Allergy and Immunology Review Committee Update
February 28, 2015

William K. Dolen, MD, Chair
Review Committee for Allergy & Immunology

ACGME Annual Educational Conference
Manchester Grand Hyatt San Diego and Hilton San Diego Bayfront
San Diego, California
February 26-March 1, 2015
Disclosures

- No conflicts of interest to report
Discussion Topics

- Introduction to ACGME-speak
- RC for A&I Membership
- RC for A&I Activities
- Working in the NAS
- ACGME Initiatives
ACGME-speak

- RC: review committee; formerly called “residency review committee” (RRC)
- NAS: Next Accreditation System; actually, the current accreditation system
- ADS: Accreditation Data System
- PR: Program Requirements
- FAQ: Commentary on the PR, reflecting the RC’s current interpretation
- In the ACGME, allergy-immunology is classified as a residency, not as a subspecialty fellowship; A-I thus has its own RC, separate from pediatrics and internal medicine
- If you encounter unfamiliar acronyms, always ask – don’t assume
RC for Allergy and Immunology Members

- William K. Dolen, MD (Chair)
- Jay M. Portnoy, MD (Vice Chair)*
- Amal H. Assa’ad, MD
- Mary Beth Fasano, MD
- Anita T. Gewurz, MD
- David P. Huston, MD*
- Bruce Joshua Lanser, MD – Resident Member
- Gailen D. Marshall, Jr., MD
- Michael R. Nelson, MD
- Stephen I. Wasserman, MD - Ex-Officio (ABAI)
- Louise King, MS – Executive Director, RC for A&I

*Terms end June 30, 2015

RC members are not allowed to discuss RC activities, accreditation decisions
Incoming RC Members

- Anne-Marie Irani, MD
  - VA Commonwealth University Health System, Richmond, VA
- Rohit K. Katial, MD
  - National Jewish Health, Denver, CO
- Beverly B. Huckman (Public Member)
  - Former Associate VP for Equal Opportunity – Rush University Medical Center in Illinois
- Terms begin July 1, 2015
RC for Allergy and Immunology Staff

ACGME Leadership
• Mary Lieh-Lai, MD, Senior Vice President for Medical Accreditation
  (312) 755-7405 – mliehlai@acgme.org

RC Staff
• Louise King, MS, Executive Director
  (312) 755-5498 – lking@acgme.org
• Karen Lambert, Associate Executive Director, RC for Internal Medicine
  (312) 755-5785 – kll@acgme.org
• Debra Martin, Accreditation Administrator
  (312) 755-7471 – dmartin@acgme.org
RC Meetings

- February 5-6, 2015
  - Agenda closed November 27, 2014
- May 28-29, 2015
  - Agenda closing March 19, 2015

Note – These are the same agenda closing dates for the submission of new applications.

These slides have been prepared in advance of the February 2015 meeting, and will be updated.
Program Accreditation

• Academic year 2014-2015
• Total Programs 75
Current RC Projects

• Implementation of the Next Accreditation System

• Revision and simplification of the case and procedure logging system

• Defining and tracking scholarly activity

• Revisions to Program Requirements
Question time!

Next up:

- The Next Accreditation System
Aims of NAS

- To enhance the ability of the peer-review system to prepare physicians for practice in the 21st century
- To accelerate the movement of the ACGME toward accreditation on the basis of educational outcomes
- To reduce the burden associated with the previous structure and process-based approach
NAS in a Nutshell

- Continuous Accreditation Model
  - ADS
  - Resident and faculty surveys
  - Milestones
  - Other data

- Scheduled Site Visits Replaced
  - 10 year Self Study Visits (no more Program Information Forms)
  - Focused Site Visit
  - Full Site Visit

- Program Requirements revised every 10 years instead of every 5 years
Data Elements of NAS

The following are the primary annual data elements:

- ADS annual update - many parameters including:
  - Program attrition
  - Program changes
  - Hospital and institutional accreditation status
- Resident (“fellow”) and faculty surveys
- Case and procedure log data
- Resident and faculty scholarly activity and productivity
- ABAI pass rate
- Milestone reports
Where did most of the NAS data elements come from?

