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## From Probation to Accreditation: Successful Change Management

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### Abstract

#### Background

In 2015 our residency program located within a regional medical campus was placed on probation. Five of the 13 citations were related to the residents' clinic experience. The resident clinic was encased within a medical culture of chronic opiate prescription management that did not provide a sufficient or balanced ambulatory education for internal medicine residents.

#### Objective

This paper describes our experience of moving from a residency program within a regional medical campus on probation to full accreditation status over a span of 19 months.

#### Methods

We used a project management approach with a strong coordinating council designed to empower leaders to effect change in the residency program and the residency clinic.

#### Results

We were able to create and enact a plan that extricated the residency's ambulatory clinic from managing a panel of approximately 700 patients requiring chronic monthly opiate prescriptions. The patients were referred to community pain management providers for these prescriptions. We established a policy of providing no chronic opiate prescriptions in the residency clinic. Residency ACGME surveys from 2015 through 2017 demonstrated improved resident satisfaction. CG-CAHPS scores demonstrated a temporary decrease in patient satisfaction scores returning to previous baseline after a year.

#### Conclusion

We employed a project management approach to get our program off probation and change the focus of our residency's ambulatory practice and re-establish its educational mission.

### Introduction

The University of Oklahoma Tulsa School of Community Medicine is a regional medical campus focused on training physicians in population-based healthcare management, patient care improvement and patient satisfaction for any clinical setting, whether that be rural or urban. In 2008, several changes were made in our internal medicine residency ambulatory practice. We recognized the volume of patients seen was inadequate to provide an appropriate educational experience. Although a sufficient number of patients were scheduled, a high no-show rate led to a low number of patients actually being seen.

To address this, we increased the number of patients being scheduled. The volume of patients seen in the resident practice increased, and a large number of new patients had Medicaid as their payment source. These patients tended to

have a higher prevalence of chronic pain syndromes and psychiatric illnesses. (1)

Leading up to this time period, chronic opioid therapy became widely promoted as an effective and safe management strategy for the treatment of patients with chronic pain syndromes. (2) In response to what was believed at the time to be an important societal need for physician education, our Department of Internal Medicine developed a Pain Management Specialty Clinic and an Addiction Medicine Fellowship collocated in our Internal Medicine clinic. Subsequent policies required more frequent visits for those patients on chronic opiate therapy.

This confluence of events led to a large number of patients treated with increasing quantities and strengths of opioids within our residency clinic. The chronic pain patients tended to have a lower no-show rate to ensure their opioid prescriptions were filled. Many visits in the resident practice

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became focused only on the patients’ pain syndrome instead of addressing other core medical issues.

In ensuing Accreditation Council for Graduate Medical Education—Residency Review Committee (RRC) site visits, the program was cited for “a high ratio of patients with chronic pain”. Although attempts were made to address the issue, the volume of patients with chronic pain did not decrease, but actually increased in the resident practice. The residency program was subsequently placed on probation in April 2015 (see Figure 1). This article describes our journey from probation to full accreditation status, and the methodology we used to achieve change within our institution.

## Methods

The University provided access to a project manager with expertise in change management to address the RRC citations. The first step was to select a Steering Committee of key leadership, including the Department Chair, Program Director, Designated Institutional Official, Associate Dean of Finance, Associate Dean of Curriculum and Faculty Affairs, and Executive Director of Clinic Operations. This Steering Committee reviewed and categorized the citations and assigned them to four working committees: Curriculum, Clinic, Hospital and Sub-Specialty, and Faculty Development and Scholarly Activity. The Steering Committee clearly defined the scope and deliverables, and assigned group leads and team members for each working committee. The working committees met regularly throughout each month, tracking the percent complete to the timeline and capturing progress, key decisions, issues and action items in the meeting minutes. The working committee leads presented a progress report to the Steering Committee on a bi-monthly basis. The Steering Committee made key decisions and resolved escalated issues as needed.

