



The Program Self-Study

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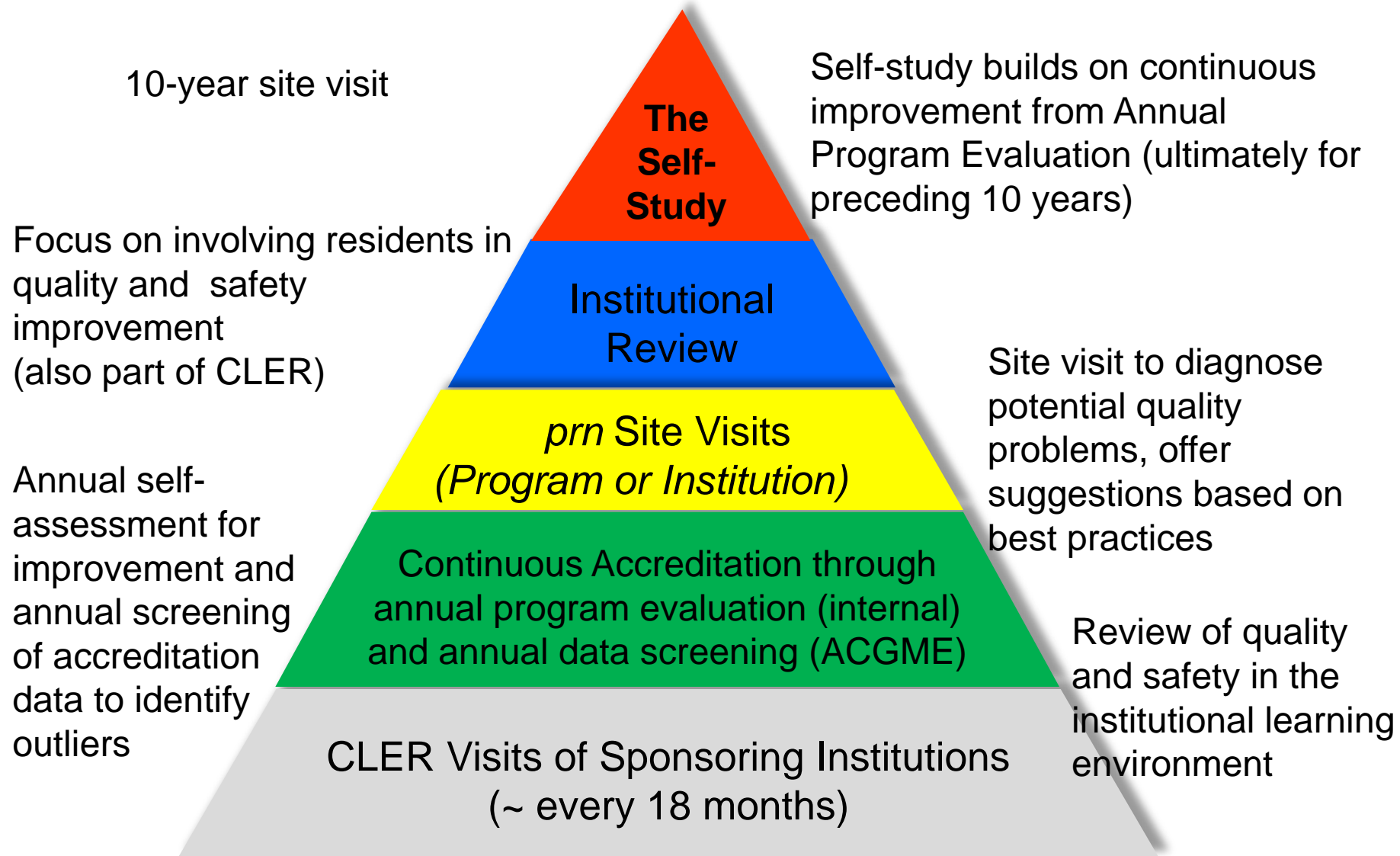
DISCLOSURES

- Employed by ACGME
- Senior Scholar at the University of Illinois Chicago
- No other activities requiring disclosure

