, if you don’t already have one, engage with a professional coach for objective input about you as a leader.
• **Grow your expertise.** Like any expert, don’t fail to read, ask questions, and take every opportunity to learn all you can. I recommend attending an ACGME Annual Conference and going a day early for the DIO-specific sessions. I also highly recommend enrolling in the AAMC GME Leadership Certificate program, designed to be truly the premier “DIO Bootcamp.” Your stakeholders will expect that you have expertise not only in education and accreditation, but also in law, immigration, human resources, counseling, remediation, and countless other domains. You can’t know it all, so work to build relationships with the people inside and outside your organization who specialize in these areas. Add them to your speed dial for when issues inevitably crop up.

• **Make time for reflection.** Even if you’ve practiced reflection intentionally before, use this opportunity to reflect at the end of each day or week. What went well? What can you do better tomorrow? What did you learn? Journal or work with a professional coach or trusted peer to talk it out. Embrace the change and hang on for the ride as you embark on this new adventure. And if you need someone to call, know you are entering a community of support – and a fellow DIO is only ever a phone call away.

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**Essential Elements of an Institutional Harassment Policy**

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**Disclaimer:** The views expressed herein are those of the author and do not necessarily reflect the official policy or position of the Departments of the Army, Air Force, Department of Defense, or the U.S. Government.

In 2018, the National Academies of Science, Engineering and Medicine (NASEM) published *Sexual Harassment of Women: Climate, Culture and Consequences in Academic Sciences, Engineering, and Medicine*. The NASEM report found four characteristics that place institutions of academic science, engineering and medicine at increased risk for occurrence of sexual harassment, including:

- Male-dominated environment
- Organizational tolerance for sexually harassing behavior
- Hierarchical and dependent relationships between faculty and trainees
- Isolating environments (settings in which personnel spend a significant amount of time)

Given that academic medicine is at higher risk, policies must be established to ensure that residents and fellows from all sexes (including gender identity), races, colors, religions, sexual orientation or national origin can train in an inclusive environment that is free from harassment. The Accreditation Council for Graduate Medical Education (ACGME) requires that each sponsoring institution must have a policy (not necessarily GME Specific) that covers harassment (sexual and other forms) and details processes for residents and fellows to both raise and resolve complaints that are safe and free from retaliation (IR IV.H.3). Although having a comprehensive institutional policy will not guarantee prevention of any future occurrences of harassment, having a policy with clear language and procedures establishes a shared mental model of behavioral expectations and helps demonstrate a culture of zero tolerance and safe reporting.

Essential GME Harassment Policy elements include:

1. **Clear language and references to overarching policies** – Institutional GME policies should have clear language and references to higher level hospital policies to ensure there are no contradicting statements and that personnel can follow the policy.

2. **Definition and examples** – Harassment may come in many forms including, but not limited to: sexual harassment,
discriminatory harassment, hazing, bullying, retaliation and/or reprisal. It is important to not only define each type of harassment, but also to include examples of what each type of harassment may look like. Clear and concrete examples outlining potential violations of policy will ensure all have a shared mental model of what harassment behavior looks like.

3. A Culture of Zero Tolerance – Harassment policies should be crystal clear that the institution has a zero tolerance policy for harassment of any kind and that any allegations will be thoroughly reviewed and addressed.

4. Reporting Procedures – Clear reporting procedures for victims ensures that all personnel understand how and ways to report. Given that some institutions are geographically separated and to create a safe reporting culture where victims feel comfortable, there should be multiple methods for victims to report harassment.

5. Confidentiality and victim support - Policies should outline confidentiality standards and what support services are offered to victims during and after investigations have concluded.

6. Transparent Investigation Procedures and Accountability – Harassment investigation procedures must be: transparent, outline behavior standards for all personnel and must discuss accountability methods for personnel found to have violated the policy.

7. Education Expectations – Policies should outline education expectations not only for orientation, but also on a continuing basis for all personnel involved in resident and fellow education.

