GME FACULTY DEVELOPMENT RETREAT

September 27, 2016

Southern Management Corporation Conference Center
620 West Lombard Street
Ballrooms A and B (2nd Floor)

Agenda

7:00am	**Registration and Breakfast**
7:30am	**Introduction** **Michael Jablonover, MD**, Chief Medical Officer, UMMC
7.45am	**Teaching in a Busy Clinical Setting** **Amal Mattu, MD**, Vice Chair, Depart. of Emergency Medicine
8:45am	**AGCME Milestones and You** **Laura Edgar, EdD**, Executive Director, Milestones Development, ACGME
9:45am	**Best Practices in Remediation** **Cases Presented By: Mary Njoku, MD**, Designated Institution Official for UMMC **Discussants: Caron Hong MD**, **MSc**, Program Director Anesthesiology, **Michael Naslund MD**, Program Director Urology, **Carolyn Cronin MD**, **PhD**, Program Director Neurology, and **Kate Widmayer, JD**, Associate Counsel for UMMS

10:45am **Two Perspectives for Promotion**
Dean's Office and Faculty
James Kaper, PhD, Senior Associate Dean for Academic Affairs
Stephen Kavic, MD, Program Director for General Surgery

11:45am **Using QA as a Teaching Tool**
Jason Custer MD, Assistant Program Director Pediatrics
Mark Kelemen MD, UMMS Senior Vice President and Chief Medical Informatics Officer
Kerri Thom, MD, Assistant Dean for Student Research and Education

12:30pm **Lunch, Networking, Adjournment**

Accreditation: The University of Maryland School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit Designation: The University of Maryland School of Medicine designates this live activity for a maximum of 5 *AMA PRA Category 1 Credits™.* Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Please register on-line at:
http://cmetracker.net/UMD/Login?Formname=RegLoginLIve&EventID=15768

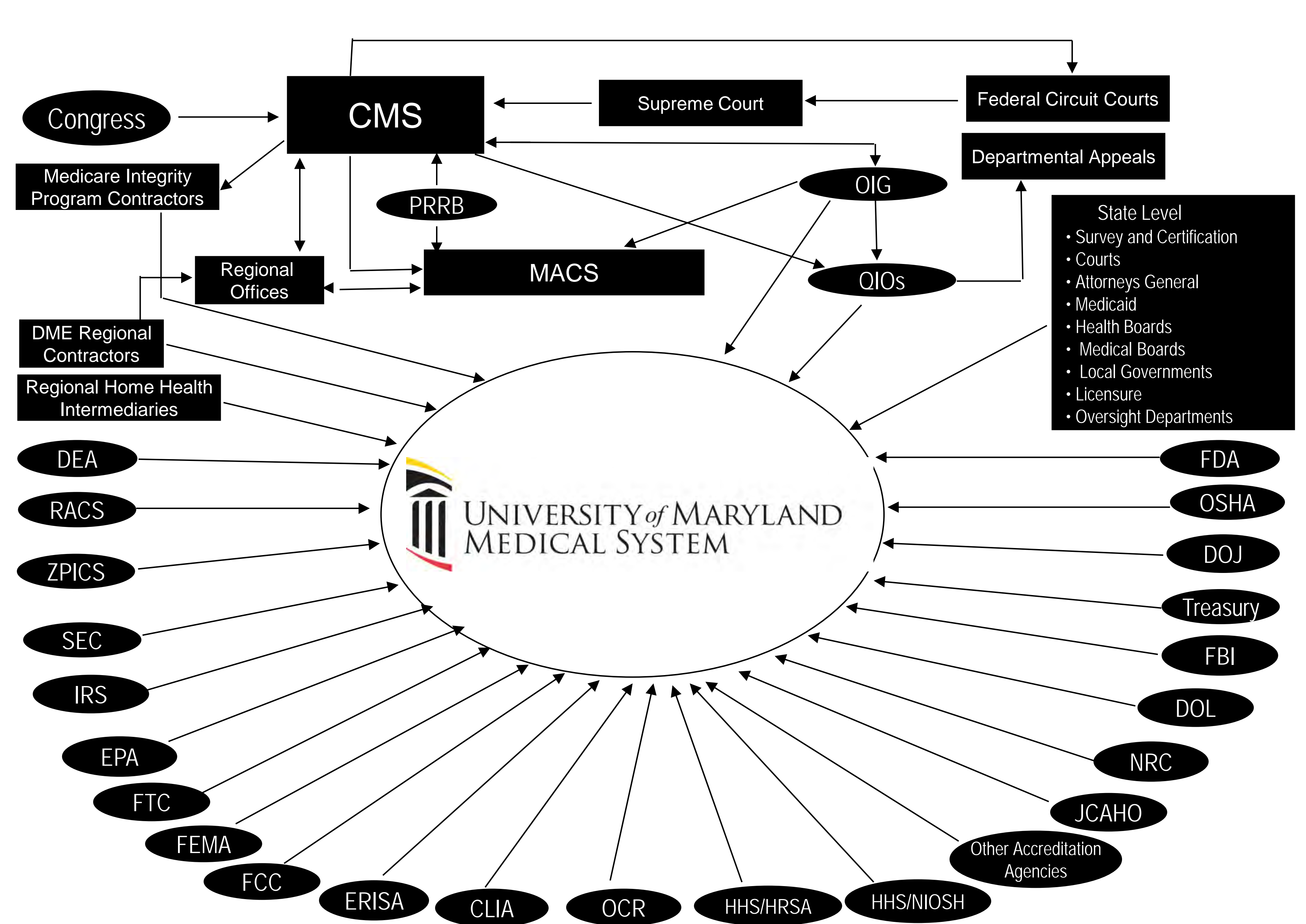
Faculty Development Retreat

September 27, 2016

Michael Jablonover, MD
UMMC Chief Medical Officer

University of Maryland Medical Center commitment

- Quality
- Safety
- Performance Improvement
- Education



Congress
CMS
Supreme Court
Federal Circuit Courts
Departmental Appeals
Medicare Integrity Program Contractors
PRRB
OIG
Regional Offices
MACS
QIOs
State Level
• Survey and Certification
• Courts
• Attorneys General
• Medicaid
• Health Boards
• Medical Boards
• Local Governments
• Licensure
• Oversight Departments
DME Regional Contractors
Regional Home Health Intermediaries
University of Maryland Medical System
DEA
RACS
ZPICS
SEC
IRS
EPA
FTC
FEMA
FCC
ERISA
CLIA
OCR
HHS/HRSA
HHS/NIOSH
Other Accreditation Agencies
JCAHO
NRC
DOL
FBI
Treasury
DOJ
OSHA
FDA

Institute for
Healthcare
Improvement

The Joint Commission

AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

MARYLAND

CMS.gov
Centers for Medicare & Medicaid Services

NATIONAL
QUALITY FORUM

The New Numbers…

2013- A New, Evidence based Estimate of Patient Harms Associated with Hospital Care James, John T. PhD

220-444,000 people died per year

What has Changed…?

- More effective
- More complex
- New medicines
- New Surgeries
- New Modalities
- New technologies
- People living longer
- Older and sicker patients
- Significant co-morbidities
- Requiring more and more difficult decisions

❖ Increasing economic pressure- value, not volume!

7 Preventable Harms

- Healthcare acquired infections (HAI)
- Medication errors
- Failure to prevent
- Failure to rescue
- Falls with injury
- Pressure ulcers
- Procedural errors

Why Does This Happen?

- **Healthcare Organizations (HCOs) accept failure as inevitable**
- **Complacency blunts the alertness of surgical and other teams**
- **Distractions during handoffs: We expect communication errors**
- **“Culture of Low Expectations”**
- **We see things every day and do nothing**

High Reliability Healthcare

A high reliability organization (HRO) is an organization that has succeeded in avoiding catastrophes in an environment where normal accidents can be expected due to risk factors and complexity.

1) Leadership committed to goal of ***zero harm***

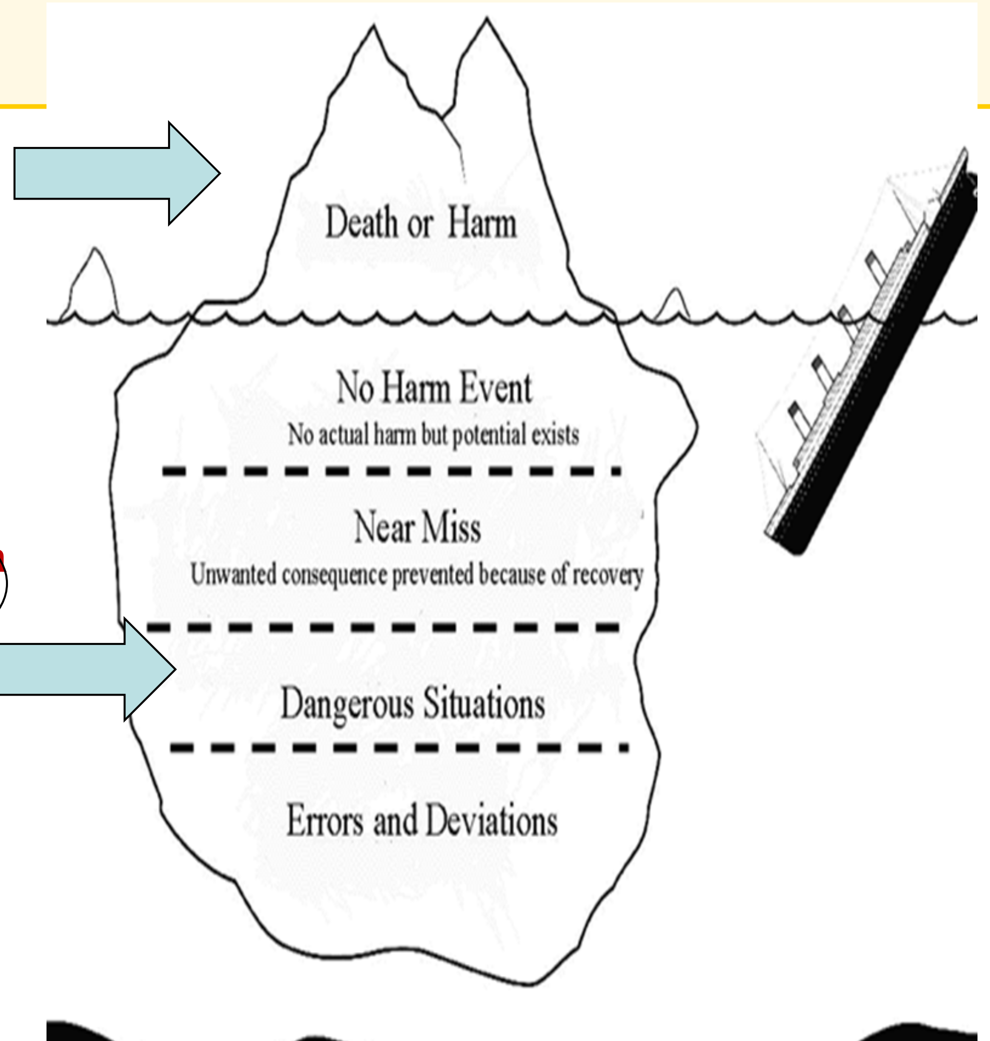
2) Safety culture embedded throughout **the organization**

3) Robust performance improvement (lean, six sigma, change management)

