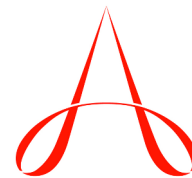


RRC NEWS

FAMILY MEDICINE



ACGME

Accreditation Council for Graduate Medical Education

DECEMBER 2010

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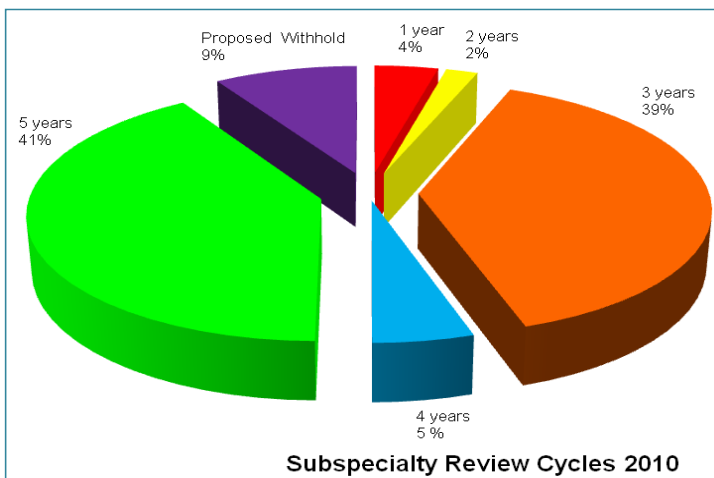
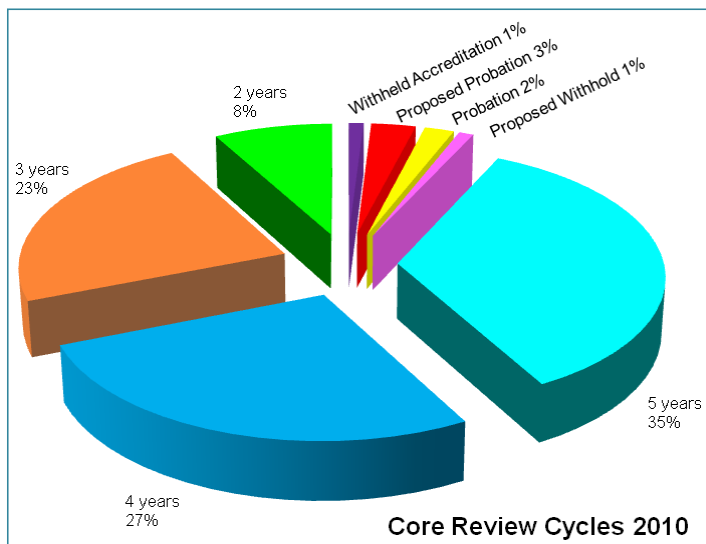
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RRC NEWS PROVIDES REVIEW COMMITTEE AND ACGME UPDATES. PLEASE CONTACT THE EDITOR WITH QUESTIONS OR COMMENTS ABOUT THIS NEWSLETTER:
MSCHWAB@ACGME.ORG.

Summary of Actions Taken at the 2010 Meetings

The Review Committee for Family Medicine reviewed 112 core, and 56 subspecialty programs at its three meetings (Jan., May, and Sept.) in 2010. The charts below summarize the actions taken this year. Also provided is a distribution of the review cycles of the programs reviewed.



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: JANUARY 24-26, 2011
AGENDA CLOSED: NOVEMBER 26, 2010

MEETING: MAY 23-26, 2011
AGENDA CLOSING: MARCH 25, 2011

Most Common Citations

The following table outlines the most frequent areas of non-compliance for core and subspecialty family medicine programs from January-June 2010:

CORE FAMILY MEDICINE	SUBSPECIALTIES OF FAMILY MEDICINE
1. Institutional Support/Sponsoring Institution	1. Evaluation of Fellows
2. Performance on Board Scores	2. Evaluation of Program
3. Responsibilities of Program Director	3. Scholarly Activity
4. Evaluation of Program	4. Supervision
5. Qualifications of Faculty	5. Institutional Support/Sponsoring Institution
6. Resident Appointment Issues	6. Institutional Support/Participating Institution
7. Goals and Objectives	7. Goals and Objectives
8. Institutional Support/Participating Institution	8. Institutional Support/Participating Institution
9. Medical Records Retrieval	9. Responsibilities of Faculty
10. Responsibilities of Faculty	10. Resources