8. Accessibility – Policies should be easily accessible to GME personnel in all clinical learning environment locations.

References

Response to the Opioid Epidemic – Successful Clinical and Educational Practices

The DOPE Study: Decreasing Opioid Prescribing through Education
Lynn Y-Nhi Nguyen, MD – PGY4 Surgical Resident and Christopher Senkowski, MD – Program Director Memorial Health University’s Medical Center at Mercer School of Medicine

Ever since pain became the fifth vital sign in 1999, the U.S. has seen a steadily increasing rate of opioid prescription, and with it, an alarming increase in opioid abuse, addiction, overdose, and death. The U.S. Department of Health and Human Services declared the opioid epidemic a public health emergency. Our task in this effort as medical practitioners is to advance better practices for pain management.

Within our general surgery program at Memorial Health University Medical Center in Savannah, Georgia, there was considerable inconsistency in the size of postoperative opioid prescriptions written by residents. Thus we endeavored to standardize postoperative prescribing efforts without sacrificing pain control through surgical resident education and patient counseling. First, residents were given one 20 minute lecture on the advantages of multimodal pain regimens and specific phrases to be used in managing patient expectations of pain. Surgery-specific prescribing recommendations were distributed in both laminated cards and electronic formats which could be saved onto cell phones. Residents were encouraged to follow these recommendations but were also allowed to use their discretion and deviate from the recommendations for any reason. An informational sheet that covered safe use of opioids, over-the-counter alternatives, and warnings of the risk of side effects and addiction was posted in clinic exam rooms and preoperative holding areas for patients to read while waiting for their physicians. It was also added to discharge paperwork and reviewed at bedside by nursing staff prior to leaving the hospital. To measure the results of these educational interventions, we recorded the morphine milligram equivalents (MME) prescribed after common operations (appendectomy, cholecystectomy, hernia repair, colectomy, breast lumpectomy, and mastectomy), rate of prescription refills, number of emergency department visits for pain, and number of admissions for inadequate pain control after surgery.

In the study period after the educational interventions, surgical residents prescribed on average 21.8% fewer MME per postoperative patient when compared prior to the intervention. Cholecystectomy patients were prescribed 25% fewer MME. Breast surgery patients were prescribed 38% fewer MME. For patients who
had laparoscopic surgery, residents prescribed 28% fewer MME. Despite these significantly reduced prescriptions, there was no increase in the rate of refill prescriptions or emergency department visits for uncontrolled pain. In fact, our statistical analysis found that a larger initial prescription actually increased the risk of emergency department visits for painful constipation, a known side effect of opioids. Prescription Drug Monitoring Program (PDMP) data for these individual patients will be reviewed again one year after their operation to see if this intervention decreased chronic opioid use, which of course is the ultimate goal.

Prior to the lecture, several residents wanted to prescribe fewer tablets, especially after less invasive procedures, but were concerned that patients would run out of tablets and require a refill or present to the emergency department with uncontrolled pain. When provided with data on opioid prescribing and strategies for handling patients’ postoperative pain, surgical residents were empowered to prescribe less opioid tablets without fear of leaving their patients high and dry. Thus, with a single educational intervention, the opioid prescribing practice of 25 surgical trainees was altered to improve the safety of pain management not just on an individual level but on a system-wide basis through 25 surgical residents.

### AAMC Educational Response to Opioid Crisis at PH-USC

**Donna D. Ray, MD** – Clinical Assistant Professor of Medicine, Geriatrics/Director, Faculty Development, OCPDSA Continuous Professional Development & Strategic Affairs

**USC School of Medicine – Palmetto Health CME Organization**

The complex issues of opioids – from stewardship to best practices in pain care, from screening for misuse to addressing issues of opioid use disorder (OUD) – can be daunting for health care systems and team members. For the Family Medicine Center of Prisma Health – Midlands and the University of South Carolina School of Medicine in Columbia, the starting point was the Program Director of the Family Medicine Residency, Paul Bornemann, MD, with an interested clinical pharmacist, Morgan Adams, PharmD, who responded to the identified need for medication assisted treatment (MAT) for selected patients with OUD and the need for related education and hands-on experience for residents. Similarly, Chris Goodman, MD, faculty member in the Internal Medicine Residency program, also began initiation of MAT.