- **Reactionary**

HRO- Preoccupation with failure

- **Anticipatory**
- **Proactive**



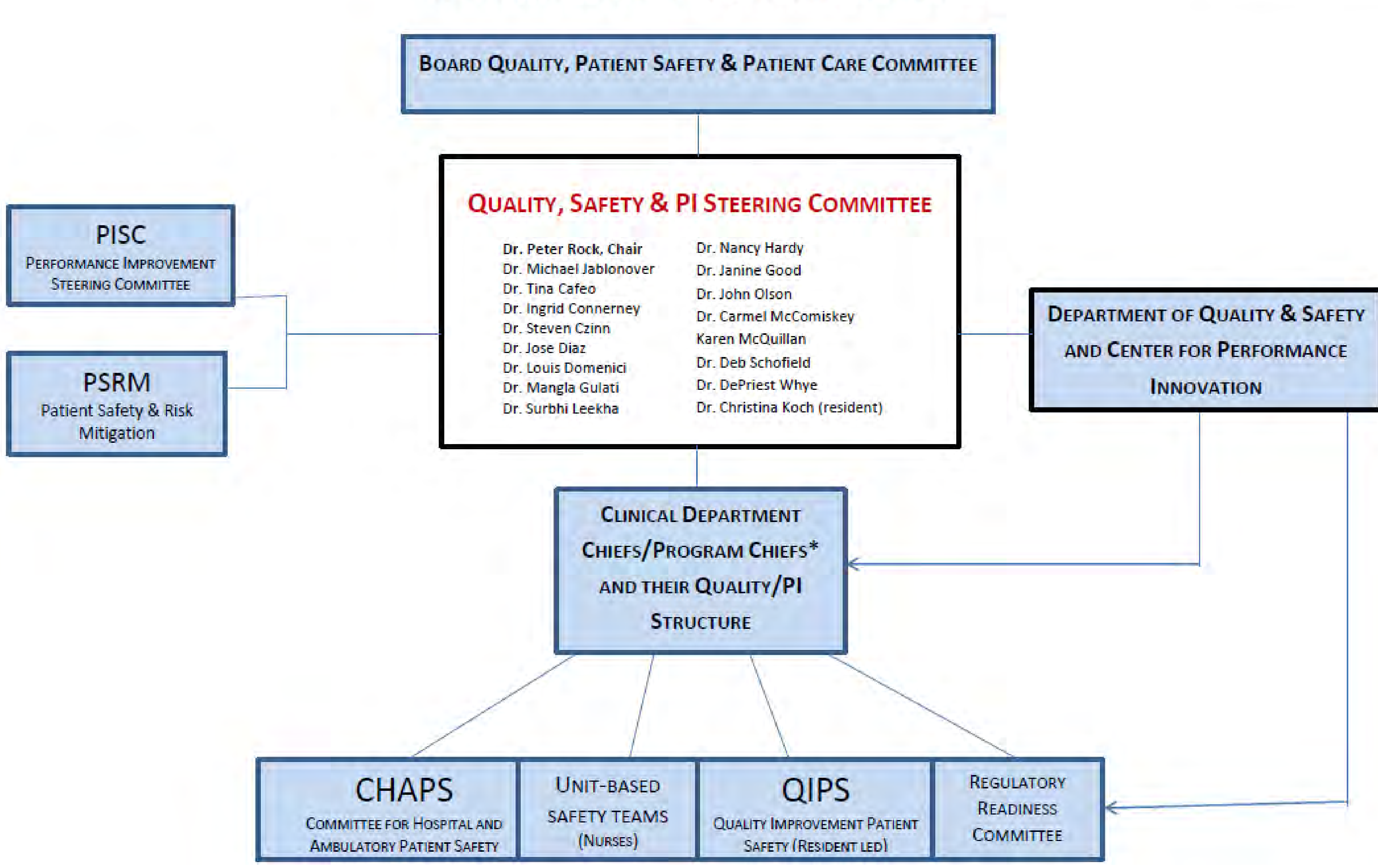
Characteristics of HROs

- ❑ **Preoccupied with Failure**
- ❑ **Resist Simplification**
- ❑ **Sensitivity to Operations**
- ❑ **Resilience**
- ❑ **Deference to Expertise**

Quality

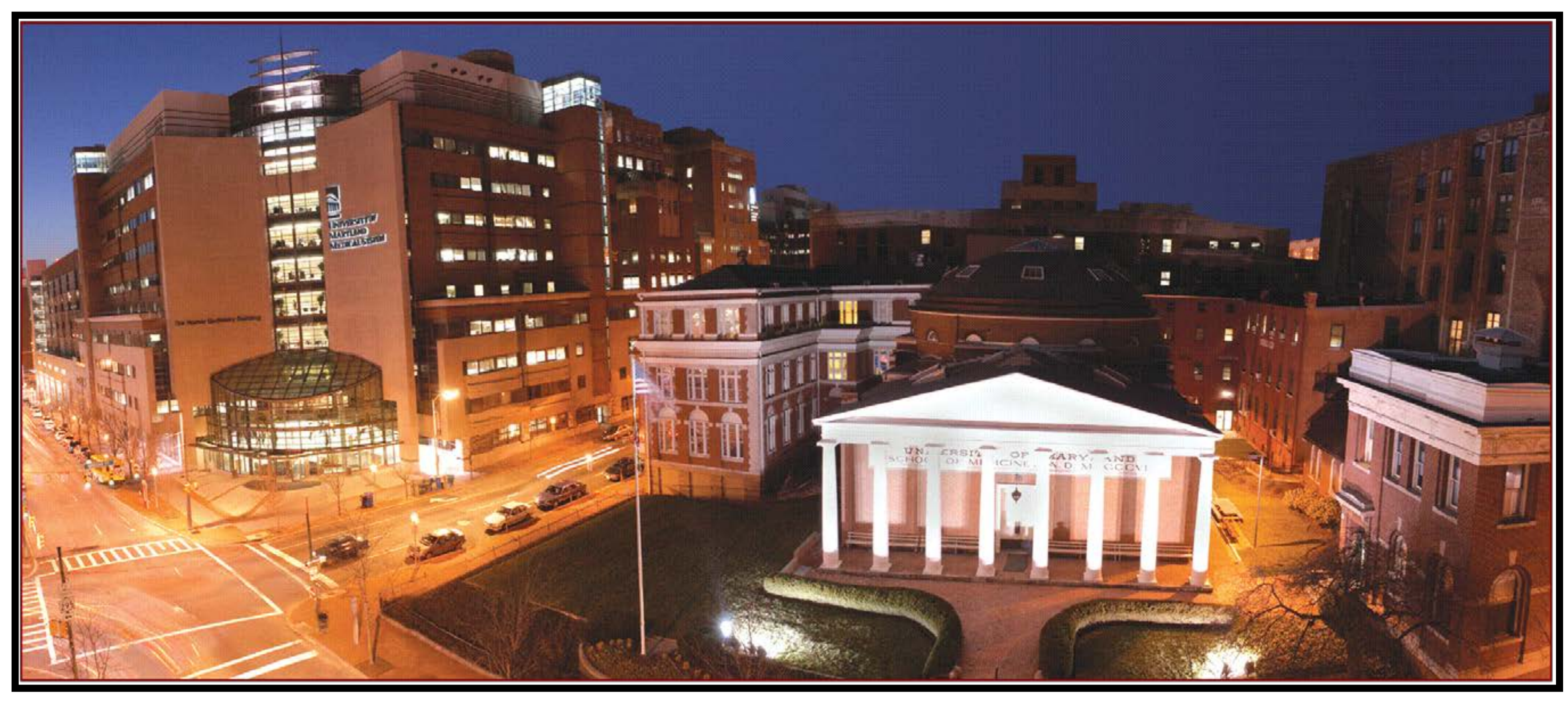
- ***High-quality care*** is care that **maximizes the likelihood of achieving outcomes valued** by patients, and requires:

- Committed leadership
- A culture of quality
    - *Dissatisfaction with the status quo; pursuit of perfection*
    - *Placing the patient first*
    - *Transparency*
- Robust Process Improvement
    - *Effective Change Management*
    - *Lean, defect-free process design and management*



Revised 9-13-16
Quality, Safety and Regulatory Readiness
Board Quality, Patient Safety & Patient Care Committee
Quality, Safety & PI Steering Committee
Dr. Peter Rock, Chair
Dr. Michael Jablonover
Dr. Tina Cafeo
Dr. Ingrid Connerney
Dr. Steven Czinn
Dr. Jose Diaz
Dr. Louis Domenici
Dr. Mangla Gulati
Dr. Surbhi Leekha
Dr. Nancy Hardy
Dr. Janine Good
Dr. John Olson
Dr. Carmel McComiskey
Karen McQuillan
Dr. Deb Schofield
Dr. DePriest Whye
Dr. Christina Koch (resident)
PISC
Performance Improvement Steering Committee
PSRM
Patient Safety & Risk Mitigation
Department of Quality & Safety and Center for Performance Innovation
Clinical Department Chiefs/Program Chiefs* and their Quality/PI Structure
CHAPS
Committee for Hospital and Ambulatory Patient Safety
Unit-based Safety Teams (Nurses)
QIPS
Quality Improvement Patient Safety (Resident led)
Regulatory Readiness Committee

Commitment to education



University of Maryland Medical Center's commitment to education

Graduate Medical Education

University of Maryland Medical Center: Our Mission

University of Maryland Medical Center is the ***academic flagship of the University of Maryland Medical System.*** *Its mission is to provide healthcare services on its* ***two campuses*** *for the Baltimore community, the State of Maryland and the nation.*

In partnership with the ***University of Maryland School of Medicine*** *and the University of Maryland health* ***professional schools****, we are committed to:*

Delivering superior healthcare,

Training the next generation of health professionals, and

Discovering ways to improve health outcomes worldwide.

We heal. We teach. We discover. We Care.

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UMMC commitment to education

- $32,000,000 in GME funding in FY 16; almost 80 programs; 900+ residents/fellows
- Trend: approximately $1,000,000 increase per year
- Hosting students from multiple schools
- External rotators
- HSL
- Simulation labs
- New MD CEO
- Medical Staff educational meetings open to all
- Developing administrative grand rounds to focus on operations and systems engineering
- Engaging residents in more committees focused on quality, safety, PI
- Engaging residents and fellows specifically in surveys focused on safety and professionalism
- Meetings with Chairs and Quality champions- explicitly seeking to have resident participation in departmental quality and safety efforts
- QIPS
- IHI education
- Telluride program
- Looking to cultivate resident leaders in quality and safety
- Working closely with SOM Education leadership to identify and address key educational (and other) concerns that we can address as partners

Thank you

Teaching on the Run!

Amal Mattu, MD, FAAEM, FACEP
Professor, Dept. of Emergency Medicine
Director, Faculty Development Fellowship
University of Maryland School of Medicine
Baltimore, Maryland

High-Yield Teaching in the ED *(Using Low Tech)*

Amal Mattu, MD, FAAEM, FACEP
Professor, Dept. of Emergency Medicine
Director, Faculty Development Fellowship
University of Maryland School of Medicine
Baltimore, Maryland
amalmattu@comcast.net

The Evidence…?

The Evidence…?

The Evidence…?

Outline

The relationship
"What if…"
Sniper rounds
3 Pearls

The Relationship

The Relationship

...between teacher and "student"

Relationship

How do you measure success in the teacher-student relationship?

Relationship

How do you measure success in the teacher-student relationship?

Is it the quantity/quality of *teaching?*

Relationship

How do you measure success in the teacher-student relationship?

Is it the quantity/quality of *teaching?*

Or the quantity/quality of *learning?*

Relationship

Basics of Overdoses/Poisonings

Hx:
- What - pill/poison
- When? → acute / chronic
- How much < # / strength
- Route: po, inhaled, IV, subcut, rectal
- Why/Priors

- Co-ingestions
- etoh?
- regular meds
- PmHx

"begins with a "D""

Tx
- Charcoal
- ~~Lavage~~
- ~~Ipecac~~
- W.B.I.
- Antidotes

1-800-2

- inpn
- tx
- resc

Phys Exam ABC!

(A) vitals
1. SaO_2
2. ↑HR, ↓HR ↑↓
3. Temp
4. BP
5. RR
6. F.S.
7.

HEENT:
pupils: miosis, mydriasis, nystagmus
(B)

CV, Resp, Abd

(C) Skin

(D) Neuro
- CN 3-12
- motor
- sensory
- REFLEXES!

Labs/Tests:

Tox: urine
- blood
- gas - VBG/ABG
- Aceta/Salicylate
- Dig, Teg - drug levels
- Etoh
- Osm

Basics
- CMP
- CBC
- lactate
- coags
- UA
- preg.

EKG

CXR
- ~~AXR~~: pills
- lead
- iron
- Li
- metals
- KCl
- CT head

DC to home → triage

BBT
lab voucher/
food

(B.O.P.) Basics of Overdoses/Poisonings

Hx:
- What - pill/poison
- When? → acute / chronic
- How much < # / strength
- ~~E~~ (Look ←)
- Route - po - inhaled - IV - subcut - rectal
- Why / Priors

- Co-ingestions
- EtOH?
- regular meds
- PMHx

"begins with a 'D'"

Tx
- Charcoal
- ~~Lavage~~
- ~~Ipecac~~
- W.B.I.
- Antidotes

1-800-2
- inpn
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Phys Exam ABC!

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Ⓑ

CV, Resp, Abd

Ⓒ Skin

Ⓓ Neuro
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EKG!

