Role and Expectation of Program Coordinators

Program Coordinators’ Symposium
Plastic Surgery – Denver, CO.
September 21–24, 2011

Ruth H. Nawotniak MS, C–TAGME
UB SUNY Surgery – Training Program Administrator
Perception and Reality

- Tasks

- Application of the 6 competencies

- Self-perception
What is the Perception?

- Always busy
- Multitasking
- Searching for answers to questions
- Asking for information to meet deadlines
- Reminding residents to be compliant with numerous regulations, requirements, policies and activities
What Is the Reality?

- Support graduate medical education
- Support the efforts and responsibilities of the program director
What Is the Reality?

- The program coordinator can do only what the program director will allow.
- Levels of empowerment
In 2001, the ACGME Outcome Project caused an unintended consequence: The coordinator’s role changed from secretarial to manager/administrator.

(Even though the title “Program Coordinator” is slowly being changed, the term “program coordinator” is still used to identify the person in the job.)
For the Program Director

- Changed expectations
  - Responsibility for the development of program and curriculum to meet accreditation standards, requiring substantial time, effort, and commitment
  - Expertise in medical education and adult learning processes and concepts

- Increased
  - The scope and depth of the function of the program director
For the Program Coordinator

- Changed expectations
  - Responsible for administering and managing the day to day aspects of the training program
  - A closer working relationship with the PD, creating a team dynamic
- Increased the scope and depth of the function of the program coordinator
Established the importance of the administrative management of the training program

- Now required a higher level of skills, ability, and knowledge that elevated the position from clerical/secretarial to manager/administrator
What are a coordinator’s roles?

- Liaison between residents and the program director
- Liaison between faculty and program director (contact)
- Manager/administrator (staff support)
  - day to day activities
  - Duty hour for compliance
  - curriculum for the development of the competencies
- Data analyst for program improvement (data entry)
- Information resource for requirements from all regulatory agencies
- Human resource for disciplinary actions, visa issues
- Arbitrator, Counselor
Perception and Reality

Tasks

- Application of the 6 competencies
- Self-perception
**Tasks of a Manager/Administrator**

- Responsible for the daily operations of the Residency program
- Provide assistance to the Residency Program Director in the design, implementation and management of administrative/academic operations for the program
  - Identify the competencies and understand their implementation as well as resident and program compliance
  - Understand curriculum, goals and objectives
  - Understand work hour regulations and monitor compliance
  - Provide reports, summaries, and reviews of all training program activities
  - Understand legal issues with regards to employment, visas, and potential disciplinary actions
Tasks of a Manager/Administrator

- Manage and coordinate the crucial interview season – we are often the “face” of the program
  - directly responsible for planning, implementing and overseeing the recruitment process
  - responding to all inquiries
  - maintaining computer database
  - screening all applications
  - organizing and actively participating in residency interviewing and selection,
  - submission of final rank to NRMP (National Resident Matching Program)
Tasks of a Manager/Administrator

- Monitor and document evaluation processes
  - Responsible for implementing evaluation systems for program curriculum, resident performance, and staff teaching performance

- Manage processes for adverse evaluations and potential subsequent actions
Tasks of a Manager/Administrator

- Understand accreditation, board, and institution requirements, including state and federal regulations
- Manage resident activities and schedules
  - full administrative responsibility for tracking, documenting and reporting of educational activities for residents
  - coordinate, develop and maintain the yearly master schedule and monthly rotations for all residents and all rotators, including outside rotations
Tasks of a Manager/Administrator

- Active involvement in site visit
  - direct and monitor all aspects of the Residency Review Committee's re-accreditation for the program,
  - responsible for both internal and RRC program reviews.
- Have knowledge of personnel and human resources issues
Tasks of a Manager/Administrator

- Maintain a close working relationship with the Graduation Medical Education Office, to remain compliant with all necessary requirements for all program residents and rotators, including appointment process and visa issues.
Tasks of a Manager/Administrator

- Access the resources and websites involved in medical education
- Utilize networking and Internet opportunities efficiently and effectively
- Provide solutions for data management issues
- Understand budgeting issues
Tasks of a Manager/Administrator