Farewell and Thank You

After more than five years of service (including two years as Chair), Dr. Janice Nevin completed her tenure on the Review Committee June 30, 2010. The Committee thanks Dr. Nevin for her countless contributions, her leadership, and her unwavering commitment to graduate medical education and the field of family medicine. Dr. James Martin succeeded Dr. Nevin as Chair beginning July 1, 2010. Dr. Martin currently serves as the Chief Medical Officer for CHRISTUS Santa Rosa, and is well known both for his commitment to excellence in medical education, and for his passion for health care reform in America.

New Review Committee Members

Since July 2010, the Review Committee has welcomed two new members. Dr. Suzanne Allen comes to the Committee from the University of Washington School of Medicine, where she serves as the Vice Dean for Regional Affairs and is a clinical professor in the Department of Family Medicine. In her current position, Dr. Allen oversees all medical education in Idaho for the WWAMI program, including undergraduate and graduate medical education. Dr. Allen also serves as the designated institutional official for the Family Medicine Residency of Idaho Program, and is responsible for all education that occurs at the main residency program and in its rural training tracks.

In addition to Dr. Allen, the Review Committee also welcomed its new resident member. Dr. Adam Roise is a third-year resident at the Northeast Iowa Family Medicine Residency Program in Waterloo, IA. A native of North Dakota, he served as a Peace Corps Volunteer in Cameroon before completing his MD and MPH at the University of North Carolina at Chapel Hill in 2008. Outside of work he enjoys spending time with his wife and 18-month-old son.

New Review Committee Executive Director

Lynne Meyer, PhD, MPH, joined the Review Committee as its new executive director in May 2010. For the last two years she has served as the executive director for the Review Committees for Emergency Medicine, Neurology, and Psychiatry. Prior to joining the ACGME, Dr. Meyer was an Assistant Dean for Medical Education and Evaluation at the University of Illinois College of Medicine at Peoria. Her interests and experiences are in curriculum development, faculty development, program evaluation, survey research and qualitative research. Dr. Meyer holds a doctorate in education and organizational leadership from the University of Illinois at Urbana-Champaign. She continues to serve as the executive director for the Review Committee for Emergency Medicine in addition to her role with the Review Committee for Family Medicine.

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 for implementation during 2011. 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. Review Committees 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 February 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.

Family Medicine Requirements Update and Timeline

The ACGME requires that each set of program requirements undergo major revisions at least once every five years, and the process is currently

underway for the Program Requirements for Family Medicine (core), as well as for those of the three subspecialties of family medicine (geriatrics, sports, and hospice and palliative care). The next step in the process for the core requirements will take place in February 2011 when the Requirement Development Committee (RDC) reviews changes proposed by the Review Committee. The proposed requirements are scheduled to be posted for public comment during June 2011, and will go into effect July 1, 2013.

Subspecialty Requirement Update

The Review Committees for Emergency Medicine, Pediatrics, and Physical Medicine and Rehabilitation worked with the Review Committee for Family Medicine on a major revision to the Program Requirements for Sports Medicine. These requirements were reviewed by the ACGME Committee on Requirements and approved by the ACGME Board at its June 2010, and will go into effect July 1, 2011. The approved requirements can be found on the ACGME website: www.acgme.org/acWebsite/RRC_120/120_prIndex.asp. In addition, the revised program information form (PIF) for Sports Medicine will be available by March 1, 2011. The posting of the revised PIF will be announced via a future *e-Communication*.

The Review Committee for Family Medicine is currently collaborating with the Review Committee for Internal Medicine on the major revision to the Program Requirements for Geriatric Medicine. The proposed draft requirements are scheduled to be posted for review and comment in June 2011, and will go into effect July 1, 2013 along with the Program Requirements for Family Medicine (core).