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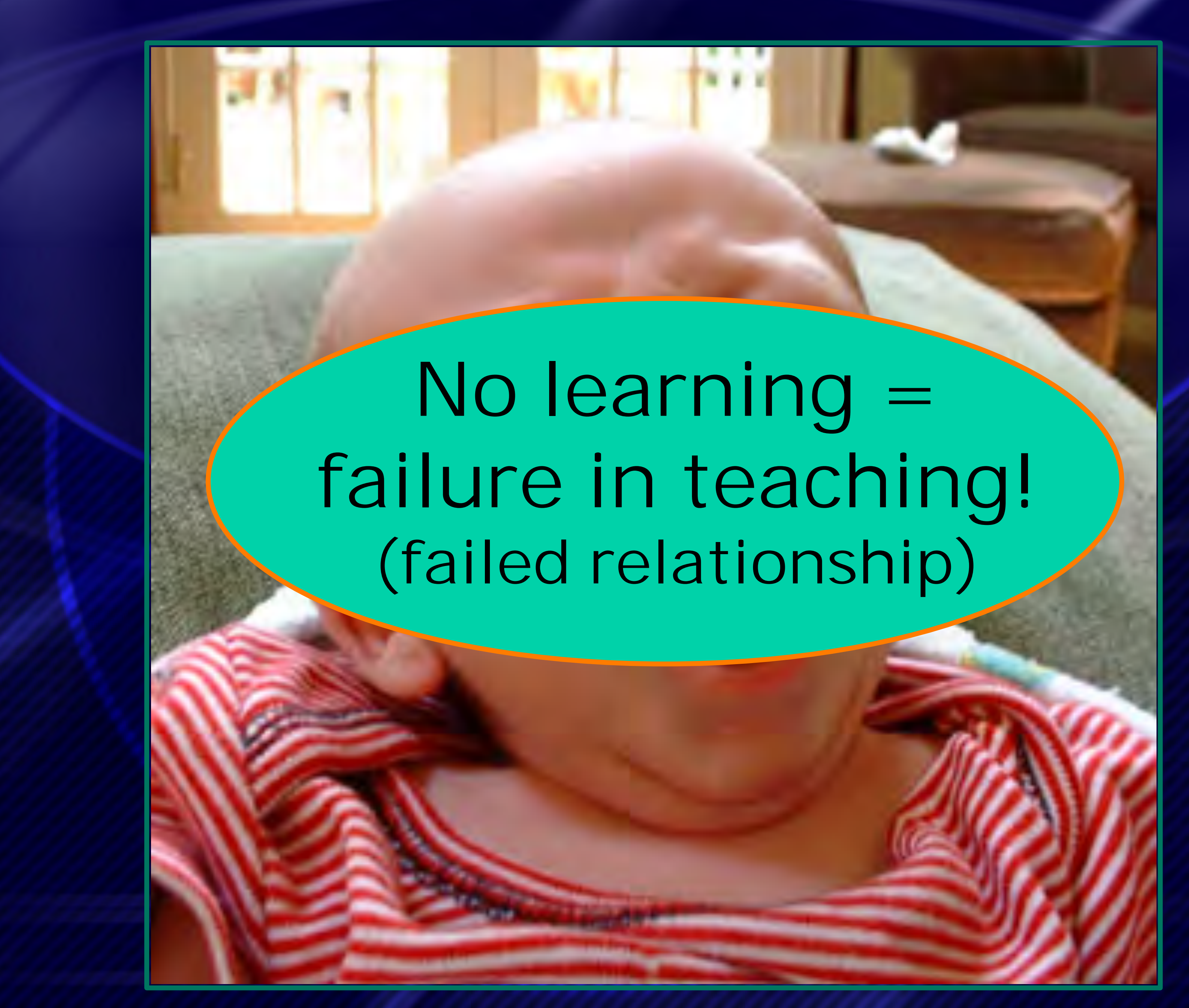
DC to home → triage

BBT, lab voucher, food


No learning =
failure in teaching!
(failed relationship)

Relationship

If the success of the relationship is based on how much is *learned*...

Relationship

If the success of the relationship is based on how much is *learned*...the "learnable moment" is more important than the "teachable moment."

Relationship

If the success of the relationship is based on how much is *learned,* a successful teacher must “diagnose the learner”

1. Teach when the student is ready.

Relationship

If the success of the relationship is based on how much is *learned,* a successful teacher must "diagnose the learner"

1. Teach when the student is ready.
2. Teach at the level of the student.

Relationship

If the success of the relationship is based on how much is *learned,* a successful teacher must “diagnose the learner”

1. Teach when the student is ready.
2. Teach at the level of the student.
3. Teach for the student, not the teacher.

Don’t teach to show off how much you know!

Relationship

If the success of the relationship is based

earned, a successful

agnose the learner"

student is ready.

l of the student.

dent, not the teacher.

w off how much you

know!

Keep the message brief (shotgun vs.....)

Relationship

If the success of the relationship is based

know!

Keep the message brief (shotgun vs. sniper)

Relationship

- If the success of the relationship is based on how much is *learned,* the <u>student</u> is more important!

Relationship

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Teach faculty how to be better teachers.

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Teach faculty how to be better teachers.

Teach students to be better learners!

Relationship

If the success of the relationship is based on how much is *learned,* the student is more important!

Teach faculty how to be better teachers.

Teach students to be better learners!

4. Demand the attention of the students! (make students take responsibility)

Relationship

- State your expectations for learning at the start of the shift/week

Relationship

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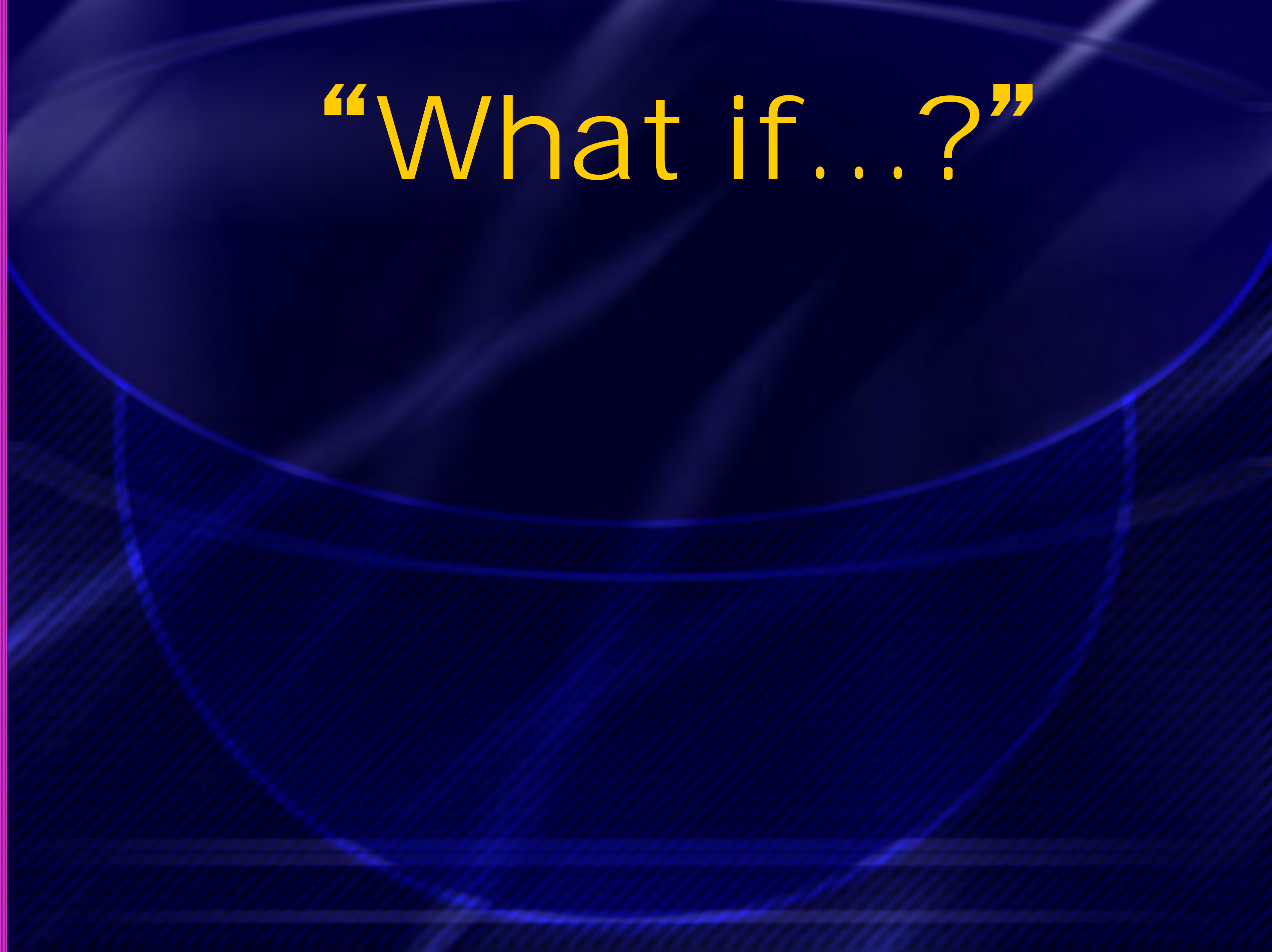
- Students are much more likely to meet your expectations if you discuss up-front

Relationship

- State your expectations for learning at the start of the shift/week
- Students are much more likely to meet your expectations if you discuss up-front
- "I'm going to assess what you've learned at the end of the shift/day."

Specific Techniques


“What if…?”

“What if...?”

Effective for...

1. Expanding the range of learning (esp. for more advanced students)
2. Keeping student “on guard,” avoiding tunnel vision
3. Learning associations
4. Making mundane cases more interesting

“What if…?”

Example:

30 yo woman presents with back ache.

VS: afeb, HR 90, RR 20, BP 160/90

Exam c/w muscular back ache.

“What if…?”

<u>Example:</u>

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Exam c/w muscular back ache.

“What if she were 28 wks pregnant?”

"What if…?"

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Exam c/w muscular back ache.

"What if she were 28 wks pregnant?"

→ Opens discussion of pre-eclampsia

“What if…?”

<u>Example:</u>

30 yo woman presents with back ache.

VS: afeb, HR 90, RR 20, BP 160/90

Exam c/w muscular back ache.

“What if that patient began to sieze?”

→ Opens discussion of eclampsia mgmt.

"What if…?"

Example:

25 yo man presents with asthma.

VS: afeb, HR 90, RR 20, BP 160/90

Exam c/w mild asthma.

“What if…?”

Example:

25 yo man presents with asthma.

VS: afeb, HR 90, RR 20, BP 160/90

Exam c/w mild asthma.

“What if he crashes, needs RSI?”

“What are your concerns? Vent issues?”

“What if…?”

<u>Example:</u>

25 yo man presents with asthma.

VS: afeb, HR 90, RR 20, BP 160/90

Exam c/w mild asthma.

“What if he crashes immediately after RSI…what could be the cause?

“What if…?”

<u>Example of associations:</u>

25 yo man presents with diarrhea.

Nothing notable to discuss???

“What if…?”

<u>Example of associations:</u>

“What if this patient with diarrhea…”

“What if…?”

<u>Example of associations:</u>

“What if this patient with diarrhea…”

“…has a pet iguana at home?”

“What if…?”

Example of associations:

“What if this patient with diarrhea…”

“…has a pet iguana at home?”

“…is 2 yo. and just had a febrile sz?”

“What if…?”

Example of associations:

“What if this patient with diarrhea…”

- “…has a pet iguana at home?”
- “…is 2 yo. and just had a febrile sz?”
- “…had ground beef and has bloody d.?”

"What if…?"

<u>Example of associations:</u>

"What if this patient with diarrhea…"

"…has a pet iguana at home?"

"…is 2 yo. and just had a febrile sz?"

"…had ground beef and has bloody d.?"

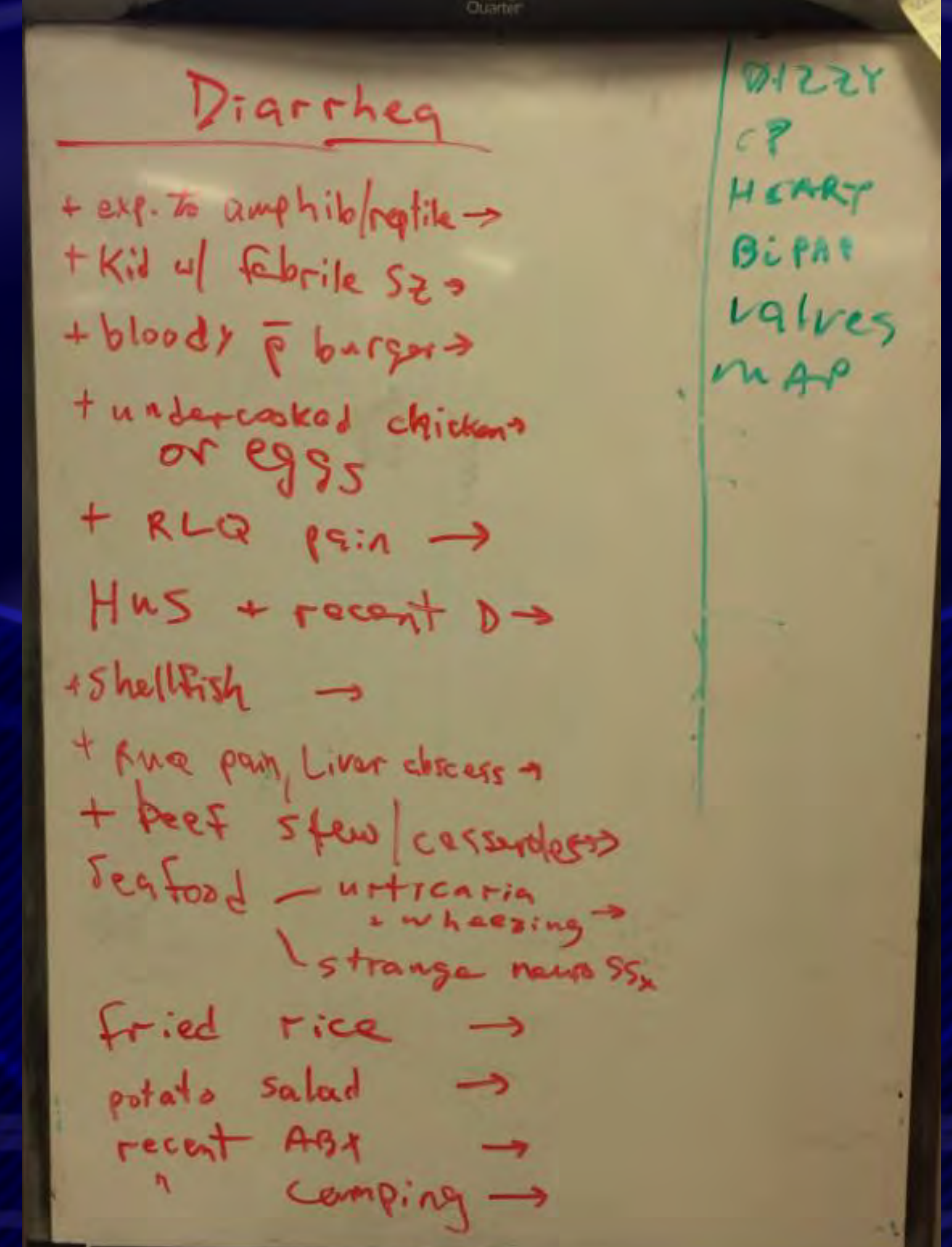
"…has severe RLQ pain (like appe.)?"

