ASSOCIATION OF RESIDENCY ADMINISTRATORS IN SURGERY

NEWSLETTER WINTER 2019

ARAS 1987

ASSOCIATION of RESIDENCY ADMINISTRATORS in SURGERY

April 22-25, 2019

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ASSOCIATION OF RESIDENCY ADMINISTRATORS IN SURGERY

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Message From The President

Happy New Year! By the time you read this, we will have all survived recruitment season and ABSITE. Next up will be Rank Order List Deadline and MATCH DAY!!! Winter is an extremely busy time in the life of an administrator. Make sure and take care of your wellness….our families, PDs and residents need us.

The ARAS Executive Committee had a very productive time in Boston during the American College of Surgeons annual meeting planning for the ARAS Spring Meeting in Chicago, IL. I want to thank the EC for all of their hard work and dedication to the committee and the upcoming meeting. There were many exceptional abstracts submitted. We unfortunately could not accept all the abstracts submitted; however, if your abstract was not chosen, please consider resubmitting it for next year. Registration will open on Monday, April 22 at 7 am followed by the New Administrators Workshop (NAW) beginning at 7:45 am. New administrators who have been in their role less than 3 years are strongly encouraged to attend the NAW. The full meeting will begin on Tuesday, April 23 at 7 am with registration/breakfast and wrap-up on Thursday, April 25 at 12:15 pm. I am very excited to announce that Dr. Kim Schenarts from the University of Nebraska will present the ARAS Keynote Address. Please check out the meeting schedule for full details on the APDS website.

We will be having daily door prizes and a special award for the newest administrator. Please remember you must be present in order to win. We are also very excited to introduce ARAS Jeopardy this year…with bragging rights and prizes for the winning team!

It doesn't matter if Chicago will be your first meeting or the umpteenth meeting you have attended, I can promise you will go home having gained a new way of doing an old task and in the process made a lifelong friend or two. The meeting should be a time to regroup and reenergize.

I am looking forward to seeing everyone at our meeting in Chicago! If you have questions, suggestions or require further information, please do not hesitate to contact me at suann-white@ouhsc.edu. From the song "Chicago" sang by Frank Sinatra,

♫ *"Chicago, Chicago, that toddlin' town Chicago, Chicago, I'll show you around, I love it, Bet your bottom dollar you'll lose the blues In Chicago, Chicago"* ♫

See you in Chicago!

SuAnn White, C-TAGME
ARAS President 2018-2019

Outreach

2018 ACS Clinical Congress Student Programs

The ARAS Executive Committee met medical students from all over the country during the American College of Surgeons Clinical Congress in Boston, MA in October 2018. The committee meets at this conference every year to plan the ARAS spring meeting, but also to spend time with medical students at the ACS Clinical Congress. The EC met with students on Sunday, October 21st during the ***Student Networking Event*** to discuss ***Useful Information for IMGs*** and ***I've Matched, Now What.*** The students varied in level from MS3 to MS4s. On Monday, October 22nd, the EC met with students varying in levels MS2-MS3s to discuss ***Tips & Tricks for ERAS, NRMP, & SOAP*** and ***Preparing for your Interview Day***. Both events had a bigger turnout than ever before with over 500 medical students attending in all! The ARAS EC looks forward to next year's ACS Clinical Congress event in San Francisco from October 27-October 29, 2019.

Membership

Top 10 Reasons to add "Renew ARAS Membership" to your Winter To-Do List

Jessica Roof

10. Networking with other like minded people

9. Access to seasoned Mentors interested in helping you grow

8. Seasoned administrator? Access to the plethora of new administrators looking to learn from YOU!

7. Sounding board for issues and concerns you are facing in your program

6. Document and Form sharing

5. Monthly reminders from our listserv

4. Periodic Professional Development Opportunities throughout the year

3. Access to THIS newsletter

2. Make new friends

1. Discounted Registration for the Annual Meeting in Chicago this year!!!

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Welcome New ARAS Members!

Eleven coordinators were approved for membership at the October 2018 APDS Board of Directors Meeting in Boston, MA. Please join us in welcoming the following new members of ARAS!

Andrea Brumback
Hospital of the University of Pennsylvania
Philadelphia, PA

Lynne Buckingham
Wright State University
Dayton, OH

Eva Janell Clements
University of Utah School of Medicine
Salt Lake City, UT

Carla Coleman
San Joaquin General Hospital
French Camp, CA

Tenesha Diaz
Einstein Healthcare Network
Philadelphia, PA

Mackenzie Eason
University of Louisville
Louisville, KY

Janice Hutchinson
University of Connecticut
Farmington, CT

Jenna Little
McGaw Medical Center of Northwestern University
Chicago, IL

Jaime McKenna
Central Michigan University College of Medicine
Mt. Pleasant, MI

Kate Kmiec
Vanderbilt University
Nashville, TN

Jenna White
MAHEC
Ashville, NC

Let's Get SOCIAL

Mentor~Mentee Update

A mentor is defined by the Merriam-Webster dictionary as someone that is a *trusted guide or counselor.* Their role is to *guide, to give advice, and to support the mentee*. We have close to 40 mentors out of our total 321 ARAS members. This is great, but with so much knowledge to share with each other, we hope that every administrator with at least 3 years experience should be able to serve as a mentor to another member!

At our spring 2018 ARAS conference, we received over 30 requests from our new administrators to be setup with one of our mentor ARAS members. With over 75 new administrators attending our New Administrator Workshop at the conference, this is highest amount of mentor requests we have received during an ARAS meeting. Please remember that you don't have to wait until the annual conference to sign up to become a mentor or a mentee, but that you can sign up on our website at any time and a member of our ARAS executive committee will be happy to arrange a match for you!

To become either a mentor or a mentee, you can visit the ARAS website at www.arasurgery.org and complete the online form. There are also announcements made and sign-up sheets available at the Spring meeting each year. In addition, you may contact the Mentor / Mentee Program Chair, Sarah Kidd-Romero, at SKidd@som.umaryland.edu for more information.