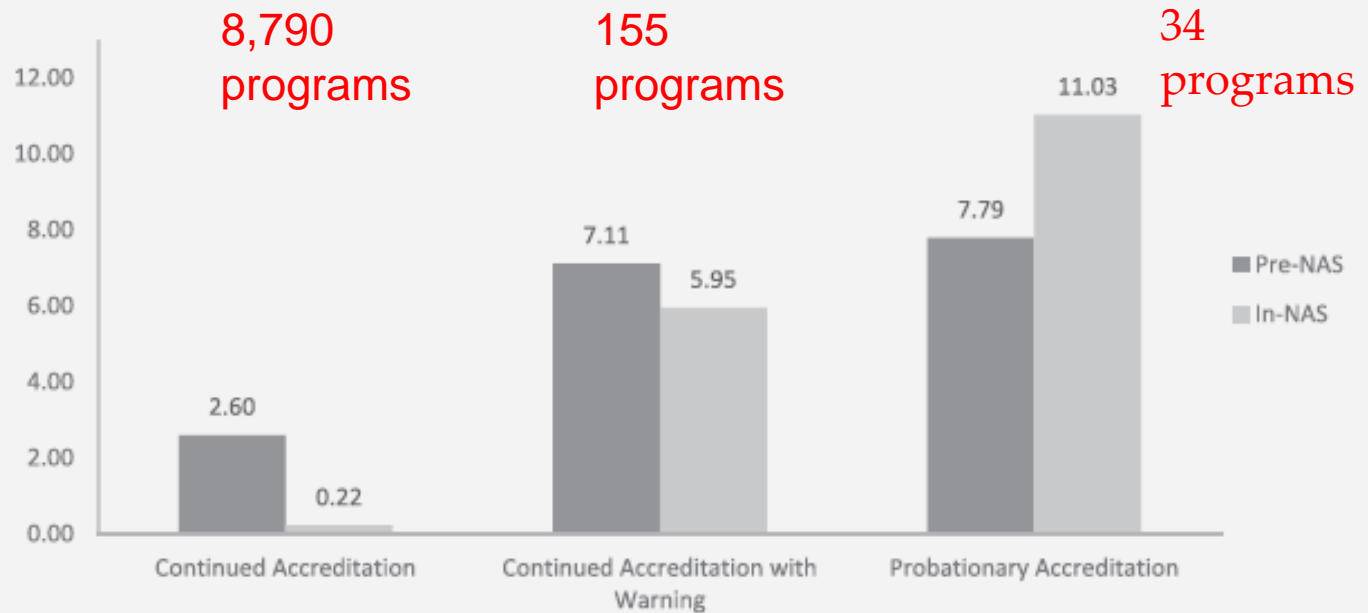
OVERALL WORKSHOP AIMS

- Discuss program improvement through the annual program evaluation and the self-study
- Describe how program how program aims, and a review of program context can serve as springboard for program improvement.
- Demonstrate aggregating and interpreting data, prioritizing area for improvements, and selecting evaluation approaches to measure the outcome of interventions.
- Articulate steps for building longitudinal improvement data, including tracking of action plans.
- Activate an improvement plan and appropriate activities for a specific program.

THE BUILDING BLOCKS OF THE NEW ACCREDITATION SYSTEM



LIMITS OF A CITATION-BASED APPROACH TO IMPROVEMENT: PROGRAMS ON FULL ACCREDITATION BY # OF CITATIONS

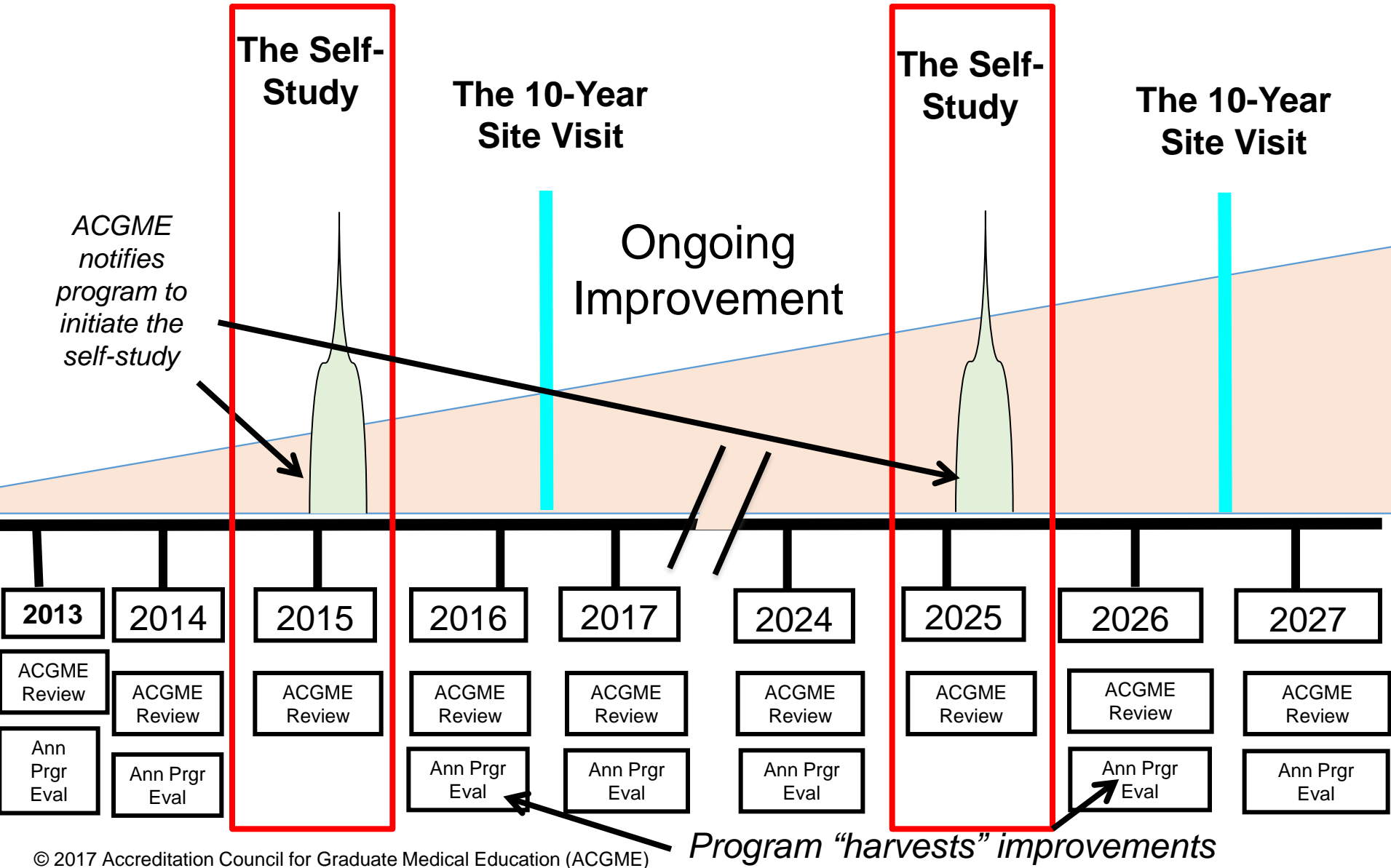


FIGURE

Average Number of Citations Issued by Accreditation Status (Pre-NAS and In-NAS)

Abbreviation: NAS, Next Accreditation System.

