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Site visits after July 1, 2011: an update

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On July 1, 2011, new Common Program Requirements for resident duty hours, supervision and other elements of the learning environment went into effect. Programs preparing for a site visit should be aware of several changes in the site visit process.

Assessing the 2011 Common Program Requirements

In keeping with the strategic goal of reducing burden in the accreditation process, the ACGME added no new Program Information Form (PIF) items to assess compliance with the new Common Requirements. Data collection is being accomplished through a brief set of questions on resident duty hours, supervision and other key elements of the new standards program will access and complete through the Accreditation Data System (ADS). The questions were made available in late June, and are part of the ADS section of the PIF. For programs undergoing a site visit in the coming 6 to 9 months, this new ADS section, information from the 2011 ACGME Resident Survey, review of documentation, interviews with program and institutional leaders, faculty and residents will constitute the data elements related to the new common standards that will be verified and clarified during the site visit.

To ensure that policy and procedure documents pertaining to the new standards are available, an updated document list has been included with the site visit announcement letter. The list also may be obtained from the Department of Field Activities "Site Visit" web page after July 11, 2011.

For programs site visited in 2012, the 2012 Resident Survey, and a Faculty Survey that will be implemented in late 2011, will include added questions on compliance with the new Common Program Requirements.

Use of the Tracer Method

Beginning in July 2011, the ACGME field representatives will use the “tracer” method to verify and clarify information during the site visit. Tracer is used by several health care accrediting organizations to assess the functioning of key processes and, by “tracing” the care of individual patients, to ensure the accreditation process is more patient-focused. Use of this approach by the ACGME field staff is intended to shift the emphasis of the site visit from the review of policies and documentation to actual processes and functions to which the policies pertain. It also seeks to promote an enhanced focus on programs’ continuous improvement efforts.

Tracer will be used to assess program/institutional processes related to compliance with the new Common Program Requirements, including monitoring of resident hours, and how programs have implemented the new standards on supervision, transitions of care and teamwork. Application of the tracer method during program site visits will entail document review and interviews with the program director, residents, faculty, and potentially coordinators and others. The field representative will complete this activity during the regularly scheduled interviews and reviews of documentation.

While the members of the field staff already ask about and report on programs’ continuous improvement efforts, an advantage of the tracer method is that it focuses on the performance of important processes, such as the delegation of progressive responsibility to residents, interventions to address duty hours non-compliance identified via program or institutional monitoring, improvement in areas that were the subject of citations during the last review, or instances of potentially significant non-compliance with the duty hour standards or other program requirements. As these processes are examined, tracer will assist the field representative in identifying and reporting to the RRC reviewer good performance or problems in elements of a process or at the interface between processes.

Pilot of collecting resident/fellow input during site visits moves to implementation

Since the spring of 2010, the ACGME Department of Field Activities has conducted a pilot to explore whether a consensus list of residents’ or fellows’ perceptions of program strengths and opportunities for improvement, collected immediately before the site visit, would be useful in setting the stage for the site visit interview. The field representative asked the program director to forward a request to the residents/fellows to compile a list of up to five strengths and up to five opportunities for improvements for further discussion during the interview.

Depending on the program, members of the field staff have opted for a single, program-level list or asked residents to compile separate consensus lists by year of training. The list is confidential, and residents or fellows are asked to e-mail it to the field representative, or simply bring it to the site visit interview. The collection of resident-perceived strengths and opportunities for improvement is done only for program site visits, not for institutional review visits.

The use of the resident consensus lists during the site visit is moving from pilot to implementation, starting in July of 2011. The ACGME's site visit announcement letters for programs scheduled after November 1, 2011 have been revised to include a request that the program director ask the residents to compile a list (or separate lists by year of training) and send it directly to the field representative. In the next few months, the members of the field staff will continue to send requests for the resident consensus list in their communication with programs.