- Administer proctor and track results of all in-training exams
- Direct and manage the annual clinical competence exam
- Track and analyze the results of annual Board Certifying Exams
- Scheduling and overseeing the Surgical Skills Lab
- Responsible for preparing and maintaining the policy and procedure manuals for the Residency Program
Success is dependent upon:

- How the program director and the resident view the position
- How committed the coordinator is to job performance and self-education
The Program Director

- Must see the position of coordinator as a mid-level manager who is professionally responsible
  - Dresses, acts, and speaks professionally
  - Self-educates
  - Works independently
- Must value the skills, knowledge, abilities, and opinions of the coordinator
- Must see that the coordinator supports the Program Director’s efforts and responsibilities
If the program director sees the coordinator this way he or she will:

- Support the coordinator’s activities
- Support their educational and professional needs
The Residents

- Must see the coordinator as an advocate and resource for them
- Must see the coordinator as professionally responsible
- Must respect the skill, knowledge, and abilities of the coordinator
  - Knows rules and expectations
  - Deals with all resident needs fairly
If the residents view the coordinator this way:

- It improves communication, cooperation, and credibility
- The coordinator is seen as an extension of the program director—promotes compliance
The Coordinator

- Must see his or her value and understand his or her role
- Must participate in self-education
  - Keep up with changes in ACGME and board requirements and expectations
- Must be a professional and act in a professional manner
Perception and Reality

Tasks

Application of the 6 competencies

Self-perception
Competency 1 – Residency Program Management

- Effectively handle accreditation issues
- Appropriately manage all aspects of the residency program
- Be sensitive to and supportive of the needs of the Program Director
Competency 2 – GME Knowledge

- Know Common, Institutional and Clinical Specialty Program Requirements
- Monitor evolving Board and accreditation processes and standards
- Apply this knowledge to the management of the residency training program
Competency 3 – Practice-Based Learning and Improvement

- Appraise the residency looking at trends in graduate medical education
- Improve the residency by applying information learned through networking and evaluation
Competency 4 – Interpersonal and Communication Skills

- Communicate effectively with Program Director, residents, faculty, medical students, ACGME, the Board, GME office, and applicants

- Network with appropriate institutions and individuals for sharing information to enhance the residency

- Take a role as counselor, liaison, and advocate to heart

- Develop clear and concise oral and written communication skills
Competency 5 – Resource Management

- Develop an awareness and understanding of the larger context of graduate medical education
- Know the resources available for managing residency programs
- Access websites and resources to find answers
- Apply this knowledge to improve the residency program
Competency 6 – Professionalism

- Develop and understanding of the confidential nature of our jobs
- Demonstrate respect for the confidences of the program director, faculty and residents
- Commit to doing the job in a responsible manner
- Present a professional appearance
Self-Advocacy

- Become a pro-active learner
  - Advocate for learning opportunities
  - Promote the role of the coordinator on a institutional and national level
  - Volunteer for special assignments or committees within your program, institution or national organization
  - Certification
9 Tips for Success (if you are a new coordinator)

- Read the ACGME requirements and the ACGME Glossary of Terms at least twice
- Read your previous site visit document and your last internal review document
- Learn the duty hour requirements
- Learn the terminology and acronyms of the ACGME and Plastic Surgery training
- Learn the competencies
9 Tips for Success

- Know the websites of the organizations that affect your job
- Get to know your GME office
  - Function and responsibilities
  - Funding
  - Partnership
- Set up a timeline for activities
- Schedule regular meetings with your program director
The Result

If coordinators view themselves this way, they:

- Become active, productive participants, involved in achieving all the goals and objectives of the training program
- Gain respect, acknowledgement, and satisfaction
Ellicott Square Building

Mosaic Floor
Sculptor: Augustus Saint-Gaudens: Caryatids on the east facade copied from the Greek Erectheum

The caryatids are 8' high weighing 3 tons.
Niagara Falls
General GME Program Management

Program Coordinators’ Symposium
Plastic Surgery – Denver, CO.
September 21–24, 2011

Ruth H. Nawotniak MS, C–TAGME
UB SUNY Surgery – Training Program Administrator
Curriculum