- In 2009, data modeling project began to identify factors that predicted high and low program performance
- A number of statistical methods were used
- Data elements assessed to determine “relative risk” to predict low performance
- Element selection needed to be:
  - Obtainable
  - Meaningful
  - Correlates with prior decisions
  - Passed statistical “muster”
  - Used in combination
- This is a work-in-progress
- New data elements likely in future
Resident and Faculty Surveys

- These surveys are a very important component of the ACGME Accreditation System
- Residents and faculty need to be advised to read the questions and answers carefully
- The RC tracks and scrutinizes survey answers very closely
- The RC assumes that answers are carefully thought-out, honest answers and will take action as needed
Case and Procedure Logs

- The RC tracks, analyzes, and scrutinizes log data closely
- The logging system needs to be brought into line with the current PR, and simplified – this is a work in progress
- The coding system looks like ICD-9, but it is not
- Residents must use ONLY the coding system in the RC pamphlet, otherwise they will have “Unassigned Diagnoses” that don’t count
- They need to log every diagnosis; see the RC FAQ for details on what to log
- They need to log every procedure; see the RC FAQ for details on what to log
Staying Sane in the NAS

- Program directors, coordinators, faculty, and residents should study the program requirements
- Your program must do the “musts”
- Your program should do the “shoulds” and should have a written reason on file for why you’re not
- Core and Detail requirements
- Also study the FAQs – they reflect current RC policy on enforcement of PRs
Sanity and the Accreditation System

- Ensure that residents and faculty are involved in scholarly activity
- Use a simple milestone reporting system
- Carefully study your yearly ADS report before submission (no blanks)
- Remember, ADS can be updated throughout the year
- Tell your residents and faculty to read the survey questions and answer carefully before submitting
- Be an ogre about the logs: every case, every procedure
- Questions? Contact the Executive Director! (First, be sure your institution allows this.)
Question time!

Next up:
- Accreditation Decisions
Accreditation Decisions - Existing Programs

- Continued Accreditation
- Accreditation with warning (no time limit)
- Probationary Accreditation (2 years)
- Withdrawal of Accreditation
Accreditation Decisions – New Programs

Accreditation Decisions: (New Application)
- Initial Accreditation
- Withhold Accreditation

Accreditation Decisions: (Programs with Initial Accreditation)
- Initial Accreditation with warning
- Continued Accreditation
- Withdrawal of Accreditation
Role of Review Committee in NAS

- Utilize data and judgment to:
  - Concentrate efforts on problem programs
  - Determine whether accreditation standards are violated and provide useful feedback for programmatic improvement
  - Determine whether these violations (citations) rise to a level requiring alteration in accreditation status
  - Motivate programs to rapidly improve, rather than playing the “accelerating accreditation action game”
  - Over time, understand and refine the nuances of the process
- Conduct complete review of the program every 10 years, using a “PIF-less,” team based, department wide evaluation of programs
NAS Year 1: Ground rules

- Basic operational principle of NAS:
  - RC will take an accreditation action on every program annually
  - All programs will receive notice regarding accreditation status between January and July
- At February 2015 meeting, RC reviewed NAS data submitted for AY 2013-2014
  - ADS annual update information submitted in fall of 2013
  - Faculty and Resident/Fellow survey data from early spring of 2014
NAS Year 1: Ground rules

- All programs with continued accreditation with warning or probation seen by reviewers
- All programs identified by NAS data as “troubled” underwent further scrutiny by RC staff and members
- What data elements were triggered?
  - Not all data elements have same importance/weight
  - Board scores and resident survey have more weight
  - Are programs still getting used to data elements (e.g., scholarly activity table)?
  - Are there patterns/trends in data?
PD Responsibility: Accurate Data

Program Director:
- Must provide complete and accurate information
- Review all information before “hitting” the submit button
- DIO should also review before submission
- Common Omissions:
  - Faculty credentials (degree, certification, re-cert)
  - Participating sites
  - Complete scholarly activity
  - Updated response to citation(s)
  - Complete block diagram
Identifying Faculty for Faculty Roster