Clarifying the Review and Comment Period for Program Requirement Revisions

As most of our newsletter readers are aware, suggested revisions to program requirements are made available to the community of interest for a period of public comment built into the approximately two-year revision process for a given set of requirements. However, the specifics of this public comment period may not be clear to all.

During the development or revision process for program requirements, which can take up to 24 months to complete, an opportunity exists for members of the public—the community of interest—to review the proposals and provide comments and feedback. The groups which constitute the community of interest, per ACGME policy, are: member organizations of the ACGME; organizations that nominate candidates for Review Committee

membership; designated institutional officials (DIOs); chairs and executive directors of each Review Committee; program directors in the specialty. These groups, as well as any additional specialty organizations identified at the discretion of the Review Committee whose requirements are in-process, are notified of the public comment period via the ACGME's weekly *e-Communication* when the proposed requirements (as well as an Impact Statement) are posted.

The length of the period of public comment is 45 days (for major revisions to existing requirements, new requirements, and focused revisions) from the date of the *e-Communication* announcement. In the case of focused revisions, only comments regarding the portions being changed, and not on the document in whole, will be accepted. The proposed document stays posted on the ACGME website for one full month after the deadline for comments, but once the deadline has passed, no comments need be accepted for consideration. Extensions or exceptions for comments received after the 45 days have passed are made at the discretion of the Review Committee. After the month has passed, the document is moved to the archives section of the web page, where it remains until the final requirements are approved by the ACGME Board of Directors.

The Review Committee evaluates all comments received, and decides which suggestions will be incorporated into the final proposal. Comments received are kept confidential, and are only viewed by members of the Review Committee and the ACGME Committee on Requirements. All comments are addressed, whether accepted or declined, in a document submitted with the final proposed requirements to the ACGME.

All requirements posted for review and comment can be found on the [ACGME website](#), by selecting the left-hand links to "Review and Comment" --> "Program Requirements". Posted along with all current documents are the deadlines for comments and the e-mail address to which comments should be submitted.

Changing a Dependent Subspecialty Relationship from One Specialty/Core Program to a New Specialty/Core Program Requires Review Committee Approval for Subspecialty Programs in Hospice and Palliative Medicine

Dependent subspecialty programs are required to function in conjunction with an ACGME-accredited residency (also known as a specialty or core)

program. The continued accreditation of the subspecialty is dependent on the specialty program's maintaining its accreditation. The dependent subspecialty program must be sponsored by the same ACGME-accredited sponsoring institution of the linked specialty program and should be geographically proximate to the specialty program. In the case of hospice and palliative medicine – the Review Committee for Family Medicine accredits all of these programs, which may be aligned with specialty programs in anesthesiology, emergency medicine, family medicine, internal medicine, neurology, psychiatry, obstetrics and gynecology, pediatrics, physical medicine and rehabilitation, radiation oncology, or surgery.

Should any hospice and palliative medicine subspecialty programs need to realign and establish a new dependent relationship with a new/different specialty/core program, the program director of the subspecialty program must first request voluntary withdrawal of accreditation through the Accreditation Data System (ADS), and then formally submit a new application to the Review Committee, per this Committee's process. The sponsoring institution's GMEC and DIO must approve both the voluntary withdrawal and the new application.

Review Committee staff members (*see p.1 for contact information*) can answer questions and provide guidance about this process.

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.

Parker J. Palmer Courage to Teach Award Recipient in Family Medicine

In late September, the ACGME announced its *Courage to Teach* award recipients. The award is named after Parker J. Palmer, PhD, a noted teacher and sociologist who wrote [The Courage to Teach](#) and other books on teaching and vocation. It is given annually to 10 program directors who have developed innovative teaching practices and demonstrated a commitment to teaching. The Review Committee

would like to formally congratulate Tsveti Markova, MD, from the family medicine program at Wayne State University/Crittenton for being a recipient of the 2011 Parker J. Palmer Courage to Teach Award. Awardees receive \$1,000 and a plaque, and Dr. Markova will be invited to the Awards Luncheon held during the 2011 ACGME Annual Educational Conference, which will take place March 3-6 in Nashville, Tennessee.

