Accreditation Council for Graduate Medical Education

Residency Review Committee for Internal Medicine (RRC-IM) Update

American Geriatric Society Meeting

Lynne Kirk, MD, Chair

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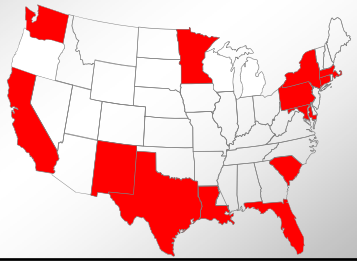
RRC Composition

- 3 nominating organizations - ABIM, ACP, AMA
- Currently 18 voting members
- 6 year terms -- except resident (2 years)
- Generalists and subspecialists

  Cardiology, CCEP, Critical Care Medicine, Endocrinology, Gastroenterology, General Internal Medicine, Geriatric Medicine, Hematology/Oncology, Infectious Disease, Medicine-Pediatrics, Nephrology, Pulmonary/Critical Care Medicine, Sleep Medicine, Transplant Hepatology
- Ex-officio members from each nominating organization (non-voting)

RRC Composition

- *Geographic Distribution*
  CA, CT, DC, FL, LA, MA, NY, MN, NM, PA, RI, SC, TX, WA



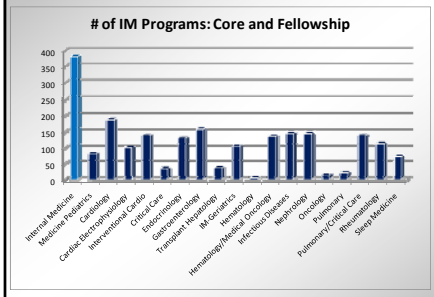
Who is the RRC-IM?

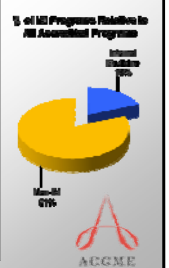
- Committee Members

Lynne M. Kirk, MD – Chair
James A. Arrighi, MD – Chair elect
Beverly M.K. Biller, MD
Heather Brislen, MD *
*Andres Carrion, MD**
E. Benjamin Clyburn, MD – Vice-Chair elect
John Fisher, MD *
John Fitzgibbons, MD
Andrew S. Gersoff, MD *
Betty Lo, MD *
Furman McDonald, MD *
Elaine A. Muchmore, MD *
Susan Murin, MD
Victor J. Navarro, MD
Andrea Reid, MD *
Ilene Rosen, MD *
Stephen M. Salerno, MD
Jennifer C. Thompson, MD

* New to RRC since July 2010

RRC-IM Oversight

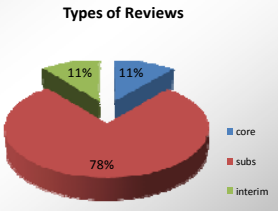




Summary of Activities 2011

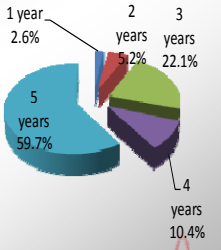
- The RRC-IM meets three times a year – January, May, and September
  - A fourth summer meeting is a business/policy meeting
- The RRC-IM reviewed 560 programs
  - Average per meeting:
    - 28 core
    - 136 subspecialty programs
    - 22 interim reports

    (progress & duty hours reports)



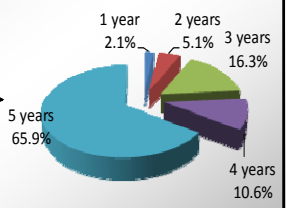
Summary of Actions 2011
Core Internal Medicine

Number of *Core IM* Programs Reviewed	101
Initial Accreditation	4
Continued Accreditation	77
Proposed Probation	2
Proposed Withhold	2
Progress Reports	11
Duty Hour Reports	5



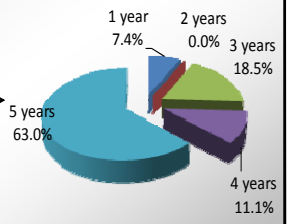
Summary of Actions in 2011
Subspecialty Programs

