Disclosure

• No conflicts of interest to report
RRC Composition

- 3 appointing organizations - ABEM, ACEP, AMA
- 10 voting members
- 6 year terms -- except resident (2 years)
- Program Directors, Chairs, Faculty
- Geographic Distribution
  - AZ, CA, IL, MI, MO, OH, NC, NY
- Ex-officio members from each appointing organization (non-voting)
RRC-EM Composition – AY 2011-2012

AMERICAN BOARD OF EMERGENCY MEDICINE
Michael Beeson, M.D. Vice-Chair
Wallace Carter, M.D., Chair
Jeffrey Graff, M.D.
Earl Reisdorff, MD, Ex-officio

COUNCIL ON MEDICAL EDUCATION (AMA)
Samuel Keim, M.D.
Susan Promes, M.D.
Christine Sullivan, MD

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
Mark Hostetler M.D., MPH
Victoria Thornton, M.D.
Suzanne R. White, MD
Marjorie Geist, Ph.D., Ex-officio

EMERGENCY MEDICINE RESIDENTS ASSOCIATION
Jonathan Heidt, MD
Term for Members

- 6 years each (two 3 year terms)
  - Resident member: one 2-year term
- Each member is evaluated by each RRC member at end of 2\textsuperscript{nd} year
- Chair and Vice Chair elected by RRC
  - Chair term is 3 years
  - Vice-Chair term is either 1 or 2 years
Responsibilities of RRC Members

- Attendance at 2 or 3 meetings each year
- Exercise fiduciary responsibility
  - Fealty to ACGME overrides allegiance to sponsoring organizations
- Maintain confidentiality
- Avoid conflict or duality of interest
- Program reviews (20-30 hours before each meeting)
Citation

- Citation = the program has not provided evidence of compliance with the requirements, or, an area identified by the site visitor is non-compliant

- **Don’t Have**
  - Patients (# & types); required certified faculty; required experience; facilities/equipment; time/support; required program personnel

- **Don’t Do**
  - Lack of evidence that required experience is provided; no documentation of compliance with requirements

- **Didn’t Carefully Proof/Edit PIF**
  - Incomplete or inaccurate information; did not fully describe/provide sufficient details; discrepant data
# Review Committee Meeting Activities and Actions for September 2011

<table>
<thead>
<tr>
<th>Approved Applications</th>
<th>Continued Accreditation</th>
<th>Other Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medicine</td>
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<td>24/24</td>
<td>2/2</td>
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<tr>
<td>Medical Toxicology</td>
<td>Medical Toxicology</td>
<td>1/1</td>
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<td>1</td>
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<tr>
<td>Pediatric Emergency Medicine</td>
<td>Pediatric Emergency Medicine</td>
<td>4/4</td>
</tr>
<tr>
<td></td>
<td>3 (reviewed as full reviews/not as an annual report)</td>
<td></td>
</tr>
<tr>
<td>Sports Medicine</td>
<td>Sports Medicine</td>
<td>1/1</td>
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<tr>
<td>Undersea and Hyperbaric Medicine</td>
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<td>1/1</td>
</tr>
</tbody>
</table>
## Review Committee Meeting Activities and Actions for February 2012

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<tr>
<td><strong>Emergency Medicine</strong></td>
<td>Emergency Medicine</td>
<td>18/18 Approved Format and Complement Requests</td>
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<tr>
<td><strong>Medical Toxicology</strong></td>
<td>Medical Toxicology</td>
<td>3/3 Progress or Duty Hour Reports Reviewed</td>
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<td>2</td>
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<tr>
<td><strong>Pediatric Emergency Medicine</strong></td>
<td>Pediatric Emergency Medicine</td>
<td>4/4 Pilot Programs Reviewed</td>
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<tr>
<td>1/2</td>
<td></td>
<td>20 (reviewed as an annual report)</td>
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<tr>
<td><strong>Sports Medicine</strong></td>
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</tbody>
</table>
Update: RRC-EM Pilot Project Programs

• A huge thank you goes to all of the programs that participated in the Pilot Project.