Sunshine Committee

The purpose of this group is to relay the care and concern of fellow members in times of need by sending wishes of encouragement or sympathy. The Sunshine Chair will send a card to members for the following reasons:

- Serious illness
- Death of a member (sent to a designated family member)
- Death of an immediate family member (parents, spouse, children, stepchildren)

If you are aware of a fellow administrator who is ill, lost a loved one, needs cheering up, or is going through a tough time, let us know.

Also, if you hear of someone who has received a promotion or an award with respect to her/his position as a residency coordinator, we would like to acknowledge this accomplishment.

Please email the Sunshine Chair, Dorothy Dickinson, at Dpettway@health.southalabama.edu, with the name, address and reason for the card.

Things to do in Chicago

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Things to do in Chicago, cont.

Eat some deep-dish pizza!

Giordano's is a quick 5 minutes walk from the hotel!

See the Iconic Chicago Theatre. This is a 10-minute walk from the hotel.

Take a walk to Grant Park & Millennium Park. Visit "Cloud Gate" aka "The Bean"

Millennium Park is only 8-minute walk from the Fairmount Hotel!

Walk along Navy Pier. At the end of the pier you will have a nice view of Lake Michigan. Probably more of a quick Uber ride than a walk to this location. But the views are well worth it!
https://navypier.org

Take a architecture boat tour of the city on Chicago's First Lady cruises. It's a great way to see the city and is hosted by the Chicago Architecture Foundation. The boat dock is a 6-minute walk from the hotel located on the Chicago Riverwalk!

If it's still cold outside, go check out one of the many museums in the city. The top museum in the city is the Art Institute of Chicago.

Annual Meeting

Seasons Change, and So Do We!
ARAS New Administrator Workshop 2019

Lisa Olson

Thinks Spring! This Winter has been a rough one for many of us throughout the country, but it is time to look forward to Spring, and the ARAS 2019 Annual Meeting New Administrator's Workshop (NAWS)! If you are a surgery program administrator who has been in your position for less than three years, mark your calendar for Monday, April 22nd, to attend the New Administrator's Workshop. This one-of-a-kind educational experience kicks off our 2019 Annual Meeting. In this workshop, experienced administrators will share their wisdom, strategies and tools of the trade to help you navigate the monthly, quarterly and yearly tasks an administrator is required to perform.

This year's workshop will take you on A Trip through the Seasons of the Year! No need to panic when that July 1st start date approaches. Our Executive Committee will expertly guide you through all the seasons of surgery residency. From onboarding and orientation all the way through graduation, and everything in between. And there is help along the way! Our mentor program pairs new administrators with seasoned administrators, eager to share their experience and knowledge with you. Look for sign-up opportunities at the meeting.

The day's learning is supplemented with networking opportunities. Not only will you have access to our ARAS Executive Committee throughout the day, serving as your guides into the wonderful world of surgery program administration, but the workshop day also provides two opportunities for networking and learning. A Dutch-treat group luncheon is planned at one of the local restaurants. We will break into groups of attendees, and each group will have an EC member at their table for questions, introductions and general guidance. You may also sign up to attend dinner with your workshop co-attendees at one of several nearby restaurants. Networking is one of the best tools an administrator can have . . . building relationships of professionals that can be ready to lend a hand now or in the future.

So, Winter, Spring, Summer or Fall - NAWS will help you prepare for it all! We'll see you in Chicago. Safe travels!

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Register NOW!!!

Registration Now OPEN!

New Administrator Workshop

April 22, 2019

ARAS Conference

April 23-25, 2019

This conference is designed to provide you with an outstanding educational experience and opportunities that will enable you to move your career forward and help you achieve and maintain success as a surgical residency administrator. You will gain new skills and knowledge to enhance expertise as a surgical administrator and increase current skill level.

If you attend only one conference this year, ARAS's annual conference is your best investment!

Register today at:

https://members.apds.org/meeting/registration

Project BOB

All Hands and Hearts
Smart Response

2019 Project Bob Chicago presents "All Hearts and Hands - Smart Response" charity event. This year we would like to help those communities that were effected greatly by natural disasters who still need help. Our focus will be helping rebuild communities in Florida (Hurricane Michael), North Carolina (Hurricane Florence), Texas (Hurricane Harvey), and Puerto Rico (Hurricane Maria). All Hands and Hearts – Smart Response efficiently and effectively addresses the immediate and long-term needs of communities impacted by natural disasters. By listening to local people, and deploying a unique model of engaging volunteers to enable direct impact, they rebuild safe, resilient schools, homes and other community infrastructure. Through volunteer and community engagement, they help families recover faster after natural disasters using the "smart response" strategy. By rebuilding in a disaster resilient way, they prepare them for future events and, through the process, strengthen both volunteers and communities. If you would like more information on All Hands and Heart, please visit www.allhandsandhearts.org.

Professional Development

Burned out: Recognizing and addressing burnout in you and your staff

Debbie L. Miller

https://journal.practicelink.com/category/winter-2019/

Practicing medicine has never been an *easy* profession. But it's also not getting any easier. Perhaps that's what makes burnout not only a reality, but also on the rise—and rising fast. Tait Shanafelt, M.D., chief wellness officer of Stanford Medicine, has found that burnout rates among physicians are now *twice* as high as that of professionals in other fields.

In the most recent data from a national research study, Shanafelt found that nearly 49 percent of physicians reported burnout, as opposed to 28 percent for other professionals.

Although physicians of all ages and time in practice can and do suffer from burnout, it's actually the *younger* physicians who seem to be particularly at risk.

"Residency is the peak time for burnout," Shanafelt says. One factor is the long hours required of training.

Female physicians report burnout at higher rates than male physicians. In one survey from Medscape, 48 percent of female respondents reported burnout symptoms vs. 38 percent of male respondents.