• This is a PD responsibility
• Identifying who to list in ADS:
  – Only physicians count as core faculty
  – Core Programs (including A&I): Only faculty who spend at least 15 hours or more/week on residency (including clinical, didactic, research and administration)
  – Subspecialty Programs: Only faculty who spend at least 10 hours/per week
  – Review instructions in ADS: List minimum number for size of program
  – Core faculty members complete the scholarly activity report and the faculty survey
Accreditation Status Options

New Applications

**Significant change:** no “proposed” withhold; applications either receive “initial accreditation” or “accreditation is withheld.”
Accreditation Status Options

Initial Accreditation

*Significant changes:* maximum length for “initial accreditation” = 2 years; can move to “continued accreditation w/o outcomes”; can move from “initial accreditation” to “initial accreditation with warning”
Accreditation Status Options

Continued Accreditation

* Significant changes: “Continued Accreditation with Warning” appears as such on website; an adverse action cannot be granted without a site visit; subs now can also be put on “probationary accreditation.”

Accredited Program:
- Continued Accreditation (CA)
- CA w/Warning
- Other (e.g. egregious)
- Site Visit

Probationary Accreditation*
- Withdrawal of Accreditation**
- CA w/Warning
- CA

* Probation cannot exceed 2 years
** Does not require Probation first
Citations in NAS

Citations are not new
- Identify areas of non-compliance
- Linked to specific requirements
- Responses required in ADS
- Citations are given and removed by RC (not by staff)

Citations received in NAS (after July 1, 2013): will require an RC member to review annually.

Citations received in the old system (given prior to July 1, 2013): will go away after two cycles of continued accreditation in NAS with no new citations.
Areas for Improvement (AFI)

- AFIs are new in NAS
- “General concerns”
- May be given or removed by staff (RC rules) or RC
- May not be specifically linked to a requirement
- Do not require written response in ADS
- Expectation that AFIs will be monitored locally
  - PD and GMEC will work to resolve
- AFIs will be tracked by RC
Citations vs AFIs

- In OAS, the main mechanism to provide feedback was through citations.
- In NAS, we have 2 methods: citations and AFIs.
- Citations require annual review by a member of the RC.

Citations will likely be used more sparingly, in hopes that AFI’s trigger appropriate local program improvement.
Letter of Notification (LON)

- New Departmental LON
  - Summarizes actions for entire department
  - Sent to core program directors, subspecialty program directors and DIO
LONs from February 2015 Meeting

• Will receive or be copied on departmental letter

……and…. 

• If program receives new citation(s):
  – will receive separate LON.

• If program DOES NOT receive new citation(s):
  – Core: will receive separate LON as well
  – Sub: will NOT receive separate LON

• If program DOES NOT receive new citation(s), but DOES receive AFIs:
  – Will receive separate LON with AFIs
Site Visits in NAS

Three types

• Full site visits
• Focused site visits for an “issue”
• Self-study visits every ten years
Full Site Visits

- Application for a new core program
- At the end of the initial accreditation period
- RRC identifies broad issues/concerns
- Other serious conditions or situations identified by the RRC
- Notification given about 60 days in advance
- Minimal document preparation anticipated
- Team of site visitors
Focused Site Visits

• To assess selected aspects of program:
  – Potential problems identified during annual review
  – To diagnose reason for deterioration in performance
  – To evaluate a complaint
• Minimal notification given - about 1 month)
• Minimal document preparation expected
• Team of site visitors
Self-Study Visit

What is it?

• Not yet fully developed
• Will review core and subspecialty programs together
• Scheduled every ten years
• Conducted by a team of visitors
• Minimal document preparation expected
• Interview residents, faculty, leadership
Self-Study Visit (cont.)

- Examine annual program evaluations
  - Response to citations
  - Faculty development
- Focus: Continuous improvement in program
- Learn future goals of program
- Will verify compliance with core requirements
Ten Year Self-Study Visit

Yr 0
Yr 1
Yr 2
Yr 3
Yr 4
Yr 5
Yr 6
Yr 7
Yr 8
Yr 9
Yr 10

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Self-Study Process

Self-Study VISIT
Question time!

