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TRANSCRIPT - GR 05 23 25 "We Miss the Precedented Times: The Chiefs' Guide to the New Normal" guest speakers Shaina Hasan, MD, Marcus Ellison, MD, Kiarash Salafian, MD. R. L. Thompson Barr, MD - Internal Medicine Chief Residents from the University of Virginia

Internal Medicine Grand Rounds

- All right, everyone. Well, welcome to our annual Chief Resident Medical Grand Rounds. We are delighted to have a great audience of faculty and residents here today. I'll take us through our Cme slides and our yeah and our presenters, objectives
- echoey today.
- All right for faculty claiming Cme credit your code.
- And then we have a packed agenda here, as anyone knows who's been to our chief grand rounds before. So we're going to start with some year end awards. We have a long tradition of resident selected awards that go to various members of our health system, community and department community. And after that we'll really appreciate and learn from our outstanding chief residents as they reflect back, look forward, and pass the baton. After a year in the life of Residency training here at Uva.
- So we'll start out with some awards that are a house staff vote to recognize some of our non-physician colleagues throughout the clinical learning environment as well as one of our er physician colleagues. So 1st off we'll start with our outpatient nurse Nppa of the year, and this award goes to first-time recipient. Karen Mcneil.
- Karen, could you please come up?
- You're done
- so. Karen's going to be our road case for the process here. So as you come up, get your award from one of the chief presenters, and come, stand over here to the left, and this will help us get a nice group photo of all of our resident voted award winners. So congratulations. Thank you. Next, our inpatient nurse, nurse, practitioner, or PA of the year award, goes to one of our palliative care colleagues Meredith Davis.
- Thank you. I don't know that I've seen our case manager of the year slip in, probably because she's working on a challenging discharge on 3 East, but in a dominant vote. Cassie Houchins, our case manager of New York.
- Right. And then our 4th Award for this page, our emergency medicine admitting resident of the year award. This is sort of like an exchange program of appreciation between 2 programs that work a lot together in the high stress environments of admitting and evaluating patients. So this award goes to Grant Robinson
- all right. So so our next page we'll start with our outstanding fellow of the year award, and we had a tie for this award this year. So one of our award recipients could not be here with us. Today is 3 h west of us in La on vacation, John Popovich. So clap for John.
- and a fitting tie with his co-fellow, Dr. Caroline Chassar.
- All credit to Dr. All right. So switching gears into the attending section, our outpatient attending of the year award. I'm confident this is the biggest audience that this

faculty has won this award before, I think the other time she won. It was in 2020 when I think we were capped to 25 people in a room. This award goes to Dr. Allison Lyons.

- and for inpatient attending of the year we have another 1st time recipient, I think, 3rd in the row. 3rd year in a row from hospital medicine, and we appreciate this attending being here post nights. Dr. Rebecca Climo.
- All right. And now I'll invite up the namesake of this award, Dr. Andy Wolf to pass out the aptly named Andy Wolf award. So this award recognizes an attending who epitomizes teaching excellence positivity, and commitment to the Residency program celebrates an individual whose contagious enthusiasm, humor, and spirit inspire those around them. The residents gave us award this year to Dr. David Guaria.
- All right. So now we'll transition into our resident to resident section. So the intern professionalism award this award started in 2020 and recognizes an individual who is noted for poise, equanimity, and professionalism amidst the chaos and demands of the Pgy. One year this year's award goes to Margo Everingham.
- the resident teaching and mentorship award started in 2022 recognizes a resident who goes above and beyond to contribute to the education and mentorship of their peers and conference, and beyond this award goes to Dr. Heather Frazier
- and our leadership, service and advocacy award started in 2020 and recognizes a resident who's a resident, feels a role model of service to the community or their colleagues. This year's award goes to Dr. Hector Pickone.
- right, and the resident esprit Corps award, recognize a resident who best embodies the idols of the program and recognizes a resident's contributions to camaraderie and well-being. This year's award, goes to Dr. Hannah Laird.

Any phone number from down.

Right, and then our last award from residence to residence the oldest award within the program. The Leroy Dunn Award, started in 1983 to honor a pgy-three, and the judgment of his or her peers deserves particular recognition for skill in the technical aspects of medicine, and the qualities of thoughtfulness, patience, and caring that marked Dr. Dunn, someone who's kind, truthful, reassuring, and infinitely patient. And this year Dr. Keenan Michaels is the recipient.

Of all time.

Alright. So to our recipients. Let's grab a group photo here, because I know some of you may need to slip out.

- Okay, thank you.
- That's all. Thanks, alright.
- So many years, we announced the Mulholland Resident Teaching awards to residents. These were announced earlier this week, but with the larger department audience I'll let everyone know we were excited to have 3 medicine residents receive these teaching awards from Dr. Lawrence earlier this week. Those residents, Tj. Babalola, Jason, Erno, and Emily Jazewski.

- So now I'll invite up Dr. Heald from the Brody committee to present the Brody resident clinician award.
- Thanks, Brian. So for those of you who don't know the Brody Committee is named for a grateful patient and Brody, who so valued and trusted her relationship with her physician, that she willed her estate to him and instructed him to make sure that Uva trains doctors with the heart and skill to provide care in the patient-centered way and personal way that he had cared for her. Clinician award recognizes residents who not only excel in the knowledge and techniques of medicine, but have intentionally built and leveraged longitudinal trust relationships to create exceptional personalized care.
- Jean Corbett was Mrs. Brody's personal physician.
- That's what she called him, the original Brody physician, and he was a Uva general and internal medicine physician here, but there are Brody physicians in every discipline and nominations for this award are accepted from more than 20 Residency programs.
- Only 5 residents are recognized each year and this year I'm proud to say that 2 of them go to the Department of Medicine.
- I would like to read you a couple of stories from the nomination letters. The 1st
- get organized.
- The 1st is a story about a three-year journey that a resident and patient had together. The patient had multiple psychiatric illnesses, was very complex, and had severe life-threatening anorexia on top of everything else.
- This resident became a strong source of weekly check-ins with the patient and arranged a team to help make sure that the patient was safe through numerous phone calls and loads of paperwork and pre-authorizations, was able to get the patient placed in a residential anorexia treatment center kept in contact with the patient through the prolonged residential treatment program and then seamlessly picked up support again after discharge.
- The Resident saw this patient through relapses after treatment, and is probably the reason that this person is alive today.
- This is just one example of many ways in which
- Dr. Robin Goodrich is a Brody resident clinician.

