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

Ben Clyburn, MD, Vice-Chair-elect
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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%

Internal Medicine
Medicine Pediatrics
Cardiology
Interventional Cardiology
Critical Care
Endocrinology
Gastroenterology
Transplant Hepatology
Hematology/Medical Oncology
Infectious Diseases
Nephrology
Oncology
Pulmonary
Pulmonary/Critical Care
Rheumatology
Sleep Medicine

ACGME
Review of Programs

• Peer Review
• Reviewers use the following information to determine compliance with the requirements:

  - Program information form (PIF)
  - Site visitor’s report
  - Resident survey findings
  - Board scores

• Program Directors: this is an open book test
  • The 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 meets three times a year – January, May, and September
  - A fourth summer meeting is a business/policy meeting
- The RRC 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

<table>
<thead>
<tr>
<th>Number of Core IM Programs Reviewed</th>
<th>72</th>
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<tbody>
<tr>
<td>Initial Accreditation</td>
<td>4</td>
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<tr>
<td>Continued Accreditation</td>
<td>52</td>
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<tr>
<td>Proposed Probation</td>
<td>1</td>
</tr>
<tr>
<td>Probation</td>
<td>1</td>
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<tr>
<td>Progress Reports</td>
<td>11</td>
</tr>
<tr>
<td>Voluntary Withdrawal</td>
<td>3</td>
</tr>
</tbody>
</table>

1 year 5.8%
2 years 7.7%
3 years 19.2%
4 years 23.1%
5 years 44.2%
### Summary of Actions in 2010

**Subspecialty Programs**

<table>
<thead>
<tr>
<th>Number of Subspecialty Programs Reviewed</th>
<th>474</th>
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<tbody>
<tr>
<td>Initial Accreditation</td>
<td>29</td>
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<tr>
<td>Continued Accreditation</td>
<td>347</td>
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<tr>
<td>Proposed Withhold</td>
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<td>Withhold</td>
<td>4</td>
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<tr>
<td>Voluntary Withdrawal</td>
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<td>Progress Reports</td>
<td>45</td>
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<tr>
<td>Duty Hour Reports</td>
<td>2</td>
</tr>
</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 fellowship programs reviewed = 474
Total # of citations = 1,027; approximately 2.2 citations/program

1. Evaluation of Fellows
   ✓ semiannual evaluation not documented;
   ✓ faculty do not routinely provide verbal feedback at the end of rotation;
   ✓ fellow's performance in continuity clinic not documented;
   ✓ appropriate evaluation methods not used to evaluate the competencies; inadequate multi-source evaluation;
   ✓ no summative evaluation;
   ✓ Procedure logs do not contain required elements
Most Frequent Citations

2. Didactic Components
- fellows not educated to recognize the signs of fatigue and sleep deprivation;
- no regularly-scheduled or -attended research conference;
- five hours of teaching rounds per week does not occur;
- instruction for basic sciences not provided

3. 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

4. Patient Care Experience
   ✓ Inadequate continuity clinic experience and/or continuity clinic patient volume;
   ✓ panel of patients does not include 25% of each gender;
   ✓ inadequate procedural experience(s)

5. Responsibilities of the Program Director
   ✓ Inaccurate/Incomplete PIF
   ✓ PD does not oversee/ensure the quality of training at all participating sites;
   ✓ unapproved changes in complement;
   ✓ no reporting relationship with the IM program director;
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, iphilibert@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
  http://www.acgme.org/acWebsite/RRC_140/Internal_Medicine_Residency_Programs_FAQ.pdf

- General Subspeciality FAQ
  http://www.acgme.org/acWebsite/downloads/RRC_FAQ/General_Subspecialty_Fellowship_FAQs.pdf

- Specific Subspeciality FAQ
Question: What are the RC’s expectations for programs with 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 between 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)
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 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)
New FAQ

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).
RRC-IM 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
  - Resident Survey used to identify programs w/ DH issues
  - Frequent citations for core and subs

- Annual; but anticipate another newsletter by end of year.
New Subspecialty PRs

• At Feb 2011 ACGME 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 June 2011 ACGME Mtg, CCM PRs were approved
  • These PRs will go into effect July 1, 2012.

