Conversations with the Residency Review Committee for Internal Medicine (RRC-IM): Meeting the IM Residency Program Requirements

Ben Clyburn, MD, Vice-Chair-elect
Jerry Vasilias, PhD, Executive Director
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RRC Composition

- 3 nominating organizations - ABIM, ACP, AMA
- Currently 17 voting members
- 6 year terms -- except resident (2 years)
- Generalists and subspecialists
  - Cardiology, Critical Care Medicine, Endocrinology, Gastroenterology, General Internal Medicine, Geriatric Medicine, Infectious Diseases, Medicine-Pediatrics, Nephrology, Pulmonology/Critical Care Medicine, Sleep Medicine
- **Geographic Distribution**
  - CA, CT, DC, FL, LA, IN, MA, NY, MN, NM, PA, RI, SC, TX, WA
- Ex-officio members from each nominating organization (non-voting)
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 *
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

# of IM Programs: Core and Fellowship

% of IM Programs
Relative to All Accredited Programs

- IM: 23%
- non-IM: 77%

Additional programs listed include:
- Internal Medicine
- Pediatrics
- Cardiology
- Electrophysiology
- Interventional Cardiology
- Critical Care
- Endocrinology
- Gastroenterology
- Transplant Hepatology
- Hematology/Medical Oncology
- Infectious Diseases
- Nephrology
- Oncology
- Pulmonary/Critical Care
- Rheumatology
- Sleep Medicine
Review of Programs

• Peer Review
• Reviewers use the following information to determine compliance with the requirements:
  - Program Directors: questions in the PIF correspond to program requirements
  - Reviewers present program to Committee
  - Committee determines degree of compliance and assigns accreditation status along with review cycle, range of 1-5 years
Summary of Activities 2010

- 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 546 programs
  - Average per meeting:
    - 20 core
    - 140 subspecialty programs
    - 20 interim reports
      (progress & duty hours reports)
## Summary of Actions 2010

**Core Internal Medicine**

### Number of Core IM Programs Reviewed

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Accreditation</td>
<td>4</td>
</tr>
<tr>
<td>Continued Accreditation</td>
<td>52</td>
</tr>
<tr>
<td>Proposed Probation</td>
<td>1</td>
</tr>
<tr>
<td>Probation</td>
<td>1</td>
</tr>
<tr>
<td>Progress Reports</td>
<td>11</td>
</tr>
<tr>
<td>Voluntary Withdrawal</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 year</td>
<td>5.8%</td>
</tr>
<tr>
<td>2 years</td>
<td>7.7%</td>
</tr>
<tr>
<td>3 years</td>
<td>19.2%</td>
</tr>
<tr>
<td>4 years</td>
<td>23.1%</td>
</tr>
<tr>
<td>5 years</td>
<td>44.2%</td>
</tr>
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</table>

AGME
# Summary of Actions in 2010

**Subspecialty Programs**

<table>
<thead>
<tr>
<th>Number of Subspecialty Programs Reviewed</th>
<th>474</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Accreditation</td>
<td>29</td>
</tr>
<tr>
<td>Continued Accreditation</td>
<td>347</td>
</tr>
<tr>
<td>Proposed Withhold</td>
<td>15</td>
</tr>
<tr>
<td>Withhold</td>
<td>4</td>
</tr>
<tr>
<td>Voluntary Withdrawal</td>
<td>32</td>
</tr>
<tr>
<td>Progress Reports</td>
<td>45</td>
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<tr>
<td>Duty Hour Reports</td>
<td>2</td>
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</tbody>
</table>

- 1 year: 3.5%
- 2 years: 11.5%
- 3 years: 17.0%
- 4 years: 15.3%
- 5 years: 52.7%
Most Frequent Citations in 2010

Total # of core programs reviewed = 72
Total # of citations = 284; approximately 3.9 citations/program

1. Citations related to curricular elements
   - inadequate continuity experience;
   - no competency based G &O;
   - inadequate exposure in IM subs

2. Citations related to program personnel
   - subspecialty education coordinator(s) not certified;
   - MICU director not certified;
   - consultations from other clinical services not done in a timely manner;
   - inadequate # of other health care professionals
Most Frequent Citations

3. Citations related to evaluation of residents

- semiannual evaluation not documented;
- faculty do not routinely provide verbal feedback at the end of a rotation;
- inadequate summative evaluation;
- evaluations not competency based;
- inadequate multi-source evaluation

4. Citations related to evaluation of program

- no formal systematic review of the program
- no action plan to address deficiencies;
- residents not included in annual review of the program;
- faculty development not tracked and monitored;
- does not share faculty performance data;
Most Frequent Citations

5. Citation related to institutional issues
   ✓ environment of fear/intimidation;
   ✓ no program letter of agreement;
   ✓ internal review did not occur mid-cycle; *
   ✓ internal review committee does not include all required components; *