  You know the the Brody award includes not just the certificate, but also the Brody Renaissance physician, PIN and check, which will show up in your regular Paycheck the second story, interestingly, is also about a patient who struggled with mental health issues.

- Including thoughts of self-harm.
- And this resident was so concerned that they shared their own phone number and made themselves available at all times to the patient. In times of need.
- Got through several crises and was able to get the patient into longitudinal psychiatric care, after which time her life changed dramatically for the better.
- Their bond was so strong that it was evidenced by this patient describing it to an unfamiliar attending, who heard about how sad she was that the Resident was graduating, and how the Resident had an indelible impact on her life.
- Dr. Corbett frequently expressed that we must be advocates for patients in our systems as well as in our clinics.

- This resident founded was a founding member of the Internal Medicine Residency, Health Equity, advocacy and leadership track, and has been deeply involved in Latino health initiatives throughout Residency. And that is why Dr. Michael Bates is a Brody resident clinical.

  Good. Thank you, Dr. Heald. And again one last award for everyone, just to again make everyone aware for a record breaking and unprecedented 10th year in a row. The graduating medical school class selected the department of Medicine as the clinical department, providing the best teaching. So my sincerest thanks and congrats to all the faculty fellows and residents who really set the standard at Uva for clinical teaching for the last decade, which is crazy to say, All right. Now it's my deepest pleasure and honor to introduce this group of chief residents who have served the department and the program since June 2024, you know, although it took a little time to gain traction. We found their group's name eventually. So you know, as all chief groups have some sort of catchy acronym or name K. Smart. I was always a big fan of shaky math that works as well as you can kind of find the letters through there. You know, chief transition always feel like a combination of goodbye and good luck, always a little like storming the castle from Princess Bride. But you know, as K. Smart took office last year, I think, like every chief group, you're probably hoping post pandemic for just a smooth and calm transition in chief year. Just everything sort of under control behind you, but I think they quickly realized this might not be one of those years. As chaos came fast, a lot of changes to the health system, external forces, local, national and global key rotations changing in our program accomplishments and disappointments alike. So thank you to this group for staying positive and professional, despite the chaos around you, you were committed and intentional, and put the residents in the department first, st always, and that's all we could ask. So now I invite up Ksmart to recap the year. There's been nothing shaky about what you've added and multiplied in the program. You have accomplished much, led. Well, and now we welcome your grand rounds. Presentation all right. Well, thank you all for for being here a lot of mentorship and support in this room. So we really appreciate you guys. So with that, we will get into our grand rounds. So we missed the precedented times, the Chief's Guide to the new normal.

- This is us. Here are our learning objectives for today. So I think what we'll focus on is sort of reflecting on what we feel like are the key qualities necessary to navigate these uncertain times that we all find ourselves in. We'll talk about some of the structural and fairness contributors to well-being in medicine and how to address them in a Residency program. We'll review some of the Acgme requirements as well around workforce diversity and education healthcare disparities and sort of at the end review some of the key successes of our year. So just to kind of frame our talk in terms of where we're at. This is us at the beginning of the year, our 1st day getting into the new office, not really knowing that this wave of what the world had to bring was coming upon us, and just before the wave arrived our 1st 2 chiefs here had babies and left me and Kia to fend for ourselves.
- But it's okay. So we, you know, we had each other's backs throughout that whole time, and frequently ran into each other's backs in our chairs, in the office and so just to remind people of like all the stuff that's happened this year that we all kind of

went through together. I don't know if anybody remembers Crowdstrike. That was my 1st days in attending on the genmed service, where none of the computers in the hospital worked. Some of the people in this room may have enjoyed that, actually, but I was stressed. We got through it, though. There's been the threat of budget cuts, the threats of job loss. There's this guy running things, threats of, you know, loss of Dei throughout the country. There was a letter that people made a big deal about that, and we'll get into.

- There was a lot of Uva alerts this year. Shelters in place, if you guys remember that the Iv fluid shortage all sort of in the background of our hospital is seeing this sort of unprecedented capacity problem and patient progression issues so thankfully. Our 2 chiefs did come back from parental leave eventually. And so we sort of, you know, tried to do the best that we could along the year to handle it all and we wanted to talk to that. Talk to you about that. So and provide you guys with a guide, or that's a good way to talk through what we thought made our year successful, and what we hope to to instill in the program and to to highlight. So unprecedented times are upon us, and they're here.
- Navigating uncertainty is hard, and we spend a lot of the year doing it regardless. We're still charged with and passionate about providing excellent clinical teaching and mentorship.
- We've thought a lot about how to do this over the course of the year, and we think it involves developing and maintaining an ethos that grounds our decisions and shapes our actions. So for us this ethos is defined by creativity, respect, and a growth mindset, and you'll see us return to these themes over the course of the year.
- So this is a graphical way to represent this. But you might ask, isn't this just the personal opinion of a couple of crusty end of year chiefs on their way out the door.
- And yes, it is but as a personal opinion doesn't cut it for grand rounds. Here's some literature to back that up.
- So the Stanford model has been one of the has been used frequently as a way to describe occupational well-being. And this study actually came out recently in academic medicine as yet another demonstration of its validity in assessing this. So the model looks like this. It has workplace efficiency, a culture of wellness and individual factors, all as being really important for occupational, well-being workplace, efficiency. Think about promotions of systems, processes, practices that promote safety, quality, effectiveness, work, life, integration, positive, patient and colleague interactions minimizing wasted time and effort. Think about that as Qi or process improvement culture of wellness. So organizational values, leadership, behaviors and cult and workplace norms that promote personal and professional growth, community agency, compassion for patients and colleagues and self.
- And then, finally, individual factors. So a broad set of variables that are expressed directly through individuals, including personal resources, behaviors, and attitudes that contribute to well-being, including individual and culturally influenced individual responses to workplace demands and stresses stressors. And we know that there are a lot of those stressors. And so the individual factors are important.
- And what we wanted to say is that we think we're onto something. It's actually interesting, because we came up with those values before looking at any of the literature, just on our reflection of the year. But if you overlay what we're talking about, it fits pretty nicely within this model. So this creativity, which we think really has driven the way that we have innovated through this year to make this year

