* Winner – APPD Quality Improvement (QI) Project Award

A QUALITY IMPROVEMENT PROJECT TO IMPROVE TIMELINESS OF SUBMISSION OF FELLOW EVALUATIONS BY NEONATOLOGY FACULTY

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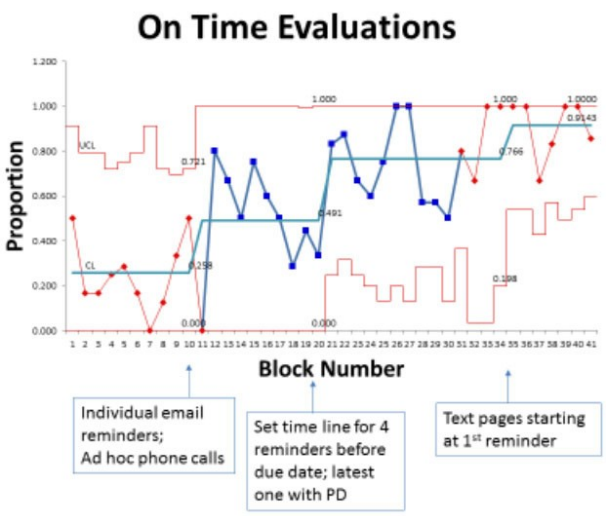
Background Evaluation of pediatric trainees by faculty is an important and required part of any training program. Timeliness is also imperative as it is an Accreditation Council for Graduate Medical Education (ACGME) requirement that at least 90% of evaluations are received on time. Our neonatal-perinatal fellowship program has a total of 12 fellows who are evaluated by 42 faculty members. We recognized that our fellowship training program was not compliant with ACGME requirements as the majority of the faculty evaluations of our neonatal fellows were being submitted late. Aim Statement Our SMART aim statement was to increase the proportion of evaluations of University of Texas Southwestern neonatology fellows completed on time by faculty to 90% by the end of the academic year. Interventions Background data for on time evaluation submission was collected over 11 rotation blocks. The fellowship program directors and coordinators created process maps and designed interventions. Three Plan-Do-Study-Act (PDSA) cycles were completed. Cycle 1 interventions included individual email and ad hoc phone calls reminders to faculty. Cycle 2 introduced a standardized timeline of 4 reminders before the evaluation due date with the last reminder being given directly by the program director. Cycle 3 added text pages in addition to emails starting with the first reminder. Data analysis was performed with Statistical Process Control. Measures Process Measures are compliance with the standardized reminder process, and number and type of reminders required. Outcome Measures are the percentage of evaluations completed on time. Results We had 87% compliance with the standardized reminder process during the last academic year. The percentage of evaluations completed on time increased from a baseline of 25% to 49% after PDSA cycle #1, 77% after PDSA cycle #2, and to 91% after PDSA cycle #3. Each cycle demonstrated special cause variation. Conclusions and Next Steps A standardized text and email reminder system for evaluation completion was successful in achieving compliance with ACGME requirements for on time evaluation submission by faculty. Next steps include deadline for completion included in first email/text, automated email from evaluation system, and condensed reminder schedule to minimize burden on program staff.



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1. FUNDING SOURCES AND FINANCIAL INSECURITY IN PEDIATRIC FELLOWSHIP PROGRAMS

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Background: Shortages of pediatric subspecialists exist in many fields accompanied by insufficient recruitment of new fellows. The current system of funding graduate medical education is inadequate. No prior studies have described the funding sources of pediatric fellowships or the effects of funding constraints, including financial insecurity. Design/Methods: We conducted a national survey of pediatric fellowship program directors (FPD) between November 1, 2016 and February 9, 2017. Information about program characteristics and funding sources for salaries and educational expenses was collected. FPD were asked to rate their security regarding funding for academic year 2019 and later (AY2019+) on a sliding ordinal scale (very insecure to very secure; 0-4). Multivariable logistic regression was used to examine the association between insecurity (<=1.5) and program characteristics and sources of funding for fellow salaries. Results: Data were obtained from 519 FPD, representing 14 different pediatric subspecialties, with a 65% overall response rate. The major sources of funding for fellows salary and educational expenses were hospital or Graduate Medical Education (GME)/Children's Hospital GME and division, respectively. Funding limitations restricted program size and access to educational resources in 23% and 36% of programs, respectively. Nineteen percent of FPD perceived their program as insecure in AY2019+. Programs were more likely to be insecure if the source of trainee salary was the division (OR 1.80 [95% CI 1.11-2.89], p=0.016) or extramural funding (OR 1.86 [95% CI 1.16-3.0], p=0.01). Programs with 7 or more fellows (OR 0.44 [95% CI 0.24-0.77], p=0.01) or programs receiving hospital or Children s Hospital GME/GME funding in years 2 or 3 (OR 0.54 [95% CI 0.32-0.89], p=0.02) were less likely to be rated as insecure. Conclusions: Funding constraints in fellowship programs have limited recruitment and access to educational resources and led to financial insecurity. More stable funding of fellowship programs is critical to maintaining an adequate pediatric subspecialty workforce.

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2. SPEAKING UP ABOUT TRADITIONAL AND PROFESSIONALISM-RELATED PATIENT SAFETY THREATS: A SURVEY OF PEDIATRIC TRAINEES

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Background: Safe and professional patient care depends on a culture in which health professionals speak up regardless of authority gradient. Objective: To measure pediatric trainees experiences, attitudes and factors associated with speaking up about traditional versus professionalism-related safety threats. Methods: An anonymous, cross-sectional survey was administered to 512 pediatric residents and fellows at two large US children s hospitals in 2015. The survey queried attitudes about, barriers and facilitators for, and self-reported experience with speaking up. In addition, two safety vignettes (traditional vignette and professionalism vignette) assessed the likelihood of speaking up, anticipated assertiveness, and perceived potential for patient harm. Results: Of 223 participants (response rate 44%); 68% were female and PGY level was evenly distributed. Respondents more commonly observed unprofessional behavior (57%, 127/223) than traditional safety threats (34%, 75/223); p<0.001, but reported speaking up about unprofessional behavior less commonly (48%,

Table: Attitudes Regarding the Climate for Speaking Up about Patient Safety Concerns versus Unprofessional Behavior

Item	X=patient safety concern % (n) Agree* N=223	X=unprofessional behavior % (n) Agree* N=223	P-value†
1. Speaking up about X results in meaningful change in my clinical area.‡§	149 (67%)	112 (50%)	<0.001
2. In my clinical area, it is difficult to speak up if I have/observe X.‡‖	37 (17%)	109 (49%)	<0.001
3. The culture in my clinical area makes it easy to speak up about X that does not involve me or my patients.‡§	134 (60%)	84 (38%)	<0.001
4. In my clinical area, I observe others speaking up about X even if it does not involve them or their patients.‡§	139 (62%)	56 (25%)	<0.001
5. I am encouraged by my colleagues to speak up about X.‡§	152 (68%)	78 (35%)	<0.001
6. I would feel safe speaking up about X.	173 (78%)	117 (52%)	<0.001
7. I have the support I need to speak up about X.	164 (74%)	114 (51%)	<0.001

* Dichotomized strongly agree/slightly agree (agree) vs. neutral/slightly disagree/strongly disagree (disagree).
† P-value for McNemar's test comparing within-respondent differences in attitudes regarding the speaking up climates for patient safety and professionalism.
‡ Items from the Speaking Up Climate for Patient Safety (SUC-Safe) Scale.
§ Items from the Speaking Up Climate for Professionalism (SUC-Prof) Scale.
‖ Negatively worded item.