Specialty can also play a role. One Medscape survey cites the following specialties have the highest reported rates of burnout: critical care, neurology, family medicine, Ob/Gyn, internal medicine, emergency medicine and radiology. Additional issues also contribute. For example, working emergency department shifts can contribute to "a distortion in circadian rhythm," says David A. Farcy, M.D., who practices at Mount Sinai Medical Center in Miami Beach and is president of the American Academy of Emergency Medicine (AAEM).Likewise, "Emergency departments are the safety net of America, social issues are mounting and resources are getting less."

The two factors most often cited in the Medscape survey as contributing to burnout are "too many bureaucratic tasks" (cited by 56 percent of survey respondents) and "spending too many hours at work" (cited by 39 percent of respondents).

Shanafelt notes another factor: complying with the demands of electronic health records. "About 37 percent of a physician's time in an examination room is spent entering EHR data into a computer," says Shanafelt—time that could be spent with the patient, and time that still often requires data entry on nights and weekends.

Bringing burnout to light

As recently as the late 1990s and early 2000s, the idea of physician wellness was rarely addressed as part of med school curriculum. Instead, the focus was on *strength* and *resiliency*. The message was this: physicians should do whatever was necessary to deal with the challenges of a career in medicine. That mindset created even more stress.

It took an increase in physician suicides to bring the matter to the forefront.

In 2012, the suicides of two residents in New York City shone a light on the issue of physician suicide. "As a result, the emergency community as a whole came together in 2016 to form a coalition of all emergency medicine groups to address wellness," says Farcy. Goals of the coalition included defining the problem of burnout and determining ways to identify and prevent it.

Benefitting from the focus

For Farcy, the topic was deeply personal. "During my medical school, emergency medicine and critical care fellowship training, physician burnout and wellness was never addressed," he says. "We were taught to just press on."

But while in residency at Maimonides Medical Center in Brooklyn, Farcy was a first responder on 9/11—an experience with memories that he put "in a box" and didn't speak about to others.

Then, during a moment of silence paying tribute on the one-year anniversary, Farcy's experiences hit him hard.

Farcy's program director took notice and invited him to her office to talk. She suggested he get help and referred him to a representative from the ACGME. From there, he visited a psychologist trained in PTSD and survivor guilt—and got the help he credits with changing his life. "I am grateful that my institution had a program in place and a plan to address the issue without fear of repercussion," Farcy says.

Antonia P. Francis, a maternal fetal medicine fellow at NYU

Burned out, cont.

Langone Health Center, reports that while she hasn't personally known any physicians who have committed suicide, "I trained at an institution that experienced two suicides of house staff within a three-week period, yet I can honestly say that during my medical training, the topic of suicide was not heavily stressed."

Francis, who works a fairly typical 80-hour a week, says, "I experienced depression and burnout during my residency training and first year of fellowship," she says. The first step was recognizing she had a problem. Then, she took action.

"I visited counselors and a therapist who specifically works with physicians who had mental exhaustion," she says. "I also learned to practice mindfulness, started journaling for stress relief, and exercised more."

Fixing the problem

Alleviating physician burnout is a complex challenge. Survey respondents cited more pay, fewer hours and patients, and fewer government regulations as key.

Early detection can also help. Farcy, who has been supervising residents in emergency medicine for 12 years, has seen and addressed depression and burnout in others. The early signs, he says, are "less involvement, less caring, and negative comments in a person who used to be very positive."

Addressing burnout, however, comes with its own land mines. Sometimes when a physician who is depressed or approaching burnout speaks to their supervisor about the issue, the physician is forced to stop working or see a psychiatrist in order to be cleared to go back to work.

"Too often, this adds to the stress by causing a new burden on the physician," Farcy says. And when a colleague has moved beyond burnout to something deeper, expressing concern may not be enough. "By the time a doctor is in the early stages of depression, it is harder to get them involved in resilience," says Farcy. "Telling them you need to go work out, do yoga, drink less, spend more time with your loved ones, etc., too often falls on deaf ears. The physician may hear it but won't change or do these things because of their underlying depressive state."

The best answer may be in fostering a community that's open to discussing burnout. Farcy says physicians need to feel free to talk openly, in a safe place, without being labeled as weak. "We have a wellness program where I work, and I have an open-door policy for anyone to be able to talk and share, without risk or fear of repercussion," Farcy says.

"Once the person begins speaking, most important is listening and creating a plan," he says.

Clif Knight, M.D., is senior vice president for education for the American Academy of Family Physicians (AAFP). He's worked in private practice, as a hospital administrator, and as director of a family medicine residency program. As a residency program director, he witnessed resident burnout and tried to help his physicians recognize their symptoms and consider counseling and coaching.

Knight stresses that burnout is not due to a lack of physician resiliency, as was once commonly thought.

"It's important to recognize that the majority of burnout is related to problems in the health care system and outside the physician's control most of the time," he says. "We need to fix the system's problems instead of addressing only the resiliency and coping skills of individual doctors."

Francis agrees. "Physician wellness isn't only about individual and personal efforts, but about change on a broader level." She suggests that institutional support and a change in our medical culture would go a long way to support physician wellness.

The path ahead

Now, medical education institutions are addressing burnout head-on. And there appears to be more help for physicians in the throes of burnout.

"Cultural and environmental changes are necessary to combat physician burnout," says David A. Rothenberger, M.D., who advises on physician burnout at the University of Minnesota. "At our institution, we have a multi-year, major commitment from the top of the organization to devote time, talent and treasure to take on this problem."

Rothenberger is also helping to build a coalition of those who want to address the issue of physician burnout. Currently, close to 80 individuals belong to the coalition, including academic and clinical leaders and staff.

Though progress is being made, Rothenberger says it will take a decade or two to fully address the issue.

"Achieving the needed transformation of the workplace culture to overcome the current physician burnout epidemic will take many years, and sustaining physician wellbeing is dependent on continuous effort to meet the future needs of physicians and other health care professionals," he says.

