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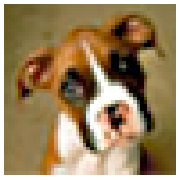

**Subject:** **CORD AA 2009 Skating where the puck will be... GME as a strategic asset**

**Date:** March 3, 2009 5:29:12 PM CST

**To:** "cord lists cordem org" <cord@lists.cordem.org>

**Cc:** Jamie.S.Padmore@Medstar.net, Robin Hemphill <robin.hemphill@vanderbilt.edu>, David Griffen <dgriffen@siumed.edu>

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We have the highest number of attendees ever for CORD AA 2009 (450+ and counting). This year's CORD AA theme is GME as a strategic asset. I want to share perspective on this theme and make a few gratuitous suggestions on things to consider reading on the plane. Three articles are at the bottom of this e-mail are worth a read.

I feel that the CORD membership is poised to make a significant impact on the national GME dialogue. I would urge CORD, PDs, the EM faculty and others to look beyond the confines of the ED and beyond the confines of curriculum management to see how they can integrate themselves into the health care systems of tomorrow.

Consider the following (simplistic) premise for the future
Less resources for GME
More resources for quality movement
Quality movement based on sustained change in behavior
Sustained change in behavior=Education
Change GME from knowledge-based residencies to quality residencies
More resources for GME

I suggest reading the article by Iglehart below on GME funding that may be of interest

We have scheduled sessions related to "GME as strategic asset" during each day to broaden the dialogue starting from a 30,000 ft view and bringing it down to personal perspectives.

Day 1 3/5 11:00am. Carl Patow will be keynote speaker (30,000 ft view) . As AIAMC VP and ACGME board member, one the discussion points will be how to integrate GME into the quality movement. I think there are tremendous opportunities to engage hospital C-suites and have residencies take a leadership role in defining and implementing quality care (with patient satisfaction as a quality proxy). I also think this fits well with PBL and SBP. Wendy Levison's recent piece in JAMA below is a good read on how to use quality improvement as a promotable academic focus. Bob Wachter (one of the founders of the hospitalist movement at UCSF) also comments on this on his blog Wachter's world. http://www.the-hospitalist.org/blogs/wachters_world/archive/2009/02/28/will-quality-improvers-find-a-home-in-academia.aspx

Day 2 3/6 1:00-2:00pm Jay Falk, Robin Hempbill, Jaime Padmore "view from the top" panel moderated by Jeff Love. (Institutional view). I think this panel will be a great resource for Pds

to find out how they can manage up well... How can they align themselves with the DIO, hospital leadership, quality program leadership etc... How can they and residencies be viewed as strategic assets when gme funding dries up. Pat Conway and Carolyn Clancys piece below is a good read on where the quality discussion is at.

Day 3 3/7 8:00-8:30am Strategic asset wrap up panel Robin Hempbill and David Griffin (personal view) The panel goal is to share personal views on GME as a strategic asset and to use this time to synthesize some of the collective wisdom that usually comes out of some of the side discussions and conversations that occur at the cord meeting. i.e. is GME as a strategic asset something that EM Pds should embrace, how do EM Pds get connected, what other resources and opportunities are there. Is this something CORD should engage in, is there CORD membership interest to take it further? In the words of Don Berwyck, EM is "rescue care" If we can get our arms around consistent quality (and use GME as quality drivers) in EM one of the more chaotic environments and "rescue" care, I think this would bode well for health care. We are the canaries in the coal mine

So while enjoying time in Las Vegas, catching up at the warm pool side welcome reception 3/4 eve,...think ice , think hockey, think where the puck will be. These are incredible times and with this are incredible opportunities to skate where the puck will be and help impact health care of tomorrow.

Thanks, Felix

1. Clinicians in Quality Improvement. A New Career Pathway in Academic MedicineKaveh G. Shojania, MD; Wendy Levinson, MD, MPH JAMA. 2009;301(7):766-768.

Academic medical centers (AMCs) strive for excellence in patient care, education, and research. Until relatively recently, academic physicians were expected to excel in all 3 areas, even though criteria for promotion typically emphasized accomplishments in research, paying little attention to faculty members' educational contributions. Tracks for clinician educators have done much to rectify this situation,1-2 with explicit guidelines for promotion on the basis of educational scholarship. With widespread interest in quality improvement (QI) and patient safety, a new challenge exists in academic medicine, namely acknowledging the contributions of faculty members who excel in these areas. These faculty members range from clinician scientists with full-time research programs focused on health care quality to more operationally oriented faculty who lead local QI projects. However, most faculties of medicine do not have mechanisms to encourage the development of faculty engaged in QI activities. In this Commentary, we outline possible career paths and promotion criteria for such faculty members.

2. Transformation of Health Care at the Front Line Patrick H. Conway, MD, MSc; Carolyn Clancy, MD JAMA. 2009;301(7):763-765.
Concern about escalating costs and the quality of health care delivered in the United States continues to mount. This has led to an increasing focus on pay-for-performance, value-driven health care and public reporting of quality and cost information. However, several authors have questioned the effectiveness of pay for performance and public reporting to improve patients'

outcomes and have highlighted the potential for unintended negative consequences. Currently, frontline clinicians are exposed to disparate pay-for-performance programs that are often uncoordinated and not clearly aligned with producing better outcomes for patients. Evidence is produced at an astonishing rate, but its incorporation into clinical practice is difficult.

3. Medicare, graduate medical education, and new policy directions. New England Journal of Medicine Iglehart yr:2008 vol:359 iss:6 pg:643 -50

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