EVERY 10-YEARS, A MORE COMPREHENSIVE SELF-STUDY AND A 10-YEAR SITE VISIT



THE CORNERSTONE OF PROGRAM IMPROVEMENT: THE ANNUAL PROGRAM EVALUATION

- Formal, systematic evaluation
- Program Evaluation Committee (PEC)
- Program Director, ≥ 2 Faculty, ≥ 1 Resident/Fellow, (PC)
- The program must monitor ***and*** track:
 - **Resident Performance**
 - **Faculty Development**
 - **Graduate Performance**
 - **Program Quality**
- Longitudinal data/action plans from the annual program evaluation provide the foundation for the self study

THE ELEMENTS OF THE SELF-STUDY

Program Description

- Succinct depiction of the program

Program Aims

- Goals of the program
- What does the program strive to “produce?”

Activities in Furtherance of the Aims

- List of actions or projects aligned with aims

SWOT Analysis

- An environmental assessment (strengths, areas for improvement, opportunities and threats)



- **Program and institutional leaders' views of key expectations for the program**
 - What kind of graduates does the program produce, for what kinds of settings and roles?
 - How does our program differentiate itself from other programs in the same specialty/subspecialty?
- **Extension of our program or department's/division's mission statement**
- **Program can begin with the program's description on its web page**
 - What do we like and want to keep, what do we want to change?

WHY IT IS IMPORTANT TO ARTICULATE AIMS

- Ensure alignment of our graduates with needs of patients and health care system
- Promote tailoring of our program to ensure that our graduates achieve the learning outcomes necessary for their intended roles and practice¹
 - If you intend to produce physician scientists, is your curriculum and mentorship system tailored in this way?
- Program Aims are a requirement of the self-study process in the new accreditation system

1. Hodges BD. “A *Tea-Steeping* or *i-Doc* Model for Medical Education?,” Acad Med 85(9) Sept Suppl 2010, pp. S34-S44.

THE ELEMENTS OF THE SELF-STUDY (2)

Action Plans

- Longitudinal data/action plans from prior annual program evaluation provide the foundation for the self study

5-Year Look Back and 5-Year Look Forward

- Review of program revisions and achievements
- Defining the five-year strategic plan

Summary of Self-Study Approach

- How the self-study was conducted
- Who was involved

“What will take this program to the next level?”

- The self-study as a catalyst for change in taking the program to the next level.

WHAT WILL TAKE THIS PROGRAM TO THE NEXT LEVEL

- This question has been a key conversation during the self-study site visit, and is being incorporated into self-study summary for all programs
- The question has two inherent components
 - What does the next level look like
 - How do we get there (and when do we expect to get there)?
 - What help, resources, etc. are needed?
- Inherent focus on the long-term and on sustainability





Program Improvement Basics and Improvement Priorities

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POTENTIAL ELEMENTS OF AN ANNUAL PROGRAM EVALUATION

Resident Performance

- *Evaluations, In-Training Exams, OSCEs*
- *Graduates' perception of readiness for unsupervised practice*
- *Performance Measures*

Graduate Performance

- *Board Certification examination (% taken / % passed)*
- *Surveys of graduates*

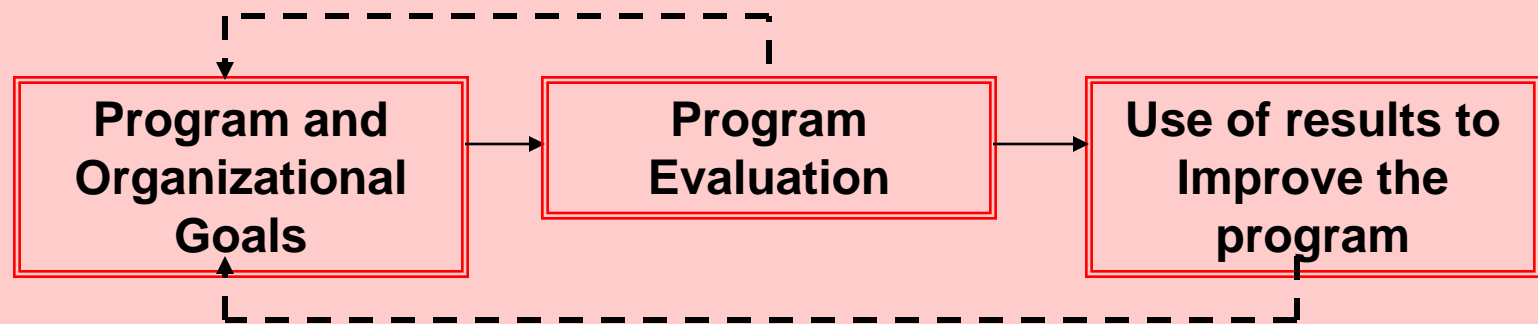
Faculty Development (and participation in development)

- *Faculty or leadership development programs relevant to role in the program*
- *Programs that enhance effectiveness of skills as educators, based on their role in the program*