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Identifying Managerial Roles of General Surgery Coordinators:

Making the Case for a Utilization of a Standardized Job Description Framework

Brianne Nickel, Jessica Roof, Scott Dolejs, Jennifer Choi, Laura Torbeck

Journal of Surgical Education

OBJECTIVE: Residency coordinators are valuable members of the education leadership administration. In General Surgery, program directors must devote time to both their clinical practice and as the leader of the education program for surgical residents. With the introduction of competencies and the Next Accreditation System, the responsibilities of training programs have increased, with much of the necessary day to day management being driven by the residency coordinator. The purpose of this study was to identify the current roles of a residency coordinator in surgery to determine appropriate language for a standardized job description that accurately describes the responsibilities of a program coordinator.

DESIGN AND PARTICIPANTS: A survey was created and distributed via email to 317 general surgery program coordinators in programs with continued, initial, or preaccreditation status by the ACGME in October–December 2017. Questions were asked about coordinator demographics, ADS involvement, and communication with program director, recruitment, and professional development. 223 coordinators (70%) completed the survey.
RESULTS: Thirty-five percent of coordinators reported that their program director expects them to complete the annual ADS update in its entirety with a final review by the program director before submission, whereas 15% stated that the program director expects the program coordinator to input, update, and submit the annual ADS update without oversite from the program director. Fifty percent of program coordinators speak with their program director 2 to 4 days a week, whereas 38% speak with their program director daily. Eighty-nine percent of coordinators reported that their program directors trust them to make appropriate administrative decisions during scheduled or emergent absences. Sixty-nine percent of coordinators strongly agreed that they assist their program directors with collating and analyzing recruitment data post-recruitment season. Eighty-six percent of coordinators regularly participate in one or more professional development activities. Forty-six percent of coordinators stated that they oversee administrative staff in their office, division, or department.

CONCLUSION: Given the current makeup of today's residency coordinator in general surgery programs, the need for baseline qualifications and a standardized job description allowing for recruitment and retention of a coordinator capable of managing a residency along with a program director. The data from our survey indicate that most coordinators currently perform tasks and take on responsibilities of a manager, but they hold current job descriptions that do not adequately reflect the role. The current proposed ACGME revisions state that there must be a program coordinator for a residency program, citing the coordinator as an integral member of the residency leadership team. Therefore, human resource departments need a job description that identifies level of responsibility, contribution, leadership, and management required of a program coordinator. (J Surg Ed 75:e38–e46. © 2018 Association of Program Directors in Surgery. Published by Elsevier Inc. All rights reserved.)

INTRODUCTION

Around the turn of the century, graduate medical education began to transform into an institution that was more receptive to the rigor of education principles, particularly in terms of curriculum, assessment and evaluation enhancement. In the early 2000s, the Accreditation Council for Graduate Medical Education (AGGME) initiated the Outcome Project which identified six competency domains and encouraged programs to enhance current evaluation and education frameworks for measuring resident and fellow performance.[1,2] Simultaneously, language was added in the Common Program Requirements (CPR) that gave common standards to all programs for monitoring resident duty hours.[3]

The Outcome Project increased the accountability for residency and fellowship programs to graduate competent physicians. Competency-based goals and objectives were created along with revision of rotation evaluations to increase the likelihood that the goals and objectives were achieved by the trainees. Continuous monitoring was required by the program director not only for ensuring trainees met the competencies, but also for work hours as well. The Outcome Project yielded a new way of thinking and teaching for academic teaching faculty.[1]

In 2013, the Next Accreditation System (NAS) brought additional facets to residency education. This included changes to the accreditation cycle requiring annual program updates and an annual program evaluation conducted by a Program Evaluation Committee. Additionally, NAS introduced milestones and the Clinical Competency Committee to evaluate resident and fellow progress regarding the specialty

Identifying Managerial, cont.

specific milestones. The impetus for both these new committees was to ensure that appropriate assessment tools, goals and objectives, policies and procedures, etc. were in place to keep the program compliant with standards established by both the ACGME and their respective specialty board.[2]

Before the implementation of the Outcome Project, a number of general surgery programs were directed by as few as two part time professionals – the program director and residency coordinator.[4] As a result of the Outcome Project and NAS, administrative burdens increased for program directors as they are required to respond to frequent changes in compliance and requirements of the ACGME, as well as other challenges in running an education program. With these burdens, the residency coordinator position has inherently morphed from a clerical, coordinator of tasks to a manager of people, policies, and competency outcomes. [2,5,6] The roles of both faculty and program directors in terms of teaching, evaluating, and directing the residency and fellowship program have been recognized and formally specified in the ACGME CPR. The residency coordinator position, however, has not evolved in terms of being specified in the ACGME CPR, and thus, their role definition remains antiquated. Fortunately, a grassroots effort initiated by the Association of Residency Coordinators in Surgery helped spearhead the formation of the National Board for Certification for Training Administrators of Graduate Medical Education Programs (TAGME) in 2006. TAGME was formally established to assess the knowledge, skills, and abilities of training administrators of graduate medical education programs and helped to elevate coordinator status.[7]

The responsibilities of a residency coordinator are broad due to the evolving education requirements by the ACGME. In surgery, residency coordinators provide a management role for the program directors given their dual role as an educator and a surgeon. Residency coordinators are active members of the surgical education team and make significant contributions to the administrative requirements set by the ACGME.

In some institutions, hiring a residency coordinator can be challenging. Human Resource offices struggle to create or accept appropriate job descriptions as they often still conceptualize and frame the position as more of a clerical role and not as an administrative one. With the minimal direction ACGME identifies for residency coordinators in the CPR, this hiring challenge will continue to exist and could likely impact residency coordinator turnover.[8]

The purpose of this study is threefold: (1) to describe the makeup of the current pool of general surgery residency coordinators; (2) to identify the coordinator's role in managing the program in terms of annual and continuous program updates for the ACGME in their data management system known as Accreditation Data System (ADS), resident recruitment, communication between coordinator and program director, and professional development; and (3) to offer a standardized job description to hire, train, and retain program coordinators that other institutions can utilize.