Number of *Subspecialty* Programs Reviewed	457
Initial Accreditation	50
Continued Accreditation	331
Proposed Withhold	16
Withhold	5
Proposed Withdrawal	2
Voluntary Withdrawal	2
Progress Reports	48
Duty Hour Reports	3

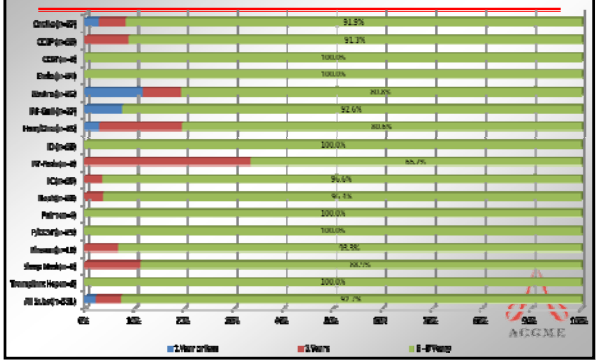


Summary of Actions in 2011
Geriatric Medicine Programs

Number of *Geriatric Medicine* Programs Reviewed	37
Initial Accreditation	3
Continued Accreditation	27
Proposed Withhold	1
Withhold	1
Progress Reports	5



Summary of Actions: Sub Review Cycles



Guidance on Interpretation of IM Program Requirements

- FAQ contain clarification and interpretation of program requirements
- Core IM FAQ
  http://www.acgme.org/acWebsite/RRC_140/Internal_Medicine_Residency_Programs_FAQ.pdf
- General Subspecialty FAQ
  http://www.acgme.org/acWebsite/downloads/RRC_FAQ/General_Subspecialty_Fellowship_FAQs.pdf
- Specific Subspecialty FAQ
  http://acgme.org/acWebsite/downloads/RRC_FAQ/151_Geriatrics_FAQ.pdf

New FAQ
Use of Remote Site for Training

Question: What are the RC's expectations for programs w/ participating sites that are geographically distant from the primary teaching site?

(July 2011 RC Meeting)

New FAQ
Evaluation of Faculty by Fellows

- ***Question: Are fellows expected to evaluate faculty at end of each rotation? What are the expectations?***

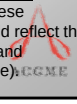
- ANSWER: The RC acknowledges that some attending assignments to teaching activities may not be tightly linked to the month-long delimited rotations/assignments. For such situations, evaluations of faculty do not need to not take place at the end of the monthly rotation, since the fellow may not have had enough exposure to a particular attending to meaningfully evaluate the attending. However, at a minimum, the RC expects that fellows will evaluate the faculty member's performance/teaching ability at least quarterly. (July 2011 RC Meeting)

Multisource Evaluation

"The program must use both direct observation and multi-source evaluation, including patients, peers and non-physician team members, to assess fellow performance in: Interpersonal communication, Professionalism and System-Based Practice."

FAQ Question: What is expected for multi-source evaluation of fellows?

Answer: Multi-source evaluations are important in the assessment for several competencies. The goal is to obtain feedback from multiple evaluators who interact with the fellow being assessed. These must include at least patients, peers, and non-physician team members (nurses, clerical staff, therapists, etc.). Forms distributed to these individuals do not have to ask each the same items, but should reflect the same general domain(s) being assessed (e.g., interpersonal and communication skills, professionalism, systems-based practice).