- Evaluation
- Rotation Scheduling
- Organizational Systems for Documentation
The Outcome Project changed the way teaching took place in graduate medical education by making it competency-based.
Traditional vs. Competency-Based Education

**Traditional**
- The goal is knowledge acquisition

**Competency-based**
- The goal is knowledge application
Traditional vs. Competency-Based Education

**Traditional**
- The goal is knowledge application
- The teacher is responsible for content

**Competency-Based**
- The goal is knowledge acquisition
- The teacher and resident are responsible for content
Traditional vs. Competency-Based Education

Traditional
- The goal is knowledge acquisition
- The teacher is responsible for content
- The typical evaluation is summative involving one format

Competency-based
- The goal is knowledge application
- The teacher and resident are responsible for content
- The typical evaluation is formative, involving multiple designs
Traditional vs. Competency-Based Education

**Traditional**
- Evaluation is norm referenced—how is the resident doing in comparison to the others.

**Competency-based**
- Evaluation is criterion referenced—how is the resident doing in relation to the standards that are individually set.
Traditional vs. Competency-Based Education

**Traditional**

- Evaluation is norm referenced—how is the resident doing in comparison to the others.

- The ACGME wanted to know if programs had the means to train residents

**Competency-Based**

- Evaluation is criterion referenced—how is the resident doing in relation to the standards that are individually set.

- The ACGME wants to know if programs are training residents to be competent physicians
Language

- Competent
- Competency
- Competencies
Language

- Competent: 1. able, having enough skill or ability to do something well; 2. adequate, good enough or suitable for something

1 Encarta English Dictionary (North America)
Language

- Competent: 1. able, having enough skill or ability to do something well; 2. adequate, good enough or suitable for something

- Competency: Dreyfus Model of Skill Acquisition
  - Novice, Advanced Beginner, Competent, Proficient, Expert, Master

1 Encarta English Dictionary (North America)
Competency Dreyfus Model of Skill Acquisition²

- Learning rules
  - Novice (rules)
  - Advanced beginner (rules + situation) UME

- Rules application in increasingly complex contexts
  - Competent (rules + perspective + accountability) GME
  - Proficient (accountable + intuitive)
  - Expert (immediately sees how)
  - Master (loves surprises) CME

² Hershey Bell, HCPro 2008
Competent: 1. able, having enough skill or ability to do something well; 2. adequate, good enough or suitable for something

Competency: Dreyfus Model of Skill Acquisition
- Novice, Advanced Beginner, Competent, Proficient, Expert, Master

Competencies: Specific knowledge, skills, behaviors, and attitudes and the appropriate educational experiences required of residents to complete GME programs.

1 Encarta English Dictionary (North America)
3 ACGME Glossary of Terms
Simplifying the Competencies
(Bridgeport Hospital & Hershey Bell)

- Medical knowledge
- What you know
Simplifying the Competencies
(Bridgeport Hospital & Hershey Bell)

- Medical knowledge
- Patient care
- What you know
- What you do/how we use what we know
Simplifying the Competencies

*(Bridgeport Hospital & Hershey Bell)*

- Medical Knowledge
- Patient Care
- Interpersonal and communication skills

- What you know
- What you do / How we use what we know
- How you interact with others / how we play nicely with others
Simplifying the Competencies
(Bridgeport Hospital & Hershey Bell)

- Medical knowledge
- Patient care
- Interpersonal and communication skills
- Professionalism

- What you know
- What you do / How we use what we know
- How you interact with others / How we play nicely with others
- How you act/how we behave
Simplifying the Competencies
(Bridgeport Hospital & Hershey Bell)

- Practice-based learning and improvement
- How you get better/how we keep doing it better
Simplifying the Competencies
(Bridgeport Hospital & Hershey Bell)

- Practice–based learning and improvement
- Systems–based practice
- How you get better / How we keep doing it better
- How you work within the system/how we help everyone else
ACGME: The curriculum should include competency-based goals and objectives for each rotation or assignment for each PGY level.
Language of the Curriculum

- Syllabus: A statement of the main subject content to be covered
  - Physician training covering medical knowledge, treatment, surgical skills and techniques in plastic surgery
Language of the Curriculum

- Curriculum: Courses taught within a topic or subject; a statement of the intended aims and objectives, content, experiences, outcomes, processes of a program, including a description of the structured and experienced methods of learning, teaching, assessment, feedback, and supervision
  - PGY level rotations
  - Surgical Skills acquisition
  - Operative experience
Language of the Curriculum

- Goal: A broad statement of intended learning; what is to be achieved; not measurable
  - The resident will successfully perform burn reconstruction.
Objective: Specifies what the learner will be able to do at the end of the time period. Objectives are measurable.