• Programs had their 7th review this past February

• We have asked that this fall, pilot programs only submit the usual ADS annual update instead of the Pilot Project Annual Report.
For Core Emergency Medicine Programs in AY 11/12, there are:

- 158 accredited programs
- Specialty Length = 4 years (34) or 3 years* (124) -- *Note 2 programs are PGY 2-4 format
- 5521/6101 filled resident positions
- Average Program Cycle Length = 4.70
  - Pilot Programs Cycle Lengths are 7 or 8 years
- 145 programs with continuing accreditation
- 13 programs with initial accreditation (accredited within the last three years)
MOST COMMON CITATIONS
Core EM AY 2010/2011

• PIFmanship
• Program Personnel & Resources: Resources (e.g., throughput times, number and types of patients, space, lab & dx imaging results on timely basis)
• Program Personnel & Resources: Qualifications of Faculty (e.g. faculty staffing levels, faculty to resident ratio; board certification)
• Scholarly Activities (e.g. faculty and residents)
For Pediatric Emergency Medicine Programs in AY 11/12, there are….

- 20 accredited programs
- Specialty Length = 2 years
- 71/75 filled resident positions
- Average Program Cycle Length = 4.10

- 16 programs with continuing accreditation
- 4 programs with initial accreditation (accredited within the last three years)
MOST COMMON CITATIONS
Peds EM 7/1/2006 – 6/30/2011

• Curricular Development (e.g., required curriculum – medicine, basic sciences, procedures, reciprocal training

• Educational Program – Patient Care Experience (e.g. number & type of patients

• Scholarly Activities (e.g. faculty and fellows)
For Medical Toxicology Programs in AY 11/12, there are….

- 28 accredited programs
- Specialty Length = 2 years
- 48/100 filled resident positions
- Average Program Cycle Length = 4.07

- 22 programs with continuing accreditation
- 6 programs with initial accreditation (accredited within the last three years)
MOST COMMON CITATIONS

- Program Personnel & Resources: Qualifications of Faculty (e.g. board certification, availability of consultants)
- PIFmanship
For Sports Medicine Programs in AY 11/12, there are....

- 4 accredited programs
- Specialty Length = 1 year
- 8/9 filled resident positions
- Average Program Cycle Length = 4.75

- 4 programs with continuing accreditation

- Note: Programs with a site visit after 7/1/2011 are reviewed by the RC-FM
MOST COMMON CITATIONS

• Scholarly Activities (e.g. faculty and fellows)

• PIFmanship
For Undersea and Hyperbaric Medicine Programs in AY 11/12, there are:

- 6 accredited programs
- Specialty Length = 1 year
- 7/12 filled resident positions
- Average Program Cycle Length = 4.00

- 5 programs with continuing accreditation
- 1 program with initial accreditation (accredited within the last three years)
MOST COMMON CITATIONS
UHM 7/1/2006 – 6/30/2011

- Scholarly Activities (e.g. faculty and fellows)
- PIFmanship
- Program Personnel & Resources: Qualifications of Faculty (e.g. board certification)
- Curricular Development (e.g., didactics)
Site Visits

- **Tracer Method**: document review and interviews with program directors, residents/fellows, faculty members, coordinators, and potentially others.
- **SV Pilot**: conducted through June 2011, now part of the process. The field staff requested that residents compile up to five strengths and up to five opportunities for improvement for further discussion during the resident/fellow interview.
- See **September 2011 RC-EM Newsletter** for more information.
FAQs

• **New FAQs** cover the following topics:
  • required critical care experiences;
  • individualized interactive instruction for planned educational experiences;
  • procedures and simulation;
  • complement increase requests; and
  • core emergency medicine PIF faculty roster directions.

Upcoming Meeting and Closing Date

- Meeting: **September 21-22, 2012**
- Agenda Closing Date: July 7, 2012
PRINCIPLES

• Graded and progressive responsibility

• Supervision that:
  • Assures safe and effective care to individual patient
  • Assures each resident’s development of skills, knowledge and attitudes
  • Establishes a foundation for continued professional growth

• Includes residents AND faculty
2011 Duty Hours

NEW SECTIONS

• Professionalism, Personal Responsibility, and Patient Safety
• Transitions of Care
• Clinical Responsibilities*
• Teamwork*
• Maximum Frequency of In-House Night Float*

* Specialty-specific PRs and/or FAQs
Data Reviewed by RCs

• Resident Survey
  • Results aggregated into 5 areas (duty hours, faculty, evaluation, educational content, resources)
  • Results compared to national normative data
  • Potential RC actions: warning letter, request for progress report, advanced or expedited site visit
HOT TOPICS

Data Reviewed by RCs

• Faculty Survey (new 2011-2012)

