Building Bridges to Move Mountains:

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• Participants will:
  – explore new ways to utilize the DIO and GME office to affect institutional change across a broad array of missions
  – examine a number of internal and external “bridge-building” functions of the DIO and GME office
  – be able to contextualize them for their own institution
  – be able to connect more efficiently with the DIO and CSuite
• Disclosures and Conflicts:

• No financial disclosures

• Dr. Schiavone:

• ACGME Volunteer CLER site visitor
• GME: intersection of many aspects of healthcare – from education to service delivery to finance to government affairs

• Healthcare is in transition
  – Opportunity to use the central “hub” function of GME in a coordinated effort to engage seemingly disparate aspects of the clinical, administrative and education enterprises.

• “Move mountains” that impede making the efficient, effective progress they desire.
  – These “bridges” may be internal or external
  – Your institution, school of medicine, the legal department, finance, the chief medical officer, ACGME and the C-suite, etc.
A dismissed Internal Medicine resident, who had been found incompetent by the CCC, has successfully appealed and been readmitted to your program after several years away from clinical training. In his first night back in your ER, he inserts a central line without first calling his attending. The patient suffers a pneumohemothorax. The attending learns about it, and advises, “CALL ME BEFORE YOU DO ANYTHING.” Later, that SAME shift, he inserts another central line again, without calling the same attending.

- Failure to call for help, which is failure to follow policy
- Egregious insubordination (second event)

You hold your head in your hands…and…
- Who do you call first?
1. ACGME
2. CFO
3. CMO
4. CEO
5. GME Attorney
• Debriefing: how to avoid in the future
• Very specific supervision policies:
• Last Chance Agreement
  – https://www.dropbox.com/s/axcj3vtxd5pdy71/LAST%20CHANCE%20AGREEMENT%20Resident.doc?dl=0
• Also need grievance and due process policies
• Ensure ancillary staff know the policies and who’s credentialed!!!
You are trying to determine whether your residents and fellows are truly integrated into the Patient Safety and Quality Improvement infrastructure of the institution. Recognizing that these areas have become a hospital priority, you want to ensure that the residents and fellows are contributing to and extracting maximum value from these institutional activities. While your programs require all residents to do a core set of IHI online modules, you know you are still struggling to achieve full integration.

- Your CMO is reticent to supply more attending time for these “extra” activities
- The residents are feeling burdened with regulations and not having enough time to learn “real medicine.”

You hold your head in your hands...and...
- Who do you call first?
1. ACGME
2. CMO
3. CEO
4. GME Attorney
5. Resident
• Debriefing: how to avoid in the future

• Create policies regarding affiliated hospitals’ obligation to integrate residents/fellows into patient safety and quality improvement initiatives

• Promulgate VA Patient Safety/Quality Improvement curriculum shared across all affiliated hospitals
  – Add VA funded Chief Resident in Quality and Patient Safety
  – Link to program: http://www.va.gov/oaa/CRQS.asp
  – Link to RFP: http://www.va.gov/oaa/TrainingAnnouncements.asp

• VA Interprofessional Fellowship Program in Patient Safety
• The senior residents in OB/GYN have come to see you. They are about to graduate and have not been allowed to perform most surgical procedures. They have observed, but have very limited surgical experience to date. The faculty are adamant that, in order to meet their required RVUs, they cannot afford the teaching time for these procedures. Clinical productivity supersedes any educational responsibilities with these procedures.

  – Residents have made their opinions clear to future program applicants. The program filled 1 out of 4 positions in the most recent match.

  – The faculty will not change the structure of the program

• You hold your head in your hands...and...
  – Who do you call first?
WHO DO YOU CALL NEXT?

1. ACGME
2. CFO
3. CMO
4. CEO
5. GME Attorney
• Debriefing: how to avoid in the future
• Know the program requirements!
• Work to assure robust surgical electronic procedure log
• Residents often *demand* training that is NOT required (e.g., robotics or experience usually gained in fellowship)
• PD/DIO must determine what training should be offered
• Address whether faculty can provide surgical opportunities if you determine it’s important
• If you determine it’s important, facilitate agreements for training elsewhere if not available at your institution
• The Program Director of Emergency Medicine calls to tell you that he has offered an excellent candidate a PGY-1 contract for July, even though the only vacancy in the program is at a PGY-3 level. The program may be expected to downsize because your institution is over the cap.
  
  – Institutional Policy is that the GME Office is the only entity authorized to offer a residency candidate a contract.
  
  – Institutional Policy further states that a program cannot replace a PGY-3 with a more junior level resident
  
  – This has happened before.

• You hold your head in your hands…and…
  
  – Who do you call first?
WHO DO YOU CALL FIRST?

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2. CFO
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4. CEO
5. GME Attorney
• Debriefing: how to avoid in the future

• Policy – Do you have one?
  – Same level – no approval required
  – More junior level – DIO has to approve

• Not following established policy? BAD PD!
Dr. Gruff, the only Orthopaedic Surgeon and a member of the core faculty in your institution, brings a family member to the Emergency Department, and bullies the resident and staff so that they will make him first priority. He takes the patient to MRI without MD orders, and demands immediate attention. He has a history of bullying residents and staff. You want him removed from the medical staff.