make our processes both in education and in clinical demands for residents a little bit easier respect and a just culture, as being important for Residency well-being, and then just important overall to strive for, and then finally, a growth mindset which encompasses a lot of the things that were highlighted on the last slide.

- We do want to add a little bit of something, though, because we talk a lot about our S. 3 decor here, and I think that this model in some ways has s. 3 decor built into all the other 3 parts. But we want to highlight that as something that we think makes our residency really really special, and that we have been infused with, and that we have hope we have infused over the course of this year.
- So we're going to do a year in review through 2024, and 2025, and not to belabor the fact that this year was wild, and we, as a chief class, are really proud of the way that it shaped us. And we want to spend this grand rounds highlighting our ethos and the way that it overlays onto the Stanford model through the winds of all that kept us busy this year.
- Creativity, respect, and growth mindset.
- I want to give an acknowledgement, though, because we're not trying to toot our own horns because we were very much shaped by the culture here. And so we want to one acknowledge Dr. As someone who's been intimately involved in shaping this program. But also all of you who've been a part of shaping us over the past 4 years culture matters.
- So I'm going to start talking about the 1st bucket. Creativity, uncertainty and change make operating residency difficult, but they also provide an opportunity for creative solutions as discussed in last year's chief grand rounds. And this is a shout out to magic. Last year's chief class backup call has been cited as a source of burnout among trainees. This is an article that I'll spare you the intimate details of, but really just know that it's been both theorized and has some validity behind it. That burnout leads to increased activation of contingency which then leads to further burnout. That's something that we have seen here in our program.
- Well, and magic showed base collected baseline data last year, which they presented a grand rounds. You can see that we had a pretty high contingency. Usage last year is something that was felt, but never really.

  Quantified in our program. 317 shifts last year is a lot that's almost a shift per day of need of contingency. Usage. The graph doesn't tell the full story, though, because the distribution of Collins was highly variable. Among and between. It's leading to. I just. Distinct sense of inequity.

- There was a variance of 6.5 11 residents were called in over 7 times to put some context to that, so.
- Alright. Great. I wanna. I wanna create space for that.
- So putting our chief picture here. Those 11 residents included both Shauna and myself.
- Not that we're crispy about it, but the 14 residents who were called in 0 to one times included Marcus, and then he always loves being reminded that he is average great. So during this year we did a contingency overhaul. At the beginning of this year. Our 1st lecture actually was not a lecture. It was a town hall where we wanted to ask residents what their concerns were and something that came up throughout the whole meeting was that contingency was a source of burnout, and that it was

they linked this directly to the sense of inequity. So some residents being called in more than others.

- We designed a new contingency system with the goal of equitably distributing the burden of call-ins among residents, and then altering the incentive structure of using contingency to reward residents who are called in to work for their colleagues and discourage inappropriate use of the contingency system.
- So the way it works is that we had a previous. The old system was a pre assigned contingency system, where people were called in according to their assigned number, and the and new innovations which is which is how we knew who was what level of contingency the new system used a points system to be able to assign who would be called in first.st So under this example, this is just a theoretical example. Everyone who was c, 1 c. 2 c. 3 c. 4. That day, still assigned to new innovations, was given a number or have a number based on the number of shifts that they've worked, and they're called in an ascending order of number of points they have. So in this example, c. 4 is called in 1st c. 2 is called in next c. 1, followed by C. 3. Don't bog down the details. No, just know that your the number of times you've worked in the past decreases your risk of getting called in the future.
- And I wanted to show up this throughout this QR. Code here. This is a link to our leader board, which is active all the time and updated instantaneously with any new contingency usage. So if you want to take a look at it, this is the record of all the times of the number of points that all of our residents have. So I'll leave a second. If people want to get their phones out and take a look at it. This a lot of very complicated Excel stuff went on here I will not take credit for. I will give the credit to chat Gpt.
- But we had some, I think, promising results. So in a survey of residents which included about 2 thirds of the Residency, so 66 residents responded. 90% said that they prefer the new system.
- A vast majority. 65 out of 66 said that they thought the new system was more equitable, and a sizable majority said that they thought the new system was more transparent. But we are all a little bit more comfortable with hard data here in internal medicine. And so we also have some. We tracked the number of call-ins throughout the year, particularly using this, using variance to assess how we were doing.
- So the total number of call-ins stayed similar. Average call-ins increase, as you would expect if we're more equitably distributing call-ins between residents, but the variance de halved so decreased significantly, and then weekly change in variances was significant. So we think we did pretty good work, and we accomplished the goals that we had set out to accomplish with this.
- So we thought this data was too good not to share. So we presented it aptum. Here's Kia having a great time in New Orleans and we wanted to award 2 other awards. Sorry you won't actually get any award. This is more just recognition. Most points for upper level is Drew riverman 11.5 involved a lot of, I think Ccu night shifts. Yep, okay. And then most points for upper levels is a tie between Elena Parcell and Rachel Cruz.
- So thank you for receiving this award for working a lot. So next steps I put a picture of calm up here. That's the name of the next chief class. So the continued refinement of the contingency system, we think we've done a lot of work this year, but it takes constant sustenance to continue working. Rolling points over. The next academic year comes with some nuances and challenges, and then we, as a

group, are planning on submitting a manuscript and think that our data is pretty unique and important to share.

