2000 ANNUAL REPORT

Accreditation
Council
for
Graduate
Medical
Education

ACGME
The Accreditation Council for Graduate Medical Education is responsible for evaluating and accrediting residency programs in the United States. We are a private-sector council operating under the aegis of five medical organizations.

Most importantly we act as a catalyst, bringing together knowledgeable healthcare practitioners, educators and administrators to resolve critical issues concerning graduate medical training.

These volunteers who participate in our Residency Review Committees are key to the efficacy of our process. Through their work we directly influence the quality of graduate medical education, the quality of healthcare institutions and, ultimately, the quality of medicine in America. Because of them the ACGME is improving the pattern of medical education and the course of patient care.

From left to right: Computer Information Services staff: Felicia Davis, Data Coordinator; Thomas Richter, Data Analyst; John Nylen, COO & Director of Computer Information Services; Rebecca Miller, Director of Operations and Data Analysis; Sheri Bellar, Help Desk Specialist; David Leach, M.D., Executive Director of the ACGME.
MISSION AND VISION STATEMENT

ACGME Mission Statement
The mission of the ACGME is to improve the quality of health care in the United States by ensuring and improving the quality of graduate medical education experiences for physicians in training. The ACGME establishes national standards for graduate medical education by which it approves and continually assesses educational programs under its aegis. It uses the most effective methods available to evaluate the quality of graduate medical education programs. It strives to improve evaluation methods and processes that are valid, fair, open and ethical.

In carrying out these activities the ACGME is responsive to change and innovation in education and current practice, promotes the use of effective measurement tools to assess resident physician competency, and encourages educational improvement.

ACGME Vision Statement
The ACGME will:
• Be a source of inspiration, encouragement, support and assistance to all who strive for educational excellence;
• Incorporate educational outcomes into accreditation decisions;
• Be data and evidence driven;
• Encourage the development of core competencies across all disciplines, including knowledge of quality improvement;
• Explore a more comprehensive role in GME policy;
• Become a world leader in accreditation efforts;
• Maintain objectivity and independence while continuing its interorganizational relationships;
• Develop a consultative role and encourage innovation.
• Be the spokesperson for GME
As I begin my term as Chair, the ACGME is quickly becoming a different organization. While still closely aligned with its member organizations (previously referred to as “parents”), it clearly has an independent organizational structure and we can now identify what is clearly separable from our founding parents. It is our challenge to make the “new ACGME” synonymous with the thoughtful, reasoned voice of Graduate Medical Education.

We are well on our way, thanks to the diligent leadership of Dr. Paul Friedmann, who served previously as your Chair. His unswerving devotion to developing a workable governance structure for the organization that each and every one of the “Member” (parent) organizations fully supported is commendable. We own Dr. Friedmann a debt of gratitude.

However, despite achieving this organizational milestone, there is much that our fledgling organization must tackle. Perhaps foremost is our need to assertively position ourselves to be visibly accountable to the various publics we serve: the profession of medicine, the enrollees in our programs of Graduate Medical Education, the institutions who sponsor residency programs, the various constituencies who fund Graduate Medical Education and this list goes on. But perhaps most important is the American public, who have placed their faith and trust in us to assure that America’s physicians are adequately trained to care for them.

As the article in the last volume of the ACGME Bulletin indicates, we are taking this responsibility very seriously. Many of the current challenges to Graduate Medical Education have a common linkage with our “public’s” expectations of what we do. The current concern about the safety of patients in our health care system certainly brings with it an expectation that our educational processes do nothing to endanger the safety of our patients. We should embrace a higher standard and accept responsibility for enhancing patient safety as we help the learning physician tend to the patients who make their clinical education possible.

The recent initiatives to organize house staff bring focus on the importance of the ACGME in assuring an environment that promotes the personal and professional well-being of those enrolled in America’s graduate training programs. These individuals have entrusted us with their professional development. We thus need to assure a stable environment, built around legitimate educational goals, that fosters that development throughout their training. To do so we need to promote institutional accountability for GME, both in the creation of a positive educational environment and in support for the Program Directors and the clinical faculty who serve as role models for tomorrow’s physicians and are so very vital to assuring the continued success of Graduate Medical Education.

The number of sponsoring organizations facing financial threats continues to grow. Organizations who are truly committed to Graduate Medical Education but who face financial difficulty find their residency programs placed in great peril. We need enhanced awareness of the critical importance of Graduate Medical Education and the appropriateness of reasonable funding of these programs.