New/Changed Requirements

- Electronic Health Record
- Simulation
- PD Salary Support
- Associate Program Director
- KCF Evaluator
- Conferences
- Practice Management
- Take *and* Pass Rate

New Subspecialty PRs

- At Feb 2011ACGME mtg, Board approved revisions to subspecialty requirements in following areas:
  - Cardio, CCEP, IC, Hem, Onc, Hem/Onc, GI, TH, Rheum, Endo, Nephro, ID, Pulm, Pulm/CCM, and Sleep Medicine were all approved and go into effect July 1, 2012.
- At the Sept. 2011 ACGME Mtg, CCM PRs were approved
  - These PRs will go into effect July 1, 2012.
- Advanced Heart Failure and Transplant Cardiology PRs were approved at the February 2012 ACGME Board meeting.
  - Applications available in ADS/website

Deleted Program Requirements

- Current "general requirements" were combined with individual subspecialty program requirements – *so, not really deleted, more integrated.*
- Death reviews and autopsy reports – *deleted*
- Specifics of the written curriculum (teaching methods, reading lists, disease mix, etc) – *deleted*
- Teaching rounds of five hours a week – *deleted*
- Conference specificity (types and numbers of conferences per month) – *deleted #s*

Update on GM PRs

- Last year, RC's were asked to not proceed with PR revisions because of preparations for NAS. In February 2012, "moratorium" was lifted.
- RCs need to come to agreement on the "general subspecialty requirements" that should apply to GM.
  - Will eliminate the potential for different expectations depending on the RC reviewing the program.
  - RCs are discussing differences, mainly related to expectations for faculty scholarly activity
- New *Expected* Timeline
  - Document should be posted for review & comment in the fall of 2012.

RRC-Communications

RRC NEWS
INTERNAL MEDICINE

Accreditation Council for Graduate Medical Education — DECEMBER 2011

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REVIEW COMMITTEE STAFF
JERRY VASILIAS, PHD
EXECUTIVE DIRECTOR

INFORMATION ON THE "NEXT ACCREDITATION SYSTEM"

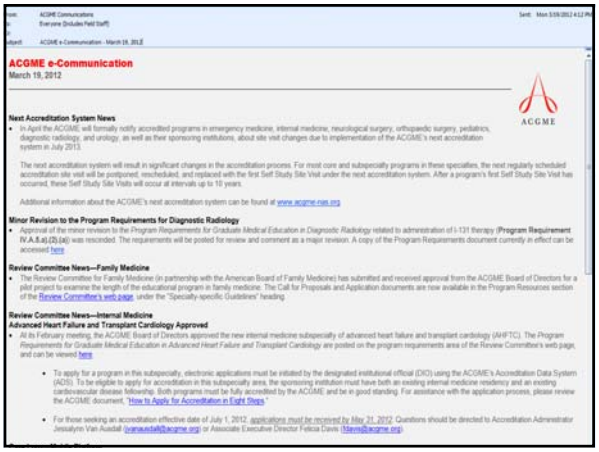
The graduate medical education community was introduced to the concept of the "next accreditation system" in March 2010, when ACGME Chief Executive Officer Dr. Thomas Nasca discussed the shift to the next system during his welcoming address at the Annual Educational Conference. The summary of Dr. Nasca's address can be found here. In brief, the next accreditation system will be very different from the current accreditation system which is associated with episodic site visits and reviews and accreditation cycles between one-five years. The next accreditation system will be more of a continuous accreditation model that will be associated with annual reporting and review of data. The next system will also foster and promote innovation and excellence, much more than the current one does. Program directors should anticipate receiving an update on when and how the next accreditation system will be implemented in the near future.

PGY-1 RESIDENTS AND MINIMUM TIME OFF BETWEEN DUTY PERIODS

A number of program directors have asked for clarification regarding the expectations for minimum time off between duty periods for PGY-1 residents, specifically related to what program directors are required to do when PGY-1 residents receive at least eight hours, but less than 10 hours of rest between duty periods. When this happens, program directors are

RRC Communications

- RRC-IM Newsletter
  - Sent to all core, med-peds and subspecialty program directors, coordinators, and DIOs
  - Most recent newsletter: http://www.acgme.org/acWebsite/RRC_140_news/140n_Index.asp
  - Twice a year



ACGME e-Communication
March 19, 2012

Next Accreditation System News

- In April the ACGME will formally notify accredited programs in emergency medicine, internal medicine, neurological surgery, orthopaedic surgery, pediatrics, diagnostic radiology, and urology, as well as their sponsoring institutions, about site visit changes due to implementation of the ACGME's next accreditation system in July 2013.