6. Service to Education Imbalance
   ✓ excessive reliance on residents to meet service needs;
   ✓ inadequate teaching ratio;
   ✓ Residents ongoing care activities exceeding patient caps;
   ✓ service responsibilities not limited to patients on the teaching service
Communicating with PDs

• Weekly e-communication
  • Contains GME information: New requirements, newsletters; updates on ACGME issues/initiatives

• E-mail status of programs on RRC agenda
  • Within 5 days after meeting will receive email w/status and review cycle

• Notification letter will be posted on Accreditation Data System (ADS).
  • Hard copies of letters not provided
  • Letter is posted approximately 8 weeks following meeting
  • Proposed adverse actions posted within 4 weeks of meeting
Resources

Who should I contact…

- Questions related to requirements or notification letter:
  - Jerry Vasilias (312) 755-7477, jvasilias@acgme.org
  - Felicia Davis (312) 755-7445, fdavis@acgme.org
  - Karen Lambert (312) 755-5785, kll@acgme.org

- Questions related to PIF content:
  - Danny Hart (312) 755-7440, dhart@acgme.org

- Questions related to complement increases:
  - Jessalynn Van Ausdall (312) 755-5784, jvanausdall@acgme.org

- Questions related to the ADS/Technical problems with PIF:
  - Raquel Eng (312) 755-7120, reng@acgme.org

- Questions related to site visit:
  - Ingrid Philibert (312) 755-5003, jphilibert@acgme.org
  - Jane Shapiro (312) 755-5015, jshapiro@acgme.org
  - Penny Lawrence (312) 755-5014, pil@acgme.org
Guidance on Interpretation of Common Program Requirements

- PD Guide to the Common Requirements: http://www.acgme.org/acWebsite/navPages/nav_commonpr.asp
- Provides PDs:
  - Explanations of the intent of most of the common requirements (particularly competency-based)
  - Suggestions for implementing requirements and types of documentation expected.
Guidance on Interpretation of IM Program Requirements

- FAQ contain clarification and interpretation of program requirements
  - Program Requirements are updated every 5-7 years, so, FAQs provide additional information quicker
- Core IM FAQ located here:
  [http://www.acgme.org/acWebsite/RRC_140/Internal_Medicine_Residency_Programs_FAQ.pdf](http://www.acgme.org/acWebsite/RRC_140/Internal_Medicine_Residency_Programs_FAQ.pdf)
New Core FAQs

Night Float vs Night Medicine

• **Question**: What is “night medicine” and how does it relate to/differ from “night float”?

• **Answer**: "Night medicine" is defined as a rotation of 2 or more consecutive nights of inpatient clinical duty which includes the following:
  • Faculty interaction that allows for meaningful evaluation of resident performance, including the opportunity for bedside teaching and observation of direct patient care;
  • Interaction with the patient’s primary daytime physicians;
  • A predefined cohort of patients for which the resident is responsible;
  • Input into the ongoing care of the patient during his/her hospitalization;
  • A defined curriculum with G&Os; and
  • Accessibility of consultants (in person or by phone).

Continued on next page…. 
New Core FAQs

Night Float vs Night Medicine (continued)

• **Question:** What is “night medicine" and how does it relate to/differ from "night float"?

• This applies to all hospital inpatient floor rotations. Emergency department rotations are not included. If these criteria are met for night duty on ICU rotations, then the night duty counts towards ICU time and not towards “night medicine.”

• The annual and total limits of “night float” as specified in the PRs will not change: “night float” must not exceed 2 months per year nor more than 4 months across the three years of residency.

• However, programs can extend the sum of “night float” and “night medicine” to 5 months over the three year residency.

• Programs are encouraged to incorporate the criteria mentioned above for “night medicine” into all night duty experiences. (May 2011 RC Meeting).
QUESTION: Can a family medicine-trained faculty member supervise IM residents in the continuity clinic?

ANSWER:

- The RC allows the PD, under rare circumstances, to appoint an experienced non-internist with special expertise to supervise in ambulatory setting (e.g., a family medicine physician with extensive ambulatory experience, procedural or other pertinent training).

- It is expected that the site director for each continuity clinic be an internist and the vast majority of preceptors be internists (October 2010 RC Meeting).
QUESTION: We do not have a traditional/conventional department of medicine. Rather, we have a service line/institute/organization in which our internal medicine faculty and core internal medicine program are seated. Does this meet the program requirement?

ANSWER: For a core internal medicine program, the sponsoring institution must establish the educational program within a department of medicine or an administrative unit whose primary mission is the advancement of internal medicine resident education and patient care. (July 2011 RC Meeting)
New FAQs

Interprofessional teams

- **QUESTION:** Must every interprofessional team include representation from every profession listed in the requirement?

  II.D.7. There must be services available from other health care professionals such as nurses, social workers, case managers, language interpreters, dieticians, etc. to assist with patient care.