• Proposed PRs for Advanced Heart Failure and Transplant Cardiology PRs will be reviewed at June 2012 ACGME Board meeting.
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
Access to an electronic health record should be provided. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development, and progress towards its implementation;

FAQ Question (to be posted): What does the Review Committee consider an example of an electronic health record (EHR)?

Answer: Fellows are expected to have access to an EHR at least at one site used for clinical training. An EHR can include electronic notes, orders, and lab reporting. Such a system also facilitates data reporting regarding the care provided to a patient or a panel of patients. It may also include systems for enhancing the quality and safety of patient care. An EHR does not have to be present at all participating sites and does not have to be comprehensive. A system that simply reports lab or radiology results does not meet the definition of an EHR.
Simulation

“Fellows must participate in training using simulation.”

FAQ Question (to be posted): What does the Review Committee consider as part of the range of simulation?

Answer: The Review Committee does not expect each program to use a simulator or have a simulation center. Simulation means that learning about patient care occurs in a setting that does not include actual patients. This could include OSCEs, standardized patients, patient simulators, or electronic simulation of codes, procedures, and other clinical scenarios.
PD salary support

“The sponsoring institution must: provide the program director with adequate salary support for the administrative activities of the fellowship. The program director must not be required to generate clinical or other income to provide this administrative support. This support should be 25-50% of the program director's salary, or protected time, depending on the size of the program.”

Rationale: The change is from a “suggested” to a “should” requirement. The RC-IM has long expected that sponsoring institutions provide adequate salary support for the program director. Adequate salary support for administration of the program enhances the program director’s ability to provide direct advocacy for the fellows’ learning experiences.
Associate PD

“Appointment of one KCF to be an associate program director is suggested.”

Rationale: This requirement is **not** mandatory; it appears as “is suggested.” It was added in response to suggestions from many program director groups to allow the program directors to delegate some of their many responsibilities to other key members within the program.
KCF Scholarship

“At least 50% of the KCF must demonstrate evidence of productivity in scholarship, specifically, peer-reviewed funding; publication of original research, review articles, editorials, or case reports in peer-reviewed journals; or chapters in textbooks.”

Rationale: This is in line with the Review Committee’s expectation that was highlighted in its August 2010 newsletter.
“At least one of the KCF must be knowledgeable in the evaluation and assessment of the ACGME competencies; and, spend significant time in the evaluation of fellows including the direct observation of fellows with patients.”

FAQ Question (to be posted): What is acceptable education for KCF who will serve as competency evaluators?

Answer: These faculty must be knowledgeable in the evaluation and assessment of the ACGME competencies. This can be achieved through participation in workshops offered through program director groups, the ABIM, the ACGME, or through local GME faculty development programs that focus on competency assessment. The evaluators are expected to have ongoing training in these areas.
Conference Format

“The core curriculum must include a didactic program based upon the core knowledge content and areas defined as a fellow’s outcomes.

The program must afford each fellow an opportunity to topics covered in conferences that he or she was unable to attend.

Fellows must participate in clinical case conferences, journal clubs, research conferences and morbidity and mortality (or quality improvement) conferences.

All required core conferences must have at least one faculty member present and must be scheduled as to ensure peer-peer and peer-faculty interaction.”

Rationale: Not a new requirement but a modified one that provides programs with more flexibility. Rigid requirements on frequency, numbers of conferences, etc are gone.
“Fellows must receive instruction in practice management relevant to their subspecialty.”

FAQ Question (to be posted): What constitutes adequate instruction in practice management?

Answer: Instruction in practice management includes the organization and financing of clinical practice including personnel and business management, scheduling, billing and coding procedures, telephone and telemedicine management, and maintenance of an appropriate confidential patient record system. Programs can comply with this requirement by developing/implementing a lecture series related to this topic.
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).
ABIM take *and* pass rate

At least 80% of those fellows, eligible to take the certifying examination, completing their training in the program for the most recently defined five-year period should have taken the certifying examination.

A program’s graduates should achieve a pass rate on the certifying examination of the ABIM of at least 80% for first-time takers of the examination in the most recently defined five-year period.
Site Visit:
Newer Practice for Fellow 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 site visits post July 1 have language about “Tracer Method” being used during the site visit.

“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 sub programs (less than 1% of all programs that participated in the RS) Mon Com is asking the RC to review accreditation history and consider whether shortening review cycles or requesting a detailed action plan.
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?