- I'll turn it over to Marcus, all right. So just to highlight just a couple of the other ways that we've tried to be creative this year. I do want to acknowledge that Acgme actually encourages us to be creative with how we individualize experiences for our residents. And this is the specific verbiage that they use. If you look at the guidelines from 2023. They want at least 6 months of individualized educational experiences. I think we do that in a lot of different ways. But this is one of those areas that you want to continue to innovate upon. And so one of the ways that we did this this year was the stem cell elective. Some of you may know or not know that previously stem cell patients were a part of our regular hematology inpatient service. However, those patients are now siloed, mostly within the app sort of care. And so we still wanted our hemock, interested residents to have access to seeing these patients and treating these patients and understanding all of the nuances that go into their care, because it is a pretty unique, patient population that we have here at Uva. So I had the opportunity to work with Dr. Velodin here on this, and I have the 6 residents who had the opportunity to rotate on the service this year. I think one of the unique things about this elective in particular is that it includes inpatient and outpatient clinics. So they're seeing really both sides of the complications of these patients care as well as some of the better outcomes in clinic.
- And so, yeah, we just wanted to highlight, as this is just one of the ways that we try to be a little more creative with some of the educational experiences.
- Finally, the last way we want to highlight creativity is our teaching. This year we wanted to call out the importance of clinical reasoning, and I think residents who've been in our lectures this year will say that we've really tried to highlight that as a skill that's important to develop.
- So just some background data, clinical reasoning is recognized as a very important part of an education in internal medicine and part of our competency. So this is from courtship directors who say that clinical reasoning is extremely to very important in skills to develop pre clerkship, and then in clinical clerkships. But that most students, they say, either have fair or poor understanding of clinical reasoning concepts by the time they hit wards and this has been behind. Why people have called for clinical reasoning to be a core competency in acgme and just important to recognize. It's not right now. So it's baked into, maybe all the other core competencies. But there's no core competency set that explicitly says you need to focus on improving your clinical reasoning, or we just specific interventions to make your clinical reasoning better. But I think it's something we focus on a fair amount of as a program.
- And another reason to highlight is that a lot of our residents this year, as well as students who are learners and students, have been really impacted by the covid pandemic. This is just to highlight that students themselves, during the pandemic felt that their education has been significantly disrupted, and particularly that their competencies or skills, they need to start residency have been diminished.
- So we thought that clinical reasoning would be a good thing to focus on. I went in a deep dive about like cognitive psychology and medical education. All of that. I think this paper is really interesting. If anyone just wants to take a mental note of that. They walk through the way cognitive psychology has tracked the evolution of our

teaching in medical school and in residency. I gave a lecture just purely devoted this over the course of this year.

- I think it was like pretty boring, but I learned a lot from it from preparing for it, so it gave me some ideas about, and gave us ideas about ways to improve our clinical reasoning, teaching over the year. So they posture. I'm going to skip all the theoretical background, all of that. But that there's 3 good interventions that have at least been somewhat studied, more data from some than others.
- So 1st is the serial queue approach which many of you are familiar with. If you've been through Internal Medicine Residency, or just in medical students, here have been part of our clerkships. So it's where you present a case and you reveal aliquots of information along the way. And this is follows are what the idea of a hypothetical, deductive reasoning. However, it's not really been studied that much. It's familiar, and we do it a lot. But it's not something that's been extensively studied. Another is self explanation, which is being used more in medical school now, which is for people, for students and learners to go out and attack the data by themselves, and attack the information by themselves, and explain it to themselves and explain it to other people. It's a successful intervention, but it's not always the best for a large noon conference where we're. We've got people of different competency levels.
- And then the 3rd is deliberate reflection, which is something that I don't think we've done a lot of, but that has really good literature behind it. So the idea of deliberate reflection is presenting cases in a way that you have multiple cases that have similar presentations. But then different outcomes and having to go back and talk about what made those outcomes similar or different.
- I'm not an expert here. I'm glancing over. I'm glazing over a lot of stuff. But that's something that I was really interested in this year, so ways that we incorporated deliberate reflection in New Conference this year as a way to improve our clinical reasoning.
- One, we had a heavy emphasis on accurate problem representation and iterating that problem representation with changes in the patient's clinical status. 2 atypical presentations of common problems was something that you saw us do a lot in conference. And then, lastly, intentional restriction of information to create ambiguity and really have to have a reflective mindset when approaching these people. And essentially all you're doing is really bringing up that type. 2 reasoning rather than the type, one fast reasoning. When you're doing that.
- With that I'm gonna hand it over to Shawna.
- So moving on to our next section of our ethos, talking about respect. So again, recognizing that respect is something that fosters trust safety, and connection which are all stabilizing forces in the face of change and unprecedented times. I'm going to talk a little bit about what we do, and maintaining a respectful workplace. We have our program Evaluation Committee, and it evaluates how the program is doing, and it asks our residents how they feel like their experience in the program is going that involves an acgme survey as well.
- And what we've seen in the last few years is that when residents are asked specifically whether or not, they've experienced personally experienced things like abuse, harassment, mistreatment, discrimination, or coercion, or have witnessed it in 2022 to 2023, 89 and 91% of the Times residents said no that improved slightly. In 2023 to 2024, where they said personally, 94% of the time. They did not experience any of these things, but about 90% of the time they did not witness. So

there's room for improvement in this domain, and there is based off of discussions with our program Evaluation Committee. A few interventions we implemented this year, one of which was maintaining open spaces for our residents to discuss their experiences and provide feedback photographed. Here is what we had as our check-ins with each class. We had a breakfast check in in the morning had gave everyone Spraco's donuts, which was a big hit, but then pictured here is our intern class, and we just asked them what things are going well, what things aren't going well and allowed it to be a safe judgmental free space for us to receive feedback in real time and for any opportunities for improvement.

