In an effort to improve wellness services for our residents, the Graduate Medical Education Committee teamed with the Employee Assistance Department to increase outreach. We hypothesized reasons for low utilization, including lack of familiarity with services, stigma, financial concerns, and lack of knowledge of how to make contact. Our goals were to provide early support from EAP for postgraduate year 1 (PGY-1) residents and familiarize residents with the services available to them, with the ultimate goal of increasing utilization of EAP services.

Intervention

Group meetings with EAP were scheduled with all PGY-1 residents within the first 6 months of training. Meetings were scheduled by the chief residents of each program so residents were in a group of their peers, with 1 or 2 PGY-2 residents present to help facilitate discussion. No faculty, chief residents, or program directors were present. An EAP counselor facilitated the discussion. Topics such as dealing with the transition from student to physician, imposter syndrome, and personal wellness were discussed.

The goals were to destigmatize use of the EAP, and to familiarize residents with the services and offerings of the program as well as to help them realize they are not alone in their journey as a resident. We felt that increased familiarity would increase the likelihood of a resident reaching out for help if needed. We also placed the EAP telephone number on the backs of all call room doors to ensure contact information was readily accessible.

Outcomes to Date

Seven support sessions were held for PGY-1 residents in the first half of the 2016–2017 academic year. They were so popular that an additional 3 sessions were added at the residents' request. In the first quarter of the 2017–2018 academic year, 20 sessions have been scheduled, with 11 sessions for PGY-2 and higher residents. There has been increased interest in scheduling repeat meetings and meetings for upper-level residents and fellows. Resident acceptance of the sessions has been excellent.

We also noted an impressive upturn in the number of individual counseling sessions. During 2016, 25 individual counseling sessions were scheduled by residents. This increased to 64 for 2017 (data through October 31, 2017). This represents an increase of more than 250% over the prior year. By the end of 2017, we should see a 3- to 4-fold increase. Due to confidentiality, we are unable to track the characteristics of the residents who sought services. At the same time, there have been no other events or interventions that might explain the increase in EAP use. We believe this early interaction has increased their comfort with the EAP staff. Residents experiencing difficulties are more apt to reach out for help and be directed to appropriate resources before a crisis occurs. This intervention utilized already existing services and infrastructure, and did not require any additional expenditures. Most programs chose to incorporate it into their normal conference time, and it allowed flexibility for different specialty needs.

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NEW IDEAS

A Case-Based Method for New Resident Orientation

Setting and Problem

Onboarding new residents at the beginning of the academic year requires orientation to a wide variety of general employment, accreditation-related, and specialty-specific educational program policies and procedures. Due to the volume of information to be presented, and the abstract nature absent relevant context (residents are unsure how content may apply to

DOI: http://dx.doi.org/10.4300/JGME-D-17-00824.1

them personally), this material is often dull, and residents are less than enthusiastic in their reception of this information. Retention and application of the material when needed at later dates is often suboptimal.

Intervention

Selected policies and procedures were identified for inclusion in an interactive, case-based workshop. Topics included:

- Competencies and milestones
- Point-of-care learning resources
- Supervision policy
- Change in patient status policy
- Work hour rules
- Vacation policy
- Sick leave policy
- Academic deficiency
- Disciplinary actions
- Physician wellness/loss
- Impaired physician
- Hostile work environment

Hypothetical but realistic "cases" were created for each topic area, with 1 to 3 discussion questions per case. Stations were created for each case around the conference room, with each case assigned a particular space. Case folders were created and identified by playing card suit (hearts, diamonds, spades, or clubs) on the "Rules/Order of Play" instructions posted on the front of each folder. Case folders were distributed across table groupings in the conference room. Residents can be randomly assigned to small groups by distributing 1 playing card to each resident.

The interactive activity is conducted as defined in the Rules/Order of Play, as follows:

- Find the group table that matches the suit of the card you drew. Complete the pretest.
- Each table contains a file folder with several cases to solve as a group. Write in the answers to the questions posed.
- Locate a gallery space and post your cases with the answers.
- When all cases have been posted, go on a "Gallery Walk": go around the room and read responses to cases from other groups. Add comments and clarification if desired. Collect a sticker from each case on your exit ticket.