Program Evaluation

- *Elements relevant to the particular program aims*

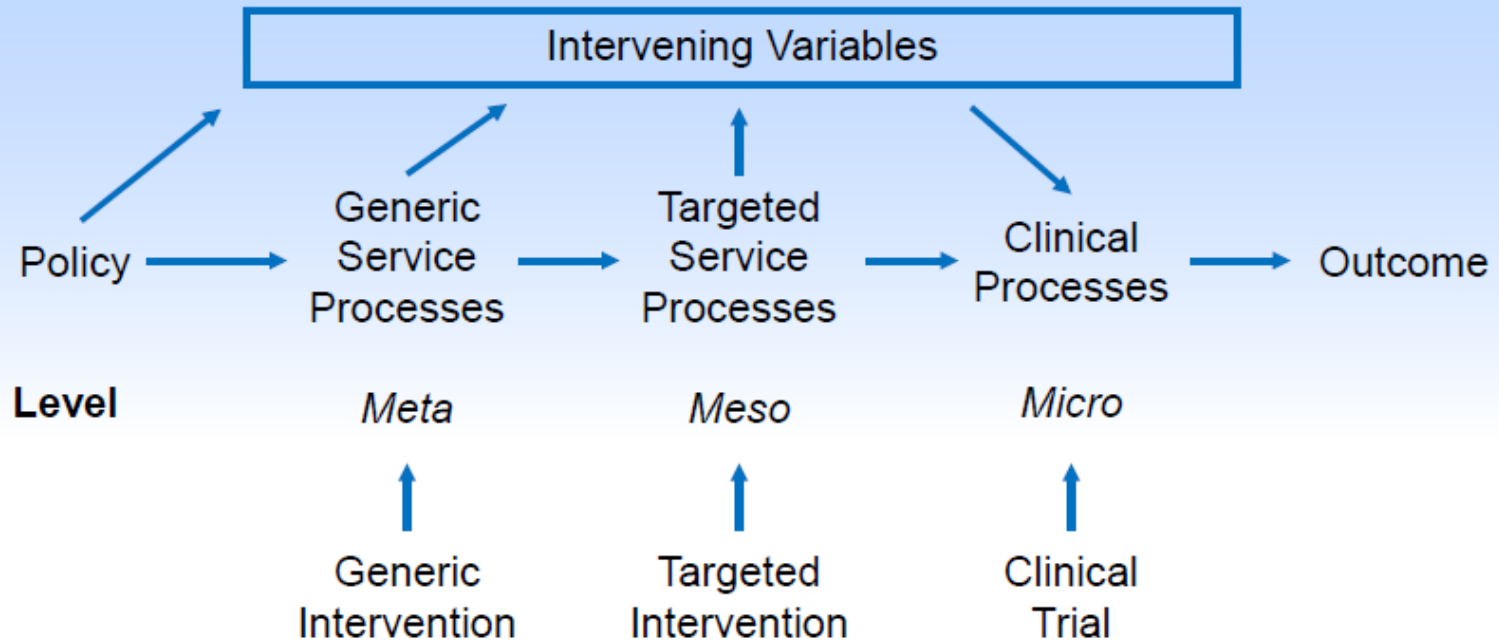
PROGRAM EVALUATION AS A SYSTEM AND FEEDBACK LOOP



***Organizational Work Processes
and Culture***

ASSESSING EFFECTIVENESS: INTERVENTIONS OCCUR WITHIN A....

Causal Chain in a System



Brown C, Lilford R. Evaluating service delivery interventions to enhance patient safety. BMJ. 2008 Dec 17;337:a2764.

WHAT ACGME HEARS FROM PROGRAM LEADERS AND FACULTY

Institutional Leaders	Faculty
<p>If you want us to achieve big, we need more than 18 months.</p>	<p>The “Threat” of RVU-based compensation:</p>
<p>Need to be sure the self-study plans and improvements don’t stop after the 10 year accreditation visit.</p>	<p>“We don’t have time to teach.”</p>
	<p>“.... Or engage in program improvement.”</p>



WHAT ACGME HEARS ABOUT THE SELF-STUDY AND STRATEGIC PLANNING

- Many program directors do not have experience in strategic planning
- Strategic Planning is a team effort
 - Sets your direction and priorities
 - Gets everyone on the same page
 - Simplifies decision making
 - Aligns activities and priorities
 - Communicates your mission
- A need for a discussion of the relationship between the core and the subs
- A need for basic ACGME resources strategic planning



WHAT ACGME HEARS FROM RESIDENTS/FELLOWS

- Conferences are stale
 - Faculty do not attend; non-interactive format
- Too much service
 - Too many patients; not enough ancillary support
- Too little supervision early in training, over-supervision and too little autonomy as they progress
- No time
 - For research, the simulation center, reflection
- Yet.... the residents and fellows
 - Like their faculty
 - Care about their patients
 - Appreciate the increased focus on wellness and well-being



WHAT ACGME HEARS: THE LARGER SYSTEM

- Faculty development needs
- Is healthcare system expansion a threat or an opportunity?
- Increasing specialization of care
 - Need for outside electives
 - Training tracks
- A need for more scholarship
- A need for Patient Safety-Quality Improvement-scholarly activities integration
- A need for more ACGME resources related to the self-study and the 10-accreditation site visit



CASE EXAMPLE 1: THE PEC AND THE CLEC

- Children's Hospital with core pediatrics and pediatric subspecialty programs
- Shifting from the Annual Program Evaluation to an ongoing efforts
- PEC meets monthly and reviews 1 rotation/experience at each meeting
- The Clinical Learning Environment Committee (CLEC) meets monthly
 - Issues for resolution can be brought to the committee by all stakeholders
 - Program director moderates; encourages open sharing and civil discourse;
- The activities are perceived to be more than worth the added meetings/time commitments

FINDINGS RELEVANT TO THE LARGER COMMUNITY

- Program actively teaches residents clinical problem solving, program improvement and civil discourse
- A sophisticated approach to the SWOT analysis
 - Focus on building strengths (PEC) and addressing weaknesses (CLEC)
- A need for “easy” interventions – the simplicity on the other side of complexity
 - Giving residents control over elements of their educational program

CASE EXAMPLE 2: THE UNHAPPY SUB-SPECIALTY PROGRAM DIRECTOR

- Cardiology subspecialty program
- Generally high-performing
- Completed the self-study at her word processor
- No input from faculty or fellows, with neither group aware of the effort or the outcomes
- Very vocal; emphasized that the program had no citations and that she considered the self-study a waste of time
- Found no value in the feedback either during a self-study pilot visit or during the 10-year site visit