**As part of the AAMC response to the opioid crisis**, three faculty members were supported by the medical school dean as representatives for undergraduate, graduate and continuing medical education at the national workshop in May of 2019. An abstract that addressed the pilot efforts in MAT was submitted prior to the workshop; as a result, our team was invited to include two residents to join us at the conference to present. This group of five left the conference with an action plan, many new ideas and a wealth of resources and connections from institutions across the country.

Our current working group of clinicians, residents, medical students, physicians, and a CME coordinator strive to improve medical education across the continuum and to enhance patient care. The collaborative work extends beyond residency clinics and inpatient services to include community partners and colleagues in the Emergency Department as well as the clinical programs of rehabilitation counseling and physician assistants. As a team, we have experienced rapid growth of networking and slow, steady growth of clinicians with MAT waiver training. Here are lessons we are learning from our work:
1. Start with commitment and interest; find the champions. When MAT was initiated, no new funding or resources were available, but passionate leaders drove change.

2. Offer MAT Waiver Training. The FM residency did so in 2018 on a voluntary basis and now includes in intern training in July. Free MAT waiver training was easily accessed.²

3. Partner.
   a. Partner with your Continuing Medical Education office. Collaboration will allow you to explore CME that meets license requirements regarding safe prescribing, for example, or add sessions to existing activities such as grand rounds or journal clubs.
   b. Build relationships with those in your community who are providing city- or county-level care. Connect with non-profit organizations in your area who share the mission of addressing the opioid crisis.
   c. Connect with other clinical training programs at your site.
   d. Connect with a medical librarian who can be invaluable in helping you locate and share educational and clinical resources in the public domain. For our institution, a subject guide was developed.³ This guide may be used for self-study or development of curriculum at various levels.

## References
2. https://pcssnow.org/medication-assisted-treatment/
3. https://uscmed.sc.libguides.com/opioidsinmeded

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### Educational Commission for Foreign Medical Graduates (ECFMG®)

**Keeping a Close Watch on Immigration Developments that Could Impact U.S. Residency Recruitment and Health Care**

**William W. Pinsky, MD, FAAP, FACC – President and Chief Executive Officer of the Educational Commission for Foreign Medical Graduates (ECFMG®)**

The immigration climate in the United States continues to be unpredictable. In April of this year, the ECFMG/FAIMER® Board of Trustees hosted a Stakeholder Engagement Forum, which included AHME Executive Director Kimball Mohn, MD, focused on immigration issues impacting U.S. graduate medical education. Dr. Mohn reported that a survey of AHME members conducted prior to the Forum showed about 90 percent of members host international medical graduates (IMGs), and about 50 percent state that immigration status does influence program directors, with most preferring physicians on J-1 visas over H1-B visas. Clearly, immigration is an issue of importance to AHME members.

**Overall Numbers**

In the 2019 Main Residency Match, non-U.S. citizen IMGs showed strong performance, with 4,028 (58.6 percent) matching, an increase of 66 positions from 2018. It was the eighth annual increase in the number of non-U.S. citizen IMGs who matched and the highest match rate in more than 25 years. While non-U.S. citizen IMGs performed well, the number participating in the Match decreased in 2019 for the third consecutive year.

ECFMG issued initial J-1 visa sponsorship for 2,890 physicians with original program start dates in June or July of this year, a 5 percent increase over 2018. As of August 6, 2019, 96 percent of these physicians had reported to their training programs. On-time reporting to training programs improved by 1 percent this year over 2018, with 93 percent of newly sponsored J-1 physicians reporting on or before their start dates.

Looking at the beginning of the IMG pipeline, as of July 2019, applications for ECFMG Certification have increased 2.9 percent over 2018, but that increase hasn’t carried over into registrations for USMLE exams, including Step 1, Step 2 CK, and Step 2 CS, which are down 6.6 percent, 6.4 percent, and 5.2 percent respectively.