### Chronic-Opiate-Requiring Patients

To address the excessive opiate prescriptions written within the resident clinic, a subcommittee determined the actual number of patients in the resident practice who were receiving opiate prescriptions at that time. Resident visits involving chronic opiate prescriptions comprised nearly 50% of the visits early in 2015 and totaled approximately 700 patients. The subcommittee decided to limit the number of chronic-opiate-requiring patients assigned per resident patient panel: zero for PGY-1’s, two to three for PGY-2’s, and no more than five for each of the PGY-3’s. The appropriate number of chronic opiate patients that residents should maintain in their continuity panels to acquire competent opiate prescribing skills was determined through discourse with program faculty, comparison with other clinical practices, discussion by the clinic working group and consensus by the Steering Committee.

Finally, we instituted a clinic-wide policy in July 2016 prohibiting prescriptions for chronic opiate therapy in the resident practices. The General Internal Medicine Faculty

were also asked to limit their own management of chronic opiate therapy to no more than a handful of patients within their patient panels, and to refer the others and any new chronic-opiate-requiring patients to Pain Management clinics in the area. All new patients’ medication lists were screened prior to scheduling initial appointments, and new patients were informed that the practice does not manage chronic pain with opiates. Those requiring such will be referred to a Pain Management clinic.

Based on the decision to limit the number of chronic-opiate-requiring patients in the resident practice, 100 patients were retained in the resident practice and 600 chronic-opiate-requiring patients were transferred to non-resident providers within the practice. This transition occurred between July and December 2016. During that time, two Pain Management physicians within the Department of Medicine took on the majority of these patients until their practice reached capacity. The remaining chronic-opiate-requiring patients from the resident clinic were divided among and transferred to general internal medicine faculty practices to assume all care, including continuing the opiate prescriptions until a referral to outside pain management was achieved. To provide residents the needed skill in prescribing opioid prescriptions, the residents were allowed to provide new opiate prescriptions for acute use. The residents were given guidance by faculty preceptors in appropriate practices, including dose and time-limited prescribing per CDC guidelines.

### Survey Information

We used our program’s ACGME yearly resident survey to look for changes in our program’s performance between the time of beginning probation to the year after we were off probation. (3) To look at the potential impact on our patients, we used our Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) surveys from Press Ganey. CG-CAHPS psychometric properties and reliability have been well described. (4-6)

### Statistical Analysis

We used basic descriptive statistics to summarize the data. Bivariate analyses were used to assess differences in responses between sub-groups defined by year. Pearson Chi-square analyses were used to assess the significance of differences between groups. This was a quality improvement project and was not designed to contribute to generalizable knowledge. For that reason, it did not require review by the Institutional Review Board.

## Results

Our residency program was placed on probation May 29, 2015. We received 13 citations, 5 of which were related to the residents’ experience in the clinic. On January 13<sup>th</sup>, 2017 (19.5 months later), our residency program was granted full accreditation with 0 remaining citations. To note, our most recent month of data shows that our resident practice saw 577 patients in May 2017. Our resident

practice is fairly well balanced with 48% Medicaid, 25% Medicare and 18% private insurance (Figure 2). Figure 3 demonstrates that the percentage of patients in the resident clinic who routinely take two or more chronic opiate prescriptions in the previous twelve months has decreased from 14.5% in February 2016 to 10.6% in March 2017, showing that we have seen *some* change in the make-up of our population. However, while many of the visits now deal with both acute and chronic pain, our residents are not responsible for writing the patients' chronic opiate prescriptions. An occasional prescription for *acute* opiate therapy is written in the resident clinic, but by and large, the nature of our practice and patient expectations around chronic pain has changed dramatically.

Data comparing our ACGME resident surveys from March 2015-2017 are seen in Figure 4 below. In 2015, 17% of our residents gave our program an overall “negative” or “very negative” evaluation. In 2016, this decreased to 13%, and by 2017 only 1 resident (3%) gave a “negative” evaluation, and no residents rated it “very negative”. Conversely, 41% of residents gave the program an overall “positive” or “very positive” evaluation in 2015, and this increased to 76% by 2017, which was a 35% increase ( $p=0.054$ ).