- Another intervention we implemented was collaborating with our women in Medicine Group, and we hosted a panel luncheon where we had a lot of faculty who have experienced challenging communication over the course of their career and talked about specific examples or skill sets that they've utilized to navigate challenging communication, and the idea with this panel luncheon was to provide our residents with a toolbox, a toolbox of different phrases, or different ways. They can approach situations that they find to be challenging in communication.
- Another intervention was, we invited the Uva Health Leadership Institute shout out to Dr. Lyons for helping us coordinate this, but they facilitated an lip, and nursing communications workshop where residents as well as nursing leadership and nursing across different aspects of the hospital, all sat down and participated in a workshop just to talk about. You know how we improve our communication with one another.
- And in the midst of all of this one other point of feedback was trying to improve some of the communication and collaboration in the Micu. So in meetings with Micu leadership, we identified a need for clarification surrounding team member roles which led to the development of a Micu, one pager document photographed here. The idea here is that a lot of our rotating team members who go through the Micu may not know exactly what a resident is, or what they do versus an app, and not understand the different timings of shifts. So this is in binders throughout all different team members, workstations in the mic you, so that they have a frame of reference. For who is this person who do I contact, and who how do I escalate? Care if I need to?
- In the midst of all of these interventions we repeated the acgme survey, and what we've seen is in the same question. Have you personally experienced or witnessed any form of harassment, abuse, mistreatment, discrimination, or coercion? We see that residents this year have said No. 94% and 96% of the time which is improved from our national average.
- So I'm really proud of the work we did this year, and I'm also going to pass off to Marcus to talk a little bit more about other elements of respect.
- All right. So I'm going to talk about respect from the lens of diversity and what that means, sort of nationally right now. And what's going on in the program. So to sort of preface this, just recognizing that respect is sort of the foundation of meaningful diversity, we have to respect each other, and individuals of all backgrounds need to be heard and empowered to contribute in an authentic way to have a healthy community.
- So diversity in medicine. I'm not going to spend too long here. But there's a ton of literature out there about how diversity improves performance in a team as well as outcomes for our patients. And this is across sort of different care environments

whether it's in the primary care setting cardiology world, the pulmonology world patients want doctors that look like them and can relate to them.

- So there is a bit of an affinity bias there, but I think that the benefits of what you get when you have a diverse workforce do translate into better outcomes for our patients. So I did find this article on in the Jama network that came out earlier this year. Regarding what does representation actually look like for internal Medicine Residency programs across the country. Right now, when you take a look at the percentages here you see, sort of the percentages in terms of ethnicities among residents as opposed to county level statistics across the country. And so what they did was pretty interesting. They used the concept of what they called a representation quotient, where you basically look at a county and say, Okay, the providers in that county. How does their sort of representation. How is that divided over the ethnic representation of the population of that county?
- So the areas of darker shade have greater representation among providers? The areas that are white have less, and so kind of starting to zoom in on where we're at. In the Atlantic South region. We see the quotients there. What I'll call attention to is, if you look up to the far right of the column, you'll see that Urms are half as represented compared to their white colleagues in the Atlantic South region, which is where we're at.
- So what does that all look like in the context of Virginia and Albemarle County, where we're at. This is our census data from estimates for 2024. You see the breakdown there, and when you zoom into Albemarle County it's pretty similar to Virginia, we're about 80% white, 10% black, Hispanic populations rising overall our population here in Charlottesville and Albemarle is slowly rising and slowly becoming more and more diverse. So we want to make sure we're still paying attention to what we're doing as a workforce to sort of match that.
- And so Acgme actually has guidelines about this as well, and they actually want institutions to create programs that foster recruitment and retention of diverse and inclusive, or, excuse me, they want us to foster diverse and inclusive programs that will improve diversity in residencies. Recently this statement came out in light of sort of the Anti Dei legislation that's coming down through the pipeline. That acgme is no, at least, for right now, temporarily suspending these requirements, they're going to be discussing it at their upcoming meeting. So Tbd on like where all this is headed and what that means for us. But I think what doesn't change is sort of what we value here at Uva and within our program. So how are we doing with the context of all of this going on? If you look back at our match data historically, we tend to match about 11 to 1516% urms throughout the years. And this year we really wanted an emphasis on, how can we still improve diversity within our program, despite, you know the tides of change that are coming. And we're proud to say that this past year in the match we had. About 30% of our program is Urms.
- There's a lot that goes into this. And it's not just about meeting a quota. The match process is very complicated. You have to get students that want to be here and still have the qualifications to be here. And I feel like that's what we got this year so big, shout out to Dr. Webb, Dr. Lyons, Dr. Dreiser, who are all a big part of these efforts, and I want to really emphasize that it's more than just. You know what we do in the interview process. It's really what we do all year long at a cultural perspective to build these bridges and get people here.
- So, moving forward from recruitment things that haven't changed yet for acgme, they still charge us with educating people about health care disparities, and how we

can address health, equity. One of the ways that we tried to do this this year, in addition to our prior curricular elements, was the introduction of equity. M. And M. Pictured. Here is Dr. Anisha Gangali, who, some of you may remember, from one of our grand rounds earlier this year, where she talked about health, equity for women through the lens of childcare, and she was a fantastic mentor. Through this process, as we sort of rolled out the idea for equity M. And M. But, in short, what it is is you have your standard, M. And M. Conference, but you are using patient safety quality improvement frameworks to understand some of the social and structural determinants that may lead to an adverse outcome for a patient. So, just as an example, this is from one of our equity. M. And Ms. Earlier in the year we talked about a case of a woman who was a patient at our Uma clinic that unfortunately died at home in the setting of polypharmacy from medications that different providers were prescribing.