**Visa Restrictions/Muslim-Majority Countries**

While the majority of comprehensive visa restrictions have been lifted, some visa classifications remain restricted for selected countries including Iran, Libya, Somalia, Syria, and Yemen. The J-1 visa classification is not among those restricted. Of these countries, ECFMG traditionally receives statistically significant numbers only from Iran and Syria. The number of ECFMG-sponsored J-1 physicians from Iran has fallen by 63 percent since 2016, and the number from Syria has decreased by 71 percent. For all Muslim-majority countries, however, the number has decreased only by 5 percent since 2016 with strong numbers from Egypt, Pakistan, Saudi Arabia, and Turkey.

**How J-1 Applicants Can Prepare**

Applicants for J-1 visas should be mindful when appearing for a consular interview. There has been a recent, minor increase in the number of visas denied because the consular official deemed that the applicant engaged in an unauthorized activity while in the United States previously on visitor visas (B-1/B-2). Visitor visas are nonimmigrant visas for persons who want to enter the United States temporarily for business (visa category B-1), for tourism (visa category B-2), or for a combination of both purposes (B-1/B-2). It is important for both institutions and individuals to understand that, while observerships are permitted for B visa holders, clinical activities are not.
Lessons Learned: The Closure of Hahnemann University Hospital

William W. Pinsky, MD, FAAP, FACC – President and Chief Executive Officer of the Educational Commission for Foreign Medical Graduates (ECFMG®)

The closure of Hahnemann University Hospital has been a lesson for us all. With nearly 600 residents and fellows in training, Hahnemann is the largest permanent closure of a teaching hospital in our nation’s history, and its consequences are proportionate to its scale. As Hahnemann’s bankruptcy closure unfolded throughout the summer in Philadelphia, ECFMG’s hometown, the process afforded an intimate view of involvement in its complexities, and its impact on the trainees as well as the overall community.

This event has demonstrated that financial interests can and will override the interests of communities. Hahnemann closed despite objections from city and state officials and in the midst of a public outcry over the negative impact on patients. Hahnemann was a “safety net” hospital, serving a large proportion of inner-city and low-income health care consumers. As Hahnemann closed its services, patients were turned away. For some patients, alternate hospitals are further away, presenting a greater burden to obtain care and a greater risk for those with emergent conditions.

The characterization of and bidding for Hahnemann’s training programs and positions as “residency assets” through the bankruptcy process belies the fact that these “assets” include hundreds of talented and hard-working trainees who have experienced extraordinary disruption and uncertainty. Although we have great concern for all the Hahnemann residents and fellows, and have advocated for them through the court system and by engaging our partners in the “House of Medicine,” the special focus of ECFMG’s activities has been the 55 residents and fellows training at Hahnemann under ECFMG J-1 visa sponsorship. These individuals were required to find new training positions quickly or face the prospect of leaving the United States. Fortunately, all of the ECFMG-sponsored J-1 physicians were accepted into other programs, although some had to relocate to other parts of the country. Like other Hahnemann trainees, they did so at significant personal expense and, in some cases, by uprooting their families.

The administrative issues associated with the transfer of trainees proved to be far from routine. While there are rules for the allocation of training positions and associated CMS funding in the event of a hospital or program closure, both of these issues became points of contention. In the case of funding, because Hahnemann had more trainees than “cap positions,” Hahnemann calculated that it could only assign a portion of the cap (albeit a large majority of it) for each trainee. This ultimately threatened to undermine the securing of new positions as, at least initially, accepting institutions were demanding full funding. Even the willingness of Hahnemann to provide malpractice trailer insurance for its departing trainees was uncertain. Additional economic and emotional hardships appeared with respect to apartment leases, enrollment of children in school, and spousal employment.

At the time of this writing, the long-term disposition of Hahnemann’s training programs and positions remains unresolved, and I am confident that the bankruptcy process, as it moves toward conclusion, has more lessons for us. Our experience with this situation thus far demonstrates the need for ECFMG, and other organizations involved in the education, training, and assessment of physicians, to intervene and help protect the interests of the next generation of physicians. In the current healthcare marketplace, where additional mergers, acquisitions, and closures are likely, we have a responsibility to help ensure that U.S. graduate medical education remains attractive, secure, and satisfying, at both the local and national levels.