- The resident makes a formal complaint to the DIO.
- The residency program has no other way to provide training in his subspecialty
- Dr. Gruff retains hospital privileges at another regional hospital, to which residents are not currently assigned

You hold your head in your hands...and...
- Who do you call first?
CASE OF THE HOSPITAL ACQUISITION:

To whom do you want the DIO to speak next?

1. ACGME
2. CFO
3. CMO
4. CEO
5. GME Attorney

WHO DO YOU CALL FIRST?
• Debriefing: how to avoid in the future

• To protect residents, GME has to have enforceable standards for faculty behavior and protocols for disruptive behavior


• BUT NEED TO HAVE PLAN B, if the faculty member has unique contributions to training program
Case 1: Ghost Writer

• The Vascular Surgery attending at your affiliated hospital calls about a second year General Surgery resident rotating on her service. In the first two weeks of the rotation, he has missed two clinics, and has been late four times (citing responsibilities at your hospital as the reason). You investigate and find he has also been copying and pasting clinical information into the EMR and at your hospital on the inpatients for whom he has responsibility.

  – The Affiliation Agreement specifically states that the other hospital will only pay for time spent at their site, according to timekeeper records

  – Because this has happened many times before, the Surgery service at your affiliate is reconsidering their participation in your training program!

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• Debriefing: how to avoid in the future

• Determine how to enforce “copy and paste” EMR policies
• VA copy and paste policy:
  http://www.va.gov/oaa/Archive/Mandatory_Training_Course_Version2.pdf
• Determine how to track time and attendance at “offsite” rotations
• The faculty in charge of resident activities at the affiliated hospital should serve on the CCCs and PECs of each residency program in which they provide some significant training
• Your affiliate should be using your electronic residency management software system so that all evaluations are incorporated into each resident/fellow portfolio
Case 5: Whose Property Is It?

• KOHO, the largest private practice group in town (Kings of Hematology/Oncology) serve as the key clinical faculty for your Hematology/Oncology fellowship program. Fellows have complained anonymously to the ACGME that KOHO MDs provide no clinical or didactic teaching, demand 24/7 care for all inpatients and round their patients separately from the fellows.

  – The competing health system has offered lucrative contracts to KOHO and they have threatened to leave in the past.

  – The ACGME expects an immediate response or they will schedule an expedited site visit.

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  – Who do you call first?
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• Debriefing: how to avoid in the future

• DIO needs to be involved in contracting with private practice (and other) faculty groups in order to establish expectations

• Need support of institutional leadership to address failure to teach/supervise/mentor

• Specific supervision policies applicable to all faculty

• http://www.uwmedicine.org/education/Documents/gme/Hematology-Oncology-Supervision-Policy.pdf
The newly hired Family Medicine Sports Medicine Division Chief has called you to initiate the new accredited fellowship, promised to her when she was recruited. You know nothing about this, nor has any funding been identified. She becomes increasingly agitated as you explain that the answer may be “no”.

- Your institution is significantly above the Cap and has turned down all requests for new positions (or programs)

- You are not included in recruitment of faculty leadership who have GME arrangements as part of their packages.

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- Who do you call first?
WHO DO YOU CALL FIRST?

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5. GME Attorney
• Debriefing: how to avoid in the future

• DIO/GME must be involved in final negotiations with anyone expecting a GME component of recruitment or retention packages

• Assure regular ongoing discussions/meetings with CFO and Finance

• Explore Assistant CMO role for DIO, etc... whatever it takes
• The newly hired Department Chair of Ophthalmology is wildly unpopular with the core faculty. At a faculty meeting 2 hours ago, the 4 key clinical faculty resigned AND immediately alerted the ACGME of the catastrophic loss of resources. The Chair has started calling in community resources to help rescue the residency program.

  – None of the community ophthalmologists have faculty appointments.

  – The community MDs are willing to host residents as observers, but are less willing to host residents as first assistants.

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WHO DO YOU CALL FIRST?
• Debriefing: how to avoid in the future

• ? (may be impossible to avoid)
• DIO should participate in Chair recruitment
• Ensure faculty opinions are heard during recruitment
• Have a Plan B if all of your faculty quit?
• Establish community ambulatory and VA relationships, if you may need alternative teaching
• GME: at the intersection of education, healthcare and administration

• AMCs have the opportunity to use the central “hub” function of GME in a coordinated effort to engage seemingly disparate aspects of the clinical, administrative, and education enterprises.

• Such engagement can help AMCs in efforts to “move mountains” that impede making the efficient, effective progress they desire.
  – These “bridges” may be internal or external
  – Build them between school of medicine and the legal department, finance and the chief medical officer, ACGME and the C-suite, etc.
Stony Brook Medicine

CFO

ACGME

Participating Site Education Director

DIO

Dean

CMO

GME Attorney
What Bridges Will You Build?