FINDINGS ON THE SELF-STUDY PROCESS RELEVANT TO ACGME'S APPROACH

- The need for a different model for the self-study, self-study summary, and the pilot site visit for subspecialty programs, particularly one-year fellowships
- Intent
 - Reduce burden
 - Enhance coordination and shared learning among subspecialty programs
- The need to offer feedback on the improvement process (not the areas of improvement selected)
- What is new?:
 - A new abbreviated format for the self-study summary for subspecialty programs
 - Direct written feedback to programs the 10-year site visit in a pilot Phase I specialties

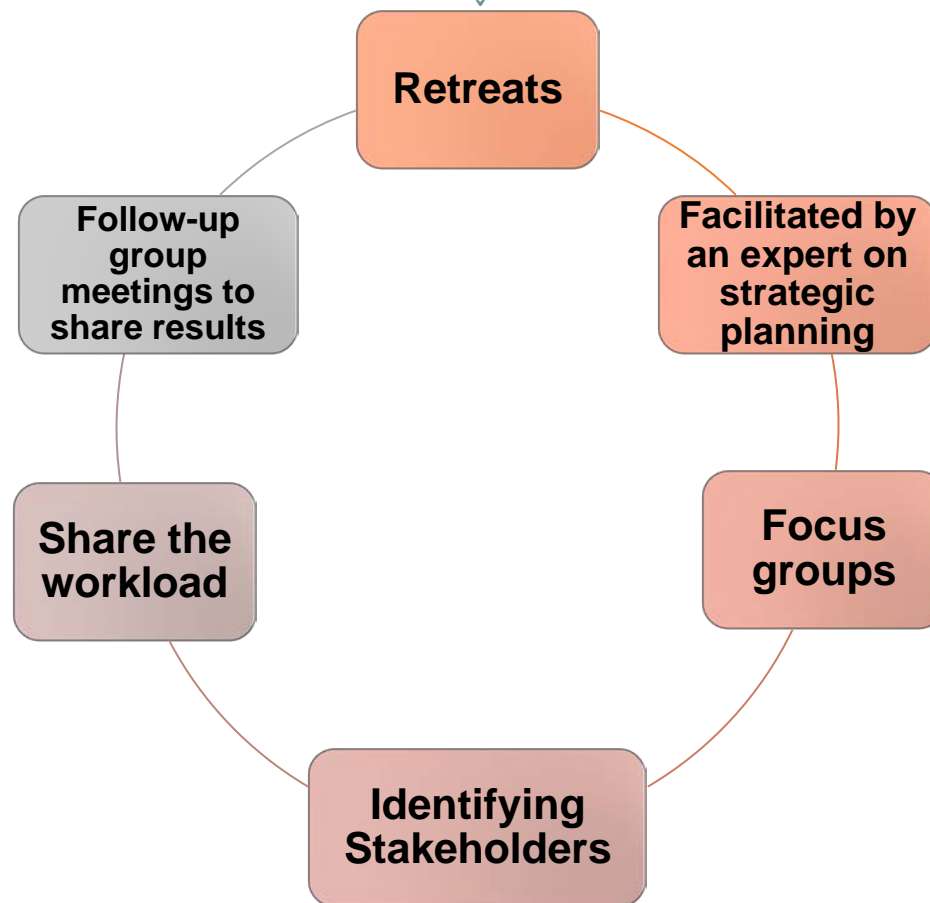


CASE EXAMPLE 3: “WE ARE IN THIS TOGETHER”

- A learning community for pediatric residency programs with an early self-study, organized by Dr. John Frohna, University of Wisconsin
- Met periodically and exchanged information on their experience
 - Completing the Self-Study and the Self-Study Summary
 - Their Self-Study pilot site visits
- Fielded questions to the ACGME and shared the answers

This can be replicated within any GMEC or another venue that convenes program directors

FINDINGS RELATED TO PROCESS: THE MORE COLLABORATION THE BETTER



- ...and don't forget the residents/fellows
- In really high-performing programs, improvement is continuous and organic

SPEAKING OF COLLABORATION: KEY ROLES FOR PROGRAM COORDINATORS

- Provide input for the annual program evaluation and the self-study
 - Coordinator's perspective and what you hear from the residents
- Record/aggregate data and improvements from the annual program evaluation and the self-study
 - Forms on ACGME web site if your sponsoring institution does not have a form
- Track action plans for areas for improvement
- Help facilitate the 5-year look back and look forward
- Ensure regular ADS updates
- Contribute to a “site visit ready” program
- Coordinate site visit planning with the assigned lead field representative
- Coordinate activities on the day of the site visit

SPEAKING OF COLLABORATION: KEY ROLES FOR CORE FACULTY

- Provide input for the annual program evaluation and the self-study
 - Faculty perspective and what you hear from the residents
- Connect the data from the Clinical Competency Committee (CCC) and the PEC
 - Use aggregate assessment data to highlight strengths and areas for improvement in the curriculum
- Help facilitate the 5-year look back and look forward
- Assume responsibility for an improvement project
 - Ensure the PDSA cycle is completed
- Contribute to a “site visit ready” program
- Provide input during the site visit day

COMMUNICATION BETWEEN THE CCC AND THE PEC

Critical due to data and role congruence

- CCC can have meaningful input into PEC identification of areas for improvement
- CCC can evaluate if an improvement showed up as improved learning outcomes

Practical Approaches

- Some member overlap
- A way of ensuring regular communication committees
- CCC input into the Annual Program Evaluation
 - Common low scoring areas on the milestones may suggest curriculum or experience deficiencies
- PEC input into the CCC work
 - Look for improvements in assessments in areas the PEC targeted for improvement

FACULTY DEVELOPMENT FOR CCC AND PEC MEMBERS

Faculty Development Topics	Faculty Roles		
	CCC Member	PEC Member	
Curriculum		X	X
Teaching Methods	X	X	
Competency-Based assessment (Milestones)	X	X	
Learner Assessment	X	X	
Sampling of performance	X		
Frame of reference training	X		
Standard setting	X		
Program Evaluation		X	
Performance benchmarks			X
Leadership		X	X
Committee Process	X	X	
Achieving Consensus	X	X	

