

Be Prepared

Thoracic Surgery Directors Association

January 24, 2009

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Objectives of this presentation:

- Understand the components of the peer review process for accreditation of your residency program
- Know the roles and understand the responsibilities of accreditation leaders
- Translate ideas from this presentation into your own program
- Implement a reasonable timeline to organize your work

Objectives, cont.

- Evaluate the quality of your program's objectives
- Demonstrate an awareness of the common problems and misconceptions about the standards and PIF completion
- Troubleshoot your own PIF
- Be confident about your next site visit

Peer evaluation process

- Subject to codified procedures developed by the ACGME
- Residency Review Committee for Thoracic Surgery
 - 7 members, including a resident
 - Ex officio members: ABTS and the ACS non-voting
 - RRC chair and vice chair
 - RRC Executive Director, non-voting

RRC Charge

- Evaluate programs consistent with the common and specialty-specific Requirements
- Comply with ACGME policies
- NB: are subject to review by the ACGME Monitoring Committee

RRC Chair

- Conducts the meeting
- Ensures compliance with Requirements and policies
- Responsible for fair and non-biased evaluation based upon the standards
- Represents the RRC at ACGME and at professional national organizations
- Direct communication with PDs and others

7 Voting RRC Members

- Evaluate programs, prepare notes prior to meeting, submit to RRC office
- Staff compiles information
- Chair conducts orderly evaluation of each agenda item consistent with policies
- Staff prepares actions; chair approval
- Distribution to PD and DIO

Conflicts of Interest

- RRC members are charged to be fair and equitable in their decision-making
- They should take care in the level and breadth of their discussions with you
- PDs should be sensible about contacting any RRC member and “generally” should limit major contact to the Chair

Program Confidentiality

- The ACGME website lists open information
- All else is your own business
- Take care about discussing critical matters outside your program/institution
- Small specialty “chit chat”

RRC Executive Director

- Staffs the RRC and others
- Administers the ACGME accreditation process
- Supervises support staff
- Primary ACGME contact
- Multiple other duties at ACGME
- Does not vote on RRC actions

Site Visitor

- ACGME employee
- Reports, clarifies, and verifies information; writes the report
- Knows the Requirements
- Knows the Policies
- Skillful interviewer who elicits similar information from several groups/persons to discern congruence (or lack of)

Designated Institutional Official

- Responsible for the:
 - Function of the institutional GME system
 - GMEC/Internal Review Process
 - Institutional and program compliance
 - Fiduciary and financial duties to the institution (varies)
 - Signature authority to ACGME (co-signs everything)

DIO/ GMEC Oversight Is Valuable

- They can help to get you what you need /fix what is broken
- Many GMEC's have ex-RRC members and others who are experienced and provide excellent advice
- Many GMEC's do excellent internal reviews and catch problems before your site visit

GMEC Functions

- Identify all areas of noncompliance before the site visit
 - Monitor improvement and correction
 - Provide educational support
 - Provide faculty development
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- NB: is a great way to get educational development for mentoring faculty and new PDs

Internal Review Process

- Must occur halfway through the accreditation cycle (check your last accreditation action)
- Program completes paperwork for evaluation by the GMEC
- GMEC interviews the PD, faculty, and residents
- GMEC writes an evaluation report
- PD reacts, improves, and corrects

Ultimate goal of internal review

- Prepare your program in advance for the upcoming site visit, correct any areas of noncompliance, give sufficient time for improvement, show incremental program improvement, and communicate the state of your program internally

Sharing

- Sharing within institutions and across specialties promotes collegiality, shows different program strengths, supports cross-learning, supports good education, decreases individual workload and on and on

Impact on the PD

- Everything goes through the DIO and the GMEC (reference the PR II.A.4n)
- Financial matters regarding the residency must be approved by the DIO
- No more “lone rangers”

Where does the buck stop? (aka who takes the blame)

- The program director vested with authority for compliance and quality of the program
- Reference the PR II.A.3 for 5 qualifications
- Reference the PR II.A.4 for 22 duties and 16 additional sub-duties

PD duties underscored

- The verbs for your duties include:
- Oversee, approve, evaluate, monitor, prepare and submit, ensure compliance, verify, implement, distribute, adjust, comply, be familiar with, obtain, devote, ne responsible and 7 ensures

The good PD

- Knowledge of the accreditation process
- Respects peer evaluation
- Knowledge of the requirements
- Values a good internal review
- Uses the DIO appropriately
- Political savvy within institution
- Ensures faculty development

Good Faculty

- Subject expert
- Skilled clinician, researcher, or scientist
- Active publication list
- Follows scientific development in the field
- Reads extensively
- Interests broader and beyond the discipline

Good faculty, cont.

