

February 2012

ACGME Bulletin

Accreditation Council for Graduate Medical Education

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Ingrid Philibert, PhD,
MBA
Editor

ACGME Announces the Next Accreditation System

Ingrid Philibert, PhD, MBA

On February 22, 2012, the ACGME released information on the rollout of the Next Accreditation System (NAS). Dr. Thomas Nasca's announcement was concurrent with the online publication of an article describing the NAS in the *New England Journal of Medicine*, and the unveiling of an ACGME "microsite" dedicated to the NAS (www.acgme-nas.org). The NAS also will be a major topic for presentations and discussions at the ACGME Annual Educational Conference, to be held from March 1-4, 2012 in Orlando, FL, and in the coming months additional more detailed information will be shared in letters to the community, in presentations at academic meetings and in the *Journal of Graduate Medical Education*.

Planning for the NAS began in 2009, as the logical progression of the ACGME's move to outcomes-based accreditation that started with the introduction of the competencies in 1999. In July 2013, the NAS will be implemented by 7 of 26 ACGME accredited specialties (Emergency Medicine, Internal Medicine, Neurological Surgery, Orthopaedic Surgery, Pediatrics, Diagnostic Radiology and Urology); implementation for the remaining specialties will begin one year later.

Key elements of the NAS are the Educational Milestones, specialty-specific achievements residents are expected to demonstrate at intervals during their training; case and clinical experience data; resident and faculty surveys; and visits to sponsoring institutions to ensure an appropriate learning environment. Together, these elements will allow the ACGME to extend the period between scheduled program reviews to 10 years.

Aims of the NAS include enhancing physicians' preparedness for 21st Century practice; accelerating the movement toward accreditation based on educational outcomes; and reducing the burden associated with the current approach. Implementation will proceed

in close collaboration with program director organizations, specialty boards, colleges and related academic organizations. ε

Tracer Method become “Trace”

Ingrid Philibert, PhD, MBA

The ACGME Department of Field Activities is renaming its approach for tracking longitudinal improvement approaches during program site visits. The new name will be Trace. In July 2011, the Department announced that its field representatives would use a process of tracking longitudinal improvements of selected program processes during accreditation site visits. The intent is to allow programs to showcase their ongoing improvement to the Residency Review Committees, but the process differs from that used by other accrediting bodies. All data collection is during the scheduled interviews with the program director, residents, faculty, and institutional officials. The field representative will complete this activity during the regularly scheduled interviews and document reviews. The new name, Trace, formally seeks to establish a distinction between the ACGME’s approach and the process used by other accrediting organizations.

The aim of Trace is to place added emphasis on actual program operations and processes and how these function, as well as showcase achievements from programs’ continuous improvement efforts (*see below about “reporting on positive aspects of your program”*). Areas for 2012 will continue to encompass monitoring of resident hours, and how programs have implemented the new standards for supervision and transitions of care, along with addressing past citations, and improvements in areas with potentially significant non-compliance identified by the ACGME Resident Survey.

Trace will also begin to be used during Institutional Review Visits, to track improvement in response to cross program patterns of citations and other institutional improvement priorities. For these and other improvement processes, Trace will offer the Review Committee more insight into ongoing improvement activities and their outcomes. ε

Reporting on Positive Aspects of Your Program

Ingrid Philibert, PhD, MBA

An analysis of site visit reports done by William Robertson, MD, MBA, a member of the ACGME field representatives, as a project supported by the Nathan K. Blank, MD, Memorial Fellowship highlighted that site visit reports for a number of programs

contained positive information on programs that went beyond indicating compliance with the common and specialty-specific program requirements.

Places to Report Positive Information

Natural places in the PIF or the site visit interviews to report positive information are:

- 1) The section on changes in the program since the last site visits; and
- 2) The section on the annual program evaluation in the evaluation section, because a functioning review should identify opportunities for improvement and programs should act on those.

Topics

Dr. Robertson's analysis and review of a larger sample of reports suggests suggested there are four common areas for positive comments:

1. Quantitative elements exceeding program requirements (examples of this rare, but may include program director salary support that exceeds the percentage indicated in the specialty program requirements);
2. Enrichment of the Educational Environment, including didactics, immersion experiences, international rotations and electives;
3. Expansion of under-developed program requirements, particularly curricular innovation and faculty development;
4. Technology enhancement (new imaging or surgical technology, simulation and other computer assisted learning modes, electronic medical records, or other technology in the learning environment).