A significant benefit of the consensus lists is that they offer the site visitor insight into trainees' perceptions of their program's strengths and opportunities for improvement. This information is used to focus the questions during a section of the resident interview. The field representative also verifies and clarifies this information during the other interviews and data collection activities during the site visit.

The information in the resident consensus lists also offers the ACGME insight into residents' unique perspective on their program and the accreditation standards. Residents/fellows and program directors have commented favorably on the way the pilot has increased trainees' sense of feeling engaged in the site visit process, particularly for larger programs where many residents do not participate in the site visit interview.

Site visit interview sequencing pilot expands

Another Department of Field Activities pilot that is being expanded is a project to change the sequencing of the site visit interviews. This began with a small group of field representatives, who tested a site visit interview sequence in which residents/fellows were interviewed early in the site visit day, after a brief introductory meeting with the program director. Besides focusing on verification and clarification of the PIF, the remaining interviews, review of data, and tours of facilities were also used to verify and clarify information obtained during the resident/fellow interview.

The initial test of this approach was successful, with residents appreciating the opportunity for more substantial input into the site visit, and program directors indicating

that the interview and review of the PIF at the end of the visit day was more efficient, allowed for better reconciliation of potentially divergent information, and focused more on the program than on minor discrepancies of the data in the PIF.

An expanded pilot will have a larger number of the members of the field staff vary the sequencing of the interviews, and collect data on which approach is best from a feasibility, practicality and information quality perspective. ■

Consistent and fair policies for dealing with disruptive physicians

Julie A. Jacob, ACGME Manager of Communications

Physicians who yell, throw things, and intimidate and insult their colleagues makes it difficult for health care professionals to work together in teams and negatively affect patient care and resident learning. That is why hospitals should have clear and consistent procedures for dealing with disruptive physicians, said Joseph Gilhooly, MD, professor of pediatrics and vice chair for education at Oregon Health and Science University. Dr. Gilhooly presented the session “Disruptive Physicians: Whose Problem is It?” at the 2011 ACGME Annual Educational Conference, held March 3-6 in Nashville, Tennessee.

The American Medical Association in 2000 defined disruptive behavior as “personal conduct, whether verbal or physical, [that] negatively affects or that potentially may negatively affect patient care... this includes but is not limited to conduct that interferes with one’s ability to work with other members of the health care team.”

“We work in health care teams, no more cowboys,” said Dr. Gilhooly. “You have to work together and you can’t work together if you’re yelling at one another.” Disruptive behavior includes yelling, insulting or berating other members of the health care team, throwing instruments or charts or sexually harassing coworkers.

Studies have shown that about 5% of physicians engage in disruptive behavior. While that may seem like a low number, Dr. Gilhooly pointed out that in a teaching hospital with 600 residents there may be 30 who are being disruptive.

Though disruptive behavior cuts across all specialties, it is more common among general surgeons, cardiovascular surgeons, and neurosurgeons. They act out for a

many reasons, he said, including stress, depression, personal problems, substance abuse, narcissism or high expectations for perfectionism in themselves and others. Disruptive physicians erode staff morale and contribute to employee turnover, said Dr. Gilhooly. About 18% of nurse turnover is due to verbal abuse, he noted. Disruptive physicians make it more difficult for residents to learn and are poor role models. Other team members are more likely to withhold information about patients due to fear, anger or, in some cases, revenge in response to disruptive behavior.

Disruptive behavior has been linked to diminished quality of patient care, medical errors, adverse events, reduced patient safety and increased patient mortality, according to a 2008 study of Veterans Administration hospitals. Because disruptive physicians can affect teamwork and patient care, it is important that hospitals educate physicians about appropriate and inappropriate behavior and have clear, equitable policies in place to deal with disruptive physicians. The Joint Commission requires hospitals to create codes of conduct for staff, as well as policies and procedures to address disruptive behavior.