THE SELF-STUDY PILOT: COMMON STRENGTHS AND OPPORTUNITIES (ALL SPECIALTIES)

Strengths

1. A collegial, supportive program-level learning environment, encompassing trainees and faculty
2. Responsive, engaged, program leaders, committed to ongoing program improvement and to the success of trainees
3. Curricula and experiences tailored to prepare graduating residents ready for unsupervised practice in the core specialty or fellowship

Opportunities

1. Expansion (campus, institution, specialty, program) and collaborations and partnerships that improve education and patient care, or increase research opportunities
2. Feedback to faculty on their educational performance, often paired with faculty development targeting faculty's role in the educational program
3. Capitalizing on expanded education technology, including simulation and online learning, to enhance and extend the experience for trainees

THE SELF-STUDY PILOT: COMMON IMPROVEMENT PRIORITIES AND THREATS (ALL SPECIALTIES)

Improvement Priorities

1. Addressing the lack of appeal and low learner engagement in didactic sessions
2. Maintaining a balance of education and service at a time of rapidly growing service volume
3. Improving the assessment system and the value and relevance of assessments

Threats

1. Program leadership turnover, and lack of succession, transition and contingency planning for educational roles
2. Increasing clinical pressures, accompanied by reduced reimbursement for services, and loss of faculty time for education, supervision and mentoring
3. Loss of community, ambulatory and other sites due to sites starting their own programs or entering larger networks that do not support an educational mission

IMPROVEMENT IN THE NAS: ACGME PERSPECTIVE

- **Improvement orientation extends to all programs**
- **Annual Data Screening**
 - Example: ~ 85% of programs placed on probation in 2014-15 returned to accreditation or accreditation with warning
 - Majority of citations resolved
- **The 10-Year Site Visit and review is not a “Citation Hunt”**
 - Will include assessment of areas not covered by the annual screening data for potential inclusion
- **Confidentiality of Annual Program Evaluation and Self-Study data related to areas for improvement**
 - Process “probed” during site visit, documents are not requested or examined. Focus on improvement process
 - Improvement “content” is considered protected QI information



The 10-Year Accreditation Site Visit What to Expect and How to Prepare

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BRIDGING THE SELF-STUDY AND THE 10-YEAR SITE VISIT: THE SUMMARY OF ACHIEVEMENTS

Uploaded via ADS shortly before the 10-year site visit

Program Strengths

- How they relate to aims and context

Achievements in Areas for Improvement

- How they relate to aims and context

Process for Improvement

- Metrics
- Useful, actionable feedback

Lessons Learned

- “Best Practices” for sharing

RC REVIEW OF THE 10-YEAR VISIT

- **Review Committee (RC) provides Letter of Notification (LON) from the 10-year (Full Accreditation) Site Visit**
 - Citations and Areas for Improvement
- **Field Staff feedback on the self-study taking into consideration:**
 - Program aims and context; improvements reported and verified during the 10-year visit
 - Effectiveness of self-study, based on process and the outcomes the program has reported
- **RC LON may amplify elements of field staff feedback or may let it stand on its own**

REVIEW OF AND FEEDBACK ON THE SELF-STUDY FOLLOWING THE 10-YEAR VISIT

SV Feedback to Program Leadership

Key Strengths:

- ...
- ...

Suggestions for how program could improve:

- ...
- ...

transcribed

Strengths/AFIs

Compliance

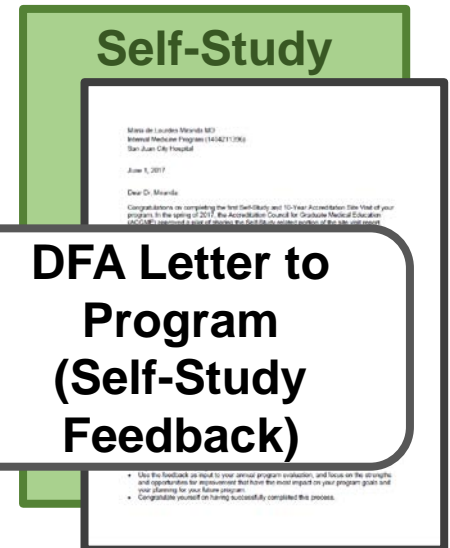
Self-Study Report

SV Report to RC

RC LON to Program (Compliance Feedback)

Self-Study

DFA Letter to Program (Self-Study Feedback)



REVIEW OF AND FEEDBACK ON THE SELF-STUDY FOLLOWING THE 10-YEAR VISIT

- Formative feedback (no accreditation impact) for the initial RC assessment of self-study effectiveness
 - Formative only feedback envisioned for the next 5 years, as the GME community and RCs learn more about program improvement in areas already compliant with the accreditation standards
 - **Feedback focuses on the “improvement process,” not on the improvement priorities the program has selected**
 - **Feedback uses the dimensions of the Program Improvement Assessment Tool (PIAT) to promote consistency in the feedback provided**

A DEVELOPMENTAL APPROACH TO CATEGORIZING SELF-STUDY IMPROVEMENT MATURITY: THE PIAT

- 5 dimensions associated with a high-quality self-study
- Consistent with the educational milestones and the CLER Pathway document
- A more consistent way of categorizing program improvement, with the ability to offer feedback tailored to the program, to get the improvement process to “the next level”
 - Eg, one would NOT provide feedback to get to Level 5 to a program currently at Level 1
- Use as a self-assessment tool, and to provide a shared mental model about improvement to programs, field staff, and Review Committees
 - Validation still ongoing, potential release expected in late 2017
 - Envisioned as part of a growing set of resources ACGME is developing for the self-study and the 10-year site visit

