From Probation to Accreditation: One Institution's Successful Journey Toward Program Improvement

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Abstract

ACGME accreditation is a fundamental requirement for residency programs. This process requires substantial resource commitment from each department and this commitment becomes even more critical when a program is placed on probation. In this article we detail the process we used to move from probation to full accreditation, including approaches to diminish duty hour violations, enhance educational quality and improved resident satisfaction.

In 2003, the University of Missouri's Department of Orthopaedic Surgery reached a nadir of three faculty with a resident complement of three per year. A leadership change resulted in a dramatic increase in faculty numbers: all new faculty members were subspecialty fellowship trained and the majority were former University of Missouri (MU) residents. During this faculty growth phase, the conception, design and funding acquisition for an 115,500-square-foot orthopaedic hospital was initiated. Also during this growth phase, the department successfully petitioned the Orthopaedic Residency Review Committee (RRC) for an increase in resident complement; the program was expanded from three to five residents per year.

An unintended consequence of this dramatic change led to a wavering in resident education. This became apparent in April, 2006, when an internal review noted educational concerns in spine surgery, sports medicine, pediatric orthopaedic surgery and musculoskeletal oncology. The review also identified a perceived lack of faculty involvement in the didactic portion of resident education. These issues were addressed in a fashion that, at the time, seemed satisfactory.

Despite these corrections, the resident staff continued to perceive a degradation of their educational experience, especially with regard to surgical training. Indeed, after the site review in July, 2008, the following was documented: "The site visitor confirmed that residents expressed overwhelming apprehension about the lack of overall operative experience which was *expressed in the form of a letter* to the site visitor addressing deficiencies in the operative experience." (Italics added for emphasis.) The residency program was placed on probation, with 16 citations focused primarily on duty hours, service-to-education ratios and educational experiences in sports medicine, adult reconstruction, orthopaedic oncology, and pediatric orthopaedics. Five of the 16 citations were rescinded after the program's responses were received and reviewed by the Accreditation Council for Graduate Medical

Education (ACGME). The resident compliment, however, was reduced to four per year as a response to the probation.

All this occurred during a time of substantial change in departmental leadership. The department chair provided 6 months' advance notification of his departure, and at his departure, an interim chairman was appointed. The program director, having been in his position for 8 years, began to prepare for an eventual transition away from his role by appointing an associate program director. Both of these announcements occurred during the month prior to the department's notification of "proposed probation" by the ACGME. Despite this leadership flux, work to correct the program's deficiencies began immediately. As a direct response to the citations, a night float system was implemented (to address violations of duty hour regulations), faculty on the adult reconstruction service were realigned, and rotations were created at outside centers in pediatric orthopaedics, sports medicine, and orthopaedic oncology.

After receiving notification of "proposed probation" and responding to the citations, the program director resigned and was replaced by a faculty member whose experience in graduate medical education was limited to clinical teaching. A new department chair arrived at MU one month after the program director change. The new departmental leadership chose to embrace adversity and moved to improve resident education: changes already made were re-evaluated, an advanced understanding of the principles of graduate medical education was conducted, the resident curriculum was re-created, and, most importantly, a culture change to emphasize graduate medical education as a primary department mission was initiated.

Evaluation of the night float system was accomplished through duty hour monitoring, via New Innovations. This data was reviewed by the program coordinator, the program director, and the duty hour subcommittee of our School of Medicine's Graduate Medical Education Committee (GMEC).

Consequently, the chairman and program director adopted a zero-tolerance policy for duty hour violations. Subsequent to these interventions, the only duty hour violations have been determined to be secondary to data entry errors.