- The resident will be able to name the indications for burn reconstruction
- The resident will spend .5 days/week in the burn clinic
- The resident will participate in two burn reconstructions each of the face, arm and trunk
- The resident will be able to explain the operative process for burn reconstructions of the face, arm and trunk
Language of the Curriculum

- Cognitive learning: Relating to the process of acquiring knowledge by the use of reasoning, intuition or perception, relating to thought processes\(^4\)

- Didactic learning: Instruction

\(^4\) Encarta Dictionary: English (North America)
Language of the Curriculum

- Adult learning behaviors
- Evidence–based medicine
- Standardized patients (SP)
- Objective structured clinical examination (OSCE)
- Total quality management (TQM) or quality improvement (QI) projects
- Program Letters of Agreement (PLA)
- Portfolio
Taxonomy

- Synonyms are classification, arrangement, organization; typically in relation to Blooms Taxonomy (handout)
Examples from the Field

- Independent Study Topics (1)
  - QI projects (improvement)
  - Health care access/utilization (resource availability)
  - Patient safety/medical errors (systems for blame-free reporting)
  - Physician wellness (resident/physician burnout)
  - Health care financing/care of the uninsured (Medicare/Medicaid)
  - Implications of new technologies (genetic testing, surgical skills)
Examples from the Field

- Independent Study Topics (1)
  - Resource allocation (competition for services)
  - Information systems/electronic records (value of automated prompts)
  - Medico-legal issues (effect of malpractice premiums)
  - Physician profiling (physician performance/patient satisfaction)
  - Population-based medicine (effect of aging population on long-term care resources)
Curriculum over length of training (2)

- Group Discussions
  - M&M Conferences (bi-monthly)
  - Patient Relations (2 hour session with patient advocacy or patient relations director)
  - Risk Management (2 hour session with risk management attorney or risk management officer)
  - Discharge Planning (discussion with utilization review nurse or social worker)
  - Coding and Billing (every 2–3 years)
  - Governance (every 3 yrs with hospital administrator or credentialling staff in conjunction with JCAHO visit)
  - Contract Negotiations (every 5 years)
Didactic Lecture Series

- Patient’s process for surgery from registration to post-surgical care (every 2–3 years)
- The Job Search (every 3 years)
- Healthcare Structure: Alphabet Soup (every 3 years)
- Contract Negotiations (every 5 years with hospital contract negotiator or a contract attorney)
- Grand Rounds (outside expertise)
- Hospital Training Sessions (on-line training or group sessions with hospital personnel)
A four week curriculum includes appropriate readings (3)

- **Week one – The health care system and how it affects delivery of care**
  - Readings: development of health care system; introduction to QI methodology
  - Activities: Patient–centered perspective on system improvement; identification of improvement opportunity

- **Week two – Who pays for care and why it matters**
  - Readings: health care financing and organization
  - Activities: Local health insurance and hospital administrators for the business of health; introduction to the complex relationships between parts of health care delivery systems; analysis of root causes of the identified system issue.
Week Three – Improving care of individuals, populations and practices
- Readings: tools for change management in clinical practices
- Quality improvement: choose QI project, justify and describe risks and rewards for stakeholders

Week Four – Reinforcement, Reflection, Preparation to Teach
- Readings: ACGME core competencies and teaching
- Activities: develop teaching plan to be used for teaching a session on SBP to peers
A week long program incorporates self-reflection activity at the end of each day:

- **Monday** – orientation and pretest; introduction to the logistics of managing a clinic; Medicaid financial screening, outpatient coding
- **Tuesday** – ER financial process, radiology, indigent health care management; billing office
- **Wednesday** – hospital processes including admissions and hospital bed management, DRG review, care manager’s rounds, coding
- **Thursday** – commercial payors and contracting; staff management training, hospital billing and denials management
- **Friday** – compliance, revenue cycle reporting, patient communication systems; debriefing and post-test
A patient simulation activity keyed to a community rotation (5)
   - Scenario based activity in which the resident assumes the role of the patient who has to work through the health care system to access resources
A focused activity on a specific component of systems–based practice (6)

- 3 part program focusing on Coding and Billing
  - Part 1 – monthly 1 hour lecture series: documentation and coding guidelines; billing and billing compliance; introduction to managed care and practice performance; job hunting, types of practices; malpractice insurance and risk management
  - Part 2 – periodic 1 hour sessions on documentation and coding
  - Part 3 – immediate feedback sessions with coding and compliance manager after patient encounter
Clinical Health Economics System Simulation (CHESS) (7)

- Treatment costs to patients and society
- Team based – 3 teams of 3 at the same time
  - Each team takes care of a panel of patients over a year’s time
  - Teams view same scenarios and choose from list of medically viable treatment options
  - Simulation provides immediate feedback on costs related to choice – reimbursement, prescriptions, tests, hospitalization, etc.
Citations for Examples from the Field


2. Davison, Cadivid, Spear. *Systems-Based Practice: Education in Plastic Surgery*. JPRS Vol 119 No 1 410–415, 2006. (Georgetown University Hospital)


THREE CAMPUSES
North, South, and Downtown
Collaboration between Kaleida and UB SUNY

- Global Vascular Institute
- Center for Clinical and Translational Research
- Biosciences Incubator
University Training Sites

Buffalo General Hospital
Women’s & Children’s Hospital of Buffalo
Veterans Affairs Medical Center
Erie County Medical Center
Millard Fillmore – Suburban
Roswell Park
Curriculum

Evaluation

- Rotation Scheduling
- Organizational Systems for Documentation
Evaluations

- A method to assess outcomes, compliance in meeting educational goals and objectives, and resident, faculty and program development
  - Clinical experience
  - Competencies
  - Quality improvement of self and others
Language of Evaluations

- Types of Evaluations
  - Formative evaluation
  - Summative evaluation
  - 360-degree evaluation
  - Self-assessment
  - Check off list
Structure of a typical evaluation

- Likert scale (numerical scale, i.e., 1–5)
- Anchors (words that explain the scaling)
  - 10% of the time; 25% of the time; 50% of the time; 75% of the time; 90% of the time
  - Rarely, Sometimes, Often, Very Often, Most of the time
  - 1 meaning best; 5 meaning worst
Managing the Evaluation Process

- ACGME requirement
  - Faculty
    - Resident
    - Program
  - Resident
    - Faculty
    - Rotation
    - Program

- Other types used
  - Self
  - Peer
  - 360
  - Activity
    - Journal Clubs
    - Grand Rounds
Managing the Evaluation Process

- **Reporting**
  - Individual (each, summary)
  - PGY level (summary)
- **Sub-standard academic development**
  - Educational Enhancement
  - Probation
  - Non-renewal of contract
  - Termination
    - Resident – withdrawal
    - Program – dismissal
Managing the Evaluation Process
Role of the Coordinator

- Input into the development of evaluation tools
- Analysis of evaluation results
- Manage assessment meetings
- Track corrective action programs
  - Make sure all facets are met
  - Maintain supporting documentation
What is coming: Phase Four: 7/11 and beyond

- Expansion of the competencies and their assessments to develop models of excellence
  - Milestones project
    - Assessing competencies with a few important measures*
    - Specialty specific
    - Attainable at specific times throughout their education.

