OPDA Fall Meeting 2024
November 22, 2024

Program Director Wellness – Stuart Slavin (sslauvin@agme.org)

National survey of PD Wellness led by ACGME focused on pain points as PDs and hope to identify best practices for these pain points. ACGME change focus from PD Wellness to Job Satisfaction Survey with well-being questions embedded.

OPDA Discussion:

- AAMC found that MDs in academic med less burned out than those in non-academic med.
- Plan to do similar survey for DIO? Faculty? Some interest to do so by ACGME. Some discussion of this PD survey every 3-year cycle.
- How do PD associations find out about new PDs to reach out and provide resources and FD to these new PDs. This will help with feeling of belonging/support and mitigate feeling overwhelmed and burn-out. ACGME has list of these new PDs which should be pushed out to the individual PD association. AAMC may have similar list. Currently, some individual specific RC push out to individual PD associations e.g. radiology.
    - OPDA attendees request for ACGME/AAMC to consider providing this list of new PDs to PD associations for outreach.

4 Main areas:

1) Job satisfaction/dissatisfaction. Likelihood to leave PD role and why?
    a. Some satisfiers – building the program, support from institutions/Chair.
    b. OPDA discussion – Consider exit survey from prior PDs on why left.
2) Mental Health well-being e.g. short burnout screen, depression screen and anxiety screen. Focus group endorse these screens but psych PDs strongly against. Those in favor felt if strong positive screen more of stimulus for change/solutions. Psych PDs in focus group felt uncovering positive screen in individuals will be stigmatizing to individual and concern for confidentiality in their environments.
3) Factors in work-life as factors in satisfiers/dissatisfiers. Looking from OPDA/PD and focus group a list of satisfiers and dissatisfiers. Focus group states ACGME is one source of stressor.
    a. OPDA discussion: Tone of communication from ACGME is often non-collaborative for example around ACGME resident survey results. All about accreditations. High concerns of residents weaponizing ACGME resident survey to get what they want. Some intimidations by rank-and-file PDs of ivory tower of ACGME. ACGME BOD aware and working to breakdown this perspective with more collegial communication and connection.
    b. Generational divide with values of current residents vs. current faculty and PDs in the middle to balance
4) Demographics of PDs. Identify or de-identify survey respondent? Specialty info important as some stressors are specialty-specific. Focus group felt needed for more impact in response. Survey do NOT connect to ADS or accreditation.

Much of this survey based on recent Program Coordinator (PC) survey. Long with 12 min completion time but over 50% response

1) PC likelihood to leave job is high – about a quarter of survey respondents.
2) #2 dissatisfier – low pay, #1 & #3 – tracking down residents and faculty to do work. Some had solutions so non-issue by involving Chair for impact.

Recent ACGME Physician Well-Being Symposium on 11.18.24

- Group of Wellness GME leaders with hope for affinity workgroup topics emerged: One being PD/PC/faculty wellness.
- OPDA Discussion: Importance of having OPDA representatives across different specialty perspectives in these affinity groups.

Updates on the Program Directors Association Guide for Residency Applicants (Margaret Lo)

This guide is a joint effort between the Organization of Program Directors Association (OPDA) and AAMC to improve communication and provide program directors guidance on key specialty-specific application information and resources. Each guide includes information on letters of recommendation, away rotations, program signals, USMLE/Complex scores, interview format, etc. The workgroup expected 4-5 program directors' association (PDA) guides and instead received a total of 22 guides in its inaugural year. The Program Directors Association Guide for Residency Applicants was launched as a pilot in the 2023-2024 application season and felt to be a success by the workgroup. All PDA guides are housed on the OPDA website https://cmss.org/programs-and-resources/opda/

The workgroup is co-chaired by Marcy Verduin in AAMC GSA and Margaret Lo in OPDA. OPDA representatives include Steve Pletcher, S. Trent Guthrie, Megan Aylor, Jennifer Beaty, and Jim Anderson. AAMC GSA representatives include Hilit Mechaber, Cheire Singer, Christin Spatz, Irena Tartakovsky, Caroline Healy, and Renee Overton.