Next up:
- Milestones
Milestones

• Created by each specialty

• A combined effort of the ACGME and Specialty Boards
Milestones Defined

General Definition

• Skill and knowledge-based developments that commonly occur by a specific time

Milestone Project Definition

• Specific behaviors, attributes, or outcomes in the general competency domains to be demonstrated by residents by a particular point during residency
A-I Milestone Development

**Working Group**
- Prescott Atkinson
- William Dolen
- Laura Edgar
- Mary Beth Fasano
- Anita Gewurz
- John Kelso
- Louise King
- Dennis Ledford
- Michael Nelson
- Stokes Peebles
- Jay Portnoy
- Nastaran Safdarian

**Advisory Group**
- Timothy Brigham
- David Peden
- Lawrence Schwartz
- Stephen Wasserman
- Richard Weber
ACGME Goals for Milestones
“Cohesion for the Continuum”

- Able to provide accountability for effectiveness of educational program in producing outcomes
- ACGME can work with:
  - AAMC, LCME to focus graduation level preparation
  - ABMS, AHA, ACCME, others to identify areas for milestone improvement at graduation from residency/fellowship
ACGME Milestones Project

Key features

- Emphasize core competencies
- Provide PD’s and others something concrete on which to base formative and summative evaluations
- Move accreditation from structure and process-based to outcomes-based
- A-I milestones are similar to information already being reported to ABAI
- Hope for future integration between ACGME and ABAI
Milestones Document

• Template for evaluating physician performance at various career points
• Based on the 6 core competencies
  – Divided into subcompetencies
  – Each has performance language to allow categorization ranging from Level 1 (entry) through Levels 2, 3, 4 (competent to graduate), and Level 5 (aspirational)
**A-I Milestone Example**

**Patient Care (#3 of 4 PC & 10 total)**

**Management Plan:** Designs an appropriate management plan that incorporates indication, risk, benefits, and cost of therapies for allergic and immunologic disorders. *(Core Competency: Patient Care)*

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recognize basic treatments for common allergic and immunologic disorders</td>
<td>• Select and implement treatment from existing evidence based therapies or clinical trials with substantial supervision</td>
<td>• Select and implement cost effective treatment from existing evidence based therapies or clinical trials with minimal supervision</td>
<td>• Independently select and implement cost effective treatment from existing evidence based therapies or clinical trials</td>
<td>• Participate in writing or reviewing practice guidelines</td>
</tr>
<tr>
<td>• Identify outcomes associated with various treatments</td>
<td>• Formulate a plan for monitoring outcomes</td>
<td>• Monitor outcomes and appropriately adjust treatment with supervision</td>
<td>• Independently monitor outcomes and appropriately adjust treatment</td>
<td>• Identify and report previously unrecognized outcomes</td>
</tr>
<tr>
<td>• Identify potential adverse events associated with various treatments</td>
<td>• Formulate a plan for monitoring and treating adverse events with substantial supervision</td>
<td>• Monitor and treat adverse events with minimal supervision</td>
<td>• Independently monitor and treat adverse events</td>
<td>• Identify and report previously unrecognized adverse events</td>
</tr>
</tbody>
</table>

Comments:
Milestones Document

- Milestones are not the only measure of competency.
- Levels 2, 3, 4 do not necessarily correlate to PGY 2, 3, 4.
- Not all Level 4 items are expected to be achieved by the end of training.
- Resident not required to meet EACH Level 4 item to graduate.
- Resident not assured of graduation solely on basis of Level 4 item achievement.
- Milestones are designed as minimum goals; most residents will accomplish more.
Milestones Document

• Designed for use by a Clinical Competency Committee which meets every six months
• The CCC reviews data from various evaluation tools, categorizes each resident as Level 1-5 for each competency (A-I has 10 reporting items)
• Individual data are NOT used for accreditation; milestones are not pass-fail items
Milestones Reporting

- November 1 – December 31, 2014
- May 1 – June 15, 2015
Clinical Competency Committee

• V.A.1. The program director must appoint the Clinical Competency Committee. (Core)
• V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. (Core)
• V.A.1.a).(1) Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team. (Detail)
• V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. (Core)
Clinical Competency Committee

V.A.1.b).(1) The Clinical Competency Committee should:

- V.A.1.b).(1).(a) review all resident evaluations semi-annually; (Core)
- V.A.1.b).(1).(b) prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, (Core)
- V.A.1.b).(1).(c) advise the program director regarding resident progress, including promotion, remediation, and dismissal. (Detail)
Clinical Competency Committee

The role of the Program Director in the CCC is undefined

- “Voting” member
- Ex-officio member
- Chair
- Not a member
Screen Shot – Core Pediatrics Milestones Reporting Form on ADS

Select the option corresponding to the resident's performance in each area below. Your selections should be based on the longitudinal or developmental experience of the resident. Evaluation must be based on observable behavior. Mouse over the radio buttons to read the criteria for each developmental level.

### Competency
**Patient Care**

#### Subcompetencies
- a) Gather essential and accurate information about the patient
- b) Organize and prioritize responsibilities to provide patient care that is safe, effective, and efficient
- c) Provide transfer of care that ensures seamless transitions
- d) Make informed diagnostic and therapeutic decisions that result in optimal clinical judgement
- e) Develop and carry out management plans

#### Medical Knowledge

- Clinical experience allows linkage of signs and symptoms of a current patient to those encountered in previous patients. Still relies primarily on analytic reasoning through basic pathophysiology to gather information, but has the ability to link current findings to prior clinical encounters allows information to be filtered, prioritized, and synthesized into pertinent positives and negatives, as well as broad diagnostic categories.
Question time!

Next up:
- CLER
CLER Program

• Clinical Learning Environment Review
• An institution-level program, not program-level
• Institutions will be visited every 18 months
• Data will not be used for program accreditation
• Programs must ensure that residents and fellows:
  – Are aware of patient safety/quality improvement efforts of the institution
  – Are actively participating in patient safety and quality improvement efforts
Case and Procedure Logs

• The logs are important components of the ACGME Accreditation System – the RC tracks, analyzes, and scrutinizes your log data closely
• The logging system is being studied; report due at February 2015 RC meeting
• The coding system looks like ICD-9, but it is not
• Use ONLY the coding system in the RC pamphlet, otherwise you will have “Unassigned Diagnoses” that don’t count
• Log every diagnosis; see the RC FAQ for details on what to log
• Log every procedure; see the RC FAQ for details on what to log
• Log data (diagnoses and procedures) are tracked, analyzed, and scrutinized closely – PLEASE LOG EVERYTHING!
Patient Log Minimums

What are the RC's guidelines regarding a sufficient number of adult and pediatric patients? [PR: II.D.1]

• Each resident must demonstrate adequate patient exposure by logging experience with 745 total diagnoses.

• Residents may log as many as 3 diagnoses/patients.
  – A patient with anaphylaxis due to peanut allergy can be listed as both a food allergy and anaphylaxis experience.

• Of these 745 total diagnoses, a minimum of 150 should occur in adult patients and 150 should occur in pediatric patients.
Where Did This Come From?

• The Review Committee used the 10th percentile values for total and diagnosis-specific data from the 2009-2010 National Resident Log Report as a reference norm.

• The Committee recognizes that when the 10th percentile for a required diagnosis is less than 5, there may be difficulties in reaching a minimum of five patient experiences.
Less Than 5 Diagnoses?

- In the event that a resident will have <5 experiences for a required A/I diagnosis (for which 5 is the minimum), the PD is required to document an alternate approach to provide the required number of experiences for this diagnosis.
- This may include development of simulated cases for the resident to manage or rotations with other programs to acquire the required minimum number of experiences.
- Simulated cases may be developed within the program, provided as programming in national or regional allergy immunology meetings, or established as an online resource (such as a PIM provided for A/I MOC).
What About Procedures?

What is the Review Committee's expectation regarding demonstrating proficiency in each of the required procedures?

• Residents must perform and evaluate the results of each required procedure at least 5 times...to the satisfaction of the PD or delegated faculty member.

• An individual resident's log should reflect the activities of that resident.