• Revised Common PIF items (available in Web ADS 6/23/11)
Duty Hour Information/Board Pass Rates (if applicable)

What percentage of residents will participate in patient safety programs during the current academic year? Leave blank if no residents are on duty for a specific year within the program. *

Year 1 Residents: __ %
Year 2 Residents: __ %
Year 3 Residents: __ %
Year 4 Residents: __ %

What percentage of residents participate in interdisciplinary clinical quality improvement programs to improve health outcomes? Leave blank if no residents are on duty for a specific year within the program. *

Year 1 Residents: __ %
Year 2 Residents: __ %
Year 3 Residents: __ %
Year 4 Residents: __ %

How often do clinical care needs (in terms of volume and/or complexity of cases) exceed residents’ ability to provide appropriate and quality care? Leave blank if no residents are on duty for a specific year within the program. *

Year 1 Residents:
- Extremely Often
- Very Often
- Sometimes
- Rarely
- Never

Year 2 Residents:
- Extremely Often
- Very Often
- Sometimes
- Rarely
- Never

Year 3 Residents:
- Extremely Often
- Very Often
- Sometimes
- Rarely
- Never

Year 4 Residents:
- Extremely Often
- Very Often
- Sometimes
- Rarely
- Never
Competencies:
Where do we need to be?

- ACGME timetable: Full integration of the competencies and their assessment into learning and clinical care
- Current: “The goals and objectives must be specific for each rotation and incorporate the core competencies”
- Future: Development of specialty-specific milestones that, when met, will foster proficiency in each of the competency domains and be outcomes driven (work has already for Radiology Milestones)
Goals and Objectives

• Competency-based
• Specific for each subspecialty rotation
• Specific for each level of training
• Reviewed and revised as needed annually
• Distributed to faculty and residents
• Discussed with residents before each rotation
What’s Next? Milestones!

• What’s a Milestone?
  • A behavior, attitude or outcome related to general competencies that describe a significant accomplishment expected of a resident by a particular point in time

• Joint venture between ACGME and ABMS
  • Representatives from ABEM, RRC, CORD, etc.
  • Met March 7, 2011 and Sept 16, 2011
Emergency Medicine Milestones Committee

- **Mike Beeson**, Chair

- **Advisory Group**
  - Wallace Carter
  - Earl Reisdorff
  - Timothy Brigham

- **Working Group**
  - Michael Beeson
  - Theodore Christopher
  - Jonathan Heidt
  - James Jones
  - Susan Promes
  - Kevin Rodgers
  - Philip Shayne
  - Mary Jo Wagner
  - Susan Swing
  - Lynne Meyer
Overall Milestone Project Goal

Obtain outcome measures (i.e. milestones of competency development) to use as evidence of programs’ educational effectiveness.
Uses and Implications

ACGME
- Accreditation – continuous monitoring of programs; lengthening of site visit cycles
- Public Accountability – report at a national level on competency outcomes
- Community of practice for evaluation and research, with focus on continuous improvement

Residency Programs
- Guide curriculum development
- More explicit expectations of residents
- Support better assessment
- Enhanced opportunities for early identification of under-performers

Certification Boards
- Potential use – ascertain whether individuals have demonstrated qualifications needed to sit for Board exams

Residents
- Increased transparency of performance requirements
- Encourage resident self-assessment and self-directed learning
- Better feedback to residents

Milestones
Outcome Project – Continued

1999 - Outcome Project Begins

2001 - Quadrads (Board, PD, RRC, Res) Convened

2002-2008 – Implementation of 6 Competency Domains

2009 – 2012 Milestone Development

- All specialties to be completed by 12/2012
- Pilot testing ongoing

2013 & Beyond

- Large scale implementation of milestones for testing
- New accreditation system launch ~ staggered approach (e.g. 4-5 specialties at first)
ACGME Timeline for Milestones

- All specialties to complete development of Milestones by end of 2012
- Milestones to go into effect by July 1, 2013
Emergency Medicine Milestones

- Based on Core Competencies
  - Patient Care- 14
  - Medical Knowledge-1
  - Professionalism- 2
  - Interpersonal Communication Skills- 2
  - Practice-based Learning and Improvement- 2
  - Systems-based Practice- 3
- A total of 24 Milestones
# EMERGENCY MEDICINE MILESTONES

## PC1. Emergency Stabilization

Prioritizes critical initial stabilization action and mobilizes hospital support services in the resuscitation of a critically ill or injured patient and reassesses after stabilizing intervention.