Evaluations of the outside rotations in pediatric orthopaedics and sports medicine have been through written and oral reports from the resident staff and from written evaluations of the residents by the faculty of those rotations. One rotation (pediatric orthopaedics) is at a site 100 miles from the residency program center, and requires the resident to be away for 3 months during their 3rd post-graduate year. Despite this burden, residents have given positive evaluations of this experience. The external sports medicine rotation is with a private practice orthopaedic group in the same city as the primary institution, so there is no travel burden. It too has received positive evaluations and support from the residents. Even with this encouraging feedback, it remains too early to determine whether there will be a resultant positive effect on metrics designed to measure learning, such as the Orthopaedic In-Training Examination (OITE). Resident satisfaction has improved, as demonstrated by independently-administered ACGME surveys and New Innovations evaluations.

The external orthopaedic oncology rotation was evaluated shortly after its inception. Unfortunately, this rotation was plagued by difficulties in communication between the home center and the external site. Residents raised concerns that the rotation did not provide sufficient clinical material in orthopaedic oncology and the rotation was discontinued after 6 months. As a result, the department elected to send each PGY-4 to a nationally recognized, week-long orthopaedic oncology course. It was also determined to continue the monthly pathology curriculum, which had been in place for many years. This series of conferences pre-dated the department's probationary status; both residents and faculty deem it to be of high importance and educational value. It is too early to determine whether there will be any impact of this curricular change on residents' OITE scores. Given that our program is not in a

large urban center, the volume of orthopaedic oncology cases is limited. We will continue to explore alternatives to expand resident education in this arena.

To maximize our efforts at program enhancement, the new program director made a concerted effort to contact directors from other programs to obtain information regarding methods for improving resident education. These interactions led to the creation of departmental committees to address: duty hours, service demands, independent practice/surgical experience, and program/faculty/resident evaluations. Each committee consisted of a faculty member and resident volunteers. Regular meetings were encouraged. One of these committees – the program/faculty/resident evaluations committee – recommended substantial changes by completely revising the bulk of the questionnaires used in the New Innovations evaluations tool. These questionnaires included faculty evaluation of residents, resident evaluation of faculty (delayed and anonymous), faculty/resident evaluation of the program, and nursing and patient evaluation of the resident staff (so-called "360-degree" evaluations). Resident evaluations of faculty are reviewed with the faculty members by the department chair during each faculty member's annual review. These documents are considered in decisions regarding faculty retention and promotion.

Institutional input was an additional and critical element of the process. The Designated Institutional Officer (DIO) served as a resource regarding ACGME and institutional Graduate Medical Education Committee policies. The fact that the institution had been placed on probation in 2008 served to focus the health system's resources towards positively impacting the resident service/education ratio. Specifically, the institution provided increased pharmacy support for medicine reconciliation as well as a reorganization of the case manager/social work system. Given the speed and magnitude of these changes, the institution petitioned for an early site review with a subsequent return to full accreditation. It was also critically important that invaluable assistance was provided from the

DIO and support personnel who were familiar with the process of writing educational goals and objectives.

To increase faculty involvement in managing the educational mission of the department, the department chair and program director appointed faculty "educational liaisons" from each service line (e.g., orthopaedic trauma, spinal surgery and pediatric orthopaedics). These faculty members worked with personnel from the GMEC office to create core competency-oriented and year-in-training-appropriate goals and objectives for residents on each service line. Most faculty had not previously received formal training in graduate medical education, so they encountered substantial difficulty in the verbalization of their educational process. The GMEC staff helped our faculty articulate and transcribe these teaching activities.

It was necessary for the residents to feel included in the revision of their educational programming. To emphasize the educational focus of the department, the program director developed two "Grand Rounds" lectures detailing the role of the ACGME in the accreditation process, with definitions and discussions of the core competencies. These lectures also reviewed the citations by the orthopaedic RRC and the program's responses to those citations. The program director's semi-annual evaluation of each resident was formalized to include specific references to the core competencies; this allowed for the creation of a competency-focused summative letter at the conclusion of each resident's training. To facilitate resident communication with the leadership, the chair instituted a monthly dinner meeting with the resident staff, and both the program director and associate program director established standing, "open-door" office hours. A mechanism was also created by which anonymous comments could be provided to the department chair or program director without need for a face-to-face meeting between the resident providing the comment and the program leadership. This has resulted in more voluntary resident communication regarding their concerns and it is a method by which the resident

staff has direct involvement in the decision-making process regarding the program. Fundamentally, this process augments both the perception and the reality that the resident staff is a functioning stakeholder in the educational process.