The next accreditation system will result in significant changes in the accreditation process. For most core and subspecialty programs in these specialties, the next regularly scheduled accreditation site visit will be postponed, rescheduled, and replaced with the first Self Study Site Visit under the next accreditation system. After a program's first Self Study Site Visit has occurred, these Self Study Site Visits will occur at intervals up to 10 years.

Additional information about the ACGME's next accreditation system can be found at www.acgme-nas.org

Minor Revision to the Program Requirements for Diagnostic Radiology

- Approval of the minor revision to the Program Requirements for Graduate Medical Education in *Diagnostic Radiology* related to administration of I-131 therapy (**Program Requirement** IV.A.5.a).(2).(a)) was rescinded. The requirements will be posted for review and comment as a major revision. A copy of the Program Requirements document currently in effect can be accessed here

Review Committee News—Family Medicine

- The Review Committee for Family Medicine (in partnership with the American Board of Family Medicine) has submitted and received approval from the ACGME Board of Directors for a pilot project to examine the length of the educational program in family medicine. The Call for Proposals and Application documents are now available in the Program Resources section of the Review Committee's web page, under the "Specialty-specific Guidelines" heading.

Review Committee News—Internal Medicine
Advanced Heart Failure and Transplant Cardiology Approved

- At its February meeting, the ACGME Board of Directors approved the new internal medicine subspecialty of advanced heart failure and transplant cardiology (AHFTC). The *Program Requirements for Graduate Medical Education in Advanced Heart Failure and Transplant Cardiology* are posted on the program requirements area of the Review Committee's web page, and can be viewed here.
  - To apply for a program in this subspecialty, electronic applications must be initiated by the designated institutional official (DIO) using the ACGME's Accreditation Data System (ADS). To be eligible to apply for accreditation in this subspecialty area, the sponsoring institution must have both an existing internal medicine residency and an existing cardiovascular disease fellowship. Both programs must be fully accredited by the ACGME and be in good standing. For assistance with the application process, please review the ACGME document, "How to Apply for Accreditation in Eight Steps."
  - For those seeking an accreditation effective date of July 1, 2012, *applications must be received by May 31, 2012*. Questions should be directed to Accreditation Administrator Jessalynn Van Ausdall (vanausdall@acgme.org) or Associate Executive Director Felicia Davis (fdavis@acgme.org).

RRC Communications

- ACGME E-Communication
  - Weekly email PD, DIOs,
  - Contains GME information: New requirements, newsletters; updates on ACGME issues/initiatives
  - "Quick" Read

Resident Survey (RS): General Information

- Administered annually Jan-May
- 70% completion rate to see summary report
- Question in RS relate to 5 content areas: *Faculty, Educational Content, Evaluation, Resources, Duty Hours.*
- *In 2009:* All core programs and fellowships with 4 or more need to complete survey annually
- *In 2010:* questions in RS were modified
- *In 2011*: revised based on input from residents and survey experts
- *In 2012*: RS revised to align with new PRs. In prep for NAS, all residents & fellows will be surveyed.

Resident Survey (RS)

- *In 2006:* ACGME Board gave Monitoring Committee (Mon Com) responsibility to oversee duty hour (DH)
- *In 2010 & 2011*: Mon Com made recommendations for programs w/ significant non-compliance w/
  - *DH as well as issues with other parts of the RS; and*
  - *DH issues over multiple years (2 of 3).*
- *In 2010*: Mon Com made recommendations for programs w/ significant issues w/ the non-DH sections of RS
- *In 2011*: Mon Com identified programs w significant issues w/ non-DH sections of the RS, but did not make recommendations for action. RC reviewed and decided these.