<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><em>Describes a primary assessment on a critically ill or injured patient</em></td>
<td><em>Recognizes when a patient is unstable requiring immediate intervention</em></td>
<td><em>Discerns relevant data to formulate a diagnostic impression and plan</em></td>
<td><em>Manages and prioritizes critically ill or injured patients</em></td>
<td><em>Develops policies and protocols for the management and/or transfer of critically ill or injured patients</em></td>
</tr>
<tr>
<td><em>Recognizes abnormal vital signs</em></td>
<td><em>Prioritizes vital critical initial stabilization actions in the resuscitation of a critically ill or injured patient</em></td>
<td><em>Reassesses after implementing a stabilizing intervention</em></td>
<td><em>Recognizes in a timely fashion when further clinical intervention is futile</em></td>
<td></td>
</tr>
<tr>
<td><em>Performs a primary assessment on a critically ill or injured patient</em></td>
<td></td>
<td></td>
<td><em>Evaluates the validity of a DNR order</em></td>
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</tbody>
</table>

**Suggested Evaluation Methods:** SDOT, observed resuscitations, simulation, checklist, videotape review
Next Steps

- EM will be used as pilot specialty in NAS
  - Begins 2013
- Integration of Milestones into EM Program
  Requirements
  - A first!
- Development of assessment methodology
  - Specialty-wide implementation of assessment methods?
  - Partner with CORD
Program Requirement
Revisions

• Former PRs are being reinserted in a different place in the PRs
  • 12 hour shifts and equivalent time off
  • limit of 60 scheduled hours per week seeing patients in the emergency department and no more than 72 duty hours per week.
Duty Hours Rules
UNCHANGED REQUIREMENTS

- 60/72 hrs/wk
- ED shift limits of 12 hours
- Maximum of 24 hrs of continuous duty (pgy2s and above)
- Call not greater than Q3 nights
- 1 day in 7 free of service obligations
- SHOULD have 10 hrs and MUST have 8 hrs between scheduled duty periods
- Educate all faculty and residents to recognize signs of fatigue and sleep deprivation
Duty Hours Rules
CHANGED REQUIREMENTS

• No more than 4 hrs transition (prior 6)
• No more than 6 consecutive days of night float (prior 9)
• “Strategic napping” after 16 hrs of continuous duty and during hrs of 10 pm-8 AM
• Internal and now external moonlighting count towards weekly hr limit
Duty Hours Rules

CHANGED REQUIREMENTS

- Program must set guidelines for circumstances and events where residents must communicate with supervising physician.
- Program must have a process to ensure continuous patient care in the event that a resident may be unable to perform patient care duties.
- Sponsoring institutions must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.
Compliance

Data Reviewed by RCs

- Resident Survey
  - Results aggregated into 5 areas (duty hours, faculty, evaluation, educational content, resources)
  - Results compared to national normative data
  - Potential RC actions: warning letter, request for progress report, advanced or expedited site visit

- Faculty Survey (new 2011-2012)
- Revised Common PIF items (available in Web ADS 6/23/11)
Revised Common Program Requirement including Duty Hours

New CPRs, including Duty Hours are effective July 1, 2011. There are new questions in ADS relating to these. FAQ websites:

Glossary of Terms related to new DH CPRs

General DH FAQs

EM Specific DH FAQs

Sample 2011 Resident Survey Report
http://www.acgme.org/acWebsite/Resident_Survey/res_Index.asp

Attestation for duty hours is not adequate.
Resident Survey

- The RRC monitors results of the resident survey on an annual basis.
- The focus is on general areas – not individual questions
  - duty hours
  - faculty supervision/teaching,
  - evaluation,
  - educational content,
  - resources,
  - patient safety and
  - teamwork)
- The RC recommends that each program investigates non-compliant areas indicated on the resident survey, and if indicated, implement an action plan where improvement can be demonstrated.
Resident Survey Update

- The first reporting period for the resident survey just opened in January 2012.
- In preparation for the next accreditation system, all residents and fellows in core specialty and subspecialty programs, regardless of size, will be surveyed.
- There is not a single, unique survey being administered; therefore, a sample of the survey questions is not available.
Depending on their responses and level of training, *residents and* fellows may not all see the same questions.

Resident Survey reports will be made available after the close of each reporting period if:

- 70 percent compliance rate and
- four or more residents participated in the survey.

