

The Residency Assistance Program in Family Practice

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The Residency Assistance Program in family practice was inaugurated in September 1975 as a plan to mobilize and finance the matching of consultant expertise in family practice residency education with program directors desiring to improve the quality of their residency programs through consultative assistance. The Residency Assistance Program is administered by a Project Board composed of representatives of four national family practice organizations. A panel of 30 consultants, carefully selected by the Project Board, are prepared for rendering effective consultative services through intensive training in consultative skills. They operate under the guidance of concensually developed standards for quality graduate education in family practice. Consultations are only scheduled at the written request of a residency program director. The confidential, nonpunitive, and voluntary nature of a Residency Assistance Program consultation is carefully guarded, because it is felt that these qualities enhance the information-sharing, collaborative problem-solving nature of the consultative process. This paper describes the development, features, and operational process of this Program.

The Residency Assistance Program (RAP) in family practice was developed to improve the quality of graduate medical education in family practice through the provision of consultative services to program directors at their request. The consultations are available to all family practice residency programs that have been approved by the Liaison Committee for Graduate Medical Education. This service is not offered to newly developing residency programs in family practice. Such programs can obtain assistance from a list of consultants appointed by the Commission on Education of the American Academy of Family Physicians.

Residency Assistance Program consultations are provided by a panel of approximately 30 family practice educators who have been carefully selected by the RAP Project Board for their expertise in the field. The panel of consultants includes representatives from community, university, and military milieus. These consultants serve for a one-year term, with the option for reappointment.

The concept for the Residency Assistance Program was initially formulated by the Director of the Division of Education of the AAFP in 1974 as a plan to respond to the heavy demands for consultative services received by the AAFP from residency program directors eager to upgrade the quality of their programs. During the period from 1970 to the inception of RAP in 1975, requests for such consultative services were handled by the medical staff of the Academy's Division of Education and through educators identified as consultants by the AAFP's Commission on Education. As the specialty of family practice expanded, with an accompanying accretion of approved

residency programs nationwide (30 in 1969 to 310 in March 1977), the demand for these consultative services became too great for this limited system to provide. The need for a panel of consultants to respond to the requests for consultative assistance soon became apparent. Since there was a growing pool of experienced and successful educators in family practice who were capable and willing to provide such services, a plan was developed to mobilize their expertise and make it available upon request. The Residency Assistance Program was developed as a vehicle to facilitate, administer, and finance the matching of consultant expertise with programs in need of such expert assistance.

Development and Organization

The plans for such a Program were initially presented at the Program Directors' Workshop of the American Academy of Family Physicians in June 1974. The proposal was subsequently presented for endorsement to each of the organizations representing family practice and their members. Initial responses were encouraging. By spring 1975, the three national family practice organizations — the American Academy of Family Physicians (AAFP), the American Board of Family Practice (ABFP), and the Society of Teachers of Family Medicine (STFM) — had committed themselves to the project as sponsoring organizations. Funds were awarded by the W. K. Kellogg Foundation in August 1975. The first fiscal year of the project began in September 1975 under a grant to the Family Health Foundation of America (FHFA), a nonprofit organization.

The terms of the Kellogg grant call for funds to subsidize the first three years of the Residency Assistance Program with an understanding that the Program will eventually become self-supportive. After the first three developmental years, it is anticipated that the cost of the Program will be amortized among the institutions requesting assistance. If necessary, the parent family practice organizations may continue to subsidize the Program to a limited degree, but major support for the continued operation of the Program will be expected to come from those institutions who receive RAP services.

