

RRC NEWS

EMERGENCY MEDICINE



Accreditation Council for Graduate Medical Education

DECEMBER 2010

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Review Committee Review Activities

The Review Committee for Emergency Medicine reviewed 56 core (including 34 pilot programs), and 13 subspecialty programs at its February and September 2010 meetings. The tables below provide a summary of the actions taken during the two meetings. Also provided in a second table is a distribution of the review cycles for the reviewed programs.

Table 1. Review Committee Meeting Activities and Actions for 2010

Approved Applications		Continued Accreditation		Other Actions	
Emergency Medicine	4/4	Emergency Medicine	18/18	Approved Format and Complement Requests	3/3
Medical Toxicology	4/4	Medical Toxicology	2/2	Duty Hour Reports Reviewed	6
Pediatric Emergency Medicine	1/1	Pediatric Emergency Medicine	2/2	Pilot Programs Reviewed	34
Sports Medicine	N/A	Sports Medicine	2/2		
Undersea and Hyperbaric Medicine	1/1	Undersea and Hyperbaric Medicine	1/1		

Table 2. 2010 Reviewed Programs' Cycle Distribution

Approved Applications		Continued Accreditation	
3 years	10	5 years	7
2 years	0	4 years	9
1 year	0	3 years	7
Proposed Withhold	0	2 years	1
Withheld	0	1 year	1
		Proposed Probation	0
		Probation	0

NOTIFICATION DEADLINES

5 DAYS AFTER MEETING:

E-MAIL NOTIFICATION OF REVIEW STATUS/CYCLE LENGTH AUTOMATICALLY SENT TO PROGRAM DIRECTOR AND DIO.

60 DAYS AFTER MEETING:

E-MAIL ALERT SENT STATING THAT LETTER OF NOTIFICATION IS POSTED IN ADS.

UNTIL THE OFFICIAL LETTER IS POSTED IN ADS, REVIEW COMMITTEE STAFF MEMBERS ARE UNABLE/NOT PERMITTED TO DISCUSS THE COMMITTEE'S ACTION OR SPECIFIC DETAILS OF THE AREAS OF NON-COMPLIANCE.

MEETING AND AGENDA CLOSING DATES

MEETING: FEBRUARY 11-13, 2011
 AGENDA CLOSED: DECEMBER 13, 2010
 MEETING: SEPTEMBER 16-17, 2011
 AGENDA CLOSING: JULY 22, 2011

The following NEW emergency medicine programs were approved during the 2010 Review Committee meetings: Congratulations and Welcome to...

CORE EMERGENCY MEDICINE:

Staten Island University Hospital Program
(February 2010)

Program Director - Moshe Weizberg, MD

Baylor College of Medicine Program (February 2010)

Program Director - Girish Bobby Kapur, MD

Dartmouth-Hitchcock Medical Center Program
(September 2010)

Program Director - Kevin M. Curtis, MD

Carilion Clinic-Virginia Tech Carilion School of
Medicine Program (September 2010)

Program Director - Jennifer J. Casaletto, MD

MEDICAL TOXICOLOGY:

Texas Tech University Health Sciences Center Paul L.
Foster School of Medicine Program (February 2010)

Program Director - Stephen Borron, MD

Washington University/B-JH/SLCH Consortium
Program (February 2010)

Program Director - Sarah Eliza Halcomb, MD

SUNY Upstate Medical University Program
(September 2010)

Program Director - Michael Hodgemen, MD

Virginia Commonwealth University Health System
Program (September 2010)

Program Director - Brandon K. Wills, DO

PEDIATRICS EMERGENCY MEDICINE:

Health Partners Institute for Medical Education
Program (September 2010)

Program Director - Manu Madhok, MD

UNDERSEA AND HYPERBARIC MEDICINE:

SUNY Upstate Medical University Program
(February 2010)

Program Director - John McCabe, MD

Most Common Citations for Core Emergency Medicine Programs for Academic Year 2009-2010

- Program Personnel and Resources: Resources (n=16) – throughput times, patient care space, office space, lab and diagnostic imaging results on timely basis, etc.
- Scholarly Activities (n=16) for Residents and Faculty
- Program Personnel and Resources: Responsibilities of Program Director (n=13) – PIF completion and accuracy, environment where residents free to raise issues, ensuring residents

relieved of duties attend conferences, ensuring residents maintain documentation of procedures, etc.

- Program Personnel and Resources: Qualifications of Faculty (n=11) – faculty staffing levels, faculty to resident ratio, Board certification, etc.