Curriculum
Evaluation
Rotation Scheduling
Organizational Systems for Documentation
Rotation Scheduling

- Clinical Experiences
  - Yearly overview
  - Strategies to meet Board and RRC requirements

- Duty Hours and Call Schedules
  - Creation
  - Tracking and Monitoring
  - Distribution
Rotation Scheduling

- ACGME – RC for Plastic Surgery
  - Clinical Experiences
  - Competencies
- American Board of Plastic Surgery
  - Clinical Experiences
- Balancing Act – Service vs. Education
  - Provide the case and patient care experiences, and meet competencies – program focus
  - Comply with duty hour requirements – program focus
  - Provide service – hospital focus
Rotation Scheduling – Strategies

Examine rotation lengths

- Pro: Determining appropriate time for case acquisition and patient case activities may free up time for educational needs; new procedural requirements
- Con: Attendings may not have resident support at all times, hospitals may not have service providers at all times

Program Director
- Data driven decision

Program Coordinator
- Analyze time frame for acquisition of required case; compare case to date reports over 2 years
Rotation Scheduling – Strategies

Eliminate duplicate rotations
  ◦ Pro: case procedure numbers are maintained; time is freed up for educational activities
  ◦ Con: eliminated rotations may need to augment with more physicians, physician assistants, registered nurse first assistants at considerable cost to hospital or practice plan

Program Director
  ◦ Decision maker; difficult position; needs objective reasoning and data
  ◦ Trends in Board and RC case experience focus; hospital patient care pool

Coordinator Role
  ◦ Supports by analyzing data and preparing reports
    • comparative data reports over 5 years;
    • trends in procedures – checks national data vs. program data;
    • case types by attending
Rotation Scheduling – Strategies

- **Optimize Resident–Attending Physician Pairs**
  - **Pro:** Attendings who teach and allow residents to operate receive resident support
  - **Con:** Attendings who do not teach are marginalized; entitlement can be a political issue;
    - Important Consideration: An attending does cases that are required, but does not facilitate resident education

- **Program Director**
  - Data driven decision, not emotional

- **Program Coordinator**
  - Evaluations of attendings as teachers, with residents comments and ratings
  - Cross compare resident case experience with each attending for the percentage of cases that the resident performs as surgeon
Rotation Scheduling – Strategies

- Examine rotation resident compliment
  - Pro: Determining appropriate resident level for types of case experiences may make a better clinical experience for both resident and attending
  - Con: Attendings may not have resident support at all times, hospitals may not have service providers at all times

- Program Director
  - Data driven decision

- Program Coordinator
  - Analyze time frame for acquisition of required case; compare case data in existing rotation time frames over 2 years
Night Float System

- **Pro:** All residents are scheduled for a night float experience. This allows those scheduled to work during the day to have more time for educational activities.
- **Con:** Residents are removed from regularly scheduled activities; access to limited clinical experiences; more vulnerable to service needs; limited educational value

Program Director

- Needs to be sure all residents are receiving equal experiences – do residents on night float between September and June get less educational experiences?
Rotation Scheduling
Yearly Overview

- Rotation schedules
  - Who makes the rotation schedule?
    - Program Director?
    - Program Coordinator?
    - How are they tracked?
  - What information is included?
  - How are they distributed?
  - How are they monitored?
Rotation Scheduling
Duty Hours & Call Schedule

- Duty hours
  - Tracking and Monitoring
  - Dealing with violations

- Call schedules
  - Typically made out by chief residents
  - Monitoring for compliance
  - Required information
    - Attending Supervisor
    - Duty hours
    - Back up plan
  - Distribution and correction
Curriculum
Evaluation
Rotation Scheduling
Organizational Systems for Documentation
- Resident
- Faculty
- Program activities
- Personal work needs
Resident – Files or Portfolios?

Definitions – (Merriam Webster)

- **File** – n. – 2 b: a collection of papers or publications usually arranged or classified.

- **Portfolio** – n. – 5: a selection of a student's work (as papers and tests) compiled over a period of time and used for assessing performance or progress.
Legal definitions

- Check with sponsoring institution – GME requirements
- What is contained in a “file”? 
- What is considered discoverable? 
- Will the advent of the portfolio as a means of collecting resident progress alter what is kept in the resident “file”?
Files

- Human resource (contents are institution specific) – Partial list
  - Application materials, Current visa information
  - Payroll information, Leave of absence / Medical leave, Medicare audit information
  - Contracts