Dr. Gilhooly outlined a process for progressive intervention when dealing with disruptive physicians. Intervention should begin with an informal talk between the disruptive physician and his or her supervisor to discuss the inappropriate behavior and try to pinpoint underlying stressors that may be triggering the behavior. If the physician's behavior persists, intervention should progress to suspension of privileges, referral to a medical staff wellness committee, a disciplinary hearing for repeated disruptive behavior that puts patient at risk and, finally, referral to the state medical board.

“Establish a code of conduct, identify the origin of disruptive behavior and work on solutions. Interventions should be applied consistently and equally,” said Dr. Gilhooly.



Patient-centered medical homes help improve patient care, says conference presenter

Julie A. Jacob, ACGME Manager of Communications

Patient-centered medical homes (PCMH) help improve the quality of health care and reduce costs, said a speaker at the 2011 ACGME Annual Educational Conference. Richard C. Wender, MD, the alumni professor and chair of the Department of Family and Community Medicine at Thomas Jefferson University and past national president of

the American Cancer Society, presented a session called “Integration of Health Care Teams in the Medical Home.” He discussed how PCMHs differ from regular medical care and described the Jefferson Family Medicine’s PCMH.

A PCMH is a way of providing care to patients that involves interprofessional teams and tightly coordinated care. The PCMHs have the following components:

- An ongoing relationship with a primary care physician;
- Comprehensive health care teams consisting of professionals such as physicians, physician assistants, nurse practitioners, nurses, pharmacies and behavioral health specialists;
- Excellent access to care through extended hours, e-mail consultations, and same-day appointments;
- A goal of informed, engaged patients;
- Extensive use of health information technology;
- Patient health registries and automated systems to remind patients about needed care;
- Constant patient feedback; and
- Performance measurement.

Studies tracking the impact of PCMHs have shown that they can lower health care costs and improve patient care. Community Care of North Carolina in Raleigh manages community health care programs for Medicaid recipients, and matched patients with PCMHs. As a result, the state has saved \$400 million in Medicaid costs, and Medicaid patients have had a 40 percent decrease in hospitalizations for asthma, a 15 percent improvement in diabetes care measurements and a 16 percent reduction in emergency room visits.

In another example, the creation of a PCMH at Health Partners Medical Group in Minnesota resulted in a 350 percent reduction in appointment waiting times, a 39 percent decrease in emergency room admissions, a 129 percent increase in patients following best care practices for diabetes, and a 48 percent increase in patients receiving best care practices in heart disease.

In 2009, the National Center for Quality Assurance named Jefferson Family Medicine as a Level 3 Primary Care Medical Home, the first large academic family medicine department in the country to receive the designation. The family medicine PCMH program, which treats many Medicaid and uninsured patients, has an interdisciplinary diabetes group visit program, interprofessional health care teams, a quality coordinator

who manages population outreach, a case manager, and same-day availability for chronic as well as acute care. Since the program began, breast cancer screenings in insured patients have increased 7.5 percent, cervical cancer screenings have gone up 8.4 percent, intermediate diabetes outcomes have improved and rates of other preventive screenings have also increased.

To make PCMHs viable on a large scale, medical payment methods will need to be changed to include payments based on quality improvement and care coordination, as well as other payment models such as bundled payments and global capitation, said Dr. Wender. However, the structure of residency education may not be keeping pace with changes in health care, including PCMHs. For instance, it is crucial that health care professionals are given more training how to work in interprofessional teams. “We must expect and nurture interdisciplinary collaboration,” said Dr. Wender.

He is optimistic that insurers will support PCMHs and provide more reimbursement for them. “This is one place where our insurers are aligned,” Dr. Wender noted. “I believe they will be open to new models of care and family medicine is more prepared for this than other specialties.” ■

Coaches provide feedback and space for reflection for residents in the Dartmouth Leadership Preventive Medicine Residency

Julie A. Jacob, ACGME Manager of Communications

In sports, a coach helps an athlete perform at his or her highest level. In the Dartmouth Leadership Preventive Medicine Residency (LPMR) program, faculty members at Dartmouth Hitchcock Medical Center who serve as coaches help residents in the program achieve their highest level of learning. At a session at the 2011 ACGME Educational Conference, Tina Foster, MD, MPH, MS, associate director of the LPMR program and Kathy Kirkland, MD, an infectious disease faculty member who serves as a coach, explained how coaching works and discussed its benefits to an audience of about 75 program directors, coordinators and designated institutional officials.