5 DIMENSIONS OF FEEDBACK ON PROGRAM EVALUATION AND IMPROVEMENT

1

Link to Aim and Context

- Are improvement activities relevant to program aims (important for programs that comply with all/most standards)

2

Completing the Plan-Do-Study-Act (PDSA) Cycle

- Early or inadequate efforts often characterized by improvement cycles arrested at the Plan phase

3

Managing Improvement Action Plans and Data

4

Stakeholder Involvement and Engagement

- “Stakeholders” are defined by the program, may go beyond trainees and faculty (eg other departments, nursing, ambulatory clinic staff)

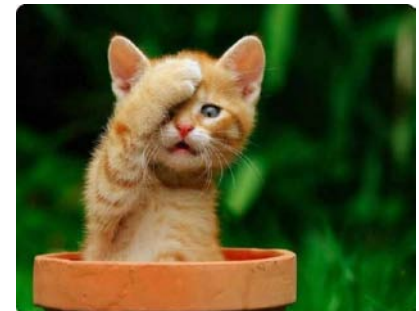
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Coordinating Program, Departmental and Institutional Aims and Priorities

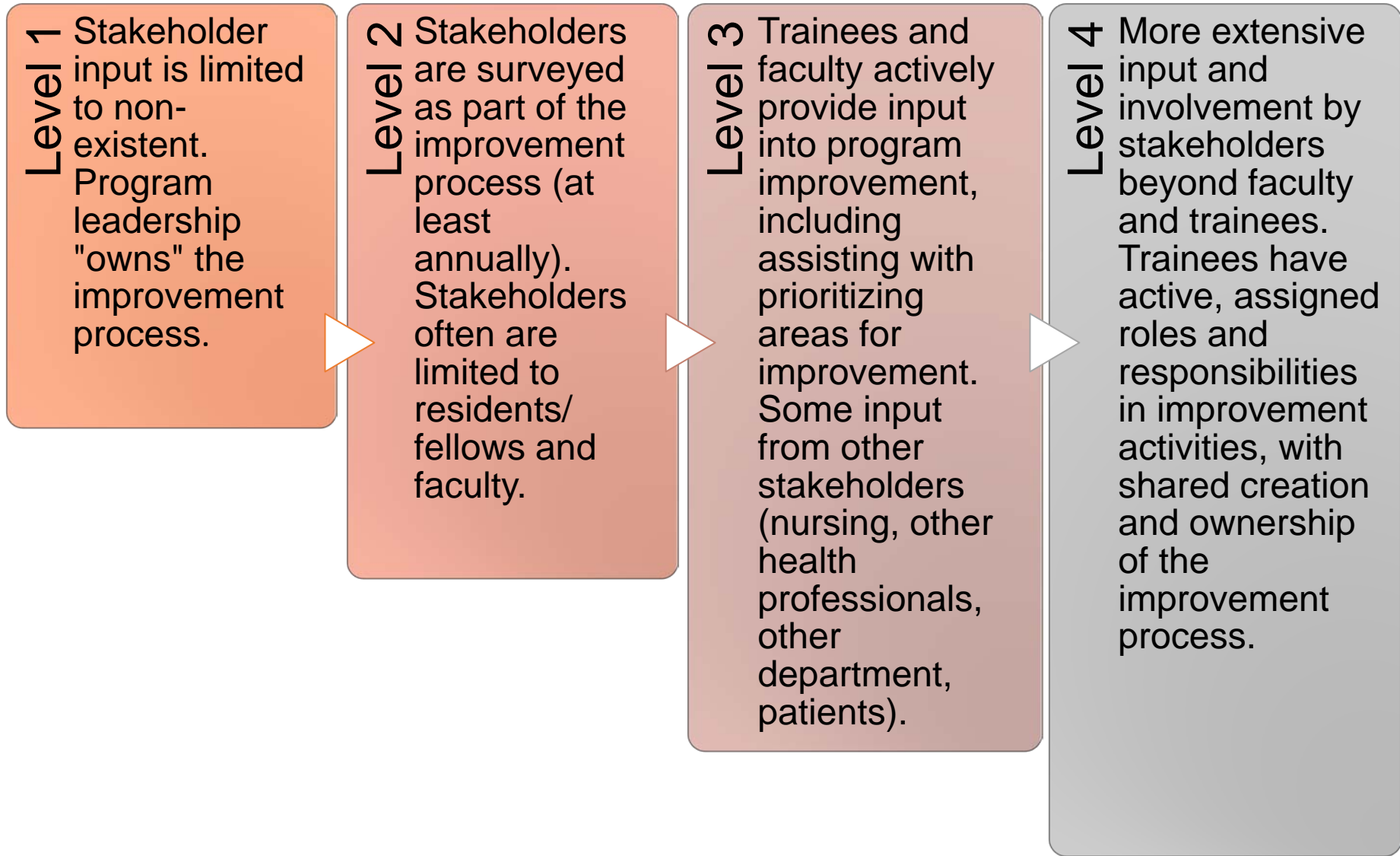
- Prioritize improvement activities with input from department and sponsoring institution leadership/oversight group (GMEC/DIO)

THE MORE COLLABORATION THE BETTER

- Retreats
- Facilitated by a expert on strategic planning
- Focus groups
- Identifying the stakeholders
- Share the workload
- Follow-up group meetings to share results
- ...and don't forget the residents/fellows
- In really high-performing programs, improvement is continuous and organic