Added information on positive aspects of the program likely is useful to the Residency Review Committees, and programs should take the time to report these, either in the PIF or during the site visit interviews. ε

Brief Item: Attestation of Duty Hour Compliance Is Not Acceptable as a Form of Monitoring

The ACGME continues to expect that programs monitor actual duty hours for residents and fellows. Asking residents or fellows to "attest" to duty hour compliance, such as through a signed document, is not sufficient as an approach for ensuring compliance. The reason is that it may put undue pressure on trainees, and may cause them to be reluctant to report areas of non-compliance to their program. In specialties with low

likelihood of exceeding the duty hour standards, it is appropriate for monitoring to take the form of periodic sampling. ε

Baldwin Series Lecturer Discusses How Economics and Social Networks Influence Medical Teams

Julie A. Jacob, ACGME Communications Manager

Applying economic and sociological principles to the study of medical teams can provide some answers to the question of how to make the care patients receive in hospitals more efficient and effective. David O. Meltzer, MD, PhD, discussed some of his research findings on that topic when he gave a Baldwin Series lecture at ACGME headquarters on November 2. The Baldwin Series brings distinguished experts in graduate medical education to the ACGME to present to ACGME staff members and guests. Dr. Meltzer, who is an associate professor of medicine and associate faculty member in the Harris School and Department of Economics at the University of Chicago, as well as director of the Center for Health and the Social Sciences at the University of Chicago, studies health care economics and public policy with an emphasis on factors affecting patient care quality and costs. He is currently conducting a research study at six academic medical centers across the country to gather data on whether a physician's status as a hospitalist or non-hospitalist affects patient care costs and outcomes.

Applying Smith's theory

Adam Smith, the 18th-century economist who wrote *The Wealth of Nations*, discussed the concept of the division of labor in his classic book. Dr. Meltzer noted that Smith believed specialization made the production of goods more efficient — up to a point. Eventually, the cost of coordinating production among evermore specialized workers outweighs the benefits of specialization. Smith's theory can be applied to the delivery of health care, said Dr. Meltzer, by examining whether increased specialization of physicians improves patient care and lowers costs, or whether the costs and complexities of coordinating care and managing patient hand-offs negate the benefits of specialization.

The United States health care system places a much greater emphasis on continuity of care and the physician-patient relationship than most other countries do, he said, adding that, "Everyone else separates ambulatory care from hospital care to a much greater degree." Hospital medicine was added as a clinical discipline in the 1990s. The specialty grew out of a belief that hospitalized patients would have better costs and outcomes if they had attending physicians who focused primarily on the care of hospitalized patients, which would allow these doctors to gain experience in this setting

and be more available at the hospital around the clock, not just in the mornings when attending physicians traditionally made rounds.

Today about 30,000 hospitalists care for about one-third of hospital patients. The question, Dr. Meltzer said, is whether hospitalists provide better care that leads to better outcomes for patients. According to Dr. Meltzer's data, when hospitalists care for patients, hospital stays are slightly shorter. There is also a small reduction in costs per admission. However, he noted, whether a patient is cared for by a hospitalist or non-hospitalist does *not* affect how a patient fares more than two months after discharge.

The spillover effect

Dr. Meltzer highlighted a few other findings from his current multi-site study. In addition to investigating the effect of hospitalists on patient care, he and his team are looking at how proximity and personal attributes of team members affect a team's communication and effectiveness. The "spillover effect," Dr. Meltzer explained, is how information, such as instructions about how to use a new drug, flows among team members.

"There's a large body of literature saying that people seek advice from people like themselves. We wondered if this was true," said Dr. Meltzer. The data indicates that physicians do, in fact, tend to seek information from other similar doctors. For example, hospitalists are 10 times more likely to ask other hospitalists than non-hospitalists for advice.

Another finding, said Dr. Meltzer, is that team members who are very closely connected to one other are less likely to be connected to numerous colleagues outside of the team. In contrast, team members who are not as tightly connected to one another are more likely to be well-connected with many people outside the team. "If you want a team that has an effect on care, you want a team that is connected to many other people," he said, adding that these are all variables to consider when medical teams are being assembled.