Yes, this year’s Annual Report will come from a different organization to be sure. But it will still come from an organization that recognizes its accountability to the “publics” we serve.

R. Edward Howell
Chair
Accreditation Council for Graduate Medical Education
Two thousand was an important year for the ACGME. On June 27, 2000, the organization became a separately incorporated 501(c)(3) corporation under Illinois law; during the summer it furthered a highly productive partnership with the American Board of Medical Specialties as both jointly sought how best to measure the general competencies of physicians and residency programs; it developed an internet-based data system that removed some of the paperwork associated with accreditation; it reinforced the accountability of Designated Institutional Officials for GME programs in their institutions; and it introduced a new financing system that both freezes fees for the next few years and supports changes in the accreditation model toward one that is more outcome-based.

The incorporation of the ACGME reflects the hard work of many of its members, especially the Executive Committee, as each of the member organizations acknowledged and supported the importance of having a board of directors with fiduciary accountability to the ACGME rather than to the appointing organizations. Incorporation was achieved with unanimous support of both directors and member organizations. Associated with incorporation is an enhanced level of fiduciary responsibility of Residency Review Committees and their members to the ACGME rather than to their appointing organizations. These are important steps to enhance public accountability.

In May and October of 2000 joint retreats were held, one sponsored by ACGME and one by ABMS that brought together “quadrads” from each specialty. An RRC Chair, board director, program director, and resident from each specialty spent two days and did extensive homework over the summer on just how their specialty would use the six general competencies to judge residency programs and individuals for accreditation and certification. Together, they and ACGME/ABMS staff produced a “toolbox” of evaluation techniques that can be applied to assess the six competencies. This is the beginning of a long term initiative to improve GME by using educational outcome measures.

The Accreditation Data System (ADS) was introduced in 2000. The first step was to capture institutional data about the residency programs accredited by ACGME. This has been successfully achieved and now makes it possible to have “Part One of the Program Information Forms” preloaded and downloadable from the internet to both reduce paperwork for the program director and to provide higher quality documents to the RRCs. The second phase of this initiative is to obtain program level data over the Internet and then resident level data. This data will enhance accreditation decisions and the community’s knowledge about GME.

The ACGME also used this system to identify and empower the designated institutional official for each institution. These individuals, ultimately accountable for all GME programs in their institution, will now receive copies of all accreditation actions and correspondence between ACGME and the institution. Data about their institution will be available to them at any time.

The previous financing system for accreditation was based on site visits and capitation fees. In 2000, this was replaced with an annual subscription model that is based on the number and size of programs. This model permits institutions to budget more accurately, reflects the shifting nature of accreditation from a site visit dependent “snapshot” of the program to one that incorporates more realtime outcome data.

The organization remains crucially dependent on the volunteers that serve on the RRCs and ACGME. The energy, commitment and expertise of these individuals are unique in American medicine and makes it possible for the profession to regulate itself. We are all in their debt.

David C. Leach, MD  
Executive Director, Accreditation Council for Graduate Medical Education
MILESTONES FOR 2000

The primary responsibility of the ACGME is accreditation of residency programs. One of the most important measures of annual activity, therefore, is the number of programs reviewed. Of the 7,765 programs accredited by the end of 2000, a full 3,545 appeared on Residency Review Committee agendas during the year, including 2,151 that were scheduled for regular accreditation status reviews. In addition, the ACGME processed 154 applications for new programs.

As a result, 45.7 percent of all programs were examined and 27.7 were subject to routine accreditation actions.

SCOPE OF RESPONSIBILITY

| ACGME-accredited programs   | 7,765 |
| ACGME-accredited specialties | 27    |
| ACGME-accredited training areas | 77    |
| Residents affected by ACGME accreditation | 97,362 |

ACGME field staff conducted 1,645 surveys, including 96 institutional surveys, 814 surveys of programs in the basic disciplines, and 735 surveys of sub-specialty programs. Volunteer physician specialists conducted an additional 103 surveys.

During regular accreditation reviews, RRCs proposed adverse evaluations for 133 programs, or 6.7 percent. Accreditation was withheld upon application in 32 cases. Fifty-two programs were placed on probation, and one reduction in resident complement were mandated. Fifteen programs had accreditation withdrawn, nine programs were administratively withdrawn, and 113 programs withdrew voluntarily.

The ACGME considered 8 appeals after formal hearings by specially constituted Boards of Appeals.