DEGREE OF STAKEHOLDER INVOLVEMENT AND ENGAGEMENT

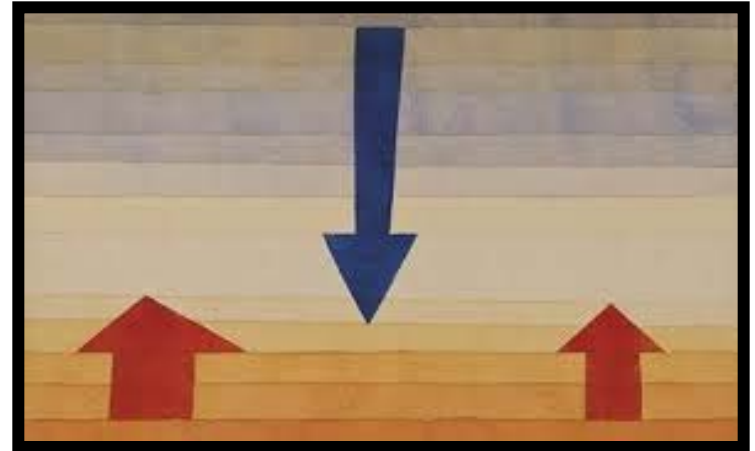


KEY COMPONENTS OF THE IMPROVEMENT PROCESS

- Soliciting input on areas for improvement
- Cycles of evaluation and improvement
- Identifying priorities
 - Engagement of stakeholders in prioritization and communication on what is feasible or not
- **Institutional input: Bottom-up (aggregation) or Top-down (institutional prioritization)**
- Tracking improvement
- Celebrating success and evaluating/revising approaches for areas still in need of improvement/refinement

LIMITATIONS OF MANY IMPROVEMENT EFFORTS

- Bottom up often does not meet top down
- A high degree of arrested development (the PDCA cycle arrests at P)
- Parallel play often the rule



Paul Klee



PDSA: MAKING IMPROVEMENTS TO THE IMPROVEMENT PROCESS

- The Annual Program Evaluation and the larger Self-Study should reflect the PDSA Cycle:

PLAN – **prepare** the change

DO – **implement** the change

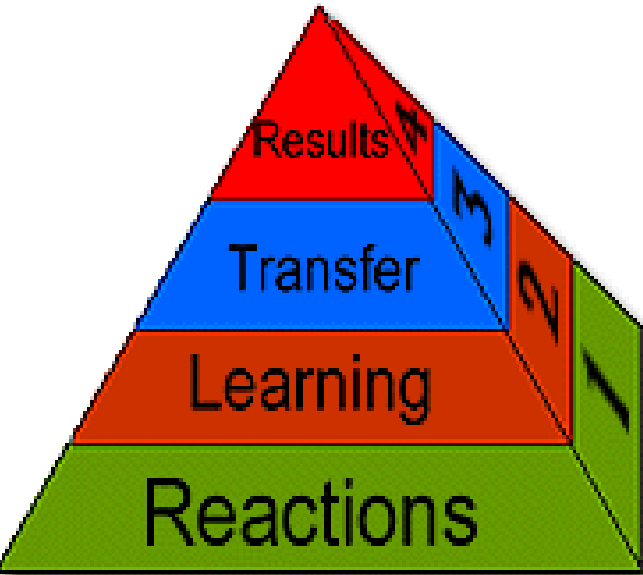
STUDY – **monitor/analyze** impact of change

ACT – **revise** and standardize the change

- What is common: **P** **D** **S** **A**

- Assessing the effectiveness of interventions is critical but frequently is not done

PDSA: MAKING IMPROVEMENTS TO THE IMPROVEMENT PROCESS



Results: Effect on the business or environment resulting from the trainee's performance

Collecting data on the effect of the educational intervention on micro- or macro-system performance

Behavior: Behavior and capability changes or improvement and implementation/application

Surveying supervisors, colleagues, collecting data on individual performance change

Learning: The resulting increase in knowledge or capability

Formal post-test of participants' knowledge and/or performance

Reactions: What learners thought and felt about the training

Participant surveys, pervasively done, most common

SAMPLE BLUEPRINT: OUTCOMES EVALUATION USING KIRKPATRICK LEVEL 4 AND IOM AIMS

- **Care should be safe**
 - Use of central-line and vent-associated pneumonia bundles
 - National patient safety goals, NQF 30 safe practices
- **Care should be timely**
 - Administration of antibiotics for pneumonia within 6 h; aspirin and b-blockers on arrival or discharge for AMI or heart failure
 - Timely communication of mammogram results
- **Care should be effective**
 - AMI, congestive heart failure, pneumonia measures
 - National Quality Forum's Ambulatory Care Quality Alliance measures
- **Care should be efficient**
 - Cost per visit, discharge, cost of poor quality, rework
- **Care should be equitable**
 - AHRQ National Healthcare Disparities Report
- **Care should be patient-centered**
 - Patient surveys of perception of care

INCREASING RELEVANCE AND REDUCING BURDEN: DAY-TO-DAY PROCESS ADJUSTMENTS

- Self-studies and 10-year site visits for programs that recently reached continued accreditation
 - These programs recently had a site visit to convert to full accreditation
 - They may not yet have an improvement track record to warrant a self-study
 - We ask them to consider aims and context in their annual program evaluation
 - Site visit need/approach determined collectively by ED and DFA
- Combining data-prompted & other scheduled visits with the 10-year site visit
 - Aim is to avoid more than one site visit/ accreditation review
 - Will work out details on an individual basis

ACGME RESOURCES

- **Development of resources for programs**

- Snippet slide set for setting Aims
- “Forced function” forms for aggregating data from an individual annual program evaluation, and across years of program evaluation and improvement

- **New Forms for Programs**

- Updated Self-Study Summary with information on the 5-Year look back and look forward
- Summary of Achievements
- Self-Study Summary Update for changes and information on the new dimensions

- **New site visit report format for 10-Year Site Visits**

- Succinct section for Self-Study reporting (will not repeat content in Self-Study Summary)
- Currently testing a prototype “combined” report for internal medicine and pediatrics subspecialties