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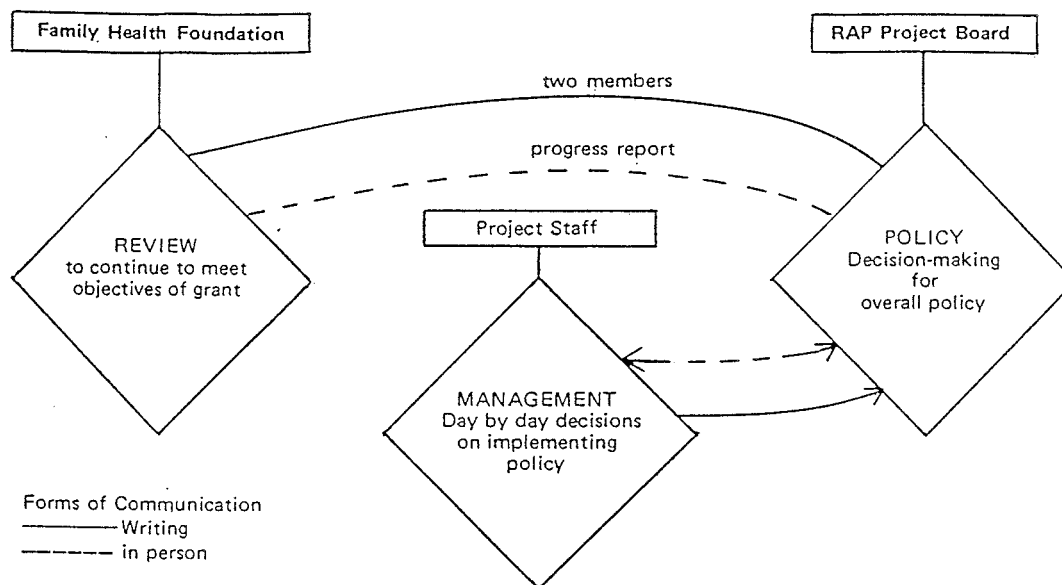


Figure 1. RAP Administrative/Management Flow Sheet

As overseer of the grant, the Family Health Foundation of America is charged with the responsibility of assuring that the objectives of the grant are met. The FHFA, in turn, delegates the responsibility for making overall policy decisions regarding the administration of the Program to a Project Board consisting of nine members — two representatives from each of the four sponsoring organizations (AAFP, ABFP, STFM, and FHFA) and the project director, as illustrated in Figure 1.

The RAP Project Board members are expected to represent the interests of the specialty of family practice and to act as liaison agents between RAP and their respective sponsoring organization. The RAP project director manages the day by day decision-making regarding the development and maintenance of the Program. The project director also acts as a link between the Project Board and the project staff whom he supervises at AAFP headquarters in Kansas City, Missouri. All RAP consultants are appointed by the RAP Project Board for a one-year renewable term and are responsible to the Project Board in the performance of their role as RAP consultants.

Early in the development of the

project it was felt that family practice residents ought to participate in the formulation of the criteria for evaluation of the residency programs. For this reason, five residents were selected to participate in the developmental and renewal stages of the RAP project. They do not, however, participate as members of a consultative team.

Unique Features of RAP

Two unique features of the Residency Assistance Program that differentiate it from other similar consultative services are: (1) All of the consultants have participated in training designed to perfect their consultative skills, and (2) The guidelines used by each consultant in evaluating a residency program were consensually developed by the total panel of RAP consultants in the fall of 1975, subsequently revised in the fall of 1976, and will be revised annually during the project. With the RAP guidelines as a resource, each consultant is capable of providing assistance to programs based upon national standards rather than upon subjective evaluation derived from individual experiences and biases.

From its inception, the keynote of RAP has been its confidential and

nonpunitive nature. The confidentiality of the Program is carefully guarded, requiring that all information flowing among the program director, the RAP consultants, and staff will be held in strict confidence. Only the requesting program director has the prerogative of disseminating the consultation report in a judicious fashion. At no time are consultations offered to a third party who wishes to obtain an external evaluation of a family practice residency program.

The original developers of RAP felt that the voluntary, nonpunitive nature of the Program would enhance its effectiveness and result in greater participation. The developers believed that family practice educators with concerns about improving the quality of their residency programs would welcome the opportunity for an external evaluation designed to help them diagnose and address problems in their programs that might hamper the quality of the educational experience offered to residents. RAP sponsors also felt that a residency program's participation in a RAP consultation could effectively demonstrate to students that their faculty is interested in continually upgrading the quality of the students' training experience.

The RAP Consultative Process

The Residency Assistance Program consultations are arranged through the RAP staff at the AAFP headquarters in Kansas City. The consultant and the program director confer in planning the events of the two-day consultative visit. On-site preparation for the visit is the responsibility of the requesting program, while responsibility for external arrangements is assumed by the staff at RAP headquarters. During the first year of the project, consultants made site visits in pairs as part of the training process. Since September 1, 1976, consultations have been performed singly.

