Editor's Note: We are pleased to present the 2017 New Ideas articles showcasing novel, implemented initiatives in graduate medical education. This year, 100 submissions were reviewed and 13 innovative approaches were selected. We encourage feedback via e-mail (jgme@acgme.org) regarding your experience with these New Ideas at your institution, as well as reactions to this section in general.

The *Consultant Chat*: A Novel Didactic Method for Specialist Presentations to Emergency Medicine Residents

Setting and Problem

While emergency medicine (EM) faculty are generally the most appropriate teachers for EM residents, there are components of the EM curriculum that benefit from specialist input. However, many times non-EM specialists have little appreciation for the challenges inherent in EM practice. In addition, presentations by specialists may address topics that are relevant to their practice, but outside the scope of EM. Residency leaders can feel challenged in giving constructive feedback to faculty speakers from other departments. In our setting, as in most, outside specialists are contributing their time without contractual requirements or personal benefit.

Intervention

We developed the *Consultant Chat*, a novel didactic format for specialists who are frequently consulted by the emergency department (ED). Expert consultants are selected by the senior EM residents and invited to come have a "chat" with our residents for 1 hour during the weekly EM conference time. These specialists do not prepare a presentation; they simply answer questions from the audience and share their experience. Residents are instructed to come prepared with questions that are specific, case based, and pragmatic. Common questions include: How would you expect us to approach "X" presentation? Under what circumstances would you want to be called in the middle of the night? What is your biggest "gripe" about cases that you have seen from the ED? Take-home points are recorded by an assigned resident and distributed to all EM residents and faculty as a summary document of "clinical pearls."

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Outcomes to Date

The Consultant Chat has greatly fostered collaboration with our specialists from other departments. In the last 18 months, we have held over a dozen Consultant Chat sessions with specialists from orthopedic surgery, plastic surgery, otolaryngology, neurology, gastroenterology, urology, and oral/maxillofacial surgery. The consultants feel honored to be selected by the residents, there is minimal time commitment on their part, and the informal atmosphere is engaging for all parties. They are motivated to share their knowledge with residents that will have a positive impact on patient care and may prevent unnecessary phone calls from the ED. The residents drive the discussion to ensure their education needs are met, and this self-directed learning style allows them to derive maximal value from the sessions. In addition, our faculty enjoy attending these sessions, as they can contribute their experience and management viewpoints, and engage their specialist colleagues in a friendly, educational atmosphere.

Our EM residents have expressed greater comfort and confidence in knowing when to consult specialists from the ED, and anecdotal evidence suggests that communication with outside departments has improved. Our specialists have gained a greater understanding of the limited resources and challenges of the ED, as these are openly discussed during the sessions. Our curriculum committee, composed of residency leadership and selected faculty and residents, has evaluated the positive feedback from these sessions and worked to make them a regular component of the EM curriculum. Our novel didactic format has proven successful in our EM program; it could also be successfully adapted to any "generalist" training program, such as family medicine, internal medicine, pediatrics, or general surgery. The Consultant Chat represents a didactic model that develops not only the medical knowledge of our trainees, but also essential skills in communication, professionalism, and collaboration.

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NEW IDEAS

A Mathematical Formula for Institutional GME Program Support

Setting and Problem

The Accreditation Council for Graduate Medical Education (ACGME) requires sponsoring institutions to provide protected administrative time for program directors (PDs) and program coordinators (PCs). Some specialty requirements state the full-time equivalents (FTEs) required for PD and PC support, while others do not. This has led to inequitable budgetary support for our institution's ACGME-accredited programs. To address this inconsistency, our Graduate Medical Education Committee (GMEC) appointed a task force in 2014 to develop a solution for transparent, equitable institutional support of ACGME-accredited programs.

Intervention

The task force consisted of graduate medical education (GME) administration and PDs representing medical, surgical, and hospital-based programs. The effort used the ACGME Common Program Requirements for PD and PC responsibilities, the ACGME's protected time requirements by specialty, and the institution's job descriptions for PDs and PCs to develop *principles of support* and to estimate work hours by administrative activities.

The task force agreed on 4 principles of support: (1) every program requires a base amount of PD and PC support for fixed work activities; (2) residents require more support than fellows; (3) large programs require more support than small programs; and (4) ACGME specialty-specific protected time requirements supersede task force recommendations.

Fixed work activities were defined as PD duties requiring completion regardless of program size. Minimum work time estimates were assigned for each of these fixed work activities. These are outlined in the ACGME Common Program Requirements and the institution's requirements, which considered factors of local practice environment and support. While such work estimates may differ across institutions, the exercise of defining minimum time to meet required activities provides transparency and explains the rationale for assigned distribution. Assuming 2080 work hours annually, estimated PD time for fixed work activities totaled 724 hours (0.3 FTE) for residency programs, 462 hours (0.2 FTE) for large fellowship programs ($\geq$ 10 trainees), and 270 hours (0.1 FTE) for small fellowship programs ($<$ 10 trainees).

Incremental work activities were defined as additional PD duties resulting from program type and size. These activities formed the basis of additional FTE support allocated based on programs being either large or small, and residency versus fellowship programs. For PC support, we created a minimum time estimate based on program type and size.

The task force devised a mathematical institutional formula to account for base FTE by program type for fixed work activities, plus additional FTE support to account for incremental work activities by program type and size.

Outcomes to Date

To assess budgetary implications, we compared historical (2014 budget) with the institutional formula (proposed 2015 budget) FTEs. Using the institutional formula, 15 of 18 residency programs had FTE redistributions: 11 in PD FTEs and 14 in PC FTEs. Of 30 fellowship programs, 28 had FTE redistributions: 14 in PD FTEs and 25 in PC FTEs. Overall, total PD FTEs were similar (17.90 in 2014 versus 17.85 for 2015), whereas total PC FTEs were higher (21.0 for 2014 versus 25.0 for 2015 [additional expense of $166,000]). The proposed institutional formula was reviewed and approved by the GMEC, as well as the institution's physician and administrative executives starting with the 2015 budget cycle.

Our model provides transparent allocation of GME funds for PD and PC FTEs, and is now used for the annual GME budget as well as for estimating minimum costs of new program leadership and support. While the institutional formula outlines a

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