“What if…?”

Example of associations:

“What if this patient with diarrhea…”

- “…has a pet iguana at home?”
- “…is 2 yo. and just had a febrile sz?”
- “…had ground beef and has bloody d.?”
- “…has severe RLQ pain (like appe.)?”
- “…recently was camping in the mtns.”


Quartet
Diarrhea
+ exp. to amphib/reptile →
+ Kid w/ febrile Sz →
+ bloody p̄ burger →
+ undercooked chicken → or eggs
+ RLQ pain →
HUS + recent D →
+ Shellfish →
+ RUQ pain, Liver abscess →
+ beef stew/casseroles →
Seafood — urticaria + wheezing →
strange neuro SSx
fried rice →
potato salad →
recent ABX →
" camping →
DIZZY
CP
HEART
BiPAP
valves
MAP

Whiteboard

People remember...

- 25% of what they hear
- 50% of what they hear + see
- 75% of what they hear, see, and do

“What if…?”

Depending on student, can focus on…

1. Hx/PE: If patient had pre-eclampsia, what other SSx to look for?

“What if…?”

Depending on student, can focus on…

1. Hx/PE: If patient had pre-eclampsia, what other SSx to look for?
2. Medication effects:
   - Patient on warfarin, ask what ABX to use if UTI present.
   - Patient on prednisone, ask what to consider if patient hypoglycemic and hypotensive.

"What if…?"

Depending on student, can focus on…

1. Hx/PE: If patient had pre-eclampsia, what other SSx to look for?
2. Medication effects:
   - Patient on warfarin, ask what ABX to use if UTI present.
   - Patient on prednisone, ask what to consider if patient hypoglycemic and hypotensive.
3. Complics: If asthmatic on vent crashes…

“What if…?”

Teach associations and summarize:

“So remember, crashing immediately after intubation = misplaced tube, tPTX, hypovolemia, tamponade.”

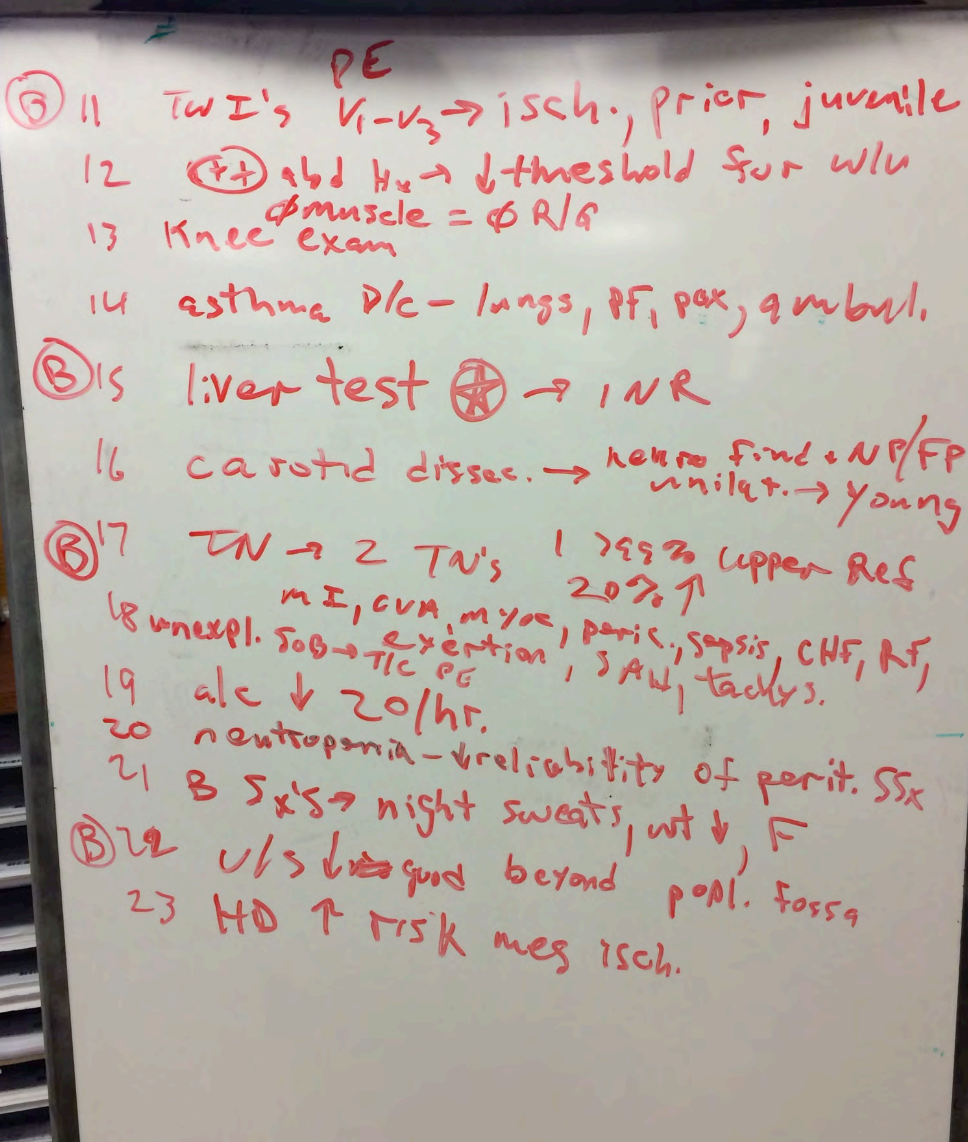
“Prednisone user with hypoglycemia and/ or hypotension → think adrenal insufficiency.”

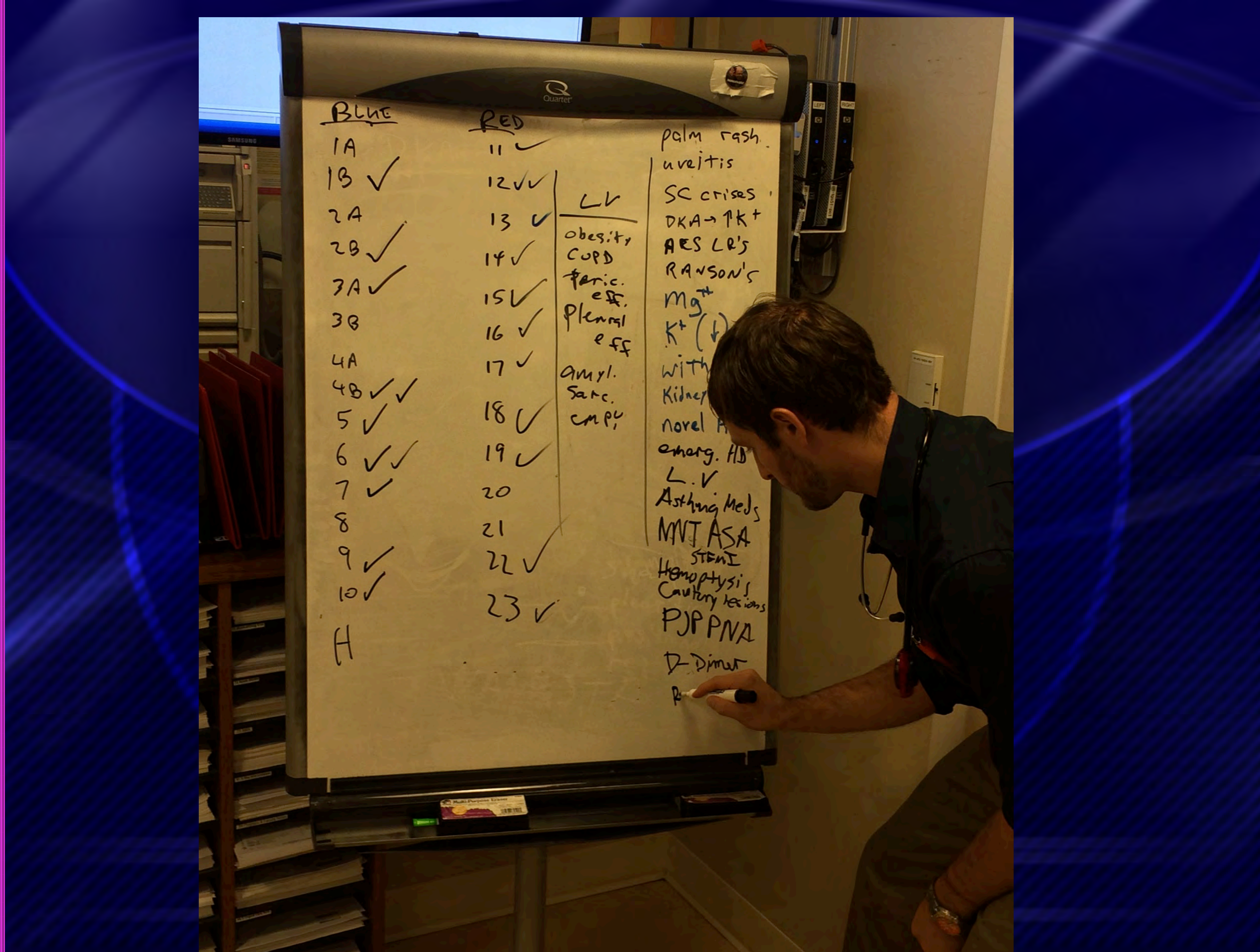
Sniper Rounds

Change User | Quick | Active Patients | 01:59

Patient Name	Date	Time	Presenting Illness	User	Location	A	Stay
Stat3, Stat3	07/30/1999	10:05	ASTHMA	Nurse	Asthma Room	3	>48 Hrs.
Smyth, J	05/07/2000	16:49	Back Pain	Nurse		3	>48 Hrs.
Smyth, M	05/07/2000	16:50	Pain	Resident		4	>48 Hrs.
Smyth, D	05/07/2000	16:50	EAR PAIN			3	>48 Hrs.
Smyth, H	05/07/2000	16:50	Difficulty Breathing			3	>48 Hrs.
Smyth, S	05/07/2000	16:51	Hives			3	>48 Hrs.
Smyth, L	05/07/2000	16:52	Laceration	Fox		3	>48 Hrs.
Smyth, R	05/07/2000	16:53	Mva			3	>48 Hrs.
Smyth, N	05/07/2000	16:53	GSW	Nurse	Bed 01	5	>48 Hrs.
Smtyh, V	05/07/2000	16:54	Head Injury	Fox		4	>48 Hrs.
Smyth, Z	05/07/2000	16:54	Cpr		Bed 02	5	>48 Hrs.
Smyth, B	05/07/2000	16:58	Sore Throat	Fox		0	>48 Hrs.
Stat19, Stat19	06/06/2002	00:23		Nurse		4	>48 Hrs.
Stat21, Stat21	06/08/2002	03:24	Asthma	Fox		0	>48 Hrs.
Stat22, Stat22	06/08/2002	03:24	Sore Throat				>48 Hrs.
Stat26, Stat26	06/17/2002	04:11	CP	Fox		5	>48 Hrs.
Stat26, Stat26	06/17/2002	04:11	CP	Fox		5	>48 Hrs.
Stat28, Stat28	06/18/2002	00:53	Chest Pain	Fox		5	28:56:29
Stat30, Stat30	06/18/2002	04:15	Fractured Ankle	Nurse		3	25:34:29
Stat31, Stat31	06/18/2002	04:40	Asthma	Nurse		3	25:09:29