- Knows the teaching-learning process
- Prepares carefully to teach
- Expects more from residents
- Motivates residents
- Good communicator
- Creates a learning environment “free from stress”

Good faculty, cont.

- Permits residents to make a decision and then defend it
- Believes each resident can learn (until proven otherwise)
- Is open and candid
- Treats residents with dignity
- Expects residents to evaluate their efforts first
- Avoids arbitrariness

Good faculty, cont.

- Bib for the past several faculty slides:
 - Some characteristics taken from K Eble, 1988
 - Others from personal unscientific survey of many residents

The bottom line is:

- If you are a named faculty member:
- -teaching is a part of your job
- -research/scholarly activities of some kind are required (some must show upper level scholarly activity)
- -faculty development required locally
- -definitive efforts and support must be documented by each

Teaching Cautions

- Some faculty are great teachers and love it; others are not and have other needed skills
- Some are great clinical teachers and others are better in the classroom
- How long has it been since anyone evaluated faculty teaching? Is this an evaluation component?

Teaching cautions, cont.

- My opinion:
- -most residents do not have the background to plan and implement your lecture series without supervision
- -residents should not be responsible for all of the presentations and teaching in your program
- Faculty instruction is mandatory for good residency education
- **NB: Again, the single most common resident comment I found this past year is that residents want more direct faculty teaching**

- Getting ready for the site visit and preparing the documents

Timeline Components

- Accreditation Action >
- Interim response to RRC and date >
- Mid-point Internal review by GMEC >
- Interim monitoring and internal reports to the GMEC >
- Program annual evaluation meetings >
- Preparation of the next PIF

Good staff support

- Absolutely necessary
- Well qualified
- Experienced

- NB: confer duties based only upon staff abilities

General issues with PIF completion

THE PREPARERS

- Must be able to interpret the requirements
- Should read them
- Must answer the questions asked
- The answer must reflect the reality of the program at the time

NB: THERE ARE COMMON REQUIREMENTS WITH A TWIST

GENERAL ISSUES, CONT.

- More than 1 person should be responsible
- Issues re' dividing the document among several people
- Faculty and resident communications
- The PIF should be an open department document, i.e., faculty and residents should read the documents and must know the program policies

GENERAL ISSUES, CONT.

- GIVEN SOME OF THE NEW QUESTIONS, IT IS MANDATORY THAT MORE THAN THE PD COMPLETE THE DOCUMENT
- THIS IS PARTICULARLY TRUE WITH ANSWERS REQUIRING EXAMPLES OF COMMUNICATION, SYSTEM BASED PRACTICE, AND PRACTICE-BASED LEARNING
- NB: THE PD MAY NOT KNOW ALL THAT IS GOING ON IN THE PROGRAM OR ON HOSPITAL COMMITTEES THAT WOULD CONTRIBUTE TO THE PIF

MY BIAS, SUBSTANTIATED BY THE RESEARCH

- A GOOD EVALUATION SYSTEM HELPS TO DRIVE A GOOD RESIDENCY PROGRAM (OR ANY OTHER EDUCATIONAL PROGRAM FOR THAT MATTER)

PROGRAM EVALUATION

- DOES NOT SIMPLY “SATISFY THE REQUIREMENTS”
- DOES IDENTIFY STRENGTHS AND WEAKNESSES
- DOES TAKE STEPS TO IMPROVE THE QUALITY OF THE PROGRAM
- DOES DOCUMENT WHAT YOU HAVE DONE
- DOES CHECK TO SEE IF THE ACTIONS HAVE REALLY MADE IT BETTER
- **NB: THE PRs CALL FOR “ACTION PLANS”**