METHODS

In September 2017, 317 ACGME program coordinators were identified from 296 accredited and 21 pre-accredited surgery programs from the public ACGME ADS database. An IRB approved web-based survey was subsequently created and distributed by email at the end of October 2017 to the 317 surgery program coordinators. Follow up emails were issued on November 15, 2017 to those who either completed the survey partially or had yet to begin. The survey closed on November 30, 2017.

The survey instrument consisted of 10 demographic questions, 8 questions about ADS completion, 10 questions on program coordinator-program director working relationship, 14 questions about resident recruitment, and 19 questions about overall program management. Answer options varied from multiple choices to open ended questions. The final question of the survey allowed participants to comment on areas of their job that they felt should also be taken into consideration when making the case for a standardized job description for residency coordinators. Individuals at Indiana University with experience in surgical education research reviewed the survey before distribution. The survey was imported and distributed using Qualtrics.[9] Once results were obtained, the data was analyzed using Statistical Analysis System software.[10]

RESULTS

The survey response rate was 70% (223 of 317). The Table shows coordinator data stratified by program type, education level, and years of experience. Overall, slightly more than half of the program coordinators work in a hospital based residency program (58%) while 42% work at an academic health center. The majority (54%) of coordinators have a bachelor's degree or higher. Nearly 40% of coordinators have been in their role less than 5 years while 35% have more than 10 years' experience. When asked about position category, 64% of general surgery coordinators identified themselves as salaried (exempt) employees and 33% identified themselves as clerical (nonexempt) employees. Salary ranges reported by the program coordinators were $30 to 40K annually (11%), $41 to 50K annually (25%), $51 to 60K annually (34%), $61 to 70K annually (16%), with 8% and 9% falling in the $71 to 80K and the $80K+ range, respectively. Regions of the country

Identifying Managerial, cont.

were not identified in the survey to take cost of living into consideration. Most program coordinators (77%) reported that they serve as a coordinator for other programs in addition to general surgery and about half of the coordinators have administrative assistance provided to them.

ADS Management

Questions were asked of the surgery program coordinators regarding their involvement in ADS. Of the 208 program coordinators who reported having completed ADS at least once, 35% responded that the program director expects the program coordinator to complete the annual ADS update in its entirety with the program director doing a final review before submission. There were 15% of program coordinators who reported that it was the program director's expectation that the program coordinator complete and submit all information to the annual ADS update without any program director oversight. Most program directors and program coordinators work collectively in some fashion to manage ADS (see Fig. 1).

Program Director & Program Coordinator Communication

In terms of communication, data collected from the survey indicated that a large percentage of program coordinators speak with their program director on a regular basis. 50% of program coordinators speak with their program director 2 to 4 days a week and 38% speak with their program directors every day. A minority speak only during scheduled meetings (6%) or when emergent/urgent situations arise (6%). Fifty-seven percent of program coordinators reported that they have weekly face to face meetings with their program directors and 24% reported having daily meetings. Most coordinators (68% agree, 23% somewhat agree) reported that they communicate effectively regarding issues and needs of the surgery residency program. With decision making, 89% of program coordinators reported that their program directors trust them to make appropriate administrative decisions in their absence (vacation, conference, emergent situations). The majority of participants strongly agreed (51%) or agreed (33%) that program directors seek their opinion when decisions need to be made regarding the residency program (Fig. 2).

Recruitment

Successful recruitment of applicants is a key component for residency programs. Of the 198 program coordinators who reported having participated in recruitment, 53% responded that they felt extremely comfortable reviewing and interpreting a medical student's Medical Student Performance Evaluation (MSPE), whereas 31% found themselves somewhat comfortable (Fig. 3). When screening applicant files, 51% of program coordinators reported that they are extremely comfortable reviewing and evaluating letters of recommendation and 35% reported feeling somewhat comfortable with this task. If asked by an external program director or physician to review an applicant's file, 61% of program coordinators reported feeling extremely comfortable and 25% reported feeling somewhat comfortable making a recommendation to their program director about the applicant. Sixty-nine percent of residency coordinators reported that they strongly agree and 16% agreed with the statement that they assist their program directors with collating and analyzing data collected post-recruitment season to create the rank list. When medical students approach residency coordinators seeking advice regarding the individual's competitiveness for the surgery residency program, 53% of program coordinators responded feeling extremely comfortable speaking to the student and 31% reported feeling somewhat comfortable.

Professional Development

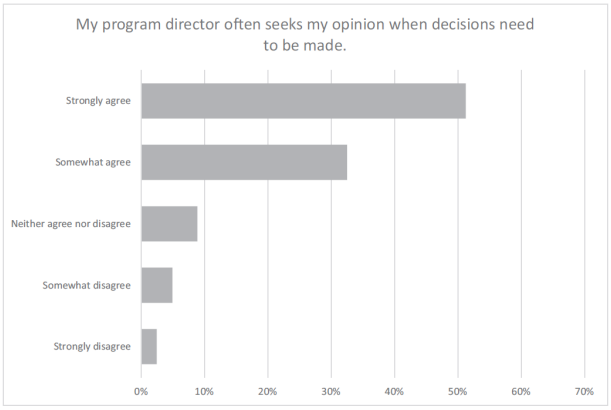
Our survey data suggested that program coordinators network and engage in professional development. Seventy-five percent reported that they cultivate working relationships with their peer coordinators within their home institution as well as with their graduate medical education (GME) office. Eighty-six percent of residency coordinators in surgery participate in at least one or more types of professional development: including attending national meetings, participating in webinars, and reading journals (see Fig. 3). Of the 71% of respondents that stated their institution provides tuition remission for employees, 41% have taken advantage of this opportunity to further their own development. As for professional development at the national level, 41 program coordinators in our study have achieved TAGME certification, 16 are in the process, and 155 have yet to engage in this opportunity.