National data will be posted to all reports in August 2012. A sample report will be available shortly.
Eligibility Requirements

• ACGME Board proposed and posted for comment:
  • Prerequisite clinical education for entry into ACGME accredited core residency program must be accomplished in an ACGME or RCPSC (Canada) program
  • Prerequisite clinical education for entry into ACGME accredited fellowship program must be accomplished in an ACGME or RCPSC (Canada) core residency program
Eligibility (con’t.)

TIME FRAME:
- Comment period ended **November 23, 2011**
- Proposed Implementation
  - July 1, 2014- Requirement becomes effective for entry into core program
  - July 1, 2015- Requirement becomes effective for entry into fellowship program
- Still waiting on finalization for these – probably will not know before July 2012
Revised Program Requirements

- Sports Medicine
  - New program requirements effective 7/1/2011
  - FAQs and PIF posted online
  - Any site visits occurring 7/1/11 or later will be reviewed by the RC-FM
  - The Emergency Medicine RRC will still have input into the Program Requirements, FAQs and PIF
Program Requirement
Revisions

Tentative Timelines

- **EMS**
  - Spring 2012: Post for Comments

- **Medical Toxicology**
  - Revisions will resume this Fall

- **Core Emergency Medicine**
  - Spring 2012: Post for Comment
Core PR Revision Focuses

- New support for APD and administrative assistants
- Decreasing faculty patient/hour ratios,
- Increased clarity for required clinical experiences/curriculum
- Increased clarity for scholarly activities
- More stringent board pass rates
Milestones

• Milestones describe performance levels residents are expected to demonstrate for skills, knowledge, and behaviors in the six general competency domains.
• Milestones will lay out a framework of observable behaviors and other attributes associated with residents’ development as physicians.
• Identification of assessment methods that will be effective in evaluating performance on the milestones is a part of this effort.
Milestones

• Joint initiative of ACGME and the specialty certification boards
• Process driven by ACGME
• Advisory group: RRC-EM, ABEM, ACGME
• Working Group: AACEM, AAEM, ABEM, ACEP, CORD, EMRA, SAEM, RRC-EM, ACGME
• 12-18 month timeline
Why The ‘Next Accreditation System’ (NAS)?

- The ACGME's public stakeholders have heightened expectations of physicians.

- Patients, Payers, and the public demand
  - information-technology literacy,
  - sensitivity to cost-effectiveness,
  - the ability to involve patients in their own care, and
  - the use of health information technology to improve care for individuals and populations.

- To review programs based on reporting of outcomes through educational milestones which is the next step for the competencies.

- To allow more programs the opportunity to innovate.
The ‘Next Accreditation System’ in a Nutshell

- NAS allows accreditation process to advance from an episodic “biopsy” model to annual data collection. RRCs will measure compliance through the evaluation of annual program data elements including:
  - Milestones
  - ACMGE Resident Survey
  - ACMGE Faculty Survey
  - Procedural/Case Log Data
‘Next Accreditation System’ Cont..

- A few anticipated immediate and long-term positive impacts of NAS on programs include:

  - Programs will no longer complete Program Information Forms (PIF) created periodically (1-5 years) to describe compliance with the requirements.
  - Programs that demonstrate high-quality outcomes will be freed to innovate as the more detailed process standards may be relaxed (e.g., hours of lectures, bedside teaching, etc.).
NEXT ACCREDITATION SYSTEM

• Maintenance of Accreditation
• Continuous, not 5-year episodic, demonstration of program quality
• Annual data submission and review
• Institutional review on a regular basis
• Program self-study every 10 years
• RC’s role will change - help program to improve - “educational prescription”
NEXT ACCREDITATION SYSTEM

- Annual Data Submission examples:
  - ADS annual update
  - Resident survey
  - Faculty survey
  - Milestones data
  - Board scores
  - Procedural information
  - Others to be determined
NEXT ACCREDITATION SYSTEM

• Program level site visit
  • LCME-like self study: several site visitors
  • Establish goals for next 10 years
  • Strive for continued improvement
  • Focus not on data verification
  • Similar to - Education Innovation Project
• Neurosurgery, Orthopedic Surgery, Urology, IM, Peds, EM, and Radiology (2013)
• Remaining RCs will follow (2014)
What does the future hold?
## ACGME Staff Contact List

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Director</td>
<td>Lynne Meyer, PhD, MPH</td>
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</tr>
</tbody>
</table>
• Thank you for attending our session
• Any QUESTIONS?