The following two articles are summaries of award winning posters that were presented at the 2019 AHME Institute.

Quality Improvement and the Program Coordinator’s Role

Crys Draconi - Tufts Medical Center, Massachusetts; Michelle Armstrong, MA Ed, C-TAGME - Loyola University, Illinois; Laurie Hein - Medical College of Wisconsin, Wisconsin; Kristin Johnson, C-TAGME - Maine Medical Center, Maine; Jane Maugerl, C-TAGME - Jefferson University, Pennsylvania; Carrie Racsumberger, MS - Roswell Park Comprehensive Cancer Center, New York; Donna Williams, MA - UT Southwestern Medical Center, Texas; LaToya Wright, MBA, C-TAGME - UT Southwestern Medical Center, Texas

Quality Improvement (QI) has been developing for over 100 years starting in medicine and moving into business as a way to improve outcomes and efficiencies. Although quality improvement methodology has changed over time, the purpose remains the same.

In medicine the regulatory oversight is constantly increasing. QI reporting is required for many accreditation standards. The Joint Commission, Centers for Medicare and Medicaid...
and the Accreditation Council for Graduate Medical Education are just a few. Within graduate medical education, requirements state that we must teach and give opportunity for continued improvement. How can we teach if we don’t know how to use it ourselves?

Continued demands put on the administrator and program equates to more items to accomplish in less time. To meet these demands, we need to learn better efficiencies through our projects. Learning QI is an excellent way to do this and implement into our program improvement. Administrators, by nature, are very organized. This also gives us an opportunity to lead others and thereby improve our own professional development opportunities. First, administrators must learn QI methods, then put them into practice by starting with a small personal project, such as improving their evaluation processes.

There are many QI models to choose from, and most institutions have some version of a quality academy or other supportive service that helps teach these methods and acts as a consultant into any project. Implementing these processes without using a model can be frustrating, stressful and often fails due to lack of action. Check with your institution as to the model they have chosen as a system to allow the proper support.

The easiest to learn and most widely taught method is called the “Model for Improvement,” also referred to as the PDSA cycle. This model is a four-step process consisting of Plan, Do, Study, Act.

- **Step One** is the [P]lan phase. In this phase you will need to state your problem, build your team, analyze the current situation, develop measures to analyze later, and decide on the change that your team is going to test. This is the longest phase and there is danger of losing momentum.

- **Step Two** is the [D]o phase. In this phase you are doing the test run of the new ideas. Give yourself a time period for testing to allow for evaluation early on.

- **Step Three** is the [S]tudy phase. In this phase you pause for reflection on the effects of your changes. You will analyze data you have collected and obtain further data as necessary. This is the most rewarding phase, as you see the passes and fails of your efforts.

- **Step Four** is the [A]ct phase, the final step before deciding what to permanently change. In this phase you decide what to do next by adopting the change, adapting and retesting, or abandoning the change altogether.

For ideas on what sort of projects you can try, turn to your Annual Program Evaluation and its Action Plans. When using the template from the ACGME, the format is already in the PDSA cycle. Remember to keep it simple and make small incremental changes before applying the next phase of changes. In your first project, it should be something small that is personal to your role and uses your program leadership as your multidisciplinary teams.

After doing just a few of these projects, you will be a pro and can develop a curriculum within your program... and even teach it yourself!
Comprehensive Analysis and Visualization of Resident Food Expenditure Data

Hayden L. Smith, PhD - Medical Researcher, Medical Education and William J. Yost, MD - Chief Academic Officer at UnityPoint Health – Des Moines

A project was initiated to analyze resident food expenditure data at a university-affiliated community-based teaching hospital to examine macro-and micro-level patterns of food expenditures. The project entailed a retrospective review of resident food charge data from August 2017 through April 2018 for six residency programs. Monthly charges were linked to individual residents and their respective residency program. Data were initially reviewed via visualizations (i.e., histograms, boxplots with overlaid scatterplots, and spaghetti graphs) and descriptive statistics (i.e., measures of central tendency and dispersion). Data were then subsequently analyzed using quantile regression to provide percentile charge estimates for the department and programs. Expenditures were also used in a meta-analysis controlling for program-level random effects and further reviewed using unsupervised cluster analyses and anomaly detection algorithms. All analyses were performed in-house within the Medical Education Department.