David C. Leach Award Recipient in Emergency Medicine

In late September, the ACGME announced its David C. Leach Award recipients. The ACGME created this award in 2008, with the first recipients in 2010. This award, which recognizes former ACGME Executive Director (1997-2007) David C. Leach, MD, is unique in that it acknowledges and honors residents, fellows, and resident/fellow teams, and their contributions to graduate medical education. The Review Committee would like to formally congratulate Andrew Miller, MD, an emergency medicine/internal medicine resident at the SUNY Downstate and Kings County Hospital Center, who is one of the recipients of the 2011 David C. Leach Award. Dr. Miller will be invited to an Awards Luncheon during the 2011 ACGME Annual Educational Conference, which will take place March 3-6 in Nashville, Tennessee.

Useful ACGME Online Resources

- How to Apply for Accreditation in Seven Easy Steps: www.acgme.org/acWebsite/home/Accreditation_Application_Process.asp
- Virtual Program Director Handbook: www.acgme.org/acWebsite/home/PDVirtualHandbook.asp
- ACGME Data Book: www.acgme.org/acWebsite/dataBook/dat_index.asp
- Frequency of Accreditation Statuses by Specialty and Average Cycle Length by Accreditation Status and by Specialty: www.acgme.org/adspublic/
- Resident Survey National Data Report - available in ADS for Program Directors:
 1. Log into ADS
 2. Click "Resident/Fellow Survey"
 3. Click "National Data"
 4. DIOs select "Reporting Tools"
 5. Click "Resident Survey National Data Overall"
- Resident Survey Institutional Data Report – available in ADS for DIOs for each sponsoring institution's programs:
 1. Log into ADS
 2. Select "Reporting Tools"
 3. Click "Institution Level Resident Survey Results"

- ACGME Outcome Project—“Educating Physicians for the 21st Century”—Faculty Development (continued on p.4)
Resources for Competency-based Education – a series of five PowerPoint presentations with facilitator’s manuals: www.acgme.org/outcome/e-learn/e_powerpoint.asp

Accreditation and Innovation

Program directors interested in having an experimental or innovative proposal, that requires a waiver of requirements, considered by the Review Committee are encouraged to complete the ACGME’s form for such proposals, and submit it to the Committee’s Executive Director, Dr. Lynne Meyer (*contact information on p.1 of this newsletter*). In order for the Committee to consider a proposal, the program must have a four- or five-year cycle length. The form for submission can be found on the ACGME website at: www.acgme.org/acWebsite/navpages/nav_program_experimentation.asp.

Change in Faculty Roster Directions for the Common Program Information Form (PIF)

To make the Common PIF consistent for all specialties, the ACGME continues to improve the faculty roster. A standard faculty definition now appears in the Accreditation Data System (ADS) and on each PIF. The subspecialty definitions are unchanged.

1. Your faculty roster must list the program director plus all emergency medicine faculty members (all below, at, or above 15 hours per week) that are included in your required faculty-to-resident ratio of 1:3 (refer to Program Requirement II.B.2.c) and the Emergency Medicine Guidelines, which can be accessed via the Review Committee [web page](#), or by clicking [here](#)).
2. In addition, a portion of the faculty you enter on the faculty roster must be designated as **core physician faculty**.

Core physician faculty are those who:

- are able to evaluate the competency domains;
- work closely with and support the program director;
- assist in developing and implementing evaluation systems;
- teach and advise residents; and
- **devote a minimum of 15 hours per week to resident education and administration.**

3. Review the faculty roster “Core Faculty” column in ADS. If needed, **indicate** “Core Faculty” by clicking the **box in that column by the name of each faculty member who** meets the ‘core physician faculty’ definition listed above. *Please note that ADS will only allow you to designate faculty members as core physician faculty if they devote a total of 15 or more hours per week to resident education and administration.*
4. Lastly, curriculum vitae must be provided for all emergency medicine core faculty members, (refer to Program Requirement II.B.2.c). and the Emergency Medicine Guidelines, which can be accessed via the Review Committee [web page](#), or by clicking [here](#).) including the program director, and should be limited to 25.

** A new faculty roster feature now allows you to remove a faculty member from your list. To remove a faculty member from your list, enter the date he/she left the program or became inactive in the “Mark Faculty as Inactive” column. This will move the faculty member to the ‘Past/Inactive Faculty’ tab, and that individual will not appear on the PIF.

E-mail WebADS@acgme.org with questions or concerns.