- 1 Pearl for each room





Quartet
BLUE
1A
1B
2A
2B
3A
3B
4A
4B
5
6
7
8
9
10
H
RED
11
12
13
14
15
16
17
18
19
20
21
22
23
LV
obesity
COPD
Peric. eff.
Pleural eff
amyl.
Sarc.
CMP
palm rash
uveitis
SC crises
DKA → ↑K+
AES LR's
RANSON's
Mg++
K+ (↓)
emerg. HD
L.V
Asthma Meds
MNT ASA
STEMI
Hemoptysis
Cautery lesions
PJP PNA
D-Dimer

"3 Pearls"

- At the end of every shift, each resident and student must write down 3 pearls they learned during that shift
- Inform at the beginning of the shift

Pearls

Nicole

1. To splint 1st metacarpal or Scaphoid - wrist + elbow, prevent supination
2. Propofol → Hypotension
   ketamine → Emergence
3. CHF → PE, Nitro + ACEI + PPV

Leen

1. Syncope + ST Elevation think Brugada
2. Dialysis (toxic) I STUMBLE
3. Propofol vs. Ketamine
   ↓ short ↓ longer

Nansen

1. Cause of LE edema in CHF.
2. Isopropyl alcohol metabolism.
3. Imaging for pseudocyst in pancreatitis

Van

1. Syncope EKG - ACS, PE, Intervals (WPW) Brugada, ARVD, HCOM
2. Li OD - Acute vs. Chronic Sxs tm - Fluid!
3. HTN ↑ is there end organ involvement (brain, ♡, kidney, eyes)

HTN
Syncope
ISTUMBLE
AKI/HD
BUCKET
PROC. SED.
SHOULDER D.SLOC

Summary

Summary

- Relationship
  - Focus on the student's needs.
  - Improving learning skills is more important than improving teaching skills.
  - Engage the student to take responsibility.
  - Tell student you will be assessing what they learned at the end of the shift.

Summary

“What if…?”

- Provides numerous new teaching opportunities with even mundane cases.
- Be imaginative! Be tangential!
- Keeps students on their toes!

Summary

Sniper rounds: commit yourself to teaching ONE pearl for each patient

Summary

Each learner must <u>write down</u> 3 pearls they've learned

Key Point!

Focus on the learner, not what you know!

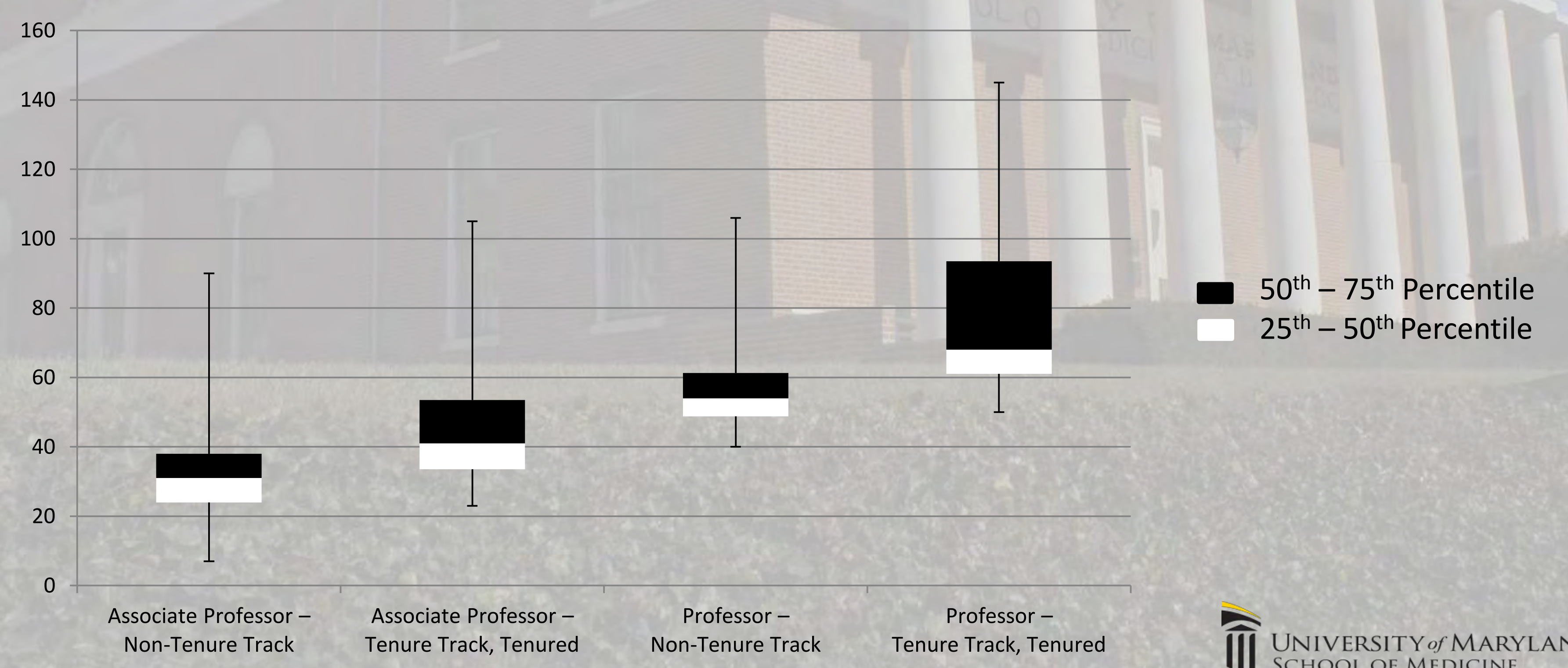
Thanks, and good luck teaching!

FY14-FY16 APT Analysis

Total Peer-Reviewed Articles for Successful *Full-Time* Promotion and/or Tenure Candidates

(does not include new appointments)

Rank, Tenure Status	Successful Actions	Total Articles the Year of Review	
		25th Percentile	75th Percentile
Associate Professor – Non-Tenure Track	65	24	38
Associate Professor – Tenure Track, Tenured	39	34	54
Professor – Non-Tenure Track	20	49	61
Professor – Tenure Track, Tenured	23	61	94



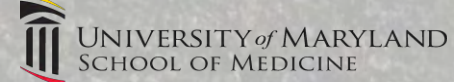
University of Maryland School of Medicine

FY14-FY16 APT Analysis

Total Citations for Successful *Full-Time* Promotion and/or Tenure Candidates

(does not include new appointments)

Rank, Tenure Status	Successful Actions	Total Citations the Year of Review	
		25th Percentile	75th Percentile
Associate Professor – Non-Tenure Track	65	254	1096
Associate Professor – Tenure Track, Tenured	39	607	2409
Professor – Non-Tenure Track	20	628	2994
Professor – Tenure Track, Tenured	23	1179	2938



Promotion: Faculty Perspective

Stephen M. Kavic, MD

Department of Surgery

University of Maryland

Baltimore, MD

The Premise:

Everybody Wants to be Promoted

Why Get Promoted?

- Validation by Department
- Recognition from School
- Acknowledgment from fellow faculty
- ? Permanent
- ? Increased compensation

Faculty Ideal

Faculty Fear

Overview

- Review of promotion process
- Resources
  - Internal and external
- Tips

The Basic Hierarchy

- Instructor
- Assistant Professor
- Associate Professor
- Professor

- Tenure and non-tenure track

The key principle is that you need to explain why you should be promoted

What You Need

- *CV*
- Reprints
- Educational portfolio
- Clinical portfolio
- Personal statement
- Letters of recommendation

The

CV

Curriculum vitae

- UMSOM format
- http://medschool.umaryland.edu/academicadmin/cv_format.asp
- Major sections:
  - Name, Date
  - Education
  - Post graduate training
  - Employment history
  - Honors and awards
  - Clinical activities
  - Administrative service
  - Teaching
  - Grant support
  - Publications
  - Major invited speeches
  - Proffered communications

Do It Now!

- There is no good reason that your cv is not in UMSOM format

SAMPLE CV

Curriculum Vitae
Name, degrees
Assistant Professor, Department of (official department name)
University of Maryland School of Medicine (or current institution)

Date August 1, 2015

Contact Information

Business Address:	Department of xxxxx Street address, Room number City, State zip code
Business Phone Number:	(410) 999-9999
Fax:	(410) 999-9999
Email:	email address
Foreign Languages:	French (working knowledge)

Education

1999	B.S., Biology, Princeton University (Magna Cum Laude)
2000	M.D., University of Arizona School of Medicine
2001	Ph.D., Neuroscience, Columbia University, Thesis Advisor – name "Title of thesis" (optional)
2002	M.P.H., Johns Hopkins School of Public Health, Epidemiology

Post Graduate Education and Training

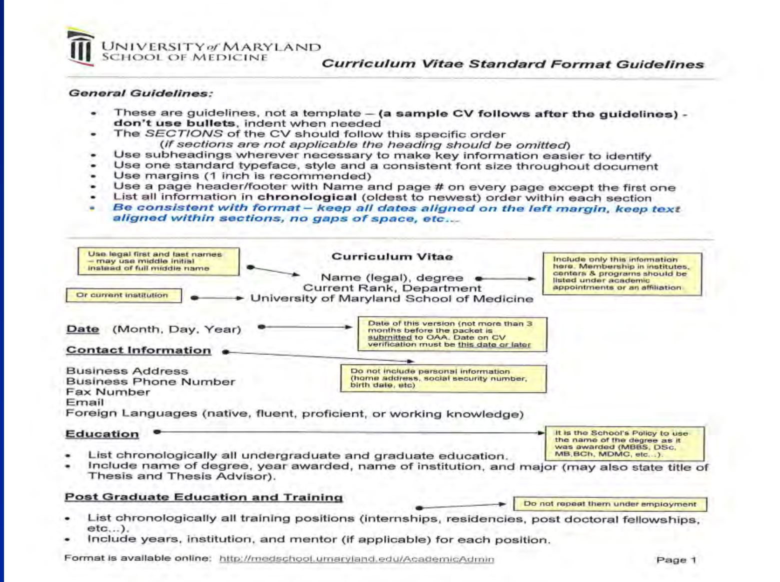
9999 - 9999	Internship, Institution Name
9999 - 9999	Residency, Orthopaedic Surgery, Institution Name
9999 - 9999	Fellowship, Neurology, Institution name

Certifications

9999	Diplomat, National Board of Medical Examiners
9999	Diplomat, American Board of Psychiatry and Neurology

Medical Licensures

Inactive	California
Inactive	New York
Active	Maryland



UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

Curriculum Vitae Standard Format Guidelines

General Guidelines:

- These are guidelines, not a template – **(a sample CV follows after the guidelines) - don't use bullets**, indent when needed
- The *SECTIONS* of the CV should follow this specific order
  (*if sections are not applicable the heading should be omitted*)
- Use subheadings wherever necessary to make key information easier to identify
- Use one standard typeface, style and a consistent font size throughout document
- Use margins (1 inch is recommended)
- Use a page header/footer with Name and page # on every page except the first one
- List all information in **chronological** (oldest to newest) order within each section
- ***Be consistent with format – keep all dates aligned on the left margin, keep text aligned within sections, no gaps of space, etc…***

Use legal first and last names – may use middle initial instead of full middle name

Or current institution

Curriculum Vitae
Name (legal), degree
Current Rank, Department
University of Maryland School of Medicine

Include only this information here. Membership in institutes, centers & programs should be listed under academic appointments or an affiliation

Date (Month, Day, Year)

Date of this version (not more than 3 months before the packet is submitted to OAA. Date on CV verification must be this date or later

Contact Information

Do not include personal information (home address, social security number, birth date, etc)

Business Address
Business Phone Number
Fax Number
Email
Foreign Languages (native, fluent, proficient, or working knowledge)

Education

It is the School's Policy to use the name of the degree as it was awarded (MBBS, DSc, MB,BCh, MDMC, etc…).

- List chronologically all undergraduate and graduate education.
- Include name of degree, year awarded, name of institution, and major (may also state title of Thesis and Thesis Advisor).

Post Graduate Education and Training

Do not repeat them under employment

- List chronologically all training positions (internships, residencies, post doctoral fellowships, etc…).
- Include years, institution, and mentor (if applicable) for each position.

Format is available online: http://medschool.umaryland.edu/AcademicAdmin

Page 1

Service

- Promotion is from the School of Medicine

- Service to the school is at a premium
  - Don’t quit hospital committees!
  - Don’t abandon the residents!
  - Do consider your UMSOM efforts

Reprints

Reprints

- The APT committee requests 5 reprints
- You choose
- “Publish or perish”
- “Publish and promote!”