Results from the project revealed there were 101 unique residents represented in the six residency programs. Monthly charge data were available for 766 onsite rotations. Percentile estimates revealed a median monthly resident charge of $141 (95% CI: 132, 149) USD. Program rankings by spending were determined and displayed using a forest plot. Programs that received the greatest amount of catered food at lectures had the lowest individual resident-level spending. Cluster analyses consisting of grouping residents based on spending, corroborated overall differences between residency programs. Additionally, plotted data (spaghetti graphs) revealed a subset of residents within individual programs who had consistent expenditures greater than program medians, with these residents serving as cost outliers. Lastly, anomaly detection analyses served to reveal monthly charges not within the norms of resident spending.

In summary, a formal examination of resident food expenditure data can assist in understanding and evaluating possible changes in the structure of cafeteria food allowances. The presented case study demonstrated analytic and visualization options for understanding local data. Graphical figures can help guide food budget decisions by sponsoring institutions. Analyzed data may also assist in determining and defining unprofessional spending patterns by residents.

CONCLUSIONS
The presented case study demonstrated analytic and visualization options for understanding local data. Constructed figures can help guide decision-making within medical education. Analyses may also assist in defining and determining unprofessional spending patterns.
Council Spotlight

AHME Joins Other National Groups in Addressing Faculty Development Needs

Rob A. Martin, MBA - Chair and G. Robert D’Antuono, MHA - Past-chair of the Council on Professional and Faculty Development (CPFD)

As AHME-member teaching hospitals grapple with the acute need to raise the standard of faculty performance in key academic areas, such as clinical teaching methods, competency-based resident assessment, feedback, quality improvement basics and faculty scholarship, AHME has joined the ACGME and the AAMC in the creation of a national faculty skills development educational program. This past January, the AHME Board of Directors approved a formal proposal from the Council on Professional and Faculty Development (CPFD) to create and implement a dedicated AHME Faculty Essentials Curriculum.

“AHME is clearly on a mission with this new resource to address the most urgent of member educational needs,” stated Tia Drake, Immediate-past President and 2019 Chair, Academic Leadership & Professional Development Committee.

“We are delighted to take up the challenge to create this exciting program that we hope will truly provide a value-added experience during the 2020 Spring Institute for those who participate,” commented Rob Martin, MBA, Chair, CPFD.

Once approved, the CPFD appointed a national Curriculum Development Committee of AHME members with expertise in the faculty development domain, which met initially last November and again at the 2019 Spring Institute in Savannah to discuss learning goals, topic proposals and to shape a final curriculum, based on a CPFD member survey conducted in 2018, as well as an environmental scanning review of literature and other national programs’ curricula.

Conceived as a three-year curriculum, each year of the Faculty Essentials Curriculum (FEC) will emphasize particular skill domains that align with ACGME-required standards of annual Faculty Development (see ACGME 2019 Common Program Req’s II.B.2.g [1-4] at https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf)

In Year 1 the theme is Faculty Skills in Teaching and Assessment, while Year 2 will cover “Teaching QI/PI Skills and Provider Wellness Management,” and Year 3 will focus on “Teaching Scholarly Activity and Research Skills.”

As a result of the Committee’s work, the FEC agenda will offer an immersive, highly interactive curriculum consisting of 8 hours of workshop sessions and 1 plenary session, for a total of over 9 hours of educational content, scheduled as a dedicated track over two days, May 13-14, 2020. The learning format for each workshop will include mini-didactic lecture, teaching video, discussion, and small group exercises to further illustrate key learning points. Both educational theory and practical strategies will be presented.

Physician participants may earn up to 9.25 hours of AMA PRA Category 1 Credit(s)™.