Dr. Meltzer ended his lecture by noting that although research supports the theory that hospitalists improve the care of patients in hospitals, research indicates that very sick people with chronic medical conditions do better when they have the same doctor for outpatient *and* hospital care. "Continuity of care works best for patients with serious medical problems who are likely to be hospitalized," he concluded. ε

The Parker J. Palmer Courage to Teach Awards Program Celebrates its 10th Year Anniversary – A Magical Time

Marsha A. Miller, MA

In March 2011 at its annual educational conference the ACGME celebrated 10 years in presenting its prestigious *Parker J. Palmer Courage to Teach Award* to exemplary program directors. Included in the grand prize was a retreat in a tranquil, natural setting, and in May 2011 the ACGME physician formation retreat celebrated its 10th year anniversary. While this sought-after award was created to honor and celebrate program directors, the intent of the retreats is to renew program directors' spirit. What was the reason?

In 2001, the ACGME saw that nearly one-third of its program directors annually left their position. Dr. David C. Leach, then ACGME CEO, had read Parker J. Palmer's book, *The Courage to Teach*, and was impressed with Dr. Palmer's *Courage to Teach* program for K-12 teachers, and he embraced his philosophy of *living divided no more* and *connecting the role with the soul*. That is, doing what is right not for one's own benefit but for the rightness of it. Dr. Leach said "good learning for good patient care" is the right thing to do, and he wanted to explore goodness and rightness and education with his colleagues. He and Dr. Paul B. Batalden, then the Director of Health Care Improvement Leadership Development at the Center for the Evaluative Clinical Sciences of the Dartmouth Medical School, enrolled in Dr. Palmer's facilitator program in order to learn his *Courage* concepts and ultimately introduce them to the recipients of the awards.

Their goals were four-fold; firstly, they wanted to honor and celebrate the physicians and leaders in graduate medical education; secondly, they wanted to renew the doctors' spirits so that they reclaimed their teaching roles; thirdly, they wanted to create a safe place for reflective practice and contemplation; fourthly, they wanted these awardees to start similar movements within their own institutions in order to revitalize learning and teaching and reflective practice. This was the beginning of the magical retreat and physician formation movement started by Dr. Leach and his friend and colleague Paul B. Batalden, MD.

Early on, their vision was to lead the retreat for ten years and then reassess, Plan, Study, Do, and Act, as Paul would say. Their goal was to indoctrinate ten physicians a year, 100 physicians, spreading the word by the time the retreat ended. Drs. Leach and Batalden exceeded their goal in creating a cadre of physicians and educators to improve teaching and learning and reflective practice in graduate medical education. To date, 102 physicians have received the *Courage to Teach Award*. That is something worth celebrating!

PICKER INSTITUTE/GOLD FOUNDATION
2012/2013 GRADUATE MEDICAL EDUCATION (GME) CHALLENGE
GRANT REQUEST FOR PROPOSAL

PICKER INSTITUTE EVALUATION COMMITTEE

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PURPOSE

The purpose of the Picker Institute/Gold Foundation Challenge Grant Program is to provide annual grants to support the research and development of innovative projects designed to facilitate successful patient-centered care initiatives and best practices in the education of our country's future practicing physicians.

This Request for Proposal (RFP) solicits proposals for projects that will run from July 30, 2012 through July 29, 2013. All awards will be made on a matching grant basis. Projects will be subject to interim reporting and review by Picker Institute. A Letter of Intent (LOI) in response to this RFP is due by March 9, 2012. Applicants who pass the LOI evaluation process will be invited, by March 30, 2012, to submit a full proposal, due on or before May 4, 2012. GME Challenge Grants will be announced on July 2, 2012.

MISSION

Picker Institute Inc. is an independent nonprofit organization dedicated to the global advancement of the principles of patient-centered care. Picker Institute sponsors research and education in the fields of patient-centered care in support of and in cooperation with educational institutions and other interested entities and persons. The Institute's mission is to foster a broader understanding of the concerns of patients and other healthcare consumers, and of the theoretical and practical implications of a patient-centered approach. As a world leader in these efforts, and in the measurement of patient's experience, Picker Institute is recognized as an important resource for information, advice and assistance. In keeping with this reputation and in fulfillment of its mission, the Board of Directors of Picker Institute support the advancement of the patient-centered care approach through a

variety of programs, awards, research and dissemination of evidence-based knowledge focused entirely on fostering the continued improvement in healthcare from the patient's perspective.