USING NEW EVALUATION SYSTEMS

- POSITIVES
 - NO PAPER (BUT PAPER IS STILL OKAY)
 - EASIER TO MONITOR COMPLETION
 - SET DEADLINES
 - NAG FACULTY
 - FACULTY ARE IDENTIFIED
 - CAN DOWNLOAD AND SAVE IN ONE PLACE
 - PROGRAM SATISFIES THE REQUIREMENTS

USING EVALUATION SYSTEMS

- NEGATIVES
 - SOME FACULTY NOT COMPUTER SAVVY
 - SIMPLISTIC CRITERIA FOR SOPHISTICATED SPECIALTIES
 - LIKERT RATING SCALES
 - TENDENCY TOWARDS POOR RELIABILITY
 - THE “SHOE DOESN’T FIT” ALL PROGRAMS
 - FEWER WRITTEN COMMENTS
 - FACULTY IDENTIFIED AND MAY FEEL THREATENED
 - THE PROGRAM SATISFIES THE REQUIREMENTS

THE EVALUATION BOTTOM LINE

- YOUR SYSTEM WORKS
 - IT IS NOT TOO COMPLICATED
 - YOU ARE NOT PAYING “LIP SERVICE”
 - COMMENTS AND ACTIONS ARE FAIR AND BALANCED
 - SINCERE IMPROVEMENT OCCURS
 - YOUR FACULTY EVALUATE
 - YOUR FACULTY CONTRIBUTE
 - RESIDENTS KNOW YOU ARE SINCERE
 - REMEDIATION OCCURS
 - UNSUITABLE RESIDENTS ACOUNSELED
 - YOUR INSTITUTION SUPPORTS WHAT YOU NEED

FACULTY EVALUATION MEETINGS

- CAUTIONS

- DO THE COMMENTS MADE VERBALLY DURING THE FACULTY MEETING MATCH THE WRITTEN EVALUATIONS THAT RESIDENTS MAY HAVE ALREADY SEEN?
- CARE RE' NEGATIVE EVALUATIONS
- NECESSARY TO REINFORCE RESIDENT POSITIVES
- PROGRAM NEED TO ESTABLISH A PAPER TRAIL OF FAIRNESS AND CONSISTENCY

DO YOUR FACULTY KNOW HOW TO TEACH?

- SOME FACULTY ARE GREAT AND LOVE IT; OTHERS ARE NOT (FOR VARIOUS REASONS)
- SOME ARE BETTER CLINICAL TEACHERS, OTHERS ARE BETTER IN THE CLASSROOM
- HOW LONG HAS IT BEEN SINCE YOU AT LEAST BRIEFLY DISCUSSED/REVIEWED EDUCATIONAL METHODS WITH THEM?

RESIDENT TEACHING

- RESIDENTS IN GENERAL DO NOT HAVE THE BACKGROUND TO PLAN AND IMPLEMENT YOUR LECTURE SERIES WITHOUT SUPERVISION
- RESIDENTS SHOULD NOT BE RESPONSIBLE FOR ALL OF THE PRESENTATIONS AND TEACHING IN YOUR PROGRAM
- FACULTY INSTRUCTION AND SUPERVISION IS MANDATORY FOR GOOD EDUCATION
- **NB: THE SINGLE CONSISTENT RESIDENT COMMENT I FOUND THIS YEAR AND LAST YEAR TOO (WITH FEW EXCEPTIONS) IS THAT ALL RESIDENTS WANT MORE DIRECT FACULTY TEACHING**

Bad things

- Copying the last PIF
- Careless last minute writing
- Unsupervised juniors responsible for the PIF
- Lack of PD oversight
- PIF content is not real
- Lack of communication with faculty and residents
- Cover ups of major noncompliance
- Ignoring areas of noncompliance

More bad things

- Inaccurate data
- Incomplete documentation
- Assuming you know the answer
- Answering the question wrong
- Not answering the question
- Not knowing what's going on
- Not cross checking the PIF with your policies

Still more

- Noncompliance with duty hours
- -monitoring matters
- -documentation matters
- -resident ethics
- -faculty ethics
- -resident ACGME web-survey
- -the great case scenario

Still more

- Handing in a late draft of your PIF to the DIO

The End

- THANKS

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