***# of programs compliant w DH, but had issue with other parts of the RS: 210** programs (4% of all programs that participated in the RS) were identified as having substantial non-compliance with at least 2 other areas of the survey aside from DH. **60** were IM core or subs.*

- **5** = immediate site visit – all programs had been warned in the past
- **2** = progress reports

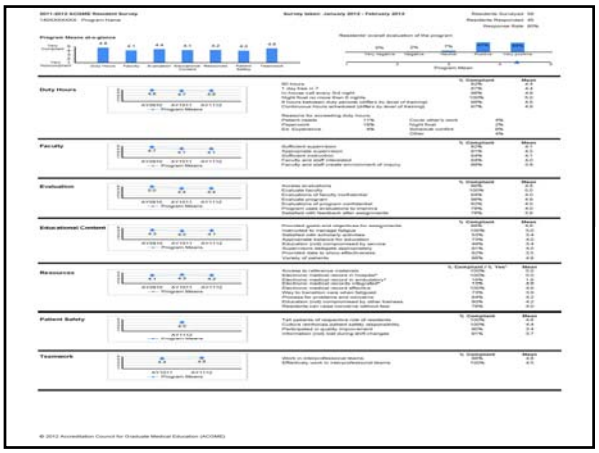
There are **8,576** ACGME accredited programs

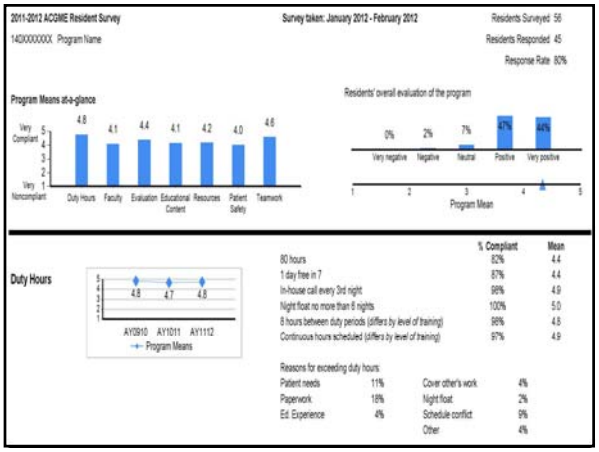
5,798 programs (65% of all accredited programs) participated in the RS (all core + sub programs w/ 4 or more fellows)

***# of program w DH issues: 173** programs (3% of those that participated in the RS) were identified as having substantial non-compliance issues w/ DH.*

- **53** were IM core or subs
  - 45 were first time offenders
  - **4** = DH + other areas (2 core; 2 subs)
  - **4** = DH in 2 of last 3 yrs (all core)

*For the **4 core IM** that had DH issues for multiple years, Mon Com recommended the RC review the programs and have then undergo an immediate site visit. RC agreed.*




2011-2012 ACGME Resident Survey
Survey taken: January 2012 - February 2012
Residents Surveyed 56
Residents Responded 45
Response Rate 80%
140XXXXXXX Program Name
Program Means at-a-glance
Very Compliant
Very Noncompliant
4.8
4.1
4.4
4.1
4.2
4.0
4.6
Duty Hours
Faculty
Evaluation
Educational Content
Resources
Patient Safety
Teamwork
Residents' overall evaluation of the program
0%
2%
7%
47%
44%
Very negative
Negative
Neutral
Positive
Very positive
Program Mean
Duty Hours
4.8
4.7
4.8
AY0910
AY1011
AY1112
Program Means
% Compliant
Mean
80 hours
82%
4.4
1 day free in 7
87%
4.4
In-house call every 3rd night
98%
4.9
Night float no more than 6 nights
100%
5.0
8 hours between duty periods (differs by level of training)
98%
4.8
Continuous hours scheduled (differs by level of training)
97%
4.9
Reasons for exceeding duty hours:
Patient needs 11%
Paperwork 18%
Ed. Experience 4%
Cover other's work 4%
Night float 2%
Schedule conflict 9%
Other 4%


The "*Next Accreditation System*"
ACGME

The 2005 ACGME Strategic Plan[1]: Emergence of "The New Accreditation Model"

"At its November 2005 retreat, the ACGME Executive Committee endorsed four strategic priorities designed to *enable emergence* of the new accreditation model:

- Foster innovation and improvement in the learning environment
- Increase the accreditation emphasis on educational outcomes
- Increase efficiency and reduce burden in accreditation
- Improve communication and collaboration with key internal and external stakeholders "