The Pre-Site-Visit Questionnaire

In order to provide a consultant with some essential background information about the residency program prior to his/her arrival on location, the residency program director is asked to complete a pre-site-visit questionnaire. This questionnaire is simple and brief, requesting only basic elements of information about the residency program that can be reported with relative accuracy. Also, each program is asked to have the following documents on hand for the consultant's use in evaluating the residency program:

1. Copy of the budget and funding sources;
2. Evaluational forms and/or written explanation of evaluational procedures in current use; and
3. Pertinent written materials which are descriptive of the program.

Collaborative Problem-Solving Process

The two days of a RAP consultative visit are a period of intense, concentrated, collaborative problem solving. The RAP consultant needs to become informed quickly about the essential aspects of the residency program, from an understanding of its organizational and economic foundation to the essentials of the curriculum and details of patient care services. Usually a RAP consultant will spend the first day of the consultation collecting information about the program through interviews with faculty, staff, and residents as well as observing on-site the ambulatory care in the Family Practice Center and the in-patient experiences of the residents.

In understanding and diagnosing a

residency training program, the RAP consultant depends upon the residency program director as a primary source of information. The information provided by him or her is considered in relation to data obtained from other sources, both within and without the program, in order to arrive at an equitable judgment of the program's strengths and weaknesses. The collaborative information-sharing relationship between the RAP consultant and the program director provides an ideal combination of internal and external perspectives about the program. The external stance of the RAP consultant allows him/her to apply a degree of objectivity not available to the program director. On the other hand, the program director can supply an important awareness of the internal dynamics of the residency program. This combined insight shared in a nonthreatening, helping relationship promotes a thorough analysis of the residency program and its particular needs for change and renewal.

The RAP Consultant's Checklist

To assist the RAP consultant in thoroughly reviewing all the significant aspects of the residency program, as determined by the RAP guidelines, a checklist of areas to observe on-site has been developed. The questionnaire and the checklist are inclusive data collection instruments which assure the acquisition of all program information that needs to be evaluated in light of the RAP guidelines. The checklist focuses on accounting for complex information that requires on-site observation and interviewing to acquire, ie, information that is difficult or impossible to collect exclusively by means of a self-report questionnaire.

The Consultation Report

When the consultative visit is completed, the pre-site-visit questionnaire and the RAP consultant's checklist provide ready references for the consultant in compiling the final consultation report. The report summarizes the material discussed by the RAP consultant and the program director in the "wrap-up" session. The report stresses both positive and negative aspects of the residency program. The recommendations are classified according to priorities given in RAP guide-

lines and are keyed as "crucial" or "enrichment" to the quality of the residency program. When appropriate, the consultant suggests strategies for implementing proposed changes. Many programs may be of such high caliber that they will merely need encouragement to continue their present plans.

Only two copies of the final consultation report are issued. The first copy is sent to the program director to be used at his/her discretion. The second copy, retained at RAP headquarters, is never released to a third party. Both copies are water-marked to identify their source.

Evaluation

The RAP Project Board has identified two methods of evaluating its own Program. The first of these is the evaluation of the consultant's immediate effectiveness and his/her personal skills as a consultant. This instrument is mailed to the residency program director as soon as the consultation is completed. Immediate feedback is given to the consultant regarding his/her personal effectiveness. The second instrument is mailed four to six months following the consultation and seeks to evaluate what changes have occurred in the residency program as a result of the RAP evaluation and consultation.

Annual Renewal and Update

In order to maintain the dynamism of the Program and relevancy of the RAP standards, an annual renewal session for all RAP consultants has been adopted. The first renewal session was held at the end of August 1976. At that time, the first four months of implementation of the Program were thoroughly evaluated with an eye toward refining written materials, updating guidelines, and improving the overall Program, based upon the experiences of the consultants in the field. The first four months had been planned as a trial period for testing the capabilities of the Program as originally designed. Anecdotal reports from residency program directors who have received a RAP consultation indicate that through its consultants, the Residency Assistance Program is making a valuable contribution to family practice education in this country.