Another indicator of ACGME's 2000 activity is the number of people and tasks necessary to accomplish this vital process. The staff of ACGME surveyors spent approximately 530 weeks on the road. In addition, volunteer surveyors made 200 trips to visit programs, RRCs held 59 meetings; the Institutional Review Committee met two times; and the entire ACGME Council met three times.

All told, volunteer physicians and administrators contributed an estimated 40,000 hours in 2000. The ACGME staff of 76 employees supported their invaluable work.

EVALUATION ACTIVITY

| Total agenda items | 3,545 |
| Regular accreditation status reviews | 2,151 |
| Adverse actions | 32 |
| Withheld | 15 |
| Withdrawn | 52 |
| Probation | 8 |
| Appeals | 3 |
| Sustained | 5 |
| Reversed | 1 |
The ACGME's 2000 revenues came primarily from fees charged to programs. The largest portion of these revenues was derived from fees charged for site visits. Much of the remainder came from annual fees charged to each program based on the number of residents enrolled. Direct contributions from the five member organizations constituted approximately one percent of the ACGME's support.

ACGME expenditures for 2000 were $14.7 million. At year-end, cash and investments totaled $12 million.
RESIDENCY REVIEW COMMITTEES

Each of the 26 Residency Review Committees is sponsored by the two or three organizations listed below. The sponsoring organizations are the medical specialty boards, the American Medical Association (AMA), and in many instances an appropriate major specialty organization. Members of the Residency Review Committees, which vary in size from six to 15 persons, are appointed in equal numbers by the sponsoring organizations. In addition to the specialty area which forms the name of the committee, other specialized training areas accredited by the committee are also indicated.

In addition to programs in these areas, the ACGME accredits special one-year general clinical programs called Transitional Year Programs. The ACGME also provides for an Institutional Review Committee, which evaluates sponsoring institutions for compliance with the ACGME Institutional Requirements.

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• AMA Council on Medical Education  
• American College of Medical Genetics |
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| **Neurological Surgery** | Specialized Areas:  
• Endovascular Neuroradiology  
• American Board of Neurological Surgery  
• AMA Council on Medical Education  
• American College of Surgeons |
| **Neurology** | Specialized Areas:  
• Child Neurology  
• Clinical Neurophysiology  
• Pain Management  
• American Board of Psychiatry and Neurology  
• AMA Council on Medical Education  
• American Academy of Neurology |
| **Nuclear Medicine** | American Board of Nuclear Medicine  
• AMA Council on Medical Education  
• Society of Nuclear Medicine |
| **Obstetrics and Gynecology** | American Board of Obstetrics and Gynecology  
• AMA Council on Medical Education  
• American College of Obstetricians and Gynecologists |
| **Ophthalmology** | American Board of Ophthalmology  
• AMA Council on Medical Education  
• American Academy of Ophthalmology |
| **Orthopaedic Surgery** | Specialized Areas:  
• Adult Reconstructive Orthopaedics  
• Foot & Ankle Orthopaedics  
• Hand Surgery  
• Musculoskeletal Oncology  
• Orthopaedic Sports Medicine  
• Orthopaedic Surgery of the Spine  
• Orthopaedic Trauma  
• Pediatric Orthopaedics  
• American Board of Orthopaedic Surgery  
• AMA Council on Medical Education  
• American Academy of Orthopaedic Surgeons |
| **Otolaryngology** | Specialized Area:  
• Otolaryngology-Neurotology  
• Pediatric Otolaryngology  
• American Board of Otolaryngology  
• AMA Council on Medical Education  
• American College of Surgeons |
| **Pathology – Anatomic and Clinical** | Specialized Areas:  
• Blood Banking/Transfusion Medicine  
• Chemical Pathology  
• Cytopathology  
• Dermatopathology  
• Forensic Pathology  
• Hematology  
• Immunopathology  
• Medical Microbiology  
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<td>Transitional Year</td>
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LIST OF PARTICIPANTS

Residency Review Committee Members

The ACGME's volunteers come from the membership of national medical societies and specialty boards across the country. They are the innovators, the pioneers, the respected experts. Each has a demonstrated history of involvement and commitment to excellence. With the ongoing support of these volunteers, the ACGME will continue to be a leader in assuring the quality of medicine in the United States. It is with considerable pride and gratitude that we acknowledge their contribution.

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New York, New York

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Bend, Oregon

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Mark Kempler, M.D.
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