- And you'll see you'll notice here that we want to highlight healthcare access in the social context. The financial stability of a patient is what contributes to their outcome. And we don't want to just have a framework for unpacking these things, but also a framework. For how can we start to think about what does an intervention look like for some of these things? And so this is from a separate equity. M. And M. We did related to an undocumented patient who had some fractured care in terms of his access to dialysis. And so what we think of the framework for, how we intervene, we talk about the interpersonal interventions, our institutional interventions, our societal interventions. And I think obviously we can't, as individuals do some of the institutional and societal ones by ourselves. So I think a lot of the discussion has to become around. Who do we partner with? And who are our change agents that we can tap into to help us take care of these complex, patient needs and with that I'll hand it over to Q.
- Thanks. So I'll talk about the next component of our ethos, which is growth, mindset. And so growth mindset is associated with how people learn and grow in the face of challenges rather than a fixed mindset, which views components or qualities as unchangeable and and appropriately said fixed growth. Mindset really focuses on improvement and the process of improvement. So individuals or institutions with a growth mindset view difficult tasks as chances to learn, and they really focus on obtaining feedback in order to overcome any setbacks or challenges that may arise and just a bit more background on this is a term 1st coined by Dr. Carol Dweck, and has been extensively studied by one of our Uma attending and internist Dr. Malad Mamari. But growth mindset, as I said, focuses on the process of improvement rather than on performance alone, or the outcome of failure or success. You use that as a chance to grow and learn from any mistakes, and then educators and institutions must work to create environments where growth mindsets can thrive and develop and is fostered.
- And as Dr. Carol Dweck appropriately stated in the growth. Mindset failure can be a painful experience, but it doesn't define you. It's a problem to be faced, dealt with and learned from, and I felt like there's no better way to exemplify this growth mindset than our acute cardiology service. And so from academic year 2023 to 2024.
- The team structure was changed from 3 teams to 4 teams, which was a very welcome change. It aligned our call, start cycle to a Q. 4 structure which aligned well with several of our other rotations. But there's still several challenges and issues that remain to be solved, namely, a rising heart failure, patient senses with

only 3 heart failure specialists to care for all of these patients. And then there's no structured timeframe for acs, heart failure rounds. And then, as we all know, Acs rounds can be quite long, and our acute cardiology attending can be rounding on 30 plus patients at times. So it's really stressful, for everyone involved not just residents however. 2 days before the start of my chief here I got a very ominous message from my predecessor, Dr. Joe Moore that changes are coming to the Cardiology service. Thinking nothing of it, I kind of just tucked it away into my inbox and went about my day.

- Couple weeks later I got another email asking to discuss some heart failure, patient rounding issues again, thinking changes would probably take several weeks to months to manifest. The next day I was presented with an Acs. New rounding structure and June 24th would be the Start date, which was less than a week after the email was received. So I do want to just highlight the impressive attitude and work ethic of not only the cardiology attendings for being flexible and and working with everyone involved in in dealing with a clunky structure that we'll get with, but also get to, but also our our residents, who really didn't shy away from any of the challenges or adversity that was created by this structure. So nevertheless, here's the structure. And if to just go about this change. The Ccu attending would now be rounding on floor heart failure patients, as our residents know. While the Acs cardiology attending would go about their rounds with half the team at 1 point and half the team at another point.
- If this schedule comes as a surprise to you, all who have rotated or attended on it. It shouldn't, because I personally taped all of these to the doors of all of the workrooms, but, as we know, it was quite challenging to follow this structure with a rising, patient census. And then you also have the issue of Tuesday mornings, where inpatient heart failure transplant listings were discussed again. Structure didn't really hold up however, recognizing the feedback that we got from residents. And really, you know, tackling the issues head on, we found that this clunky rounding structure needed to be changed. As I'm sure you're aware, there are still no defined times for the Ccu attending to round on heart failure, patients that led to long gaps in between separate rounds. And then the long rounding times continued. But despite that, there's outstanding collaboration between medicine and cardiology on creating really great solution that I think our residents are excited about. I hope the Cardiology department's also excited about. And so here's the new structure that will start at the end of June. And so, rather than an attending like Dr. Patrick Stafford, rounding on dozens of patients on the Acs service.
- He will now have a new colleague, such as Dr. Jonathan Pan, who's joining our cardiology faculty this upcoming year, and the service is split in 2. So one attending will take half the service, the other attending will take the other half, and this will almost assuredly leave to improved rounding times, better education, better patient progression and more, and then just circling back to the Stanford model of occupational well-being that improved workplace efficiency, that rounding should lead to better resident satisfaction and ultimately occupational well-being, as was mentioned before.
- But of course it doesn't just start at the individual level. The leadership and the institutional level should really model growth, mindset and willingness to learn. And I feel like that's what makes our Residency program so special is that we constantly acknowledge the fact that we can improve, and we have our own shortcomings, and that's led by Dr. Lau and the rest of our Apds and our chair of medicine as well.

And so, going back to our Pec committee, we recognize that the Ccu resident structure was a little bit clunky as well, where you had your week of night start at the second week, and then you returned on the second Sunday of rotation to a new team.

