American College of Medical Practice Executives

Starting an Oral and Maxillofacial Surgery Fellowship

Case Study #3

Submitted August 13, 2015

This case study is being submitted in partial fulfillment of the requirements for election to Fellow.
I. Introduction

From 1987 to 1999, St. John’s Mercy Medical Center, a level-one trauma center in St. Louis, Missouri, had a very successful Oral and Maxillofacial Surgery (OMS) residency program. Due to the hospital’s economic hardship, hospital administrators eliminated the residency program in June 1999. The hospital still needed 24/7/365 OMS coverage, however, which provided an opportunity for a private OMS practice to move into the hospital and serve the need for facial trauma coverage and other OMS services.

The owner of this private practice had been connected to the previous residency program and determined that an OMS fellowship program could be a way to reintroduce an OMS teaching component into the hospital without the burden of a full residency program. Because there was already a framework established, a rotation in place, an abundant number of OMS surgical cases, and a supportive hospital culture, the practice examined the feasibility for developing an OMS fellowship program. Such a program would not only make strong use of the hospital’s preexisting framework to serve a medical need but also benefit the practice by 1) attracting prestige to the practice on national and international scales, 2) offering a recruitment opportunity to consider fellows for hire, and 3) fulfilling the practice owner’s interest in teaching young surgeons.

The purpose for originating an OMS fellowship program was clear and convincing, so the private OMS practice decided to proceed. However, there remained many, many practical questions about how to implement such a program, especially how to organize and fund the fellowship. The responsibility of identifying the best fellowship structure and determining the financial feasibility of hosting such a program fell to the practice manager.
II. Alternatives Considered

The practice manager identified two main avenues for structuring the fellowship: 1) Accredit the fellowship through an established organization, or 2) Create an independent fellowship, structured either as for-profit or not-for-profit.

The Commission on Dental Accreditation (CODA) was one avenue through which the fellowship could be accredited and organized. The benefits of working with CODA were significant. The CODA process of accreditation provides considerable authority to the fellowship, assuring fellows, specialty boards, and the public that the training program is in compliance with published standards\(^1\). The name recognition of CODA, not to mention the accompanying financial stipend it offers fellows, would help attract more competitive candidates for the new OMS fellowship. Moreover, CODA offers its own system of accrediting and evaluating programs. Accreditation actions by CODA are based on information gained through written submissions by program directors and evaluations made on site by assigned consultants. CODA has established review committees in each of the recognized specialties to review site visit and progress reports and make recommendations to CODA. Review committees are composed of representatives selected by the specialties and their certifying boards.

The CODA accreditation system, with its many rigors, also offered disadvantages. First, the accreditation process is time-consuming. The fellowship must be reviewed by the appropriate review committee and approved by CODA prior to the implementation to ensure that the program meets and continues to meet the accreditation standards. What’s more, successful accreditation is not assured, so there is a risk involved in the process. CODA staff reviews the report to assess its completeness and to determine whether the change could impact the program’s potential ability to comply with the accreditation standards. If this is the case, the report is reviewed by the appropriate Review Committee for the discipline and by CODA. Furthermore, CODA’s educational standards did not entirely align with the needs of the new OMS fellowship. The fellowship had to comply with CODA’s standards, which limited the potential for
individualization and contextual nuance. In particular, the subject of the fellowship had to be chosen from a list of three areas of OMS training (Cosmetic Oral and Maxillofacial Surgery, Oral/Head and Neck Oncologic Surgery, or Pediatric Craniomaxillofacial Surgery) with minimum amounts of surgical cases in that one subject. The practice owner, however, wanted to provide a full-scope OMS experience that included all three surgical areas.

Another avenue for external accreditation was the Accreditation Council for Graduate Medical Education (ACGME). The benefits of accrediting through ACGME were like those of CODA. The ACGME process of accreditation assures fellows, specialty boards, and the public that the training program is in compliance with published standards. That sense of authority derived from ACGME name recognition would help attract more competitive candidates. Furthermore, whereas CODA offered its own set of funding for the fellow, the ACGME accreditation allows for Medicare funding to help offset program costs.

The disadvantages of accrediting through ACGME were similar to the disadvantages of working with CODA. To garner the ACGME stamp of approval, the fellowship had to go through a rigorous and time-consuming accreditation process, and because successful accreditation was not assured, the time-cost was risky for the practice. In addition, the fellowship had to comply with ACGME’s accreditation standards, which limited the practice’s freedom to craft a fellowship program that met its and the hospital’s needs. Finally, the practice would have to identify a sponsor, such as the hospital, which would require relinquishing administrative rights and control to the sponsor/hospital, which could lead to future conflicts.

If the practice pursued an independent fellowship without external accreditation, one option would be to develop a for-profit program. This model would provide the practice with significant financial benefits and operational freedoms. The practice would create a custom-built educational system, clinical rotation schedule, and fee and services schedules that meet the needs of the practice. The practice could also benefit from the fellow’s services and on-call Emergency Department compensation. There would also be partnership opportunities with external
organizations and services that would both enhance the fellowship and the practice’s networking. And finally, from a pedagogical standpoint, the independent fellowship would give the practice total freedom to establish the program’s agenda, rotation, guidelines, standards, evaluation system, and core competencies. This would ensure that the fellowship aligned dynamically with the needs of the practice and local OMS cases.