The Gold Foundation is a nonprofit organization dedicated to the advancement of humanism in medicine, restoring a balance between the science of medicine and compassionate, respectful patient care. The Foundation is a proponent of medical care that is as humanistic in its delivery as it is sophisticated in its technology to improve healing and healthcare outcomes. The Gold Foundation supports the development and dissemination of innovative medical education that furthers this mission.

PROPOSALS SOUGHT

The Picker Institute/Gold Foundation Graduate Medical Education Challenge Grant Program is seeking proposals that illustrate specific interventions and innovations in graduate medical education programs that facilitate the development of best practices regarding patient-centered healthcare and/or humanism in medicine. The expected outcome of a grantee's project will be a demonstration, including a robust dissemination plan, of the measurable effects and sustainability of the effort to enhance compassionate, patient-centered-care in residency education. For example, past projects have included:

- ⇒ The development of a curriculum to help physicians understand the special needs of young patients with chronic illness as they transition from pediatric to adult care
- ⇒ The design of a patient simulator to objectively assess a resident's ability to practice the principles of patient-centered care as they are embodied in the ACGME's core competencies
- ⇒ The development of a curriculum designed to raise resident awareness of their patients' cultural and spiritual needs

Always Events® are defined as procedural and substantive actions that should accompany every patient experience. The grants committee is looking for proposals that can assist in identifying Always Events® and demonstrating their efficacy. Picker Institute strongly encourages alignment with Always Events®. In preparing your proposal please keep in mind that Always Events are not merely things that the health care system/organization does but need to be reflected in the patient's experience. It is important that these experiences be significant, evidence-based, measureable, affordable, and documented.

The improvement should be consistent with at least one or more of the Picker Institute Principles of Patient-Centered Care and/or Gold Foundation's criteria to advance humanistic care. Evidence of an alignment with at least one of the ACGME core competencies is necessary. (see appendix 1 for PII/Gold Foundation/ACGME principles)

The Picker Principles of Patient-Centered Care embody Picker Institute's conviction that all patients deserve high-quality healthcare, and that patients' views and experiences are integral to improvement efforts. The Picker Principles were codified in 1989 in response to the qualitative patient research conducted in 1988 that led to the design of the first Picker inpatient survey and a national study of patients' experiences of care in U.S. hospitals in 1989.

ELIGIBILITY

Picker Institute and the Gold Foundation have developed the Challenge Grant Program in cooperation with the Accreditation Council for Graduate Medical Education (ACGME). Residents and/or faculty from any graduate medical education (residency) program that is ACGME-accredited are eligible to apply to the Challenge Grant Program.

FUNDING LEVEL

During the 2012/2013 grant cycle, up to 4 deserving proposals that pursue the goal of enhancing patient-centeredness and humanism in medicine will receive a Challenge Grant from Picker Institute of up to \$25,000 for a project period of up to one year.

The grantees and/or their institutions will be required to provide (at a minimum) a 100% matching contribution to the proposed project in the form of financial resources, committed and dedicated measurable time by project staff, other approved matching commitments or all of the above. A Letter of Support is required from a Department Chair or Designated Institutional Official stating the intention to provide the matching funds.

Key Dates for the 2011-2012 GME Challenge Grant Cycle

DATE	MILESTONE
JANUARY 21, 2012	DISTRIBUTION OF GME CHALLENGE GRANT REQUEST FOR PROPOSAL
MARCH 9, 2012	DEADLINE FOR EMAILING LETTER OF INTENT (LOI) TO SUBMIT A FULL PROPOSAL
MARCH 30, 2012	NOTIFICATION OF REQUEST FOR FULL PROPOSAL
MAY 4, 2012	DEADLINE FOR SUBMITTING THE FULL GME CHALLENGE GRANT PROPOSAL VIA EMAIL
JULY 2, 2012	ANNOUNCEMENT OF AWARDS
JULY 30, 2012 THROUGH JULY 29, 2013	GME CHALLENGE GRANT PROJECT CYCLE (SUBJECT TO RECEIPT OF SIGNED GRANT AGREEMENT)
JULY 29, 2013	SUBMISSION OF GME CHALLENGE GRANT PROJECT FINAL REPORT

LETTER OF INTENT: MARCH 9, 2012

All applicants **must** submit a Letter of Intent (LOI) to the Picker Institute by March 9, 2012. Submission of the LOI is a **prerequisite** for the Challenge Grant award.