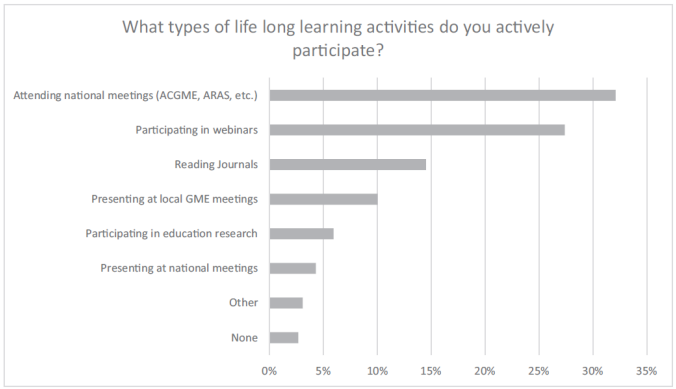
Many coordinators do have managerial roles. Of the 201 respondents, 46% reported having a responsibility of overseeing up to five staff. These staffs include administrative assistants, assistant residency coordinators, other specialty residency coordinators, and medical student coordinators. Eighty-five percent of the coordinators that oversee staff perform annual reviews.

DISCUSSION

With the introduction of ACGME's Next Accreditation System, the role of the program coordinator has changed dramatically. The implementation of annual ADS updates along with management of the Clinical Competency and Program Evaluation Committees has not only added significant hours to an already full work week for coordinators but has added higher level skill ability to accomplish these tasks. Currently, the General Surgery Program Requirements that pertain to the program coordinator are as follows11:

Identifying Managerial, cont.





II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. (Core)

II.C.1. There must be a full-time surgery program coordinator

designated specifically for surgical education. (Core)

II.C.1.a) Programs with more than 20 residents should be provided with additional administrative personnel. (Core)

Aside from these three core requirements, no other language is provided that identifies what specific skills, abilities, or expectations are needed for a program coordinator. In a recent study by Fountain et al., a list of job responsibilities reported by a sample of surgery residency program coordinators was identified. The responsibilities varied and included both clerical (i.e. payroll, rotation schedules, travel reimbursement, etc.) and managerial tasks (i.e. project management, duty hours oversight, HR tasks, etc.). Based on data collected in our survey, general surgery residency coordinators assume responsibilities that ensure effective administration of the program similar to what Fountain et al reported, and yet at times also take on responsibilities that fall more in the purview of the program director.[8] For example, the majority of program coordinators work collaboratively with their program directors to complete the annual ADS updates but there was 35% who reported completing ADS in its entirety with the program director only doing a final review before submitting. Additionally, 15% reported that the program director's expectation was for the coordinator to complete and submit all information to the annual ADS without director oversight. With the introduction of NAS and the annual ADS update (which eliminated the Program Information Form for site visits), program coordinators should be expected to not only contribute, but also to accurately report data and information into select sections of the annual ADS update given their day to day involvement of managing the residency program. However, per the CPR designation regarding program director responsibility, the final overview and submission of the update is the sole responsibility of the program director.[12]

When it comes to recruitment, program coordinators review and interpret medical students' MSPE's, evaluate letters of recommendation, and assist program directors with collating and analyzing data to create the rank list. Our data revealed that 89% of program coordinators reported that their program directors trust them to make appropriate administrative decisions in their absence. Interestingly, almost half of program coordinators have a supervisory role and are responsible for completing annual performance reviews of staff.

Surgery residency program coordinators, as our data suggest, perform tasks that require them to have the ability to make decisions, interpret, evaluate and analyze data, and supervise personnel. Program directors recognize the amount of work that program coordinators perform with day to day management of the training programs. Program directors count on the coordinators to be in the office every day and serve as the first point of contact for residents, fellows, and medical students. The ACGME site visitors are also cognizant of the level of involvement program coordinators provide. During site visits, reviewers will often ask program directors what happens if the program coordinator leaves (resigns, FMLA, etc.) and what backup plans are in place.

With the continued emphasis on programs meeting competency-based educational outcomes, the administrative burdens will likely remain, if not increase, for program personnel. In the Fountain et al study, the authors set out to provide an analysis of data identifying a potential mass turnover in surgery residency coordination. Of the 153 Association of Residency Coordinators in Surgery members surveyed, 60% considered resigning in 2016. As for the

Identifying Managerial, cont.

reasons for resigning, 35% of participants reported reasons due to work load, 33% due to their salary, and 31% due to lack of administrative help. As Fountain et al suggest, perhaps more of a movement could occur to develop a standardized job description for hiring residency coordinators to then be shared with human resources (HR).[8]

In some institutions, HR offices are often unsure as to how to appropriately classify residency coordinator roles because there is not a standard job description from ACGME, therefore the default is to assign program coordinators to a clerical, hourly role. As the language currently exists in the ACGME CPR, there is too much ambiguity for HR personnel, who are generally not intimately involved in the graduate medical education realm, to accurately classify the coordinator role leading to the varied pay discrepancies and job classifications reported in our data.