- We're changing that this next year. We're gonna put nights at the end of the rotation which should lead to improved patient continuity, better team structure, and continuity there, and hopefully better satisfaction amongst our residents as well and then our interns rotation structure was also especially clunky. They started their week of nights the following week during the end of the second week, and then, after finishing their night week stretch on Saturday morning, they returned on Sunday for one last call day, which they lovingly referred to as a blank U shift. So we are now changing that into a line with their upper level. They'll be spending 2 weeks on same team with their upper level. They'll have a week of nights on the acute cardiology service, and again, that should lead to improved satisfaction on this rotation, and hopefully have your rest so just to summarize again. Inevitably there will be some pluses and minuses, but hopefully the better, patient, resident fellow and attending continuity will be a welcome change. It'll be kinder on the Circadian rhythms for residents and no more. One off. Call day shift at the end. Unfortunately, our weekend night float. Maybe it gets a bit tougher now, as they'll have to rotate for a single night on the mic. You night float service. But that'll at least give a reprieve to our mic, you residents.
- So I'm going to continue with our growth mindset section, talking a little bit more about mentoring research and fellowship building upon the work of my predecessor, Kara Harrison, who is the other research chief within the previous model. For whenever a resident was interested in research or identified a subspecialty and wanted to pursue fellowship. We had different layers of advising and support available for them, starting from peer support, having a faculty research mentor or core faculty advisor. And finally, program director support from Dr.
- Kara started to introduce a chief resident advising role. So to have a more infographic for you guys, when an intern comes into our residency, and they think that they've identified subspecialty that they want to go into. They look at everything, and they say, Wow! I have 2 years to complete all of this research productivity that will help my Cv. But truly, objects in the mirror are closer than they appear, and residents often find that this is a very abbreviated timeline. So typically what happens is that we have a intern who perhaps halfway through the year identifies a research mentor, and they're really excited about it. So we've introduced a touch point at halfway after the halfway point of intern year, where myself, as the Chief Resident, sits down with the intern helps make sure that they've identified a research mentor or starting to be on track. And if they haven't, then giving them guidance for good research mentors in that area that they're interested in. And oftentimes our residents find that even if they have a good research mentor and a good research project.
- Things can just not work out so early on in the Pgy 2 year we've introduced another touch point where myself, as the Chief Resident sits down with the Resident discusses. If there's been any setbacks and helps them pivot, maybe find another research mentor or another project, so that they continue to be productive. So by the time they finish the end of Pgy 2 and sit down with Dr. Utlaut for fellowship, advising, they feel like they're in a good spot, and they're good to go.

- I'm really, really proud of our residents in this past academic year alone, and this doesn't even show all of our residents who have gone to conferences, but presented at regional and national levels, and who have really embraced the growth mindset where they have taken their own initiative to find something they're interested in, produce work and really learn and be an independent learner from there. We've been so proud because we've seen a really strong fellowship match. You can see in this past year alone, we've had residents across all different specialties, match to a variety of very strong programs.
- The next question that a lot of people ask of our program was, Well, did you have a hundred percent fellowship match rate? And, to be quite frank, that answer is, no, I'm a case in point. I did not match this past year, and it was disappointing. It was hard, and it was unexpected and unprecedented but I think the thing that I want to highlight here, especially in the growth mindset section is again, it's not thinking about our failures and sitting in that, it's thinking about. How can we come back from that? We have all of these resources that we have in place for our residents? And yes, research and productivity is important in order to help them succeed and match. But that's not everything that helps people match.
- If I'm to highlight just our most competitive subspecialties in the past year alone. For Gi, for example, you can see the number of unmatched positions has been steadily increasing in the last 4 to 5 years, with a 65% match rate. We see the same for cardiology with a 66% match rate hematology oncology with 72% match rate and palm crit with a 70% match rate.
- So I don't want to make everyone feel sad that this is the case. I think what we should reframe it as is when a resident doesn't succeed in the way they expect.
- How do we come back from that? Who do they who do we lean into? And I don't want to be cliche, but it's really the program and the community. Oh, I'm gonna have.
- So again, coming back to our ethos, and what's at the center of everything.
- Oh, guys, it's ours. Free decor.
- It's our way. It's the way our residents connect with each other, how we support each other and how we love each other.
- So I want to use the last few minutes to just talk about the residents and talk about how we connect with each other.
- So target starting with, like the Residency program events that we've all been so grateful to have seen over the course of our chief here, starting off with our Intern Appreciation Day. So this gives our interns just well needed time off the pager to connect with each other and celebrate them. But at the same time we recognize that the transition to Pgy 2 is hard. Becoming. An upper level is hard. We also have a retreat for them to sit with each other. Talk about the challenges, talk about their concerns, and give them the skill set to feel like they can succeed as an upper level throughout the year. We've also introduced fun conferences. So rather than hearing Thompson talk about clinical reasoning all the time we have introduced what's photographed here? Conference Olympics. So during the summer Olympics. We just had a fun conference for residents to participate in fun activities and to continue to celebrate our residents. We have events like fall retreat.
- We have our annual holiday party. We've had. Kia's white elephant, which has grown every year this past year, was to the point where the residents broke Kia's couch, because all of them, as you can see, we're sitting on it and broke it. So he's not moving with that couch, and then we've continued to celebrate our residents in

the springtime with our winter doldrums. We hosted a movie night for them. Dr. Climo hosted them in her home for a movie night or trivia night. We had our residents go out into the community and volunteer at habitat for humanity. We've hosted a breakfast potlucks for them.