Let's Do the Numbers

- Associate Professor
  - 25 Peer-reviewed publications
- Professor
  - 50 Peer-reviewed publications

- Watson and Crick wrote 1 two-page paper!

The Educational Portfolio

The Educational Portfolio

- Summarizes your experience with teaching
- OK, everybody teaches
- How can you describe and quantify what you do?

Educational Portfolio

- Direct teaching
- Mentoring and advising
- Educational leadership
- Educational scholarship

Educational Portfolio

- Documentation of teaching
  - Where, when, to whom, etc
- Educational materials you created
  - Handouts, lecture materials
- Documentation of effectiveness
  - Student ratings
- Outcomes
  - Improved performance on shelf exam
- Honors and awards

Preparing Your Portfolio

- Begin now!
  - Keep track of your lectures
  - Maintain records of your own evaluations
- Visit a website
  - https://cft.vanderbilt.edu/guides-sub-pages/teaching-portfolios/

See Nancy Lowitt

- Associate Dean of Faculty Affairs and Professional Development
- Nlowitt@som.umaryland.edu

The Clinical Portfolio

The Clinical Portfolio

- What do you bring to the table as a practitioner?

- Patient care
- Leadership roles

Patient Care

- What are your areas of expertise?
- What is your volume of practice?
  - Compare visits or procedures to average in the Division
- What is your quality of care?
  - Performance metrics
- How have you changed practice at Maryland?

Making The Portfolio

- Talk to your Division Administrator
- Get control of your own data
- Gather data to reinforce the scope of the problems that you address
  - Just like the introduction in a paper or a grant

The Personal Statement

The Personal Statement

- You probably thought you had written your last personal statement!
- A summary of your experience and your philosophy

Personal Statement Sections

- Introduction
- Teaching and education
- Clinical responsibilities
- Research activities
- Administrative service

The Personal Statement

- Allows you to reflect
- Allows you to place context around data
- Allows you to describe what roles are most meaningful to you

Writing the Personal Statement

- Just start!
- Write each section as if you were describing your roles to a visiting professor who has not reviewed your cv
- Keep it brief!
  - A few paragraphs per section
  - 4 pages total, maximum!

Letters of Recommendation

Letter from the Chair

- You must have the support of your Department chair!
- Best place to start the process is with a conversation with the Chair
- The Chair's office is intimately familiar with the format and the timing

Internal Letters

- At least 3, no more than 5
- Writers have same or higher academic rank as proposed for candidate
  - No bullying residents for kind words!
- Letters are solicited by Chair or Departmental Committee
  - You provide suggestions
  - Think carefully about who would recommend you

The Letters Themselves

- Have a very specific format
  - Exact name, title, specific rank and tenure status
- Must conform to the format
- Leave as much time as possible to ensure the letters are completed!
  - Choose reliable writers!

External Letters

- At least 5, no more than 7
- Writers have same or higher academic rank as proposed for candidate
- Solicited by Chair or Department, at your suggestion

Independent Letters

- At least 3 have to be "independent"
- Not a collaborator, colleague, mentor or mentee
- Concept is person who knows your reputation
- Perhaps study section member, co-moderator on a panel, professional society or committee member

Getting Letters

- Start thinking about your references
  – Assemble a list with contact information
- Consider independent writers
  – Make sure that you are active on committees, at conferences, etc.

Final Thoughts

Timing of Promotion

- Rule of thumb:

  Typically five years or more at level before promotion

Timeline

- Decision to promote
- Application November
- Department committee December
- APT Spring
- Effective date July 1

And Most Importantly

Find Some Friends!

- You will need help and advice throughout this process
- Someone that has gone through this will provide more insight than any brief talk

Summary

- Getting promoted is good
- Getting promoted is a bit of work for the faculty member
- Knowing what will be asked helps you meet requirements in advance

Quality Improvement (and Patient Safety) as a Teaching Tool

Jason W. Custer, MD
Kerri A. Thom, MD, MS

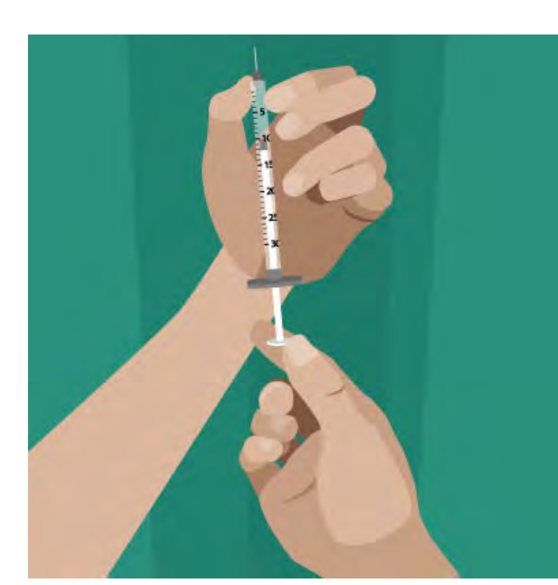
A Case

- On a busy night in the emergency department of a pediatric hospital, an intern orders an insulin dose with an extra “0” for a patient with diabetes and hyperglycemia.

- The electronic ordering system does not flag the order, and the nurse doesn’t catch it before he administers the ten-fold dose.

- As a result, the patient experiences mild hypoglycemia; when given orange juice, the patient’s blood sugar levels increase.

- After ensuring the patient is OK, both the nurse and the intern go back and check the insulin order, discovering the dosing error.



From: IHI Open School:
http://app.ihi.org/lmsspa

An Opportunity Missed

- The intern immediately alerts the attending. The attending reassures her that "no harm was done," but wonders aloud if they should file a voluntary electronic report "just to cover ourselves."

- No one informs the patient, who has no parents at the bedside, of the error.

Every day opportunities

- Ordering an unnecessary test
- Failing to remove an invasive device that was no longer needed
- Neglecting to stop an antibiotic despite negative cultures
- Delays in discharge or in performing a procedure
- Suboptimal communication
- Wrong medication dosages, late medications or missed doses

From Our Patients

- https://www.youtube.com/watch?v=3SfrQnwRIjU

Carole Hemmelgarn

“Where we are *NOW* as a healthcare system and where we are *TEN YEARS* from now is going to look vastly different”

From Our Patients

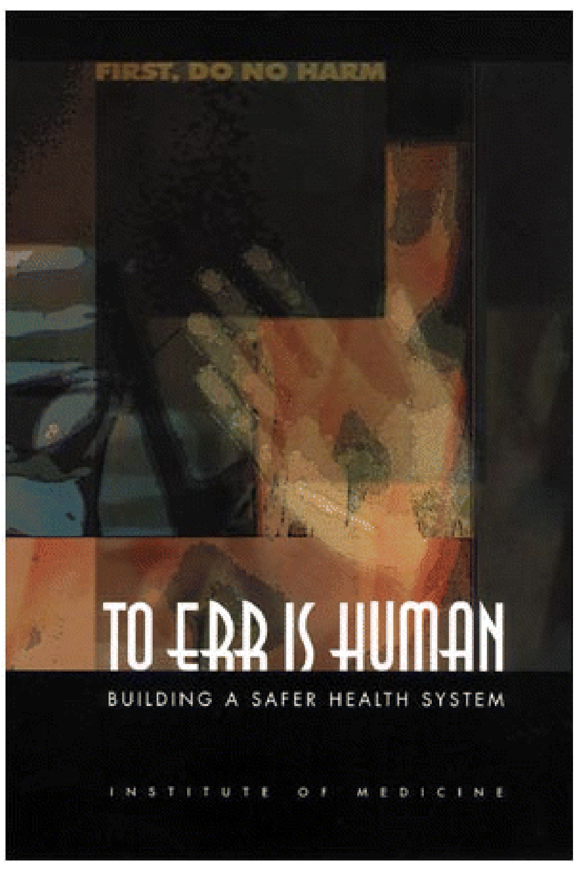
- https://www.youtube.com/watch?v=3SfrQnwRIjU

Components of QI

- Ongoing assessment
- Examines systems/processes
- Patient and outcome-oriented
- Seeks improvement
- Better patient outcomes; better patient care
- **Data driven**
  - *'integrated into the overall process of delivering health care rather than a stand-alone activity"*

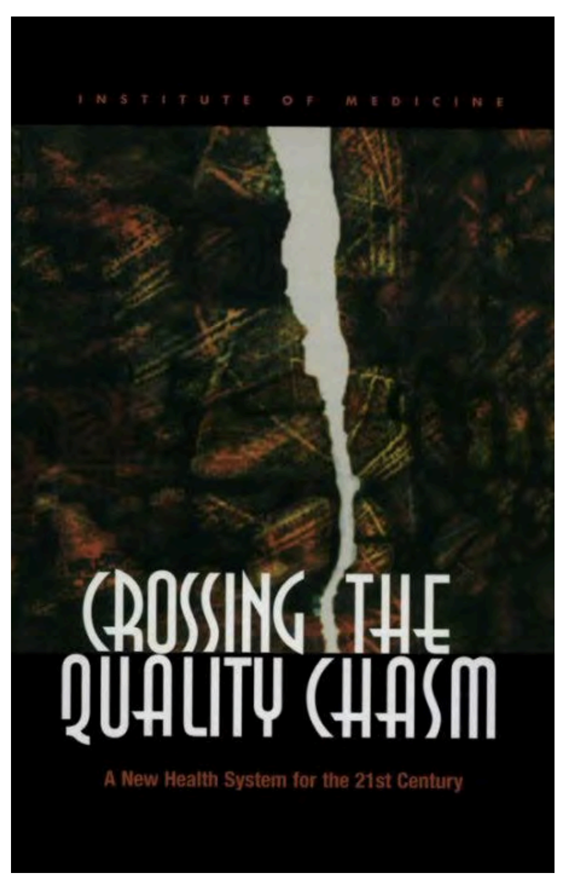
Healthcare Quality
The Current State?

Building the case for CHANGE



1999

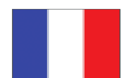
98,000 people die each year of ***PREVENTABLE*** errors



2001

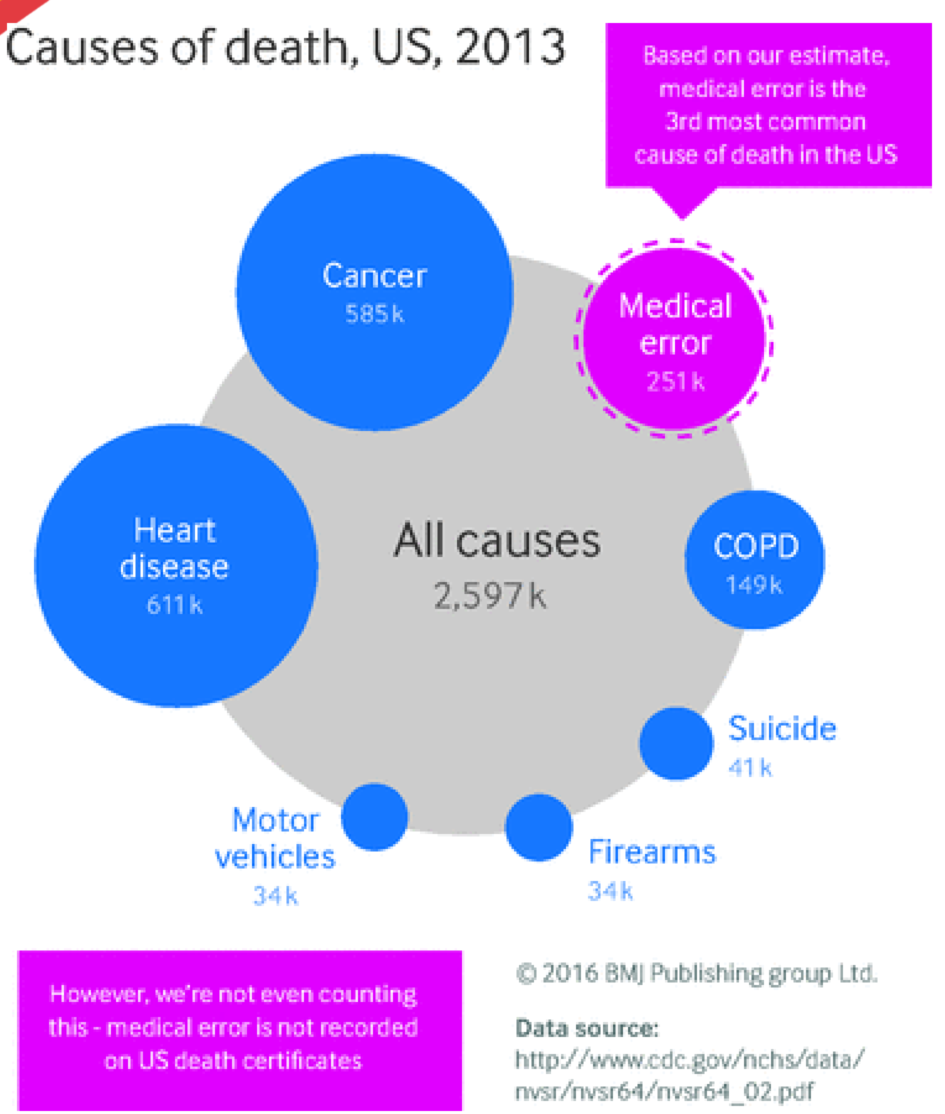
Americans NOT receiving quality healthcare