Providing HR departments with a more defined scope of responsibilities for program coordinators could help ensure equitable compensation and give applicants a clearer picture of what the coordinator role involves. In 2014, a Coordinator Description Task Force (CDTF) was created by an internal medicine program coordinator to propose a change in language in the CPR to better define what is expected of a program coordinator for the Phase II rollout.[13] In their proposal, they advocated for changing program "coordinator" to program "manager."[14] Taking into consideration both the CDTF's formal proposal of the change in language and the data we obtained in our study, we have proposed a job description template for a general surgery residency coordinator position that we hope can assist surgery programs with future hiring. We, too, are advocating for the position title of Program Manager to reflect the more managerial skills one needs to be most successful in this profession (Appendix A). Our template was modeled using descriptive verbiage in the proposed revision to sections I-V of the ACGME CPR. We support the proposed language changes in the CPR stating that residency programs must have a program coordinator,[15] rather than program coordinators belonging in the grouping of "necessary professional, technical, and clerical personnel for the effective administration of the program."[16] We also support that at least 20 hours of the week should be dedicated for administrative time for the residency coordinator.[17]

To be more explicit about the program coordinator responsibilities, we advocate that the ACGME delineate the role of the program coordinator in the same way expectations are stated in the CPR for program directors using the language in the background and intent description regarding the requirement that programs must have a coordinator. The description of the program coordinator in the 2017 CPR proposal background and intent is specific language that is needed for HR departments to identify level of responsibility, contribution, leadership, and management required of a program coordinator. This then would allow HR departments to more appropriately determine both job classifications and salary grades for a managerial position.

There were several limitations to this study. Not all respondents answered every question and the reasons are unknown. Regions and cost of living adjustments were not considered when identifying salary ranges. This study only looked at the perspectives of residency coordinator respondents. A future study would also account for the program director perspective.

CONCLUSIONS

The call to action that we request of the Association of program Directors in Surgery is to submit a proposal in conjunction with the Association of Residency Administrators in Surgery to further delineate the roles and responsibilities of the program coordinator. These roles should be outlined and agreed upon by both entities, then submitted for consideration to the Surgery Resident Review Committee as an update to the Program Requirements for Surgery. Precedent has already been set by other programs to give further definitions to ensure substantial support from an administrative perspective. Most notable being Pediatrics as their specialty requirements outline a percentage of Full Time Employees for program directors, associate program directors, and coordinators based on the number of trainees in their program. If this delineation is achievable, then a more robust definition of the program coordinator role should also be achievable.

APPENDIX A. POSITION TITLE: PROGRAM MANAGER – GENERAL SURGERY

A. Primary Role

General Surgery Residency Program requires a lead administrator that manages day-to-day operations of the residency program. This person serves as an important liaison with learners, faculty, staff, institution Graduate Medical Education (GME) office, and ACGME. The General Surgery Residency Program Manager is a recognized member of the education leadership team.

B. Primary Responsibilities

Recognize and understand the policies implemented regarding General Surgery residency training from both ACGME and American Board of Surgery. Must be able to lead through change and manage up when new requirements for residency training are implemented.

Identifying Managerial, cont.

Collate, review, analyze, interpret, and present data to the Program Director, Clinical Competency Committee, Program Evaluation Committee, and other members of the education leadership team to assist in the evaluation of resident progress, rotations, faculty teaching performance, and other programmatic education activities that impact resident training.

Effectively communicate with Program Director, faculty, residents, staff, and other personnel that work for or with the General Surgery Residency Program (ACGME, American Board of Surgery, etc.).

Direct residents in the successful navigation of the administrative requirements established by institution GME and ACGME. This includes follow up with incomplete requirements, informing Program Director when residents get behind with meeting requirements, and verifying requirements are met before residents graduate.

In conjunction with the Program Director, maintain electronic ADS data base, ensuring that all data collected and entered regarding resident scholarly activity is accurate. The Program Manager is also responsible for ensuring that all faculty CV data (physician and nonphysician) is entered correctly, as well as recording annual scholarly activity. Assist Program Director with accurate completion of other required ADS sections.

Participate in professional development activities such as institution GME programs, webinars provided by ACGME, reading literature, etc. Become a member of Association of Residency Administrators in Surgery and attend annual conference in conjunction with the Association of Program Directors in Surgery.

Must have 20% of their week protected for completion of daily and monthly administrative tasks as assigned by Program Director, institution GME, and ACGME.

C. Qualifications

Minimum education: Bachelor's Degree; combination of education and experience may be considered.

Skills: Strong organization and communication skills. Ability to work with Microsoft Office applications. Ability to quickly learn new data management systems (Med- Hub, New Innovations, E*Value). Able to work independently and with teams. Must be able to keep identified conversations and meetings confidential. Attention to detail with data entry, management, and presentation.

Note: Direct verbiage pulled from 2018 proposed revisions

(background and intent) of Sections I-V CPR

under section II.C. Program Coordinator

http://www.acgme.org/Portals/0/PFAssets/Reviewand

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Did You Know?

ACGME Spotlight: How will the 2019 ACGME Common Program Requirements affect our programs?

Darlene Norton

By now, we have all seen the ACGME Common Program Requirements (CPR). Programs are expected to have integrated the new requirements by the new academic year (7/1/2019); if not, citations will be issued beginning 7/1/2020.

There are now two sets of Common Program Requirements one for Residency programs and one for Fellowship programs. When I read the CPRs, I like to review with the background and intent (B&I) for the change. It makes language a little easier to understand and it seems clearer to me as to why the change was made and how we need to best implement any changes in policies, etc.

Let's review some of the highlights from new requirements:

- ◊ **Program Letter of Agreements** – will be for a 10-year duration instead of 5 years
- ◊ **Recruitment/retention** – recruitment should include a diverse workforce (includes: residents/fellows, faculty and staff)
- ◊ **Resources** – Lactation room within the hospital for residents
- ◊ **Program Director** – states 20% time commitment for the program director (but for General Surgery 30%) - dedicated 8 hours per week. The minimum years of experience for a program director were lowered from 5 to 3 years.
- ◊ **Faculty** – required annual faculty development with defined components; **Core faculty** no longer identified with an hours commitment (15 hours), but by significant role.
- ◊ **Program Coordinator** – clearer definition of support – no less than 50% FTE. The background and intent recognizes skills in leadership, personnel management and encourages professional development.
- ◊ **Resident Appointment** – complement increases of less than 8 weeks automatically approved.
- ◊ **Education Program** – programs should make available to candidates information as to "program aim", so the candidate can make an informed decision as to the fit of the program for them.
- ◊ **Goals and Objectives** – will need to reflect changes in language of competencies.
- ◊ **Evaluation** – ABS board pass rate report will change from 5 years to 3 years – to provide more data; **PEC** has a broader definition for assessment; **Faculty evaluation** - a more defined process for evaluation of faculty.