[1] ACGME 2005 Strategic Plan: Emphasis added by Thomas Nasca, MD, CEO

Next Accreditation System (NAS) Big picture…

- Less prescriptive ACGME program requirements
- Less frequent changes to program requirements
- Continuously monitors outcomes and other predictive measures
- Continuously holding sponsoring institutions responsible for oversight of educational and clinical systems
- Promoting curricular innovation
- Enhance curricular and rotation design flexibility

Next Accreditation System (NAS) Elements

- Formal in depth self study and site visit every 10 years
- RC receives data continuously
- RC tracks data on each program
  - Milestone performance data (for core initially; subs to follow in the future)
  - Resident survey data
  - Faculty survey data
  - Board certification performance data
  - Other ADS data
  - *Other data elements identified as important by the RC*

Next Accreditation System (NAS) Milestones – what are they??

- Observable developmental steps moving from Novice to Expert/Master
- Organized under the rubric of the 6 domains of clinical competency
  - Describe a trajectory of progress from neophyte towards independent practice
  - Articulate shared understanding of expectations
  - Set aspirational goals of excellence
  - Provide a framework and language for discussions across the continuum
  - Will allow for normative data to make relative comparisons
- Work on Milestones development has been underway for some time in core, and is expected to start with subs soon

	Competency	Unacceptable			Ready for unsupervised practice	Aspirational
Not seen by Program Director (ACGME data)	Dreyfus Developmental stage		Advanced Beginner	competent	Proficient	Expert
	Demonstrates professional and respectful interactions with patients and families	Disrespectful in interactions with patients and families.	Respectful in interactions with patients and families. Is available and responsive to patients, families, peers and team members.	Demonstrates compassion, empathy and respect to patients and a commitment to relieve pain and suffering.	Goes beyond responding to the expressed needs of patients and Families Anticipates and advocates for and works to meet the needs of patients and families.	Able to incorporate patient differences and preferences into the plan of care in a way that patients and families recognize this sensitivity

Next Accreditation System (NAS) Timeline

- Phase 1 specialties: *Pediatrics; Internal Medicine; Diagnostic Radiology; Emergency Medicine; Orthopedic Surgery; Neurological Surgery; Urological Surgery*
- Phase 1 specialties will enter preparatory year 7/2012
- Phase 1 specialties “go live” 7/2013
- Phase 2 specialties enter preparatory year 7/2013
- Phase 2 specialties “go live” 7/2014

Preparatory Year

- The RC will spend much of 2012 "preparing" for the NAS
- First, the COMMON PRs will be categorized, then the SPECIALTY PRs.
  - ***Outcome PRs*** *– PRs written as outcomes*
    - *Example: Fellows must be able to demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well the application of the knowledge to patient care (CPR IV.A.5.b)*
  - ***Core Process PRs*** *– PRs that are fundamental to maintain an quality educational program*
    - *Example: There must be a single program director with authority and accountability for the operation of the program (CPR II.A.1).*
  - ***Detailed Process PRs*** *– PRs that provide additional details or an explanation for core process PRs*
    - *Example: Program Director should continue in position for length of time adequate for continuity of leadership and program stability. (CPR II.A.2)*

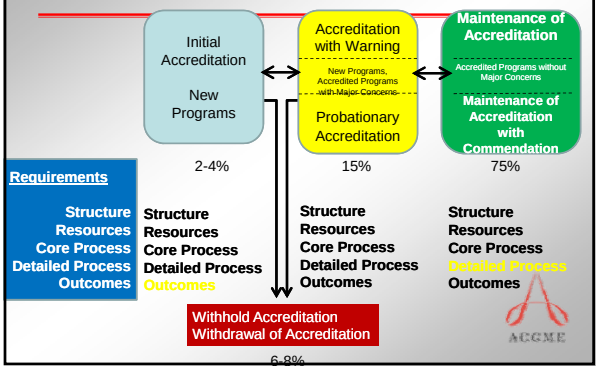
Preparatory Year

•Programs identified as being in "good standing" based on defined metrics (resident survey, faculty survey, board scores, other data, etc.) will be allowed to "innovate", meaning they will not asked whether they are adhering to detailed process PRs.