At the same time, the program director – with assistance from the associate program director and personnel from the DIO's office – began rewriting the Program Information Form (PIF), with the specific mission to create a document that accurately reflected the residents' educational experiences. This required the program director to meet with the educational liaisons to obtain basic knowledge regarding each service line. It was necessary that clear communication could occur between very different sub-specialties within orthopaedics. Initially, the program director failed to internalize the absolute requirement that the PIF was singularly his responsibility. He realized that he needed to be conversant will all aspects of the PIF and knowledgeable regarding all aspects of the educational mission of the program. We found that the best method to accomplish these goals was for the program director to write and revise the majority of the PIF personally. This process benefitted from professional editing, both from the GMEC office and our department staff. The program director constructed the PIF to reflect the reality of the program as a matter of course and with the clear understanding that the site visitor would focus on discrepancies between the educational experience detailed in the PIF and information gleaned from interviews of residents and faculty.

Simply put: If you do it, write it down. If you do not do it, do not say that you do it. If you do it well, highlight it. If you do it poorly, detail a method of evaluation and a plan for remediation, including a method to assess the outcome of the remediation. It was our perspective that, given the limited time that was allotted for the actual site review, the quality of the PIF was of critical importance.

As the PIF was being revised, the program's Resident Handbook was also re-written. Again, we consulted with those who had extensive experience in the creation of such a document. In this context,

the program director for the Obstetrics and Gynecology Department at the University of Missouri provided great assistance, especially with the sections on resident evaluation and discipline. Sections on the grievance policy reflected institutional policy, and educational goals/objectives were those created by the educational liaisons. The educational processes noted in the PIF (e.g., educational leave for orthopaedic courses) were noted in the handbook, as were policies for vacation, meetings, and travel. All residents were required to attest, by signature, that they had read the handbook, and a copy of the handbook was made available to the site visitor.

Given the importance of the residency program to the department as well as the increasing complexity of graduate medical education, the program director requested that the position of program coordinator be enhanced. This previously was at the administrative assistant level. With the strongest support of the department chair, this position was transitioned to a management level with commensurate salary increases and higher education requirements. This position was filled – although after the site review – by an applicant with a Master's degree in Health Administration and five years of experience as a program coordinator. An additional administrative assistant was hired to support the new program manager.

As a very important adjunct to the resident evaluations noted in New Innovations, the program leadership paid special heed to the annual ACGME resident survey. We felt it reasonable to assume that the issues addressed in this survey are of significant interest to the ACGME and that the resident responses reflected their perceptions of the quality of resident education. In our situation, changes already in place produced a substantial improvement in survey scores as compared to the prior year.

Due to the timing of our July, 2010 site review and the meeting schedule of the Residency Review Committee, we were not apprised of the result of our site visit for 6 months. Ultimately, we were happy to receive full accreditation with a three-year review cycle, a commendation, and only a single citation,

regarding a lack of PGY-1 education in anesthesiology. We feel a strong sense of accomplishment in going from 16 citations to 1 and accreditation validates the work so many put in to make this review a success.

Successful exit from probation requires a concerted effort on the part of the program leadership and the faculty, as well as extensive involvement of the resident corps. In the PIF, the citations leading to probation must be addressed individually and in aggregate with specific plans for remediation and mechanisms for plan evaluation. The PIF must reflect the reality of the program and all involved in the site review must be conversant with the contents of the PIF. All documents requested by the site reviewer must be readily available, and there must be strict adherence to the schedule set by the site reviewer. At the core, however, our successful transition away from probation was the result of a leadership driven, fundamental culture shift reemphasizing the importance of the educational mission of the department.

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