A weakness to the independent, for-profit model is that the practice would have to build all of its revenue streams from scratch, and there would not be a predetermined, existing influx of external funding, as there was with the CODA fellowship or Medicare revenue via ACGME. Furthermore, recruiting competitive candidates for the fellowship would be more challenging without the prestige that comes with CODA or ACGME approval. This would be especially true for the first few years until the program developed greater national recognition and could report attractive educational outcomes.

Another option for an independent fellowship was to formalize it as a not-for-profit organization. In addition to all of the educational freedoms enjoyed by an independent fellowship, this structure would also yield the tax benefits enjoyed by not-for-profit entities, including exemption from corporate income tax for all fellowship-related revenues. In addition, any external corporate partners making donations in support of the fellowship would gain the additional benefit of tax-deductibility. To that end, the fellowship program could also solicit charitable donations for its work from the public as well as grant-making institutions, which a for-profit program would not be eligible to do. Finally, the not-for-profit model would establish the fellowship as a separate legal entity from the practice, which would provide a useful degree of separation from the interests of the practice.

The primary disadvantage of the not-for-profit avenue was that it would require time, effort, and legal expertise beyond that of a practice manager. The practice would have to seek outside support, which would contribute to start-up costs. Additional start-up costs included the hire of an attorney to write and file documentation, the application fees, and state incorporation
fees. Finally, because a not-for-profit is dedicated to the public interest, its financial information is open to public inspection. This was not a serious drawback, but it did mean that salaries and other expenditures of the fellowship program would be available for public viewing.

III. Chosen Solution

A. Procedures Used To Select Solutions

The practice manager conducted considerable amounts of research into the organizational models of other fellowships. This is how the two primary routes were identified: accredited or independent. To learn more about accreditation, research was needed for the program regulations, standards, and requirements of both CODA and ACGME. This research was conducted online and through phone calls. Additional research was required about the requirements and benefits of for-profit and not-for-profit organizational structures to determine benefits and weaknesses. The practice manager then presented a cost-benefit analysis to the practice owner and recommended a solution for proceeding with their fellowship.

B. Solution Chosen

After reviewing the requirements, costs, and benefits of each organizational structure for the fellowship, the practice proceeded with establishing a nonprofit subsidiary to host the fellowship program.

C. How Solution Was Implemented

The practice recognized the value of CODA’s and ACGME’s existing standards and used those as a starting place for its own fellowship. The practice manager developed program requirements that mirrored CODA and ACGME standards but adapted them to create a new, full-scope OMS fellowship program. The practice went on to create a surgical and clinical rotation internally, and it also established relationships with other specialties to create surgical, clinical,
and educational opportunities that enhanced the fellowship program. Putting this structure together also enabled the practice to determine how many fellows could be accepted each year based on the rotation training sites.

Structurally, the practice manager set about establishing the not-for-profit entity that would host the fellowship, including the use of external contractors (e.g., a lawyer) to ensure legal compliance. Afterward, the practice manager created a program budget based on research of other fellowship programs. And the practice also solicited sponsorship donations from corporate partners to secure program funding.

The last stage was promoting the fellowship to attract applicants for the inaugural application cycle. The practice manager solicited OMS resident program directors, advertised in trade journals, joined online OMS student forums, and started interviewing applicants from different parts of the U.S. to promote the fellowship as a unique OMS opportunity that no other practice could offer. The practice manager later published surgical case logs and testimonials from previous fellows in order to attract top-caliber applicants by providing evidence of the fellowship’s comprehensive OMS experience.

IV. Lessons Learned

The process of researching fellowship structures and creating one from scratch yielded several important lessons. First, the ACGME and CODA accreditation regulations are exceptionally valuable for structuring a clinical educational experience, but they are also rigid. In this case, they would have prevented the fellowship from offering a comprehensive oral and maxillofacial surgical education, which the practice wanted as a key asset to set its fellowship apart and thus attract strong applicants. Second, establishing a not-for-profit organization is difficult but not unmanageable. It requires an investment of both time and money, and it’s definitely worthwhile to obtain outside legal counsel to help navigate the process. This will help limit the practice manager’s time spent on the process and ensure legal compliance. Third,
hospital politics are complicated and difficult to navigate. Finally, the fellowship benefited significantly when the practice sought external partners to contribute to the fellowship program by sharing expertise, knowledge, and insight that the practice manager did not have.

V. Recommendations for other Practice Managers

If there is a need within the medical specialty for a new, unique fellowship opportunity and it will benefit the practice, consider taking these steps to establish the program:

1. Identify other fellowships that can serve as organizational models and research their processes.
2. Establish consensus within the practice. A new fellowship requires 100% support and commitment.
3. Seek professional and legal advice to reduce time cost and reduce the practice’s liability.
4. Develop a program structure with clear and concise objectives, rotations, educational and training components, and tools to measure feedback.
5. Track all surgical case logs, and then use the data to market the fellowship and recruit top candidates. If the fellowship can demonstrate that it provides exciting surgical opportunities, the applicant pool will become more competitive.
6. Research places to advertise for recruitment, such as student forums, websites, trade journals, and program directors in the specialty.
7. Ensure the practice website features the fellowship on the home page with a detailed description of this program as well as photos of current and past fellows.
8. Seek out compatible people who are amenable to the fellow’s outside clinical service rotation.
9. Develop a certification of completion and evaluation process to conclude and grow the program.
Endnotes