We compared our CG-CAHPS surveys between May 2016 and May 2017. To note, our overall composite provider scores have seen little change ( $p=0.94$ ). However, they demonstrated substantial month-to-month variation, with a five month trend scoring lower than the 80<sup>th</sup> percentile between July and November 2016 (not shown) when a large number of patients on chronic-opiate-requiring patients were being referred to other pain medicine providers in our community.

## Discussion

Residency programs are small organizations that are enfolded within their larger departments and enveloped by their governing medical school. Changing these programs is exceedingly difficult because of layers of institutional inertia. As Kotter has rightly pointed out, the first step to changing an organization is to create a sense of urgency. (7) Nothing feels quite so urgent to a residency Program Director as when the accreditation letter arrives announcing the program is on “probation”. To all involved—the departmental and university leadership, the residents, the teaching faculty—there is a sense of shame: How did we end up in this position? How could we have prevented it? Who is responsible for this? It is interesting that so few residencies have written about their experience. We could find only two others. (8,9)

Our experience of finding our residency on probation mobilized our leadership at the highest level to respond. Our Dean pledged resources to ensure our success. Our Department Chair made changes in personnel and engaged the project manager to lead the change processes. Following along with Kotter's steps in change management

theory (7), we created a “guiding coalition” in our Steering Committee and the various working committees. We developed our “shared vision” and strategies through a collaborative process that included faculty, residents, school of medicine personnel and nursing staff in the clinic and ensured the “communication of the vision” through multiple meetings at all levels. Our Department Chair “empowered” the clinic manager and our clinic Medical Director to take “broad-based action”. We set “short-term” goals that produced some early “wins”, and we were able to “consolidate the gains to produce more change”.

Other structural changes to our residency that occurred concomitantly deserve mentioning, as there were many issues beyond only the residency clinic. Our inpatient experience was consolidated into one teaching hospital to better support the residency's educational mission. There was a change in leadership during this time, including the medical school Dean, the Department Chair and the Program Director. The new Dean empowered the Designated Institutional Official to drive change in all the residencies on campus, including ours. Our new Department Chair was empowered to hire more faculty, improving the faculty-to-resident ratio, and allowing faculty focused time to teach.

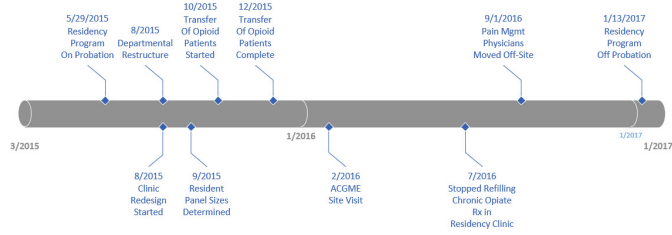
We also had several limitations. Our electronic health record made obtaining patient level data difficult. The volume of referrals required to move the patients to pain management practices in the community taxed our referral office greatly. Difficult conversations with the patients on opiates as they were transferred to other providers brought a great amount of stress to our office staff and providers for a number of months. While we delivered one large group session on dealing with difficult patients to our staff when the policy was first enacted, we should have prepared a plan of helping them with the stress and the emotional turmoil on an ongoing basis. Additionally, we could have done a better job of educating our patients about the planned changes and their expected impact. We sent an introductory letter and had signage, but we could have provided ongoing updates, as people often receive when there is “reconstruction” interruption. In essence, we were reconstructing the clinic. We suspect the amount of change and the dissatisfaction with our new policy and its communication had a direct impact on patients' willingness to recommend the clinic, sense of the provider's respect for them and belief about the amount of time the provider spends with them.