Faculty Roster in Program Information Forms Includes Four Educational Activity Categories

In order to be consistent among all specialties, the ACGME has revised the Faculty Roster in the Common PIF, by expanding the ‘Average hours/week devoted to Resident Education’ to include four categories - clinical supervision, administration, didactic/teaching, and research. The PIF for emergency medicine already includes these areas so no modification is necessary. For each faculty physician listed in the PIF roster, the program must insert the hours for each category of resident education according to the following legend (in the future this information will appear in the PIF as a ‘mouse over’).

Category of Resident Education	Examples of Resident Educational Activities
Clinical supervision	Bedside rounds; outpatient precepting; operative supervision
Administration	Program oversight; curriculum development; faculty, resident and program evaluation; career counseling
Non-clinical didactics/teaching	Lectures; simulation; case discussions; preparation time for and participation in: journal clubs, conferences, lectures, simulation, case discussions, manuscript editing with resident
Resident research	Mentoring and/or working with residents/fellows; peer-reviewed funding; publication of original research or review articles in peer-reviewed journals or chapters in textbooks; publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; participation in national committees or educational organizations

FAQs

The following FAQs have recently been developed and will be posted to the Committee's web page on the ACGME website in the future.

Complement FAQs for PR II.A.4.n).(2)

Q: What do I need to do to request a permanent change in my program's resident complement?

A: A change in resident complement and/or program format must be submitted through ADS. The DIO of the sponsoring institution must sign off on the change via ADS before it can be processed and acted upon by the Review Committee. In addition, please click on the "Resident Complement" link on the [Review Committee's web page](#) for additional data that must be submitted along with your request in ADS.

Q: How long does it take to receive a response from the Review Committee regarding complement change requests?

A: Normally, the Committee is able to respond with an answer to your request in approximately two to three weeks. Occasionally, requests will need to be reviewed at the time of the next Review Committee meeting. If that is the case, Review Committee staff at the ACGME will contact you.

Q. How can program format be changed in ADS?

A: ADS is currently programmed to only accept change requests for a three-year format. As such, a request for a change in program format must include, in the Educational Rationale, what is being requested (if it cannot be accommodated in ADS). For example, "This program is currently a PGY 2-4 format with 7-7-7 (21) resident positions. We are requesting to go to a PGY 1-3 format with 8-8-8 (24) resident positions." You will also need to describe your transition plan from the current format to the proposed format in the complement change educational rationale section in ADS.

Individualized Interactive Instruction FAQs for PR II.A.4.t

Q: What types of activities can programs use to take advantage of the opportunity for Individualized Interactive Instruction?

A: The goal of individualized interactive instruction is to give program directors the ability to adjust curricular needs to the individual needs of their residents. It is important to note that simply reading or answering questions does not meet the requirements for planned educational activities.

In order for an activity to qualify as individualized interactive instruction, the following four criteria must be met:

1. The program director must monitor all activities for resident participation.

- 2) There must be an evaluation component.
- 3) There must be faculty supervision.
- 4) The activity must be monitored for effectiveness.

Examples of individualized interactive instruction might include:

- A resident preparing for and/or taking a quiz or test, and receiving timely feedback about his or her performance
- A resident spending additional time in the simulation lab or cadaver/animal lab because he or she needs more practice with a certain procedure
- Board review study sessions with colleagues or faculty for residents who are doing poorly on quizzes/tests

Program Requirement Revisions

The Program Requirements for Emergency Medicine, as well as those of two subspecialties of emergency medicine are in the revision or development process:

- Emergency Medicine – the proposed requirements will be posted for public comment during the latter part of 2011. The anticipated effective date is July 2013.
- Medical Toxicology – Tentatively, these are expected to be posted for public comment in March 2011. The anticipated effective date for the requirements is July 2013.
- Emergency Medical Services – The program requirements for this new subspecialty are currently in the beginning stages of the development process, which takes approximately 18-24 months.

Your Feedback is Requested

The Review Committee has asked the Council of Emergency Medicine Residency Directors (CORD) for feedback on the following topics:

- the ACGME Case Log System (Please note that if you are a new core program and do not have a case log system in place; or are an existing core program and need a system, please contact Review Committee staff about the ACGME Case Log System which is available for free.);
- defining the necessary components of non-emergency medicine curriculum for core programs;
- defining the educational components and providing justification for a fourth year of education during a core program; and,
- revision of the Program Requirements for either/ both Emergency Medicine and Medical Toxicology,

or development of the Program Requirements for Emergency Medical Services.