Please note the list above does not list all of the new requirement changes. It is recommended that you read through carefully and discuss with your program director and GME Office. It will take time to prepare for updating and implementing into your program. FAQs are pending. These are always very helpful.

Our ***ARAS Ad-Hoc ACGME CPR Committee*** is going to present at the ARAS National Conference in Chicago in April on this topic, which will be very beneficial to us all. As a member of ARAS, you know we will be sharing "best practices" and ideas. That is what makes our organization so wonderful and resourceful.

Has your GME already begun assisting you with the transition and implementation of the new CPRs? I certainly hope so. We have a lot to do to get ready for July! I hope to see you in Chicago.

ABS Spotlight
Preparing Grads for the 2019 Surgery Qualifying Exam

Barbara Jalbert Gerkens

The start of the application process for the 2019 General Surgery Qualifying Exam (QE) is just around the corner, so here are a few tips when helping your chief residents complete their applications:

- **Make sure that a chief year is listed (Residency - R5 Chief).** Residency - 5R is not a chief rotation and no assumptions are made regarding training when reviewing applications.
- **Payment must be made when the application is submitted electronically.** Applicants should not wait for items to be marked RECEIVED to pay.
- **All rotations and non-clinical time from the start of residency is noted.** Conference, meetings and presentations are not considered clinical time.
- **PGY 4 residents** interested in applying must meet ALL of the application requirements, including case numbers. Programs (not individual residents) must provide the ABS via email the name(s) of interested PGY 4 residents.
- **2019 QE application deadline is April 15, 2019.** This is the date application materials are to be RECEIVED in the ABS office, not the postmark date. *The ABS will not reach out to applicants when items are missing or incomplete.*
- **The late period is April 16, 2019 to May 15, 2019.** A $200 late fee is charged for applications RECEIVED in the ABS office during this period.
- **Check with your carrier to see if items are received.** Due to volume, ABS cannot confirm receipt.
- **Please allow 3-4 weeks to process and mark items RECEIVED.** Applicants should check their Status of Application page for updates. A notation will be made if the application is deficient in any way. Applicants will not receive an email.

While the General Surgery Certifying Exam (CE), otherwise known as the oral exam, may seem far in the future, **your chief residents should begin the application process for a full and unrestricted medical license now!** The time it takes to obtain a full license is often underestimated by QE candidates. Without a full and unrestricted medical license and payment of the exam fee, a candidate cannot be registered for the CE and he/she will **not** have a final assignment to an oral exam. The exam may fill prior to the candidate obtaining a full license and/or paying the exam fee.

The ABSITE is done for another year! Here are few tips to keep in mind for next year that may help prevent some unnecessary panic:

- The program's log-in to the ABS website (absurgery.org) is the 4-digit ABS program number following by "G" and a password that is generated yearly. This log-in is for the ABS website ONLY and is not for the testing website. This code will appear in the subject line of ABS emails.
- A "Welcome to the ABS In-Training Exam" email from ITS Customer Support is sent directly to the program director and program administrator with log-in credentials to the testing website: absite.programworkshop.com. *This is a different log-in from the ABS website log-in.*
- The ABSITE order form is pre-populated with your residents' names and clinical levels as listed on your ABS trainee roster for the academic year. If a resident is missing or the name is incorrect on the order form, it is because he/she was not listed or listed incorrectly on the ABS trainee roster.
- Once ACGME-accredited, programs that have dual accreditation with the American Osteopathic Association (AOA) will now take the ABSITE during the allopathic examination window.

NEWSLETTER WINTER 2019

TAGME Update

Linda Shaffer

The National Board for Certification of Training Administrators in Graduate Medical Education (TAGME) was established to advance the profession of those who manage residency and fellowship programs. By creating an assessment process that requires the demonstration of high-level competence and expertise in GME program management, TAGME certification has set the standard for administrators, coordinators and managers since 2005. Successful attainment of the C-TAGME credential provide employers, colleagues and the public with the assurance that certified individuals possess the necessary knowledge, experience and skills to perform their duties in a professional and competent manner.

Achieving the C-TAGME credential is accomplished through a combination of experience, continuous education and successfully earning a passing assessment result. For those seeking to maintain the credential, demonstration of personal professional activities through leadership or scholarship are added qualifications. As of 2016, eligibility for TAGME certification was broadened to a global assessment to be inclusive of all ACGME/AOA accredited specialties and GME-office coordinators.

The evolution of TAGME's assessment process has kept pace with the continuously shifting professional expectations and responsibilities of the GME professional. This year, TAGME is introducing a new format for candidates to apply for and complete the certification assessment.

Prior to 2019, a 2-part assessment that was completed by each candidate at home over several weeks.

Beginning this year, assessments will be taken in a single 3-4 hour session at proctored testing sites with results immediately available. Candidates can self-schedule their assessment appointment upon application approval and will have the option to choose a date within 2 six-week assessment sessions. Hundreds of U.S. and international testing sites are available. For those needing to retake either the 2019 Initial or Maintenance of Certification (MOC) assessment, this attempt may now be scheduled within the same calendar year.

2019 TAGME Dates/Fees:

Application submission	May 1 – June 15
Application review & notification	Rolling through June 30
Assessment scheduling	Upon application approval
Session 1 Assessments	August 1 – September 15
Session 1 Retakes	September 16 through October 15
Session 2 Assessments	October 16 – November 30
Session 2 Retakes	December 1 – December 31
Initial or MOC	$350.00
Retake (2019 Initial or MOC)	$150.00
Retake (2018 Initial or MOC)	N/C

National Board for Certification
TAGME
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