The live program will be preceded a few weeks by an online recorded lecture and required readings as a means to engage registered participants in considering the concepts of applying adult learning and instructional theories to teaching in medical education. A live webinar will also be scheduled next June to conclude the Academy program on a topic complementary to the overall curriculum. A detailed program curriculum will soon be available on the AHME website.

“The Curriculum Development Committee’s goal was to provide a blended curriculum of adult learning theory as well as easy to adopt, practical strategies in each session to improve faculty performance immediately in key areas,” noted Rebecca Daniel, MD, Chair-Elect (2020) of the CPFD.

Among the confirmed guest faculty are Kelley Skeff, MD and Georgette Stratos, PhD, Co-Directors of the Stanford Faculty Development Center. For over thirty years, since 1985, Dr. Skeff and Dr. Stratos have been engaged in teaching physician-teachers how to teach better. To date, they have trained hundreds of faculty throughout the U.S. and internationally in over nine countries. On May 13, Drs. Skeff and Stratos will teach a 4-hour block using their established curriculum. Other confirmed faculty experts include Donna Ray, MD, and Renee Connolly, PhD, Timothy Graham, MD and Jack Contessa, PhD, and other AHME members, who will teach the remainder of the curriculum covering teaching methods, competency-based assessment, the hidden curriculum, and other topics.

Both AHME members and non-members will have the opportunity to participate in the program now scheduled for May 13 and 14, during the 2020 Spring Institute, at the Marriott Harbor Beach Resort in Ft. Lauderdale, Florida. We strongly encourage all COIL, COE, CPFD, CTYPD and COPAC members to forward the program information to your residency program directors and faculty. The program is intended for physician faculty in all specialties, in particular, junior faculty new to their academic teaching responsibilities, faculty in community teaching hospitals, and those faculty wishing to improve their teaching skills.

For more information, please contact:
Rob Martin at: Robert.Martin2@nyulangone.org
Rebecca Daniel at: Rebecca.Daniel@stjoeshealth.org
Robert D’Antuono at: grd1951@gmail.com
EDUCATIONAL OPPORTUNITIES

Details on AHME’s educational sessions are posted at www.ahme.org when registrations open. Notification is made via email so be sure to keep an eye on your inbox for upcoming events.

AHME Academy
The AHME Academy is a one-day primer for new residency program administrators to gain an overview of their duties and for experienced administrators to learn some fresh approaches to their responsibilities. Its format allows for great networking and opportunities to learn the latest and greatest happenings in medical education. They typically occur two times per year and are often hosted by a member hospital in easily accessible locations.

AHME Webinars
AHME conducts six webinars per year on topics relevant to the field of medical education. Hosted by a specific Council each time, the webinars are one hour in length and feature experts from around the country. And you don’t have to leave your desk to participate!

Upcoming Webinar Schedule!
AHME Members can register for the full series of webinars at a 25% discount. Members still have the option of registering for individual webinars at the regular rate of $80/per session.

Schedule: Sponsoring Council

<table>
<thead>
<tr>
<th>Date</th>
<th>Sponsoring Council</th>
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<tbody>
<tr>
<td>December 3, 2019</td>
<td>COPAC (Council of Program Administrators and Coordinators)</td>
</tr>
<tr>
<td>January 14, 2020</td>
<td>COIL (Council of Institutional Leaders)</td>
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<tr>
<td>March 5, 2020</td>
<td>COE (Council of Osteopathic Educators)</td>
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<tr>
<td>June 2, 2020</td>
<td>CPFD (Council on Professional and Faculty Development)</td>
</tr>
<tr>
<td>August 4, 2020</td>
<td>COIL (Council of Institutional Leaders)</td>
</tr>
<tr>
<td>October 6, 2020</td>
<td>CTYPD (Council of Transitional Year Program Directors)</td>
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</table>

Package Price: $360.00
(includes 6 sessions shown in the schedule above)

Contact the AHME office at 724-864-7321 or info@ahme.org for more information or to receive the Webinar Package Registration Form. AHME members can also purchase the package on the Events page of the AHME website (www.ahme.org).