Please send CORD feedback on any of the above topics to Executive Director Lynne Meyer: lmeyer@acgme.org or 312.755.5006.

Update on Impact of Approved Revisions to the Common Program Requirements on Specialty-Specific Program Requirements

Revisions to the ACGME Common Program Requirements related to duty hours in the learning and working environment were approved by the ACGME Board of Directors on Monday, September 27, 2010 with an effective date of July 1, 2011. The revised Common Program Requirements include several sections that necessitate further specialty-specific definitions. Several of these areas, as denoted by an asterisk below, require immediate action by the Review Committees; others may be developed over the next year for implementation in July 2012. No other additions will be made to the duty hour section or other sections of these requirements.

Areas that Require Specialty-Specific Definitions to be Developed by Each Review Committee:

1. Define licensed independent practitioners who may have primary responsibility for patient care (VI.D.1).
2. Describe achieved competencies under which PGY-1 residents progress to be supervised indirectly with direct supervision available (VI.D.5.a.1).
3. Specify optimal clinical workload (VI.E).
4. Define elements of teamwork that must be present in each specialty (VI.F).
5. Define Intermediate level residents and residents in the final years of education (senior level residents) (VI.G.5.b and c).*
6. Define circumstances when "senior residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty (VI.G.5.c.1).*
7. RCs may specify the maximum number of consecutive weeks of night float and the maximum number of months of night float per year (VI.G.6).*

** must be defined or specified by the Review Committees for review at the June 2011 ACGME Board meeting.*

Review Committees will develop these definitions by December 15, 2010 and submit them to the ACGME for review and approval at the February 2011 ACGME meeting. The approved definitions will be posted shortly after the ACGME meeting and, as already mentioned, will become effective July 1, 2011.

ACGME Resident Survey Aggregate Reports are Useful to Programs, Sponsoring Institutions, and ACGME Review Committees

A common topic facing Review Committees is the disposition of results of the Resident Survey and how the results in particular may impact a program's accreditation status. The ACGME and its Review Committees take residents' engaged participation in this annual survey very seriously. In response to numerous recent inquiries regarding this topic, the ACGME wanted to provide clarification on how it utilizes the information gleaned from survey responses.

Use in Program Evaluation:

Review Committees, programs, and sponsoring institutions consider residents' evaluations of their programs important sources of information about program quality (CPR V.C.). Since the implementation of the annual ACGME Resident Survey in 2004, many programs and sponsoring institutions have used its results to focus improvement efforts, and as one method of gathering resident input. After the survey window closes, the program director and designated institutional official (DIO) can assess an aggregate summary of the results for their individual program or sponsoring institution, and implement an action plan to address issues of concern. In addition, many programs and institutions use their own survey to assess programs that are not eligible to complete the ACGME survey (i.e., fellowship programs with fewer than four fellows) or to explore topics of local or institutional relevance.

Use during Accreditation Site Visits:

During site visits, the ACGME field staff representatives use the results of the ACGME Resident Survey, along with other information provided by the program or institution, to verify and clarify issues during this part of a program's accreditation assessment. Information from the site visit, along with all other accreditation documents, is considered by the Review Committee to determine accreditation outcomes.

Use by ACGME and Review Committees:

Beginning in 2007, the ACGME and its Review Committees initiated standardized follow-up with programs and institutions when the results of the Resident Survey exceeded an established ACGME compliance threshold for duty hours (these plans were communicated to the GME community in a special message from Dr. Thomas Nasca in September 2008 - www.acgme.org/acWebsite/home/SpecialMessage-CEO2008Sept22.pdf - as well as through individual Review Committee newsletters). Then, in 2009, the

Council of Review Committees and ACGME senior leadership discussed methods for aggregating data from multiple areas of the survey as a way for Review Committees to review interim (between site visits) information about programs and sponsoring institutions. Additionally, the aggregation of individual survey questions into domains of program functioning (faculty, evaluation, educational content, resources, duty hours) offers a way to learn about areas and patterns of noncompliance that may be present in a program.

This year, the ACGME Board of Directors recommended that Review Committees follow-up with programs that had significant noncompliance with the aggregated duty hour domain, as well as significant non-compliance in two or more other domains (faculty, evaluation, educational content, resources). Of the 5703 programs that participated in the 2010 ACGME Resident Survey, 274 (4.8%) required follow-up. Follow-up methods included letters sent to program directors and DIOs requesting that they implement improvement plans to address the problem areas, and, for 34 programs, scheduling early site visits. The ACGME sent a copy of any letter sent to a program to the chief executive officer of that program's sponsoring institution in order to involve him or her in supporting program improvements.