The LOI must succinctly explain, in **no more than two pages**, how the project expects to incorporate the patient's perspective and humanism into graduate medical education and care delivery. The letter of intent should address:

- 1) which of the eight Picker and/or Gold Foundation principles the proposal seeks to achieve, which ACGME competency is being addressed;
- 2) a project description, statement of need, target population (including estimate of number of medical professionals and trainees, as well as patients) and project methods.
- 3) a commitment to sustain and replicate the project after the one-year grant period;
- 4) a brief description of how you will assess project outcomes and
- 5) a brief statement of how you will disseminate results in and beyond your institution;
- 6) specification of an Always Event(s)[®]. (please view the Always Events website for additional information→ <http://alwaysevents.pickerinstitute.org>)

Electronic submission of LOI is required. LOIs should be sent to hhonor@pickerinstitute.org **on or before close of business on March 9, 2012**. Letters should be addressed to the Picker Institute Challenge Grant Committee. The letter may be included in the text of an e-mail or submitted as an electronic attachment. Word or PDF is appropriate. The LOI should not exceed 2 pages.

Always Events[®] are defined as procedural and substantive actions that should accompany every patient experience. The grants committee is looking for proposals that can assist in identifying Always Events[®] and demonstrating their efficacy. Picker Institute strongly encourages alignment with Always Events[®]. In preparing your proposal please keep in mind that Always Events are not merely things that the health care system/organization does but need to be reflected in the patient's experience. It is important that these experiences be documented.

The LOI must also include the following:

- Institution/financial liaison name, mailing address, telephone and fax numbers, e-mail address
- Principal investigator name, mailing address, telephone and fax numbers, and e-mail address

RECEIPT OF FULL PROPOSALS: MAY 4, 2012

Applicants must submit the following required materials:

- ⇒ Cover Sheet (attached)- this is a two page document
- ⇒ A Proposal (word limit: 2,000 words): the word limit pertains to the narrative portion of the proposal and does not pertain to attachments, CVs, bio-sketches, IRB statement, coversheet, budget or letters of support.
- ⇒ A Budget
- ⇒ Project Implementation Timeline broken down by month and including specification of deliverables
- ⇒ IRB statement
- ⇒ Curriculum Vitae for the Principal Investigator(s) and co-Principal Investigator; also, bio-sketches for primary project staff
- ⇒ Letter(s) of Support

Applicant's Proposal:

Proposals must include the following. Project description (not to exceed 2,000 words):

:

1. **Rationale for the project:** Applicants must provide a concise rationale stating the fundamental need the project is designed to address.
2. **Literature Review**
3. **Specification of the patient-centered aims** of the project, including identification of the Picker Principles, Gold Foundation and ACGME competencies that will be addressed.
4. **Specification one or more Always Event®.**
5. **Strategies for implementation, Identification of work product(s) and deliverables:** Applicants must describe the specific strategies, programs, or interventions that will be implemented to achieve the proposed advancement of patient-centered care. Applicants are encouraged to consider ways to include patients and families (e.g., patient and family advisors) as partners in the planning, implementation, and oversight of the proposed project.
6. **Outcomes and Evaluation:** Applicants must describe the expected outcomes and specific plans to evaluate the GME Challenge Grant initiative.
7. **Sustainability and Replicability:** Applicants must explain how the project will be sustained after the grant funding is completed. Applicants should also show the potential for project replication at their own and other institutions.
8. **Dissemination:** Applicants must describe how the work and results of their GME Challenge Grant initiative will be **robustly** disseminated, in a multi-faceted manner, to key audiences in the national/international medical education community. One required dissemination aspect, is submission of an abstract/manuscript to the Journal of GME; also, Picker requires that web-based dissemination be included.
9. **Institutional Review Board statement:** All applicants must indicate whether they have received IRB approval for their project proposal, or whether they have applied for such approval. If IRB has not yet been obtained, applicants should provide expected timeline for the decision.
10. **Institutional Cost-Sharing:** The grantees and/or their institutions will be required to provide a 100% matching contribution in the form of financial resources, committed and dedicated measurable time by project staff, other approved matching commitments or all of the above. The budget must clearly detail how the applicant or applicant's institution proposes to fulfill this requirement.
11. **Evidence of Institutional Support:** A letter of commitment and support is required from the Department Chair or other designated (authorized) institutional official to ensure institutional support for recipient's work. This letter must also demonstrate an intent to consider adoption of the project in other departments as appropriate. As a demonstration of support, this letter must include an agreement on project cost-sharing (see budget information for details).
12. **Curriculum Vitae/Bio-sketches:** CV for the Principal investigator and co-Principal Investigators, and bio-sketches for primary project staff members: A short (no more than 4 pages) CV for the Principal Investigator and co-Principal Investigator needs to be included. The shortened CV should include education, residency, fellowships, positions held, and all relevant presentations and publications, along with any other relevant accomplishments. Short bio-sketches for each primary project staff member; these should be no more than one page and should focus on experience applicable to the proposed project.
13. **Timeline:** Project Implementation Timeline broken down by month and including specification of deliverables. (please utilize the attached Timeline Template)