In conclusion, we used a project management approach to change the focus of our residency clinic. We created policies to guide the reassignment of patients on chronic opiate therapy to outside providers and re-established a focus on general internal medicine within our residency clinic. The residents' experience in clinic has contributed to their improved satisfaction with the residency. Patients' experiences during this time were variable, and those receiving chronic opiate prescriptions were often frustrated with the change. Our resident clinic saw a slight

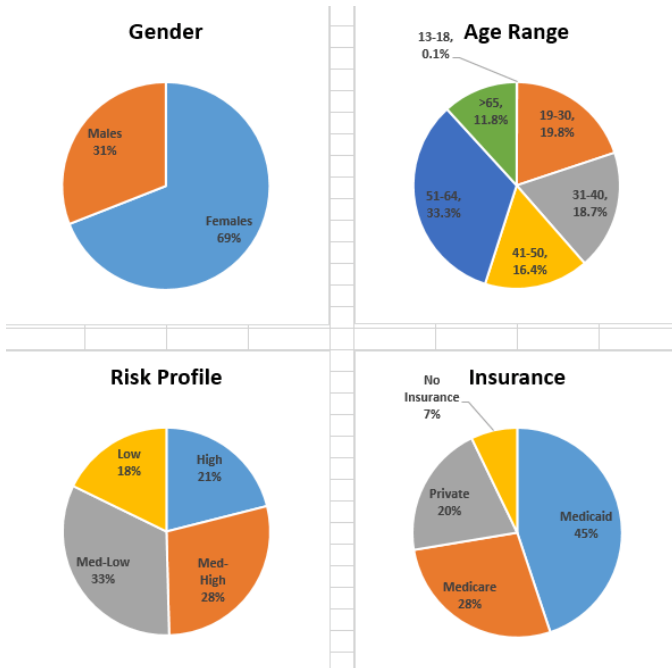
decrease in volume for a few months that quickly recovered as more general internal medicine patients found that we now had access for their routine problems. After the change, the tenor and make-up of our residency patient encounters provided a more satisfying and diverse experience for the residents and the faculty.

**Figures**

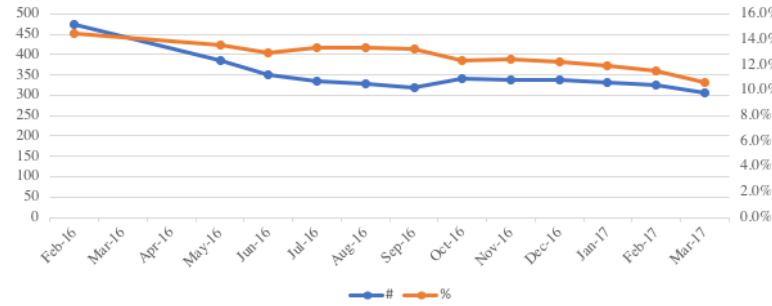
**Figure 1: Timeline of events in our residency accreditation**



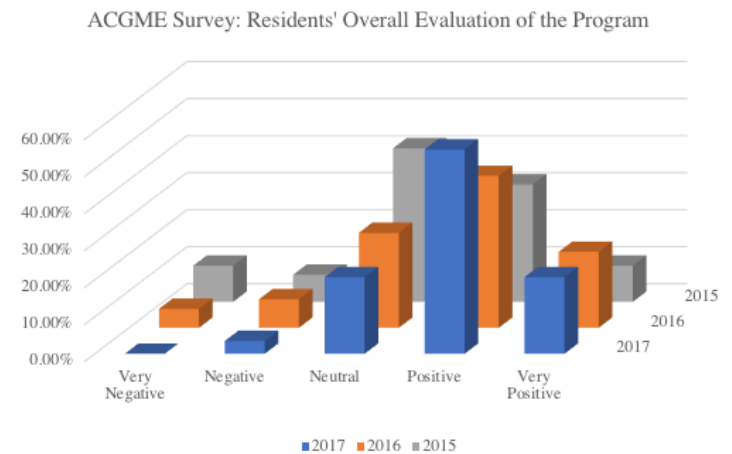
**Figure 2: Demographic make-up of the resident clinic, July 2016**



**Figure 3: Rolling average of Patients with More than 2 chronic opiate pain prescriptions in the residents' clinic in the last 12 months**



**Figure 4: ACGME Survey: Residents' Overall Evaluation of the Program**



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