Results Available in the ACGME Accreditation Data System (ADS):

DIOs and program directors are encouraged to continue using the results of the ACGME Resident Survey as an ongoing quality improvement tool. Multiple reports are available to provide this resource to programs and institutions via ADS:

- Programs can view the **2010 Resident Survey National Data Overall** report by selecting "Resident/Fellow Survey" from the left-hand menu, and then clicking on "National Data." DIOs can view this same report selecting "Reports" from the left-hand menu, clicking on "Reporting Tools," and then clicking on "Resident Survey National Data Overall."
- DIOs can view the **Aggregate 2009-2010 Institution Level Resident Survey** report for each sponsoring institution by selecting "Reports" from the left-hand menu, clicking "Reporting Tools," and then clicking the "Institution Level Resident Survey Results" link and selecting the 2009-2010 academic year.
- **2009-2010 Resident Survey individual** reports have been reposted with a *new* column that displays the "National Noncompliance Rate." Programs can view the report by selecting

“Resident/Fellow Survey” from the left-hand menu, and then clicking on “Aggregate Report.” DIOs can view this report by selecting “Program & Resident Info” from the left-hand menu, clicking “View and Update Sponsored Programs,” and then selecting the report link for each program under the “Resident/Fellow Survey Report” column.

- Programs can view the **Aggregate 2007-2010 Combined Resident Survey Results** report for programs with fewer than four active residents: by selecting “Resident/Fellow Survey” from the left-hand menu, and clicking on “Aggregate Report.” DIOs can view this report by selecting “Program & Resident Info” from the left-hand menu, clicking on “View and Update Sponsored Programs,” and selecting the report link for each program under the “Resident/Fellow Survey Report” column.
- The **2010 Resident Survey National Data for Specialty-Specific Questions** report is **only** available for specialties that have a specialty-specific survey section. Programs can view the report by selecting “Resident/Fellow Survey” from the left-hand menu, and clicking on “National Data—Specialty-Specific Questions.” DIOs can view this report by selecting “Reports” from the left-hand menu, clicking on “Reporting Tools,” selecting “Resident Survey National Data—Specialty-Specific Questions,” and then selecting the 2009-2010 academic year.
- Programs can view the **2010 Resident Survey National Data by Core Specialty** report by selecting “Resident/Fellow Survey” from the left-hand menu, and clicking on “National Data by Core Specialty.” DIOs can view this report by selecting “Reporting Tools” from the left-hand menu, clicking on “Reporting Tools,” and then selecting “Resident Survey National Data by Core Specialty.”

ACGME 2010 Emergency Medicine Resident Survey Results

The annual Resident Survey for emergency medicine residents was administered during March and April 2010. The survey results (148 programs, with a response from 4,621 out of 4,947 residents) indicate highly engaged learning between faculty and residents. There were 97,771 respondents included in the national normative data.

- Questions pertaining to FACULTY (Q1-6) had an average compliant response rate of 92.0% and ranged from 72.2% (Q4) to 98.5% (Q2).
- Questions pertaining to EVALUATION (Q7-8, Q11-12, and Q15) averaged a 98.5% compliance response rate and ranged from 96.4% to 99.6%.
- Questions pertaining to the EDUCATIONAL CONTENT (Q9-10, Q13-14) averaged 98.5% compliance and ranged from 98.7% to 99.9%. Additional educational content Questions 19a and 19b had compliant responses of “extremely often” or “very often” 90.3% (Q19a) and “never” or “rarely” 83.3% (Q19b).
- The questions regarding RESOURCES (Q16, 17a) had compliant response rates of 83.2% and 96.3% respectively. An additional resources questions (Q17b) had a compliant response of “extremely satisfied” or “very satisfied” 87.7%. The remaining resources question (Q18) had a compliant response rate of 93.4% for “at all times”.
- DUTY HOUR compliant responses (“extremely often” or “very often”) for questions 20a-20f ranged from 88.4% (Q20f) to 98.8% (Q20b). Responses marked “not applicable” had an average response rate of 3.3%. Additional duty hour questions (Q20g-20i) had compliant responses (“extremely often” or “very often”) with an average response rate of 53.8%. Responses marked “not applicable” for Q20g-20i averaged 41.5%. For duty hour question 21 – “If you noted any issues with duty hours in the section above, would you say that those issues occurred mostly on rotations to other services outside your specialty? – responses were: Other Services (24.6%), Within My Specialty (1.3%), Both (1.1%), N/A (73.0%). Noncompliant responses (“sometimes”, “rarely”, or “never”) for questions on duty hours (Q20a-20i) ranged from 0.4% to 2.1%.