Building the case for CHANGE



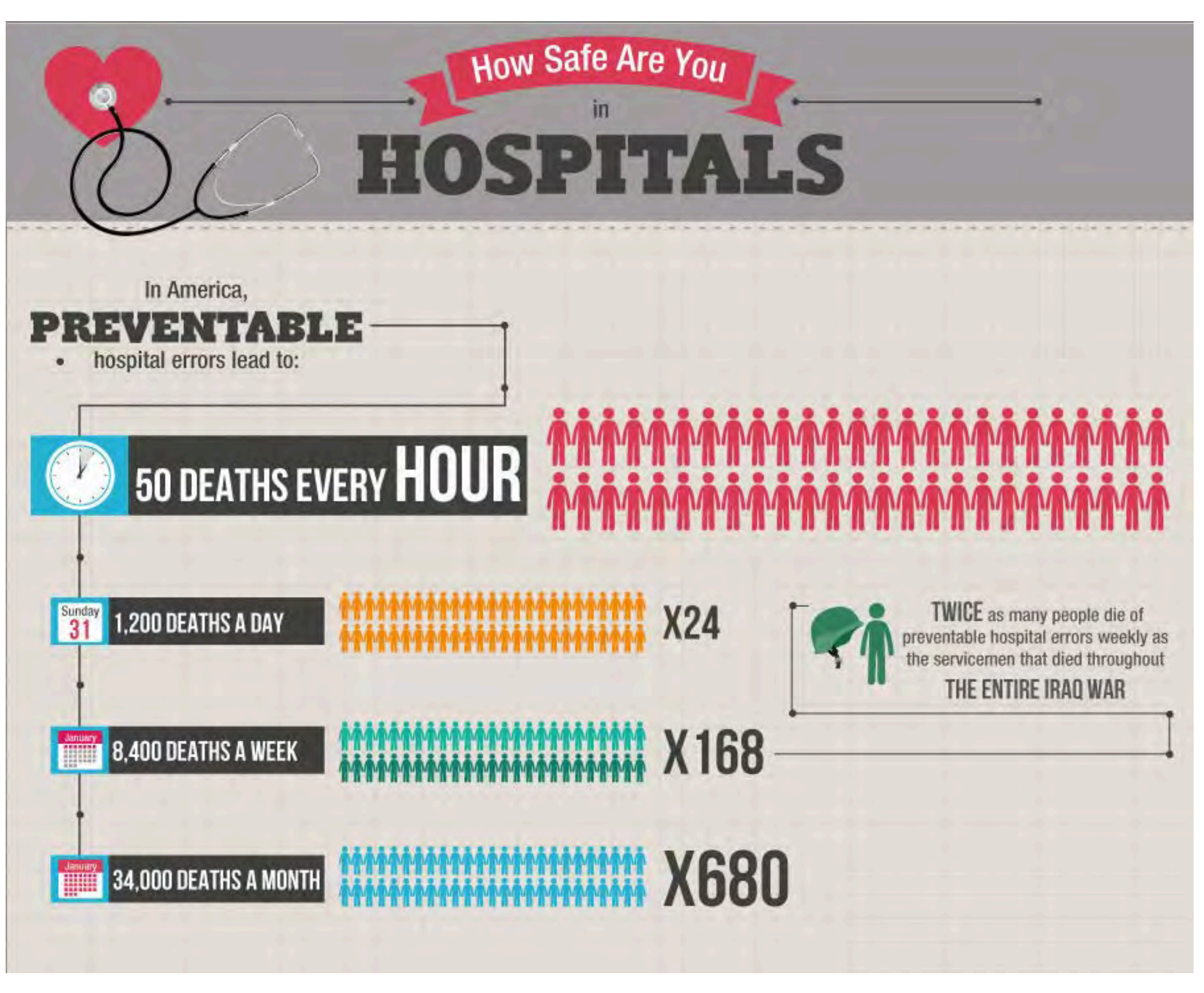
3 (Paris: OECD, Nov. 2013).

Building the case for CHANGE



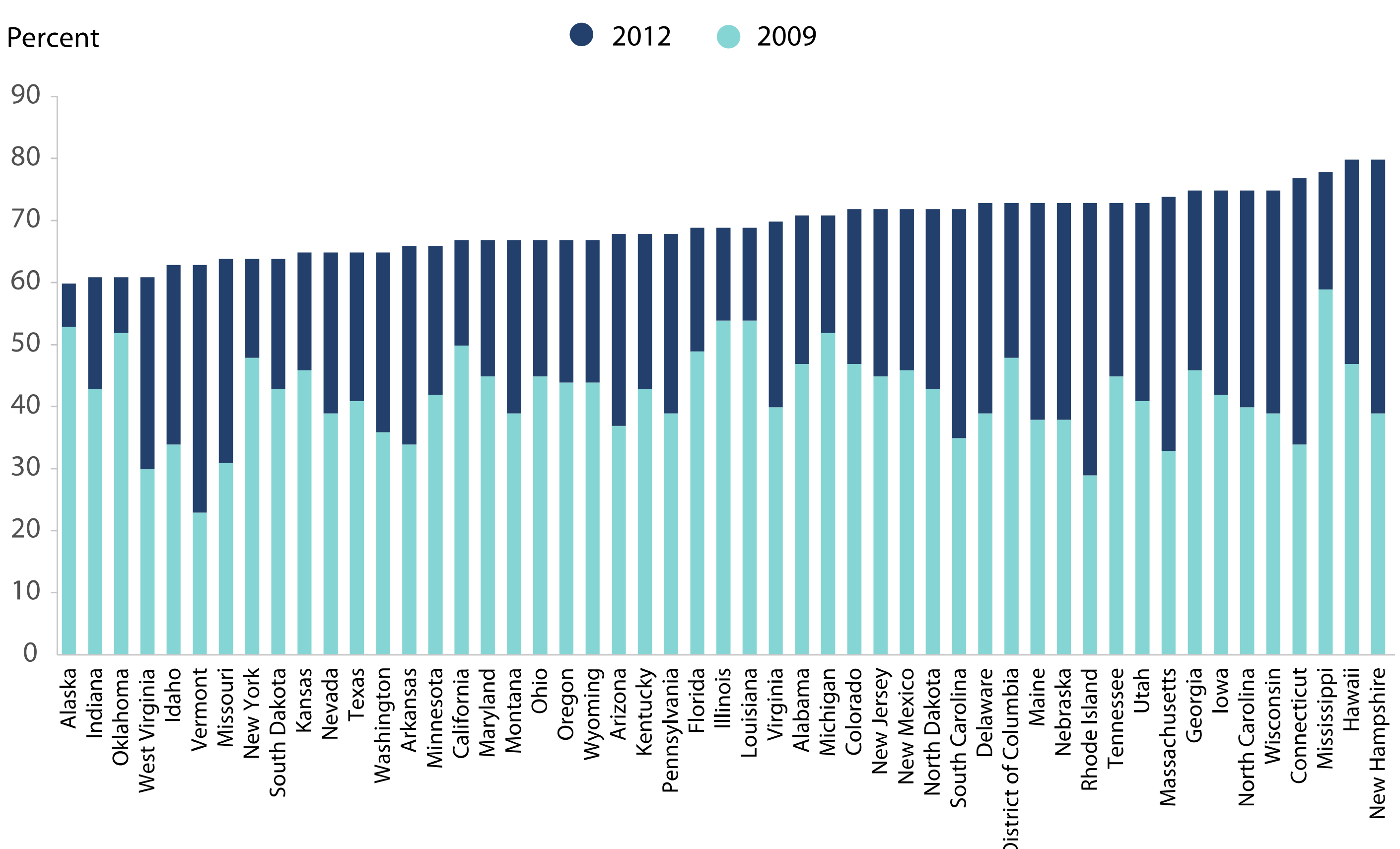
Medical Errors are the *THIRD* Leading Cause of Death in the US

Building the case for CHANGE
Where are we falling short?



Building the case for CHANGE

Where are we falling short?



Building the case for CHANGE

Where are we falling short?

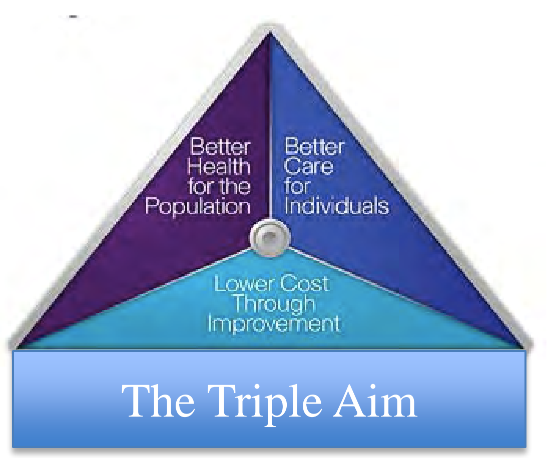
- Preventable errors/harm
- Access to care/healthcare disparities
- Avoidable utilization of care
- Over treatment
- Over diagnosis
- Unwarranted variation of care

Where do we want to be?

The Triple Aim

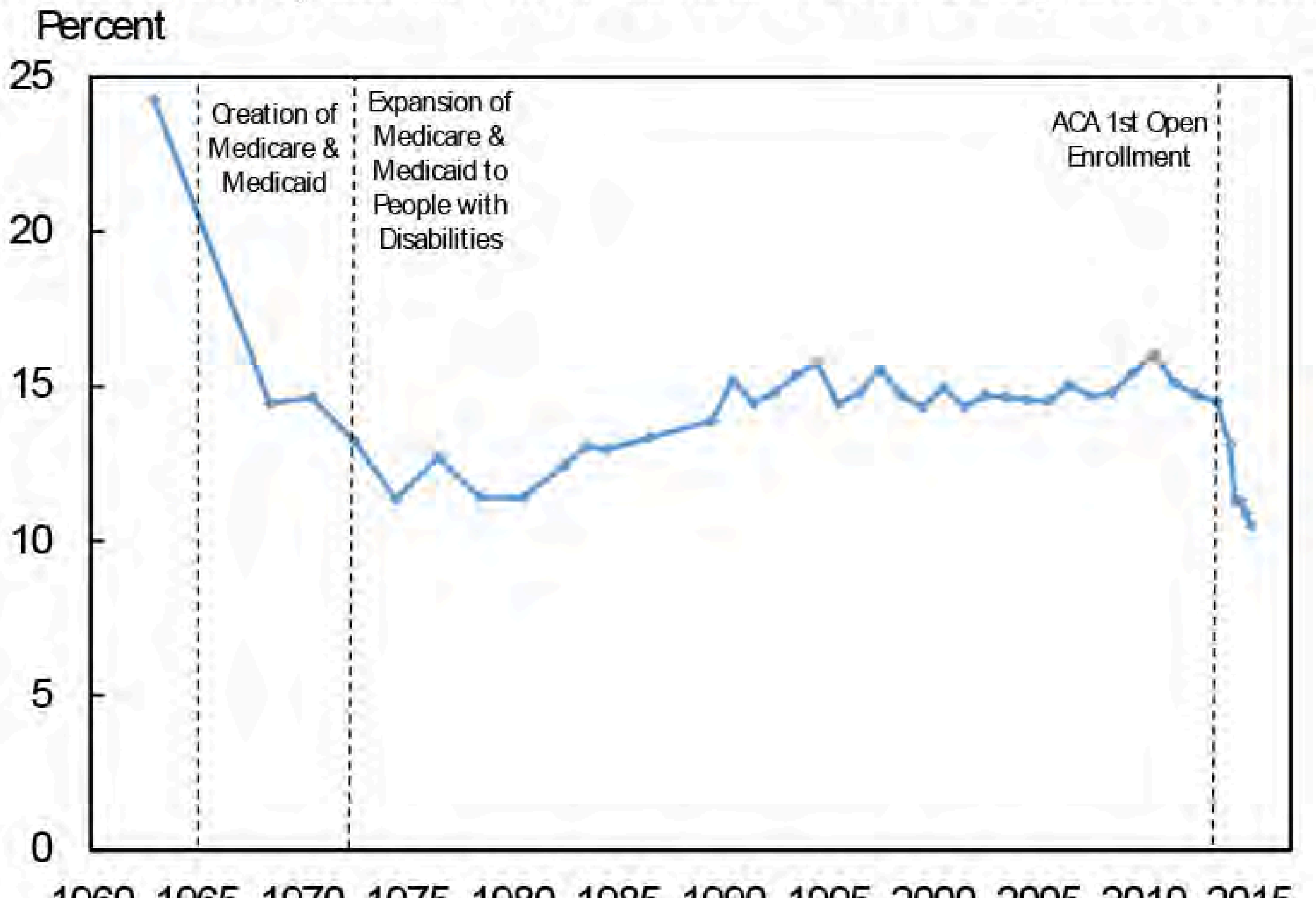
The Affordable Care Act

- Insurance reform
  - *Increase access of care*
  - *Reduce cost of care*
- Healthcare care system reform
  - *Increase quality of care*