The workgroup met in October 2024 to discuss next steps for version 2.0 of the PDA guide. The group decided not to change any of the parameter questions but maybe streamline some of the questions. Other next steps include:

- Adding new question about secondary/supplemental application materials required and time frame/turnaround for submission. Example – additional LOR, secondary essays, short video (since Student Deans noticed this past application season from some specialties)
    - GSA members raised concern of residency program's use of Google forms, AI, and other platforms that applicants are asked to input their info in their secondary/supplemental applications --) this violates FERPA and do not protect applicant data.
- Posting some guide exemplars. Surgical – Ortho. Non-surgical – Peds, IM
- Finding a less clunky, more interactive platform for PDA to enter info on the guide.
- Continue to encourage each PD association to post its completed guide onto its own specialty PD association website.
- Plan for each PD associations to update its PD Association Guide by May 1st for the 2025 application cycle.

OPDA Discussion:

- Plenty of discussion on improving the IT process and platform to be more user friendly and interactive w/ ability to edit in real-time for any new changes. The current fillable pdf template of the guide was felt to be clunky to use and too static to change any information. Perhaps something housed within the Residency Explorer
- Plenty of discussion on increasing marketing to student applicants and student deans. The ERAS team provide links on the ERAS Participating Specialties page. However, this would not include specialties using a different application platform than ERAS. AAMC GSA disseminate the OPDA link to the PDA guides to Student Affairs Deans to make students aware of the resources available, as well as to the osteopathic and IMG communities. Suggestion to post within AMA Frieda site.
- Suggestion for a feedback link on the OPDA website for anyone who views the PDA guides to provide feedback/comments.

<u>Supporting Struggling Learners</u> (Bill McDade, Chrissy Babcock, Vanessa Grubbs)

In GME, PDs need be cognizant of different bias when addressing remediation e.g. in-group bias, confirmation bias, discrimination, gender bias, etc.

AGME Equity Matters site launched with resources to help learn about and mitigate these biases.

Major issue is being a bystander of retaliation acts by others on struggling learners due to hierarchy. No one on team speaks up against retaliation and micro/macroaggression. Importance of psychological safety - evidence of strong association to trainee satisfaction in learning environment.

CMSS invested $16.2 billion in 2021 to build diverse physician workforce but no data to demonstrate outcomes. Thus, impetus for study on disciplinary experiences of resident physicians.

- Residents from all specialties participated except RadOnc. Highest % were IM, Sgy, FM
- Residents across different racial backgrounds – White 30%, Black 11%
- In disciplinary experiences survey, 21% negative feedback (50% black, white 19%)
- In survey for due process concerns, 3% on remediation/probation (Black 6%, White 2%) and 58% felt due process not followed and 78% felt action unjustified.
- For in-depth interviews, emerging themes:
    - Residency need to be safe space to learn to survive especially from Black, Latinex who feel they have a microscopic lens on them at all times.
    - White residents felt no negative disciplines b/c they feel they make no mistakes. Implications of being raised with successful social determinants e.g., parents of doctors or lawyers so challenge remediation plans more. Few felt targeted for mental health issues.
    - Asian residents felt the pressure of lens as “model minority” and set to higher standards. Also raised by “following rules” so less likely contest remediation plan.

<u>Institutional process for supportive remediation at UChicago</u> (Chrissy Babcock):

Combined effort from GME and HR. Change language from remediation to Professional Development Program (PDP). PD meets with DIO and HR right at time of resident being put in remediation.

- Discuss areas of challenges for remediation of specific resident and identify relevant resources for remediation.
- Have templated language for PD to use and communicate to remediating residents on the process.
- Co-develop the professional development program specific to the resident's need. Plan duration is 3 or 6 mos. cycle then closed out and not part of residency formal packet if successful. This makes PD accountable and allows follow-through.
- PDP include areas for residents to provide comments/feedback.
- Full confidentiality – only those who know are PD/APD, DIO and resident.
- Importance of removing the clinician hat and not try to diagnosis the remediating resident. Need HR hat and residents need to take initiative for self-identify their issue and take initiative to reach out for help which GME can support. Ex: Depression

OPDA discussion

- Opportunity to offer external mentor/coach within program direction associations for remediating resident? This removes the internal and emotional toll out for residents within their institution.
    - Physician Just Equity group and National Council of Residents (NCR) do have such program. Issue is physician volunteers so busy and limited availabilities. Often residents come to the council too late when ready to be dismissed.
- How to share resources or one-stop repository of resources for faculty development and program directors to be experts ibn the remediation? Institutions do this locally. ACGME has a lot of tools for these resources.
- Future topic suggestion - PD development on how to address patient feedback that is racist against residents.