• When more than one resident participates in a given procedure, each should log it, providing the criteria in the FAQ have been met.
Procedures

- Allergen immunotherapy
- Contact or delayed hypersensitivity (anergy) testing
- Drug hypersensitivity diagnosis and treatment
- Food hypersensitivity diagnosis and treatment
- Immediate hypersensitivity skin testing
- Immunoglobulin treatment and administration [this applies to use of intravenous (IV) or subcutaneous (SC) immune globulin for replacement therapy or use of other immunomodulator therapy]
- Pulmonary function tests (PFT)
A&I Program Requirements

- The current A&I Program Requirements went into effect on 1 July 2014
- Common Program Requirements have been revised and will become effective July 1, 2015
- A&I Program Requirements also include revised eligibility requirements for the Common Program Requirements which become effective July 1, 2016
- There are also Program Requirement FAQs
- An ABAI request for a focused revision to the ACGME A&I Program Requirements to include Family Medicine in the eligibility criteria was not supported by the public review process
Scholarly Activity

- At least 50 percent of residents and faculty members must participate in scholarly activities
- Peer-reviewed funding
- Publication of original research in a peer-reviewed journal
- Dissemination (as evidenced by review articles or chapters in textbooks)
- Application (as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings); or must present scholarly discussions (journal club, grand rounds, etc.)
Question time!

Next up:
• Highlights of the FAQs
Single Accreditation System for AOA-Approved Programs

On February 26, 2014, the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM) announced their agreement to a Memorandum of Understanding (MOU) that outlines a single graduate medical education accreditation system for residency and fellowship programs in the United States.

Click here for the executive summary of the MOU

The single accreditation system allows graduates of allopathic and osteopathic medical schools to complete their residency and/or fellowship education in ACGME-accredited programs and demonstrate achievement of common Milestones and competencies.

Over the next five years, beginning July 1, 2015, AOA-approved programs and sponsoring institutions will have the opportunity to apply for ACGME accreditation. The ACGME and AOA have created and will continue to create elements of operations and infrastructure to ensure a smooth transition to the single system.

Click here for the timeline

Contact Us
E-mail questions to info@acgme.org

Single Accreditation System for AOA-Approved Programs Main Page

Education
Opportunities for Education about the Transition to the Single Accreditation System

Application Process
The following guidelines apply to currently AOA-approved core residency and subspecialty programs that apply for ACGME accreditation.

Education
Opportunities for Education about the Transition to the Single Accreditation System

Application Process
The following guidelines apply to currently AOA-approved core residency and subspecialty programs that apply for ACGME accreditation.
Accreditation of AOA Programs

AOA-Approved Program

Program is under aegis ACGME-accredited sponsoring institution

Yes

AOA-Approved as of July 1, 2015

No

Program begins standard ACGME application process at any time through the DIO of an ACGME-accredited sponsoring institution.

No

Program cannot apply under the terms of the agreement between AOA, AACOM, and ACGME; program begins standard ACGME application process at any time through the DIO of an ACGME-accredited sponsoring institution.

Yes

Sponsoring institution applies for ACGME accreditation

April 15, 2015 – June 30, 2020;
Receives “Pre-Accreditation Status”

Program submits ACGME application with ACGME-accredited sponsor endorsement

July 1, 2015 - June 30, 2020;
Receives “Pre-Accreditation Status”

Yes

Program had matriculated residents/fellows as of July 1, 2015

No

Review Committee assesses substantial compliance with current ACGME requirements

Yes

Review Committee assesses substantial compliance with current requirements, with two exceptions:
1. Program may have AOA-certified co-program director
2. AOA-certified faculty members are acceptable

No

B

C

A

ACGME
Timeline for Accreditation

• To apply, programs must be associated with ACGME-accredited sponsoring institution or institution with “Pre-Accreditation Status”

• Window for institutional accreditation open 1 April 2015 - 30 June 2020

• New institutional application process
Webinars

- Previous webinars available for review at: http://www.acgme-nas.org/index.html under “ACGME Webinars”
- CLER
- 2013 Coordinator Webinars
- NAS Phase I and Phase II: Overview of Next Accreditation System
- Milestones, Evaluation, CCCs
- Stand-alone slide decks for GME community: NAS, CCC, PEC, Milestones, Update on Policies
- Self-Study
Question time!

Thank you