Best Practices from Our Members

AHME News likes to feature articles that highlight members’ best practices. We invite you to submit your institution’s best practices in any area of medical education to Venice VanHuse, Editor, at vvanhuse@northwell.edu

REMEMBER AHME MEMBERS:
Information about AHME happenings are communicated to the membership via Constant Contact, an email marketing provider. When you opt out of those mailings, you no longer receive information from AHME staff or leadership – including announcements about upcoming webinars and other educational opportunities. Don’t miss out! Stay connected by keeping your contact information current with AHME staff.
The Institute is your one-stop opportunity to hear from the most influential people in key medical education organizations. Representatives will be on hand to present the most up-to-date topics from their organizations. AHME members and other experts in the medical education continuum fields will be well represented in the speaker roster as well.

Some of the other features of the 2020 AHME Institute include:

- **Extensive programming** with multiple breakout sessions
- **Other experts in the field** of medical education to provide you with the most up-to-date, nuts-and-bolts, take-and-use-today information
- **Networking** opportunities through meals and fun events...including a Tuesday evening cruise through the famed Fort Lauderdale waterways to a private island for dinner (see below)
- An **on-site poster session** to present what you and your peers in other institutions are doing to improve and advance your programs
- **Exhibitors** with practical products and services to help you do your job
- **Sessions expressly for Program Administrator & Coordinator** learning
- **Specific programming for Transitional Year** professionals
- **Dedicated sessions focused on topics specific to professional and faculty development** (see “Council Spotlight” article on page 11)
- **Sessions geared to the work of your Institutional Leadership**
- Information relevant to the **Osteopathic educators** community

The Marriott Harbor Beach provides modern amenities with sophisticated style and easy access to all that this beach town has to offer. And the educational program will be just as great: presenters from across the country who are bringing their expertise on a slate of topics designed to help you be better informed and better able to do your job.

As if all of the above isn’t enticement enough, AHME has booked a fun adventure for Tuesday evening aboard the Jungle Queen Riverboat! Self-pay tickets are $55 each, which includes a narrated sight-seeing cruise on the Fort Lauderdale waterways to a private island, where you will enjoy an all-you-can-eat dinner served tableside and a variety show or your own exploration of the island’s lush landscape and exotic animals as entertainment. The dock is located within walking distance of the Marriott Harbor Beach so you can stroll to the boat and have a wonderfully relaxing evening. Advance purchase is required.

The full 2020 AHME Institute brochure, the link for the dinner cruise, and other information will be available on the AHME website (www.ahme.org) in early November.
Welcome to the AHME MESSAGE BOARD CORNER.

In this section we highlight recent active Message Board threads which may be of special interest to you.

These threads are linked in the pdf version of the newsletter on the AHME website so you can go directly to the conversation and read the current content. If you are a member of the Message Board you can join in the conversation. Remember the AHME Message Board is open to all medical education professionals; not just AHME members.

Feel free to register yourself or send this link to others who may be interested:

AHME Message Board Registration Site

Or if you prefer, contact Karen Zagar, the Message Board Administrator at karen@ahme.org and she will get you activated.

Here are several recent threads:
• Experience with VSAS
• Meal Stipend – How much do you provide?
• CME structure/leadership and support
• Program Coordinator Competencies/ Milestones

AHME News Feedback

Please give us feedback on the AHME News content and coverage by sending an email to sandi@ahme.org. If you have ideas and suggestions for topics or questions you would like to see covered in the News, let us know. Counterpoint opinions on content and issues are always welcome and appreciated.

THE MESSAGE BOARD

has the following topic areas for medical education professionals to post questions and seek information from others:

• Undergraduate Medical Education
• Graduate Medical Education
• CME, CPD, and Faculty Development
• Miscellaneous Topics
• Program Administrator Forum
• Transitional Year Program Forum

If you haven’t done so already, please sign up and start sharing with the medical education community.
REMEDIATION of the STRUGGLING MEDICAL LEARNER
Jeannette Guerrasio, MD

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