Engaging Gen Z for Success (Natalia Khosla, Deborah Spitz)

Characteristics of GenZ learners:

- Love digital platform
- Desire convenience, immediacy, and pragmatic approach to learning
- Limited attention span
- Open minded and socially inclusive and highly value DEI and social justice
- At risk of isolation and insecurity
- Open awareness and discussion of mental health

Learning preferences:

- Visual and interactive learning over written or didactic learning
- Collaborative learning either in group work or peer-to-peer
- Real-world application. How does their learning apply to real world clinical experience?
- Expectation of getting immediate and real-time feedback and information to learn

- Heavy emphasis on Well-being, Mental Health Awareness and Sharing, Work-Life Balance

GenZ Resident perspective:

- Roles of trainees
    - critical of grunt work (do not like "well that is how it is" and feel as gaslighting) and look for opportunity to change
    - residents feel they are in limbo - students vs. employee. Being scrutinized on performance yet autonomy for pt care
    - Opportunities: Open discussion on acknowledging grunt work in residency and attempt to reduce them and on employee vs. student aspects of residency
    - More receptive if included in discussion of issue and development of solutions
- Learning style
    - Skeptical of lecture format. Favor hands-on approach, live talk-through clinical reasoning. Using various learning modalities including AI learning tools.
    - Get confused by the variation in attending teaching and patient care styles and do not like being dogmatic on teaching style.
    - Dislike framing as the only right way to do things.
    - Many buy study guides with own funds. Consider offering these to trainees
    - Opportunities: Poll students to determine preferred learning style. Set expectations early and gather input on these expectations. Suggest FD on teaching style and rounding style.
- Unconventional career paths
    - More want alternative paths w/ intersections in medicine e.g. dermatology + social justice/health advocacy. Opportunities: Poll trainees anonymously for interest w/i and outside of medicine. Offer mentors with similar interests who connect trainees to these intersections. Consider flexible and innovative residency structure e.g. Stanford, B&W Hemi-Doc program
    - Transition from "what I want to be" to "what I want to do". Opportunities: FD on career counseling, create innovative and diverse pathways. Keep a database of physicians who are cross disciplinary
- Technology
    - Too many disparate communication tools e.g. emails, texts, apps. Need consolidate technology communication. Opportunities: Poll trainees for preferred all-in-on communication platforms e.g. Slack, Discord
    - Prefer text style communication over emails and talk more causally in texts than professionally.
    - Feedback not received early enough to adjust and too formalized. Opportunities: Importance of real-time instant and informal formative feedback over sit down formal summative feedback at end
    - Paper pre-rounding and rounding inefficient. Prefer electronic pre-rounding tools. Opportunities; Provide iPad or apps to trainees for rounding
- Professionalism

- Generation gap in language norms e.g. “OK, cool” seen as professional. Opportunities: Agree upon and show evidence on importance of proper language, dress, and other norms.
- Set expectations on hard-line rules vs. negotiable rules. Allow residents to weigh in instead of imposing norms

PD Perspective:

- Generational divide in learning environment which made PD feel disempowered
    - Slow to provide feedback on issues to PD leadership
    - Learn on their own and do not feel need to learn from PD.
    - They talk to each other within the group but not to GME leadership. Do not know how to talk or work as a group
    - Savvy with technology and develop their own tools e.g. feedback app, applicant evaluation tools
    - The Covid group of learners heard a lot of horror stories that “front line was dangerous” so mistrust of the clinical learning environment

Opportunities for programs:

- How to leverage comfort with technology e.g. simulation curriculum
- How to foster teamwork and collaborative learning
- EM – changing EM qualifying examination to include more hands-on skills e.g. POCUS
- IM – FD and curriculum development in gamification (Kahootz, Mirror), simulation/POCUS. Engage residents in SM communication.
- Peds – Invite learners including Chief Residents into action teams and committees e.g. racism, simulation
- Future topic suggestion: What we learn from our residents and Gen Z children to improve our teaching?