14. **Budget:** A budget must be included with the project proposal. Budget should include costs associated with planning, implementation, evaluation and dissemination of the project. Note on indirect costs: Picker Institute policy allows for grant funds to cover overhead costs at a rate not to exceed 10 percent of total direct costs. The 10 percent IDC is included within the \$25,000 grant fund, the IDC is not included outside of the \$25,000. The 10 percent allowance is intended to include space rental, furniture, equipment, heat, electricity, accounting services, library services and the like. Subcontracts with an institution and direct educational support (including fellowships, scholarships, tuition and stipends) are excluded from the indirect cost calculation.

SELECTION PROCESS

Proposals will be reviewed by the administrative offices of Picker Institute to ensure eligibility and completeness. An expert review committee, convened by Picker Institute and the Gold Foundation, will then evaluate proposals using the following criteria:

- ⇒ The extent to which the project/interventions are innovative and will advance patient-centeredness and humanism in graduate medical education residency programs and institutions that sponsor these programs;
- ⇒ The feasibility of the research/project design and methodology;
- ⇒ The quality of the evaluation and assessment process;
- ⇒ The potential that the research/project could be replicated in and disseminated to other residency programs/sites; and
- ⇒ The qualifications of the principal investigator and primary project staff.

The Challenge Grant Review Committee will make final selections of proposals for the Challenge Grants, utilizing the evaluative input of the expert reviewers and the following additional criteria:

- ⇒ The relevance and significance of the proposal to the purpose and goals of the Picker Institute / Gold Foundation Challenge Grant Program; and
- ⇒ The adequacy of the budget, timetable and other key resources.

Proposals deemed ineligible will not be accepted. Picker Institute will send notice to the applicant that their proposal has been rejected for failure to follow guidelines.

The actual number of Challenge Grants awarded will depend on the nature, quality and level of requests received in the 2012 Challenge Grant Program year. Grantees may be asked to present their findings at a Picker Institute Educational Workshop during the 2012 award cycle.

TERMS AND CONDITIONS

Grants will be contingent on the mutual agreement of Picker Institute and the grantee to applicable terms and conditions of grants, such as provision of proof of matching contribution, right to review and comment on potential publications, grantor acknowledgment, prior approval requirements, required fiscal and progress reports and so forth.

PROPOSAL SUBMISSION

It is required that submission of all the materials related to the proposed project be sent either in one electronic document by e-mail to Picker Institute (hhonor@pickerinstitute.org), or by registered letter. Upon being invited to submit a full proposal, all complete applications must be received by the May 4, 2012, deadline.

CONTACT

Ms. Hannah Honor H. RN, BSN, Challenge Grant Program Coordinator
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Picker principles of patient-centered care are:

Respect for patients' values, preferences and expressed needs

Patients want to be kept informed regarding their medical condition and involved in decision-making. Patients indicate that they want hospital staff to recognize and treat them in an atmosphere that is focused on the patient as an individual with a presenting medical condition.

- Illness and medical treatment may have an impact on quality of life. Care should be provided in an atmosphere that is respectful of the individual patient and focused on quality-of-life issues.
- Informed and shared decision-making is a central component of patient-centered care.
- Provide the patient with dignity, respect and sensitivity to his/her cultural values.