  II.D.8. Consultations from other clinical services must be available in a timely manner in all care settings where the residents work. All consultations should be performed by or under the supervision of a qualified specialist.

- **ANSWER.** No. The RRC recognizes that the needs of specific patients change with their health status and circumstances. The intent of the requirement is to assure that the program has access to these professional and paraprofessional personnel and that interprofessional teams will be constituted as appropriate and as needed (September 2011 RC Meeting).
…should have 10, must have 8 hours between duty periods…

<table>
<thead>
<tr>
<th></th>
<th>8 to 10 hours</th>
<th>Less than 8 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PGY-1</strong></td>
<td>Scheduled or expected duty hour period should be separated by 10 hours. If residents get less than 10 but at least 8 hours, PDs does not have to document reason.</td>
<td>PGY-1s are not allowed to have less than 8 hours off between duty periods.</td>
</tr>
<tr>
<td><strong>PGY2-3</strong></td>
<td>Residents should receive 8 hours off between duty periods.</td>
<td>Documentation of reason for each episode where resident remains on duty for less than 8 hours (PR IV.G.5.c).(1).(b))</td>
</tr>
<tr>
<td>(residents in their final years of education)</td>
<td></td>
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</tbody>
</table>
RC-Newsletter

- Sent to all core, med-peds and subspecialty program directors, coordinators, and DIOs

- Most recent newsletters:  

- Highlights:
  - Definitions in New Common Program Requirements
  - Night Float / Night Medicine FAQ
  - New use for Resident Survey
  - Frequent citations for core and subs

- Annual; but anticipate another newsletter by end of year.
Minor Edits to the core PIF

Edited several existing questions.

- Edited question related to faculty inpatient/outpatient data to Y/N instead of narrative
- Edited question related to direct observation tools used are identified
- Edited question about cost effective care

Removed several questions b/c did not provide useful information;

- Removed several competency question related to who is involved with multisource evaluation because redundant with info ACGME collects
- Removed individual questions under each competency related to how program uses assessment to determine if resident is performing at appropriate level and condensed into one question

Added several questions

- Added question asking # of weeks of night float and night medicine, and whether program has a curriculum for night medicine
- Added 2 questions to continuity: (1) how does program demonstrate that residents have effectively established long term healing relationships with their patients, and (2) how does program ensure longitudinal relationship b/w residents and supervisors.
Site Visit: Newer Practice for Resident Input

- Implemented in 2010, residents in programs undergoing a site visit are asked to submit a consensus list of five program strengths and opportunities for improvement directly to the assigned field staff representative.

- The list is held confidential – residents are asked to e-mail it to the field representative, or bring it to the site visit interview.

- The information offers site visitors insight into residents’ unique perspective on their program and the accreditation standards.
Site Visit

Use of “Tracer Method”

- Site Visit letters announcing visits after July 1 have language about “Tracer Method.”
- “Use of this approach by the ACGME field staff is intended to shift the emphasis of the site visit from the review of policies and documentation to actual processes and functions to which the policies pertain. It also seeks to promote an enhanced focus on programs’ continuous improvement efforts.”

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: several difficult questions in RS were modified
• In 2011: RS was revised based on input from residents and survey experts
• In 2012: RS will be revised again to align with new PRs.
Resident Survey (RS)

• 2006: ACGME Board gave Monitoring Committee responsibility to oversee duty hour (DH)
  • Review national reports and recommend to RCs how to handle program outliers = programs with substantial non-compliance rates

• 2010 & 2011: Mon Com had recommendations significant non-compliance with
  • DH + issues with other parts of the RS; and
  • DH issues over multiple years (2 of 3).
Resident Survey (RS)

8,576 ACGME accredited programs

5,798 (or 65.2% of all accredited) programs participated in the RS (all core programs + subspecialty programs w/ 4 or more fellows)

173 programs (or 3% of those that participated in the survey) 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 programs (or less than one % of all programs that participated in the RS) that had DH issue over multiple years Mon Com is asking the RC to review these program’s accreditation history and consider shortening their review cycles.
Next Accreditation System (NAS) Attributes

- Accreditation in the future, will be different from the current model.
- Dr Nasca will provide community more details about the Next Accreditation System (NAS) very soon.
- Broadly speaking, NAS will …
  - Foster innovation; reward excellence
  - Less frequent revisions to program requirements.
  - Longer accreditation cycles
  - Continuously monitors outcomes and other predictive measures
  - Continuously holding sponsoring institutions responsible for oversight of educational and clinical systems
Next Accreditation System (NAS) Elements

- Formal in depth self study and site visit every 10 years
- RC received data continuously – at least annually
- RC tracks data on each program
  - Milestone performance data
  - Resident survey data
  - Faculty survey data
  - Board certification performance data
  - Key quality/patient safety data
Questions?