<u>Understanding Osteopathic and IMG Residency Applicants</u> (Tracy Wallowicz, John Gimpel, Wendy Kim, Steve Attanasio)

IMG – MD from med school outside of US or Canada regardless of citizenship

Total IMG practicing in US = 263, 000

Perceived Challenges:

- Myth - PD and PC do not have all the time to credential and verify IMG requirements. ECFMG verify training transcripts and other verifications for credentialing prior to onboarding
- Myth - IMG may not be qualified as US med grad counterparts.
  ECFMG verify training qualifications and able to work with other countries to certify their qualifications. Gaps in training on average is 2 years per ECFMG study but concern by PD is what they were doing in 2 years gap, and most are observerships

Advantages of Osteopathic applicants:

- Emphasis on clinical reasoning and hands-on care from day 1
- 8 different specialty programs recognize holistic applicant reviews and COMLEX scores (EM, FM, OB-GYN, IM, etc.)

OPDA PD internal survey:

Advantages:

- Increase training on hands-on manipulation and PE skills
- Diversity of experience and perspective
- Prior clinical experience, life experience and maturity
- Very motivated

Disadvantages:

- Uncertain how to assess clinical training in home country
- Variability of clinical education
- Language and cultural barriers leading to communication issues
- Possible gaps in clinical practice
- Understanding COMLEX scores when compared to USMLE

OPDA Discussion:

- It will be helpful for PD to get detailed information on the clinical training environment of a DO medical school and new medical school. PD reluctance on DO applicants due to this reason.
- How to take heterogenous teaching experiences to level out the educational experience in the transitions to residency onboarding process. AACOM has resources for TTIR
- FAIMER launched 5-hour EHR educational module to be available right after match for IMG. Exploring what other resources for IMG to ensure PDs that IMGs able to start on Day 1
- USMLE required for ECFMG certifications but explore other requirements to certify IMG readiness
- 9 states legislation for IMG to be able to practice independently if practicing in hometown. Legislators passed w/o input from state licensing boards and medical accrediting bodies. State licensing boards discovering difficult implementing legislation due to vague implementation standards (e.g. similar training experience but what does it mean by similar?) and not enough IMG interest. Large collaborative between Inteath, ACGME, ABMS to help define these standards.
- Possible collaboration w/ OPDA and Intealth workgroup e.g. application review process

New VA Onboarding Process (Skip Walton)

New electronic onboarding system (APS) 18 months ago. There will be a LOT of extra security clearance work on the VA Academic Affiliates' end which the HPTs will not see. Not know how long

background check will take but likely not much impact to US HPT but more cumbersome for non-US HPT

NADIO and OPDA both submitted formal letters of rebuttal to Secretary of VA for concerns that these new VA onboarding process will preclude HPTs from accessing VA sites and clinical experiences.

New VA onboarding requirements for Health Professional Trainees (HPT):

1) US citizens in country for > 3yrs get Tier 1 background check and 3-year PIV card
    a. Tier 1 background check require fingerprints, online SF-85 questionnaire which then VA staff has to agree to review. Trainees will get email to self-complete online and enter their info directly on this new VA APS.
    b. Record of arrest and prosecution background checks. Continuous FBI database checks
    c. This process will not prevent residents from working at VA while securing clearances are ongoing in the background, but PDs need to have plan on what to do if +background checks.
2) Non-US citizen need Federal Record background check and PIV-I card security clearance which will be repeated every 180 days. More resource and time intensive
    a. Need provide info on their VISA, citizenship, appt type at VA, passport info which goes through Federal records check. VA trying to push this part out so at same time as Visa processing check.
    b. Unclear if this process will prevent non-US residents from working at VA while securing clearances are ongoing. Not know how long background checks will take.

VA had planned to roll out new onboarding in Feb 2025. Electronic software updated sooner so roll out starting now for all non-US citizen HPT in the country in a training program who has not yet undergone the VA onboarding process. Otherwise, new process to launch tentatively in April-May 2025 for all US citizen HPT who are new to VA system.