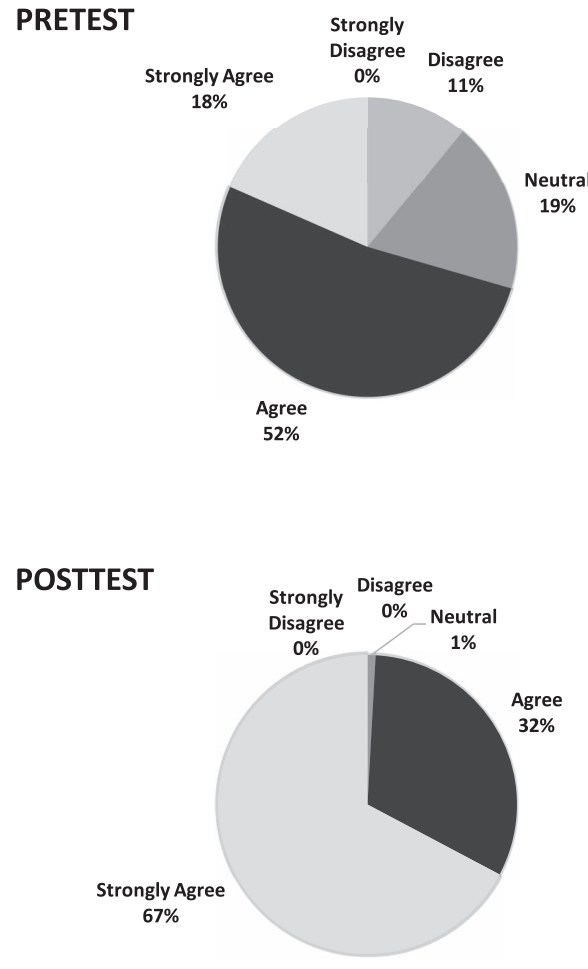

FIGURE
Resident Self-Rating: Level of Policy and Procedure Understanding

- When you have collected a sticker from each case, return to your seat.
- Graduate medical education leadership and administrative staff will lead a group debrief and answer remaining questions.
- Complete your posttest, and then bring your exit ticket, signed "House Staff Manual" receipt, and posttest to the session leader.

The workshop concluded with residents reconvened in the large group for a lively question-and-answer session.

Outcomes to Date

This workshop has been administered in 2 consecutive academic years. Data presented are aggregated across the 2 resident cohorts.

Pre- and posttest questions were identical. Residents responded to each statement by selecting 1 of 5

options, ranging from strongly disagree to strongly agree. Residents demonstrated marked increase in their understanding of the various policy and procedure topics, as evidenced by comparison of pre- and posttest responses (FIGURE).

The question-and-answer conclusion to the workshop resulted in a much more robust discussion of topics and further potential application scenarios generated by residents than seen in previous years with the more traditional didactic review of policies and procedures.

Feasibility: presentation of policies and procedures during orientation for new residents can be effectively delivered in a case-based, interactive format. There is minimal cost for supplies and approximately 1 hour of staff time to prepare materials for the workshop. This workshop is easily replicated across programs or sponsoring institutions.

Acceptability: This format leads to greater engagement with the content by residents. Self-evaluation by residents indicates improved understanding of the materials. Further study should measure residents' retention and ability to reference and apply over time.

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NEW IDEAS

Tackling Implicit and Explicit Bias Through Objective Structured Teaching Exercises for Faculty

Setting and Problem

Numerous studies have demonstrated that clinicians' implicit racial bias contributes to health care disparities. Furthermore, this "silent curriculum" impacts the medical education provided to our trainees, and likely perpetuates cultural stereotypes. Many physicians and trainees have written essays describing distressing experiences with explicit bias. Unfortunately, despite the important role implicit and explicit bias play in our clinical learning environment, there are few faculty development resources on recognizing and addressing bias. Objective structured teaching exercises (OSTEs) have been used successfully to assess and improve faculty members' teaching abilities in a number of areas.

We utilized an OSTE as a tool to teach faculty how to identify and tackle both explicit and implicit bias. Our objectives were (1) to design a workshop using a 2-station OSTE on recognizing and managing implicit and explicit bias as part of a department-wide faculty development program; (2) to assess feasibility and acceptability of the program; and (3) to assess the effectiveness of the program using a retrospective pre-post survey.

The NYU/Bellevue Hospital Pediatric Residency Program is a multi-site urban program with 58 categorical residents, 32 fellows, and 75 core faculty. All core faculty participate annually in a department-wide faculty development session.

Intervention

We created a 2-station OSTE utilizing actors as standardized learners (SL). At 1 station, faculty helped an SL manage explicit bias against her, expressed by a family requesting a non-Muslim physician. At the second station, faculty precepted an SL on rounds who expressed implicit bias in creating a discharge plan by assuming an immigrant family was not concerned with their child's long-term cognitive development. Both scenarios were derived from true situations faced by our clinicians.

Faculty worked in pairs, each playing a member of the care team, allowing them to address the case and the SL together. This structure allowed faculty to observe and learn from one another. Each station consisted of 10 minutes performing the task, 5 minutes of self-evaluation by faculty, and 5 minutes of verbal and written feedback by the SL using a checklist. A brief didactic on bias was provided prior to the OSTE and a debriefing followed the OSTE. Participants completed an anonymous workshop assessment, using a Likert scale of 1 to 5 (exceeding expectations) to assess the OSTE and a Likert scale of 1 to 10 (effective) for the retrospective pre-post survey. The workshop was conducted twice over 6 months.

Outcomes to Date

Forty-one of 47 (87%) participating faculty completed the workshop assessment. The mean overall OSTE

DOI: http://dx.doi.org/10.4300/JGME-D-17-00906.1