listener then has 60 seconds to reframe the peeve into a positive by connecting the emotion to a value (*Clearly it is important to you that residents understand the "why" along with the "what" we do as physicians*). These exercises require the teacher to be present, cognitively agile, and connect emotionally, thereby strengthening interpersonal connections and relationships. Various teaching scenes are then established by asking the audience to define "who," "what," and "where" questions, or scenarios can be provided. This gives participants the opportunity to apply the improv skills of "Agree," "Yes and . . .," and "Make Statements" (not questions disguised as statements, thereby showing respect and adding value to the interaction) as clinical teachers. Depending on time at the initial session, the teaching scenes can start (or continue to occur) at subsequent sessions. All sessions close with a large group debriefing discussion to identify benefits and barriers of using improv skills as teachers.

Outcomes to Date

This interactive and LOL (laugh-out-loud) approach to faculty development has been presented locally and nationally to rave reviews. Evaluations from a regional and a national meeting (N = 50) utilized a 4-point scale (1, strongly agree/yes definitely, to 4, strongly disagree/no definitely not) with mean responses for all items less than 1.2. The items included: The session "increased my repertoire of teaching strategies"; The session made me "be truly present—attentively listen, focused on now—not what I'm going to say next"; The session made me recognize that "improv utilizes many of the same skills associated with expert teaching" and I would "recommend this session to other medical educators." The item "Session rocked/was a mic drop!" was rated strongly agree by over 85% of respondents (remainder agree). Long-term follow-up using local participants' teaching evaluations baseline/post is anticipated.

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NEW IDEAS

All GME Is Local: A Novel Approach to GME Governance in a Consortium Model

Setting and Problem

In a newly formed graduate medical education (GME) consortium model supporting a complex academic

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health system, one of the initial challenges involved preserving the important role of leadership and relationships at the local level, while at the same time formalizing a consortium model of GME governance. In our consortium, consisting of 72 Accreditation Council for Graduate Medical Education (ACGME) accredited programs, 8 programs accredited by other entities, and 17 non-accredited programs, we recruited 4 Associate Designated Institutional Official (DIO) leaders from within our system, each with an extensive background in GME as a current or former program director. We have further created a job description (BOX) with specific expectations for the Associate DIO role.

Intervention

In response to the need for centralized governance, as well as leadership and oversight at the local level, we instituted a tiered organizational structure utilizing an Associate DIO model. Each Associate DIO maintains a critical role and function within the consortium model. The Associate DIO has protected time (with a goal of at least 20% effort) carved from their clinical productivity expectations to dedicate to this role and its responsibilities. The cost of this time is covered by the local entity.

The Associate DIO serves as the designated entity leader for local GME oversight of the clinical learning environment. In this capacity, the Associate DIO is known and recognized locally by program directors, coordinators, residents, and fellows as the local GME leader. The Associate DIO also serves as the chair of the Local Graduate Medical Education Committee (GMEC), a subcommittee of the Consortium GMEC, and also represents the hospital entity to the Consortium GMEC.

In addition to Local GMEC oversight and Consortium GMEC representation, the Associate DIO maintains a key role in oversight of programs and the GME workforce, including integration of GME with quality and safety initiatives as well as ongoing surveillance of the overall clinical learning and working environment.

The Associate DIO maintains a list of hospital or entity program citations or concerns, and works with local program directors to develop improvement plans. All program citations or concerns are also contemporaneously monitored by the Consortium DIO and Consortium GMEC. The role of the Associate DIO is to provide local assistance, follow-up, and expertise to assist programs and to provide regular reports to consortium leadership. The Associate DIO maintains a central role in the special focused review process for programs within their hospital or entity, and also contributes to special reviews for other programs within the consortium.