- Communication
  - Written documentation such as letters and emails

- Medical
  - Immunization records and health related material
Files

- Resident Files – two of the three – Human resource and communication file
  - Application – reasons for hiring
  - Contracts – continuation of training
  - Formal letters of performance – evidence of formal status
    - Transfer from one program to another
    - Promotion to next year level
    - Remediation
    - Probation
    - Non-renewal of contract
    - Dismissal
  - Miscellaneous communication
    - Verification forms
    - Completion of medical records notifications
    - Loan deferment paperwork
Types of Portfolios

- Working: Organizes ongoing work effort documentation
- Performance: Showcases best effort, best practice or final product
- Career-focused: Contains all materials needed for further career development
Working Portfolio

- Designated by Program Director
- Ongoing submissions of work effort
  - Self-reflection
    - Patient encounters
    - Operative cases
  - Formative evaluations
  - Feedback
  - Curriculum course work
  - Manuscript drafts and editorial comments
Performance Portfolio

- Designated by Program Director
- Self-selected examples of best work or best outcomes
  - Presentation / manuscript
  - In-service scores
  - Self-assessments
  - Presentations
  - Summative evaluations
  - File review summaries
  - Exit and end of the year evaluation summaries
Career-focused Portfolio

- Documents that support life after residency
  - Needs for fellowship application
    - USMLE and in-service scores; medical school transcripts and letters
  - Needs for Board application
    - Documentation showing compliance with Board requirements
  - Needs for medical staff privileges
    - Copies of medical school and training certificates
    - Copies of course certificates, i.e. ATLS, ACLS
Paper vs. Electronic

- Technology advances
- Commercial products such as New Innovations and E-Value!
- Time and equipment factors
  - Scanner
  - Time filing paper vs. time spent at scanner
  - Back-up system
  - Archiving
- Usage
  - File review with program director
  - CD vs. paper that residents take with them
- Resident
- Faculty
- Program activities
- Personal work needs
Educational File?

- Evaluation summaries by residents
- Evaluation summaries by medical students
- Communication from Program Director
- Resident
- Faculty
- **Program activities**
- Personal work needs
Interview Season

- Applications
- Interview Day Processes
- NRMP requirements
- Ranking
- Follow-up; Survey and survey results
Mock Orals
Scholarly Activities
Conferences
  ◦ National
  ◦ Program
    • Grand Rounds
    • Journal Clubs
    • Other conferences
Graduation
- Resident
- Faculty
- Program activities
- **Personal work needs**
  - Emails
  - Schedules
  - Work day
  - Stacks of paper
Personal work needs

- Emails
  - Folders
- Schedules
  - Electronic
  - Paper Calendar
  - Multiple person office
  - Personal schedule –
    - Close office door for periods of time
    - Block off “meetings” to protect time
    - Work from home
Personal work needs
- Work day
  - To do list
  - By what happens
  - Immediate folder
  - Pending folder
Personal work needs

- Stacks of paper
  - Color coded Folders
  - Current activities
  - Issues
  - Data gathering
  - Filing for residents – pile, folder, alpha pendaflex file

- Office policy and procedure manual
  - Navigation trails for websites and log in information
  - Copies of letters and forms used
  - Processes outlined
Sharing
THANK YOU!

- Ruth H. Nawotniak MS, C–TAGME
- 716–859–7756 – phone
- rhn@buffalo.edu
Resources

www.acgme.org/Outcome/ – Outcomes Project
www.acgme.org/outcome/about/faq.asp
www.acgme.org/Outcome/assess/Toolbox.pdf
www.acgme.org/Outcome/assess/ToolTable.pdf
www.acgme.org/outcome/implement/rsvp.asp
www.bridgeporthospital.org/gme/residency
www.acgme.org/Glossary of Terms


Smith, Gary. Documenting the Competencies, 2006 HCPro conference.

New Common Program Requirements Duty Hours

- 16 hour maximum for PGY1
  - How schedule
    - Off-setting schedules
    - On call
  - Issue for small programs
    - Consolidate hospital usage
    - Appropriate resident compliment
  - Maintain team dynamics
- 2 transition years – PGY1 and PGY2
- Special circumstances for PGY2–5
  - How document
Dramatic increase in “must” statements
Workshop Activities

- Blooms Taxonomy
- Choose competency
- Create activity
- Determine goal and objective
- Determine level of activity
- Determine assessment method