•Detailed process PRs do not go away. PDs will not need to demonstrate compliance w/ these PRs, unless it becomes evident that a particular outcome or core process is not being achieved.

EXAMPLE: Continuity Clinic Experience. The outcome is for fellows to achieve ongoing meaningful interaction with a panel of patients. The "particulars" in the PRs are the detailed process .

Conceptual Model of NAS



Preparatory Year

- The common PRs have been categorized, now the core IM and sub PRs are being categorized into *Outcome*, *Core*, and *Detailed Process*
- Once PRs have been categorized will be vetted for "review and comment"
  - Akin to vetting process for proposed changes to PRs
  - In order to be transparent with community + to see if there is agreement
  - Will me posted very soon for a 45 day period
- Will likely see NAS categorized PRs posted on website in late April/early May
  - Categorization needs to be approved by ACGME's Committee on Requirements in September of 2012.

Preparatory Year

QUESTION: How will the transition to NAS affect my site visit that is tentatively scheduled for the fall of 2012 or early 2013?

- All programs in "good standing" in the current system (4-5 yr review cycles) will get a "bump" of some type –
  - They will not be visited in the fall.
  - They will be visited under the NAS.
- Most programs with 3 yr review cycles will also get a "bump"
- Programs with review cycles of 2 yrs of less will undergo a site visit under the current system.
- Programs that received initial accreditation will also undergo a site visit as planned under the current system.

Preparatory Year

- In general, site visits as you've known them in the past *will go away in the NAS as will what went along w them…*
  - *"The NAS will eliminate the program information form, which is currently prepared for site visits.*
  - *Programs will conduct a 10 year self study, similar to what is done by other educational accreditors."*
- The Self Study site visit will replace the current site visit.
- Once the *first* Self-Study is scheduled, every other Self Study will take place every 10 years.
- The Self Study will couple the core and subs together & will not use a static/descriptive tool (PIF).
- More will be communicated to you about the Self Study soon.

Preparatory Year

- *QUESTION: So, under NAS all site visits will be replaced with Self-Study site visits and ACGME/RC will not come for a visit except for every 10 years?*
- Answer: Although the Self-Study will take place every 10 years, the RC will be reviewing annual information supplied by program (Fellow Survey, Faculty Survey, Board score data, other ADS data, Milestones data – in the future, other variables identified as important by RC – to be determined) and will be able to request site visits whenever data element(s) show outliers/extreme responses.
- So, in the NAS the RC *will be able to request site visits not associated with Self-Study*, often to clarify extreme data responses, but site visits in NAS will be targeted or focused visits that will not necessitate use of a PIF.

Information on NAS:

http://www.acgme-nas.org/

Questions?

New FAQ
Use of Remote Site for Training

Question: What are the RC's expectations for programs w/ participating sites that are geographically distant from the primary teaching site?

- ANSWER: The RC considers a participating site "remote" if it requires extended travel (consistently more than 1 hour each way) or the radius b/w the site and the primary site exceeds 60 miles. The RC expects the following when remote participating sites are used:
- The program has provided educational rationale for the use of the remote site in ADS.
- The PD has final authority over all aspects of training at the remote site.
- If experiences at the remote site will be required experiences, this info will need to be disclosed to all applicants prior to entering the program.
- No more than 25% of the educational experience can occur at remote sites.
- The program will need to ensure the fellows have housing available at the remote sites, at no cost to the fellows.
- The program will need to establish a mechanism that allows:
  - Fellows to participate in conferences at the primary site (electronically), or make available conferences with similar educational value at the remote site;
  - Faculty at the remote site to interact with faculty at the primary site;
  - Fellows at the remote site to interact with other fellows at the primary site; and.
  - Fellows to participate in interviews with the site visitor at the time of the program's site visit. (July 2011 RC Meeting)