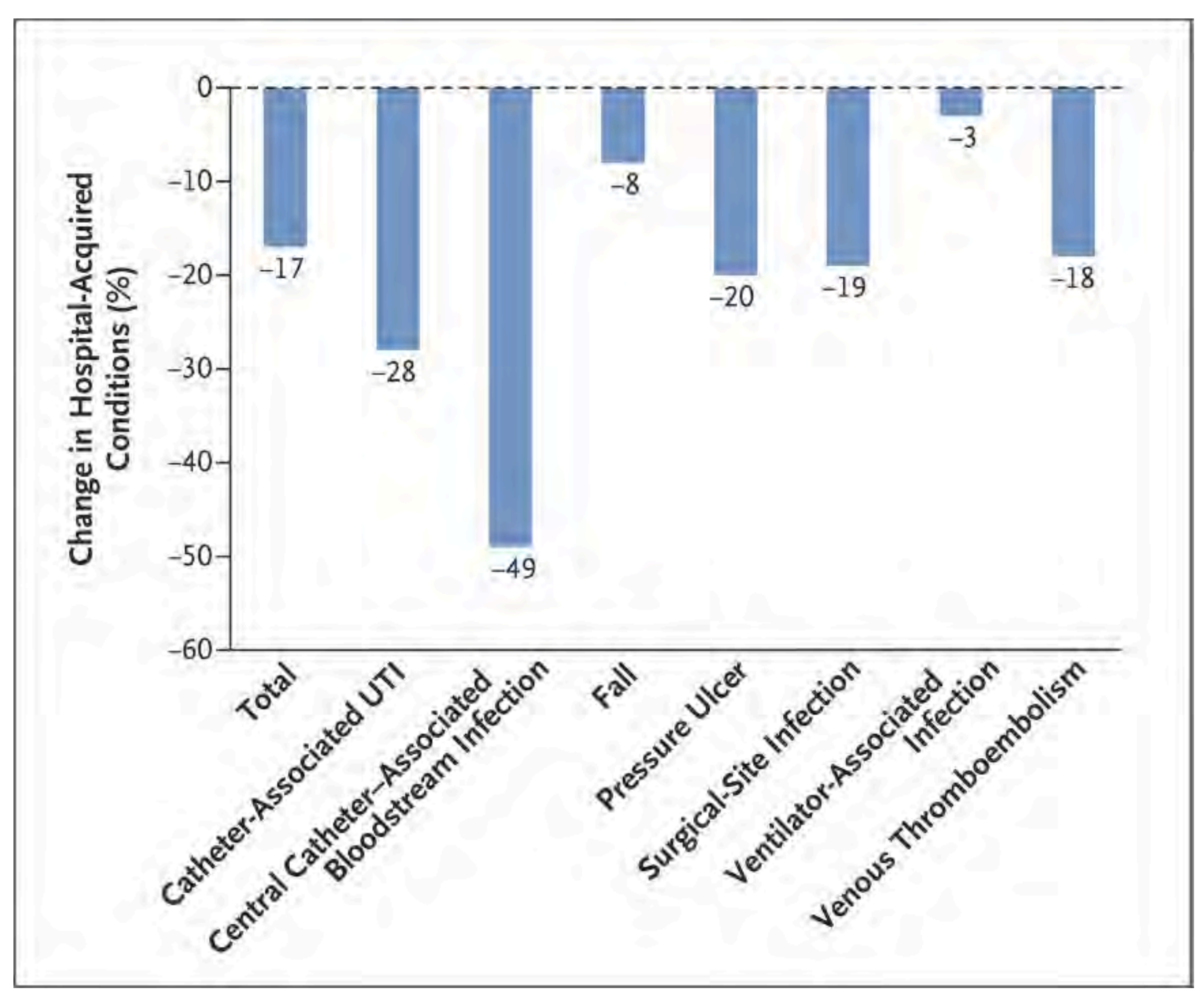


The Affordable Care Act

Is it working?



The Affordable Care Act
Is it working?

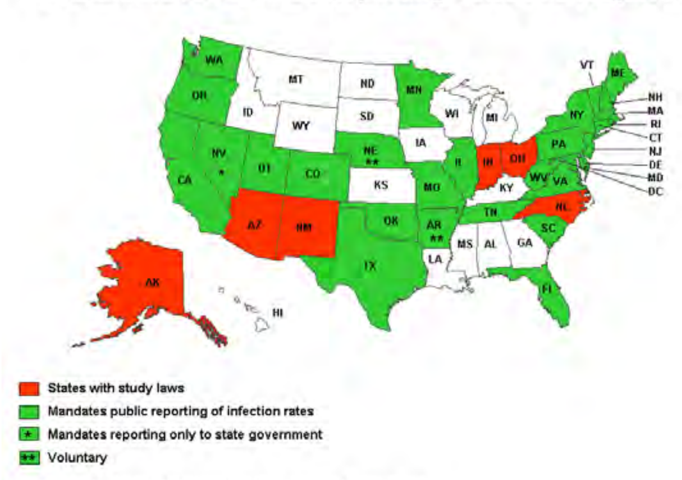


Blumenthal et al, NEJM, 2015

How else does change happen?

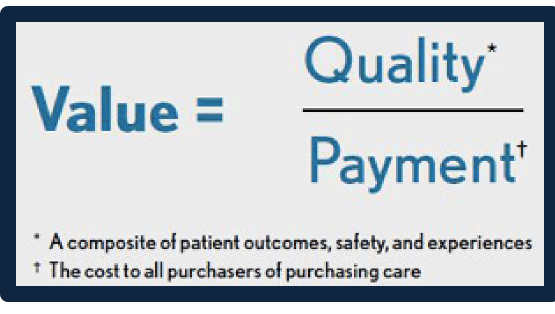
Transparency

- Availability/accessibility of health information
- Sharing of data



How else does change happen?
Accountability ($)

- Pay-for-quality, value-based-purchasing
- CMS, healthcare-associated conditions
- Certain preventable conditions are not reimbursed
- Healthcare infections, falls, blood clot
- CMS, hospital readmissions reduction program
- Financially incentivizes readmission reduction after high volume, high cost diagnoses (e.g. pneumonia, heart attack)

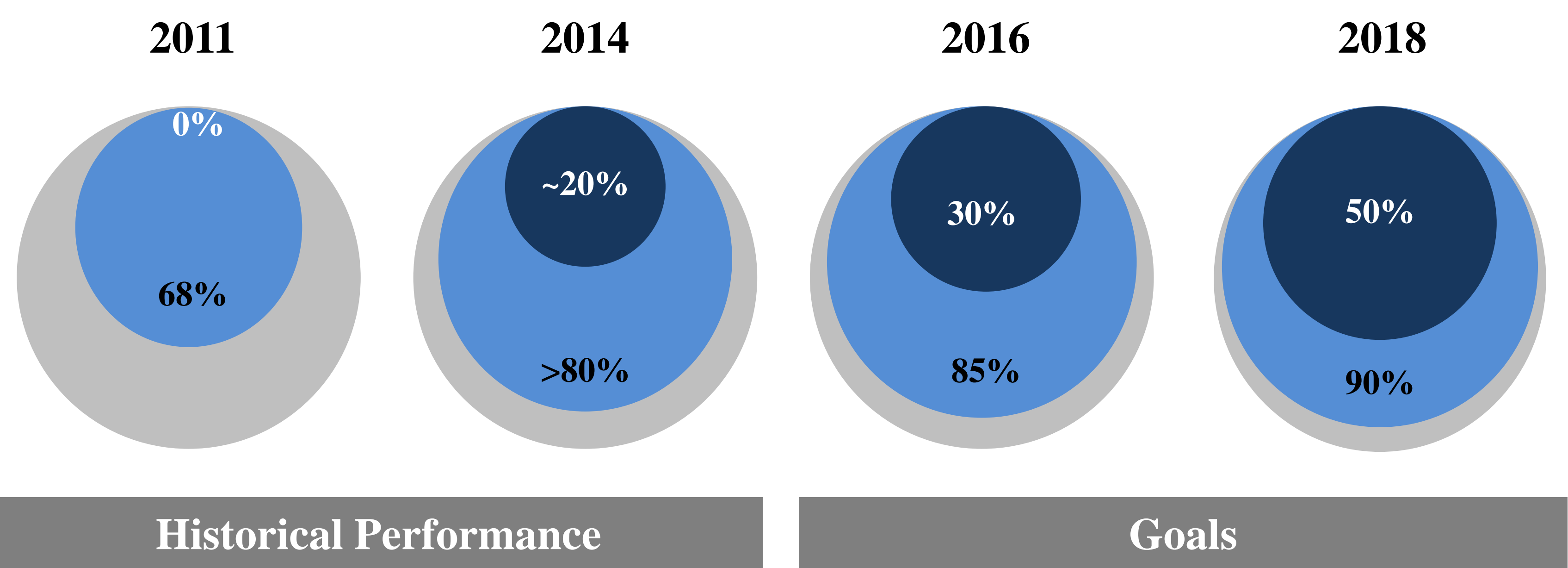


Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

Alternative payment models (Categories 3-4)

FFS linked to quality (Categories 2-4)

All Medicare FFS (Categories 1-4)



Why Teach PSQI?

✓ … it is the right thing to do

✓ … it is good for patient care

✓…. we are (will be) held accountable throughout our careers

Leveraging Trainees to Improve Quality and Safety at the Point of Care: Three Models for Engagement

Laura Johnson Faherty, MD, MPH, Kedar S. Mate, MD, and James M. Moses, MD, MPH

Model 1
Short Term – rapid cycle, team based

- Engage rapidly changing teams
- The team identifies a short term project at the beginning of a rotation

- Pros
  - *Requires intra-professional collaboration*
  - *"Team need" – team has to identify and own the project*

- Cons –
  - *Risk of Improvement Fatigue at the unit level*
  - *Showing improvement may be difficult*

Model 1 - Examples

- Incident report entry at the end of rounds every day
- Workflow improvements –
  - *Residents carrying specific phones in the PICU for nursing communication*
  - *Written sign-out improvements*
- Hand hygiene/device removal champions on rounding teams
- Real time debriefings

Medium Term – Unit Based

- The team is not the focus, rather the unit or service is the focus of the improvement
- Trainees are engaged at the beginning of the rotation to on-going QI initiatives

- Pros
  - *Engage residents interested in QI with the leadership of the unit*
  - *Project can be geared towards 2-6 months*
  - *Enough time to demonstrate sustained improvement*
- Cons
  - *Need metrics and sustained data collection*
  - *Trainees may not be personally invested*

Medium Term – Unit/Service Based Examples

- Team moving discharge times earlier in the day
  - *Break in rounds to work on discharge paperwork*
- Difficult airway identification
- Improvement in hand-offs

Model 3
Long term – Health System Wide

- Aligning trainees with institutional goals
- Present monthly statistics to large audience for buy in
- Pros
  - *Trainees as a workforce to help with institutional goals*
  - *Utilization of institutional resources*
- Cons
  - *Trainees may not have a defined role*

Long term – Health System Wide Examples

- Develop groups of trainees or have a project that is based in a particular training year
  - *A residency class develops a QI project around out-patient asthma medication compliance*

- Readmission reduction
- Venous thromboembolism screening and prevention
- Reduction of CLABSI and CAUTI
- Improving patient satisfaction

Dr. Suntha's 100 day plan

		30 Days		60 Days		90 Days
Physical Environment (L. Taylor, Rowan-Braun, Ray)	● (green)	• Define/confirm characteristics of a "picture perfect" room, who is responsible for tasks associated with room turnover & process for responding to deficiencies found in final check	○	• Conduct proof of concept trial for processes agreed to for 4-5 or units (e.g.: ICU, IMC, MBU, Peds)	○	• Modify processes based on proof of concept trial & implement new "picture perfect" room program
Quality (Jablonover, Gulati, Rowen, Patel)	● (yellow)	• Develop & distribute clinical service dashboards for with inpatient volume & P4P metrics	○	• Present Professionalism Survey results to clinical leadership • Re-introduce "Great Catch" program	○	• Develop key strategies to address Professionalism Survey results • Develop Quality "Top Issue Report" for each service

What can we do as educators?

What can we do as educators?

- Culture of Safety
- Effective Communication
- Collaborative Care/Teamwork
- Management of Risks
- High Quality Care, Process Improvement
- Professionalism
- Leadership