- Dr. Utlau hosted them in his home and provided an excellent dinner, great pasta, and then we hosted some pickleball. I'm going to pass it off to Kia to highlight a little bit more about our residents.
- Great job. So I loved. What class did a couple of years ago, where they highlighted some resident life events that really helped create this great culture and esprit de corps. So, starting with pets and hobbies, we had Hector, who adopted a dog named Leo Alex adopted a brachycephalic dog named Walter as a pug owner. I recognize the challenges with those breeds.
- We had several marriages and engagements. Of course I'm gonna start with myself. I got married this past August. Jack got engaged, he somewhat told people Ben Robinson got engaged with the help of Shaina creating a funny plan. James and Amber got engaged.
- Margo and Matt recently got engaged.
- Owen and Matt got engaged.
- Soham is getting married next weekend and Rachel and Evan or Pgy ones are getting married next month
- Hakeem got married, but he didn't request his wedding off, so we had to do that after the fact, I don't know any other details about this wedding.
- We also had a host of I will just call other events.
- Jack succulent, died that he mentioned from a couple years back.
- James and Amber are building a house, and James is keeping a very close eye. Despite having absolutely no construction experience.
- Connor and Drew became dads to bees, despite Drew being quite scared of bees and a group of medicine residents. In fact, we ran the Charlottesville 10 Miler. I got smoked by Dr. Ulau, but we both got crushed by Dr. Mcgee and Dr. Badaraca to keep ourselves humble and then for some new additions again, tons of new babies joined the Uva Imr family. This year Shaina had a baby, leaving me alone with Marcus, and then Thompson had a baby, leaving Marcus alone with me. Catherine Fortune had a baby.
- Daniel Cook had a baby girl.
- Michael Bates had a baby as well. Zoy had her baby recently, and there's several more on the way that I'll let you find out in due time. And recruitment. Shouting out another predecessor, Margo Tanner. She did a great job of reinvigorating our social media presence, and I tried hard to carry on that momentum, and I just want to acknowledge just the tremendous effort by our residents, our faculty to help with recruitment, such as our open houses that we put on. Hannah Laird finally took over the Instagram Takeovers. Despite my objection to Dr. Lau. I wanted to keep it going but she did a great job, and then we had a Cmc. Halloween themed Cmc. Where we dressed up as office characters, and Dr. Lau dressed up as Marty Mcfly.
- And then it's always nice to see on Instagram just how well we're doing with engagement. We've gained about 300 followers in the last year, which is okay. But you can see some ebbs and flows. And if you're looking at this huge dip. That's Match Day, where we lost 37 followers nevertheless, we came back from it growth mindset of 30 plus followers that day. And we're still trending upward 3.5% in the last 3 months, despite likely some hard feelings from applicants who unfollowed us.

- And then you always have to keep people get keep yourself humble and Margo highlighted. That May 9th was a particular bad day for me and my post but we do a lot of little touch points along the way, and these things matter, and and every interviewer or most interviewers will send their applicants that they interviewed a personalized postcard. And this is Connor Horns from Kara last year that he brought with him from South Carolina, and it just goes to show like these touch points that Marcus has mentioned really do matter and can help change a applicants rank list.
- and we're quite excited with our new intern class there.
- I'm sure they're gonna be just a tremendous class, and I'm so excited for them, and I'm personally so sad I won't be able to be here to see their growth this next year and through their residency.
- All right. So we're getting close to the end here. So stick with us so future directions for calm. So talking to you guys right now.
- I think there's a lot that you could that you can do. And I'm sure you guys have your own ideas about where to take things next in the program. So these are just our thoughts, you know, taken with a grain of salt. But I think obviously, contingency is going to be a continuing sort of development. It was a source of burnout for the program. I think we made some great strides this year, and how we revamped it. So I'm excited to see where you guys take that next geography and patient progression. This is sort of the elephant in the room. I think Dr. Helgerson's over there chuckling but I think this is going to be a time of growth for all of us in the Medicine Department as we learn how to adapt to this growing, patient census that we've been dealing with all year. And I think you guys will definitely be the calm in the storm as we adjust to that building upon the momentum we had with recruiting a diverse workforce, I think, especially in the political climate right now, this only gets more and more challenging. So I just want to reemphasize the importance of collaborating with people and not doing this alone and also connecting with our students here, regionally, nationally and then navigating the oncology service is another one where I think there's going to be some growing pains there and then, I think, important to keep in mind as we focus on efficiency and how we can adapt our structure to these changes, we want to make sure the educational mission stays at the forefront as well, and that balance has to be there, and I think if the balance is appropriate, residents respond well to that and then continuing to foster interprofessional communication. You guys can't do this job alone, and we want to make sure that we're being respectful of the people that make our jobs easier.
- So everybody calm down. I think it'll do a great job.
- So the picture on your left was us at the start of Chief Year, and the picture of the the right is us a few weeks ago. So we're a little closer now, as you can see thankfully, not too many not too many gray hairs. So it's been a humbling experience for all of us. So we want to end this by just saying, Thank you.
- Thank you to the Apds core faculty members. Our leadership at the operational level, just our educators and frequenters of the chief's office. We just want to say, thank you. To all of you guys, you guys have been a source of strength, education, mentorship, and we wouldn't be standing here without all of you. I want to say a special thanks to our Admin team, Joy, Terry, Aaron. Tony you guys are really the spine for the program. You guys keep us in check and make sure that we're getting things done? We really literally couldn't do this job without you guys. So just huge. Thank you to what you guys do day in and day out.

- And then last, but certainly not least. Dr. This is really your program. We feel like you taught us a lot in terms of you know just how to be good leaders, how to be good educators, and you welcomed us into your home, into your family, and we just can't say Thank you enough for the opportunity to serve the program in this way, and you know we'll always call you papa if you didn't know. That's what we call I don't know if you knew that. But when you leave we call you, and then one more acknowledgement is just to the amazing Residency family that, and all of our residents, you guys are what makes this job so enjoyable along with Dr. Allowing the rest of the people we work with. But your passion, enthusiasm, dedication, and resiliency are are things I look up to, and I think the rest of us look up to as well. And I feel like you guys support us just as much as we try to support you also. I think we'll miss, you guys so much. And miss being so intimately involved with the Residency program. So thank you so much for everything.
- Any question.
- We do have a gift. Yeah, special presentation that Emily Jazeki will tell us about.
- Thank you. We just wanted to thank all of our chiefs, Dr. Lau and our amazing administrative staff for a wonderful year. We had some end of the year gifts from all of you from all of us.
- Thanks, everybody. Yeah, thank you.