Coordination and integration of care

Patients, in focus groups, expressed feeling vulnerable and powerless in the face of illness. Proper coordination of care can ease those feelings. Patients identified three areas in which care coordination can reduce feelings of vulnerability:

- Coordination and integration of clinical care
- Coordination and integration of ancillary and support services
- Coordination and integration of front-line patient care

Information, communication and education

Patients often express the fear that information is being withheld from them and that they are not being completely informed about their condition or prognosis. Based on patient interviews, hospitals can focus on three kinds of communication to reduce these fears:

- Information on clinical status, progress and prognosis
- Information on processes of care
- Information and education to facilitate autonomy, self-care and health promotion
- Communication should always be empathetic and take in to account how a patient may react and interpret such information

Physical comfort

The level of physical comfort patients report has a tremendous impact on their experience. From the patient's perspective, physical care that comforts patients, especially when they are acutely ill, is one of the most elemental services that caregivers can provide. Three areas were reported as particularly important to patients:

- Pain management
- Assistance with activities and daily living needs
- Hospital surroundings and environment kept in focus, including ensuring that the patient's needs for privacy are accommodated and that patient areas are kept clean and comfortable, with appropriate accessibility for visits by family and friends

Emotional support and alleviation of fear and anxiety

Fear and anxiety associated with illness can be as debilitating as the physical effects. Caregivers should pay particular attention to and engage their patients in dialogue around such issues as:

- Anxiety over clinical status, treatment and prognosis
- Anxiety over the impact of the illness on themselves and family
- Anxiety over the financial impact of illness

Involvement of family and friends

Patients continually addressed the role of family and friends in the patient experience, often expressing concern about the impact illness has on family and friends. These principles of patient-centered care were identified as follows:

- Accommodation, by clinicians and caregivers, of family and friends on whom the patient relies for social and emotional support
- Respect for and recognition of the patient “advocate’s” role in decision-making
- Support for family members as caregivers
- Recognition of the needs of family and friends

Continuity and transition

Patients often express considerable anxiety about their ability to care for themselves after discharge. Meeting patient needs in this area requires staff to:

- Provide understandable, detailed information regarding medications, physical limitations, dietary needs, etc.
- Coordinate and plan ongoing treatment and services after discharge and ensure that patients and family understand this information
- Provide information regarding access to clinical, social, physical and financial support on a continuing basis

Access to care

Patients need to know they can access care when it is needed. Attention must also be given to time spent waiting for admission or time between admission and allocation to a bed in a ward. Focusing mainly on ambulatory care, the following areas were of importance to the patient:

- Access to the location of hospitals, clinics and physician offices
- Availability of transportation
- Ease of scheduling appointments
- Availability of appointments when needed
- Accessibility to specialists or specialty services when a referral is made
- Clear instructions provided on when and how to get referrals

The Arnold P. Gold Foundation criteria to advance humanistic, patient-centered care:

- shows respect for the patient’s viewpoint ;
- displays effective and empathetic communication and listening skills
- demonstrates sensitivity in working with patients and family members of diverse cultural and social backgrounds;
- is sensitive to and effectively identifies emotional and psychological concerns of patients and family members;
- engenders trust and confidence;
- adheres to professional and ethical standards; and
- displays compassion and respect throughout the patient interaction.

ACGME Core Competencies

The improvement should also be directly applicable to one of the following ACGME core competencies.

- Patient Care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health
- Interpersonal and Communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals
- Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

Picker Institute/Gold Foundation

Cover Sheet

Graduate Medical Education Challenge Grant Program Matching Grant Project Proposal

Project Title:	
Principal Investigator	
Title / Department:	
Name of Grantee Institution:	

Applicant Contact Information

Mailing Address:	
Telephone Numbers:	
Fax Numbers:	
Email Address:	

Institutional Contact Information (person authorized to negotiate/sign Grant Agreement)

Name:	
Title:	
Telephone Number:	
Fax Number:	
Email Address:	

GME Challenge Grant Program

Matching Grant Project Proposal

Area of Specification	Description
Project Title	
<p>Briefly Describe your Challenge Grant Project</p> <p>“Project that illustrates specific interventions and innovations in graduate medical education programs that facilitate the development of best practices regarding patient-centered healthcare and/or humanism in medicine.”</p>	
<p>Describe the basic plan for implementation</p> <p>“Strategies, programs, or interventions that will be implemented to achieve the proposed advancement of patient-centered care.”</p>	
<p>Describe the measures that will be utilized</p> <p>“Specify the measures that will be utilized to evaluate the GME Challenge Grant initiative.”</p>	
<p>Please tell us how you will overcome the challenges the new ACGME resident hours guidelines will pose with regards to implementation of your initiative.</p>	
Requested Grant Funding Amount	
Matching Grant Funds	