BOX MedStar Health Associate Designated Institutional Official (DIO) Job Description

The Associate DIO will:

1. **Serve as the designated entity leader for Local GME oversight of the clinical learning environment.**
2. Should be known and recognized locally by program directors, coordinators, and residents and fellows as the Local GME leader.
3. **Serve as the chairperson of the entity GMEC, represent entity/hospital to the consortium GMEC, and provide monthly reports to each group.**
4. Entity GMECs are subcommittees of the consortium GMEC. Each entity GMEC should include at least one resident member. The Associate DIO works with GME staff to set the local entity GMEC agenda, which should address any issues in the clinical learning environment, resident/faculty surveys, program deficiencies/citations, Section VI of the ACGME Common Program Requirements, and local operational matters. The Associate DIO will provide a report monthly to the consortium GMEC and, in turn, report on consortium GMEC business to the local entity GMEC.
5. **Serve as the first-level reviewer for academic due process (requests for review), and in a hands-on role as part of any inquiry related to misconduct or grievance.**
6. Associate DIOs agree to cross-cover each other in the event of any conflicts of interest, conflicts with vacation or timing of requests, or other related matters.
7. **Maintain a list of entity ACGME program citations/concerns and work with program directors to develop improvement plans, milestones, and a timeline for correction.**
8. All program citations or concerns are also monitored by the Consortium DIO and Consortium GMEC. The role of the Associate DIO is to provide local assistance, follow-up, and expertise to assist program leaders with action plans. This information should be provided in regular reports to the Consortium GMEC.
9. **Work collaboratively with the Physician Health Committee, GME, and Occupational Health; work to oversee local resident health/well-being matters, in addition to remaining available in moments of crisis or urgency.**
10. Information will be provided to the Associate DIO regarding local monitoring needs, accommodation requirements, and/or need for any supportive/wellness check-ins with residents or fellows.
11. **Serve as a coach and mentor to new program directors.**
12. Associate DIOs will formally reach out to new program directors and establish a coach and mentor relationship. In novice period, the Associate DIO will work to assist with required ACGME filings and submissions, including review and approval prior to submission.
13. **Additionally, the Associate DIO will:**
    - Participate in or lead local chief resident meetings
    - Lead local GME town hall meetings
    - Champion resident-specific efforts in quality and safety initiatives
    - Assist with communicating important information to residents, fellows, program directors, and program coordinators locally
    - Participate in any local special focused review process

Abbreviations: GME, graduate medical education; GMEC, Graduate Medical Education Committee; ACGME, Accreditation Council for Graduate Medical Education.

The Associate DIO serves as a first-level reviewer for academic due process, and maintains a hands-on role as part of any inquiry related to misconduct or a grievance. If a conflict of interest exists, another Associate DIO within the consortium provides cross-coverage. They also serve as a coach, advisor, and mentor to new and rising program leaders to ensure smooth transitions and succession planning. Other responsibilities include leadership in local chief resident meetings and GME town halls, communications, championing of resident and fellow efforts in hospital quality and safety initiatives, and participating in wellness initiatives.

Outcomes to Date

Experience from the first full year employing the Associate DIO model within our consortium has been universally endorsed as a success. Each Local GMEC serves to further enhance opportunities for program director and resident involvement and engagement in the consortium. The Associate DIO model has allowed us to embrace the nuance and diversity within our consortium at the local hospital or entity level, while simultaneously maintaining a centralized GME governance structure reporting to the DIO and Consortium GMEC.

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NEW IDEAS

Applying Time and Motion Methodology to Calculate Program Coordinator FTE

Setting and Problem

The program coordinator (PC) is a valuable resource to the administration of graduate medical education (GME) programs. However, there is lack of consensus across the 28 Accreditation Council for Graduate Medical Education (ACGME) specialty-specific program requirements regarding the PC full-time equivalent (FTE) allocation needed to effectively administer ACGME-accredited residency and fellowship programs. Since the transition into the Next Accreditation System and the implementation of the Milestone Project and the Clinical Learning Environment Review, the administrative responsibility demanded of PCs and the time needed to complete associated activities have drastically increased. The Department of Laboratory Medicine and Pathology (DLMP) at Mayo Clinic has experienced significant growth in new subspecialty GME programs without corresponding PC FTE growth. While it was evident that incremental FTE was needed, requests for incremental staffing positions are heavily scrutinized in today's resource-strapped environment. Without an accepted productivity formula for staffing, DLMP lacked evidence to justify the hire of an additional PC.

Intervention

Therefore, DLMP undertook an innovative approach for calculating productivity and determining the necessary PC FTE using principles adapted from traditional time and motion studies, a methodology commonly employed by industrial engineers and

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