The Dartmouth LPMR is a two-year program in which residents earn a master’s degree in public health and learn how to lead improvements in health care, while simultaneously participating in a residency program for their chosen specialty. During

the second year of the program, residents develop and lead an improvement project in a clinical setting. Coaches meet regularly with the residents throughout the program.

A coach-resident relationship is not quite the same as a mentoring relationship, Dr. Foster and Dr. Kirkland noted. Unlike mentors, whom residents choose on their own, the program's leaders match each resident with a coach. The coaching relationship is also more structured than an informal mentoring relationship, they said. A coach must agree to coach a resident throughout his or her two years in the program. Coaches, who have supported time for their work, are expected to meet with their resident at least once every two weeks, as well as attend writing collaborative, work-in-progress sessions and journal club sessions with their mentee.

"Coaches have to be committed to being part of a community ... you are expected to attend all the leadership seminars with the residents and all the writing collaborative sessions with the residents," said Dr. Kirkland. During the coaching sessions, the residents discuss and reflect upon their experiences, while the coaches ask questions and give feedback. Coaches also provide a "space" for reflection, said Dr. Foster.

When asked to describe the coaching relationship, Dr. Foster and Dr. Kirkland said, residents have said that it "is like being on a nature hike with a docent who suggests looking under rocks to see what you might have missed on your own," "produces a very rich set of reflections, insights and new discoveries," and that it is "similar to having a sage and dispassionate guide on your journey." Coaches in turn, have described being a coach as "fostering personal growth of the trainees as well as personal awareness and self-mastery by the coach" and "relying on mutual trust and respect" and "providing a learning experience for both coach and student."

Over the 8 years since the residency and the coaching program began at Dartmouth, program leaders have observed that the mutual commitment to improving health care bonds together each coach-resident pair. Dr. Foster and Dr. Kirkland described this commitment to improving health care as a "third thing," referring to the title of an essay in which poet Donald Hall described how the love of poetry was a "third thing" in his marriage to fellow poet Janet Kenyon.

Dr. Foster and Dr. Kirkland ended the session by asking participants to role play being a coach and resident by taking turns discussing a challenging situation, or one that tied into larger professional issues. ■

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Book Review: “*Leading Change in Healthcare*”

Peter Block’s foreword sums up the tenor of *Leading Change in Healthcare*, “The change efforts chronicled in this book demonstrate that when you focus on relationships you can produce amazing outcomes.”

Behind the title is a book written for health care managers, but equally pertinent to the leaders of residency programs and sponsoring institutions. *Leading Change in Healthcare* offers practical guidance for how to transform one’s managerial and administrative skills using approaches that are empirically-based, people-centered and relevant to improving the patient care and learning environment. The editors, Suchman, Sluyter and Williamson, have extensive experience in leading change in health care organizations. The main strategy proposed and described in the book is “Relationship-centered Administration,” including approaches to delegation and accountability that are sensitive to the relationships among the participants. Other key themes include the concept of “emergent design” and the value of the collaboration. The book’s perspective is that “leadership is more about taking the risk of acting in a new way than having the right answers.”

A strength of the book is that it demonstrates how the principles of relationship-centered administration are put into action using case studies of organizational change resulting from new ways of communicating and forming relationships. The case studies include hospitals, primary care settings, professional education and international non-governmental organization.

Suchman AL, Sluyter DJ, Williamson PR. Eds. *Leading Change in Healthcare*. Forewords by Peter Block, Carol Aschenbrener, and Ralph Stacey. 2011. Ashland, Ohio: Radcliffe Publishing.