The table below highlights select Resident Survey questions where non-compliant responses from emergency medicine are greater than all specialty programs combined (national normative data), OR if non-compliant emergency medicine responses are greater than 10%. In addition, this table includes the average response rates for emergency medicine specialty specific questions.

(continued on p.8)

Table 3: 2010 Emergency Medicine Resident Survey Data

	Emergency Medicine (EM) Non-Compliant Specialty-Specific Data	National Non-Compliant Normative Data
Responses to Survey		
Q16 – Has your ability to learn been compromised by the presence of trainees who are not part of your program, such as residents from other specialties, subspecialty fellows, PhD students, or nurse practitioners?	16.8%	17.5%
Q17b – How satisfied are you with your program’s process to deal confidentially with problems or concerns you might have?	12.3%	20.6%
Q19b – How often has your clinical education been compromised by excessive service obligations?	16.8%	29.1%
	EM Specialty-Specific Questions	
How many faculty attend and meaningfully participate in scheduled weekly conferences?	None (0.1%) Few (12.1%) Some (45.8%) Most (37.1%) All (4.9%)	
Has your program director (or designee) met with you and conducted a formal review of your overall progress and performance in this program?	No, not this year (1.0%) Once this year (31.8%) 2-3 times this year (61.8%) 4 or more times this year (5.4%)	
Does your program provide you an opportunity to perform an appropriate number of procedures to be competent?	Yes (98.2%)	
Does your program provide you an opportunity to direct an appropriate number of major resuscitations to be competent?	Yes (98.6%)	
Does your program provide you an opportunity to become a competent Emergency Medicine physician?	Yes (99.5%)	

Next Accreditation System Focus of CEO’s Speech at 2010 ACGME Annual Conference

The ACGME is continuing its transition to a system of accreditation that encourages and recognizes innovation, improvement, and excellence, Thomas J. Nasca, MD, MACP, chief executive officer of the ACGME, said at the 2010 Annual Conference.

Dr. Nasca discussed the ACGME’s shift to the next accreditation system in his March 6 welcoming address, “Transitions in the Learning Environment: Milestones, the Next Accreditation System, and Other Factors Influencing Graduate Medical Education,” to attendees of the 2010 ACGME Annual Educational Conference. The Conference, which was held March 4-7 at the Gaylord Opryland in Nashville, Tennessee, attracted a record crowd of approximately 1,600 program directors, program coordinators, designated institutional officials, and other people involved in graduate medical education.

The shift to the next accreditation system began in the early 1990s when the ACGME introduced the Outcome Project, which requires residents to master six general competencies: interpersonal skills and communication, medical knowledge, patient care, practice-based learning and improvement, professionalism, and systems-based practice.

The ACGME is working with Review Committees, and specialty medical organizations and boards to develop

specific benchmarks of skills and knowledge that residents in every specialty must achieve at certain identified points or stages during their residency education. These benchmarks, or milestones, not only will help to demonstrate that all graduates meet the core competencies, but will enable both programs and the ACGME to certify that the residents meet them.

“We have entered an era of zero tolerance for medical errors and the public has very high expectations for the quality of care that they will receive,” said Dr. Nasca. “The profession, and those of us involved in the education of the next generation of physicians, must enhance the public’s trust in the profession and the quality of care provided by our residents in the teaching setting.

The next accreditation system will have longer accreditation cycles for strong programs, an emphasis on innovation and excellence, and more frequent collection and review of data between site visits. It will require more accountability from institutions that sponsor residency programs, more sharing of aggregate graduate medical education data, and less frequent revisions of standards.

Dr. Nasca noted that three principles underscore everything the ACGME does: the safety of patients under the care of residents and faculty in teaching institutions; the safety of patients that will receive care in later years when residents practice independently; and the assurance that residents are being educated in a safe, humanistic environment that nurtures professionalism and the effacement of self-interest.

The ACGME Board of Directors discussed next steps for this new accreditation system at a strategic retreat in February. The Board appointed a task force to develop recommendations for the next accreditation system, which will be presented to the Board in February 2011.

Save the Date:
2011 ACGME Annual
Educational Conference

Beyond Boundaries

Gaylord Opryland Resort Hotel
and Convention Center
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March 3-6, 2011

[click here](#) for more information; [registration](#) now open