Accreditation and Innovation

Program directors interested in having an experimental or innovative proposal 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.

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 Resources for Competency-based Education – a series of five PowerPoint presentations with facilitator’s manuals: www.acgme.org/outcome/e-learn/e_powerpoint.asp

Change in Common PIF Faculty Roster Directions

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

When completing the faculty roster section of the Common PIF, please continue to follow the family medicine-specific instructions. These are specified below as they appear in ADS:

- 1. FACULTY DATA:** List all physician faculty who have a significant role (teaching or mentoring) in the education of residents and who have documented qualifications to instruct and supervise. List the FM physician faculty in your program who devote more than 200 hours per year to resident education (refer to the Program Requirements) in the following order: (1) full-time, (2) part-time, and (3) volunteer faculty.
- 2. Other Faculty:** After listing the FM faculty, identify the primary physician faculty members responsible for teaching FM residents in the following areas (listed in this order): Human Behavior/Mental Health; Adult Medicine; Cardiology; Critical Care; Obstetric Care; Gynecologic Care; Surgery; Orthopaedics; Sports Medicine; Emergency Medicine; Neonates, Infants, Children and Adolescents; Older Patient; Skin. Provide a one page CV for anyone who is not ABMS-certified.

Faculty-Resident Ratio: A full-time commitment is at least 1400 hrs/yr (or 27 hrs/wk) devoted to the residency spent in resident administration, resident teaching, resident precepting and attending duties, exclusive of time spent in direct patient care without the presence of residents. All programs in operation must have at least 2 FM faculty members (the PD and one other faculty member) who devote at least 1400 hrs/yr to the program. Additionally there must be 1 full time equivalent (FTE) FM physician faculty for every 6 residents in the program. Do not count the PD in the faculty-to-resident ratio. Once a program has 2 full time faculty members, several faculty can make up the remaining FTE: for example, 2 faculty who are half time (700 hrs/yr or 14 hrs/wk) constitute 1 FTE.

All physician faculty must:

- devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong

interest in resident education;

- administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas;
- participate in faculty development programs designed to enhance the effectiveness of their teaching and to promote scholarly activity;
- establish and maintain an environment of inquiry and scholarship with an active research component;
- regularly participate in organized clinical discussions, rounds, journal clubs, and conferences;
- encourage and support residents in pursuing scholarly activities

To summarize the above, your faculty roster must list the program director plus all family medicine faculty members (all below, at, or above 15 hours per week) that are included in your required faculty-to-resident ratio of 1:6. Then list the primary "Other Faculty" for each requested area (i.e. Human Behavior/Mental Health; Adult Medicine; Cardiology; etc.).

In addition, a portion of the faculty you enter on the faculty roster must be designated as **core physician faculty**.

3. 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.**

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.*

Lastly, curriculum vitae must be provided for the program director, any family medicine faculty member who is not ABFM-certified, and any other faculty member who is not ABMS-certified.

** 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 with all other specialties, the ACGME has revised the Faculty Roster in the Common PIF for the following specialties: anesthesiology, colon and rectal surgery, dermatology, *family medicine*, medical genetics, nuclear medicine, obstetrics and gynecology, orthopaedic surgery, pathology-anatomic and clinical, pediatrics, physical medicine and rehabilitation, and radiation oncology, as well as for the transitional year. The revision expanded the ‘Average hours/week devoted to Resident Education’ to include four categories - clinical supervision, administration, didactic/teaching, and research. NOTE: the total number of hours worked previously entered for each faculty member has been stored; however, the data for these four categories will initially appear as zeros. 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

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 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 the 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/SpecialMessageCEO2008Sept22.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 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."

Save the Date:
2011 ACGME Annual
Educational Conference

Beyond Boundaries

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

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

ACGME 2010 Family Medicine Resident Survey Results

The annual Resident Survey for family medicine residents was administered during March and April 2010. The survey results (445 programs, with a response from 8,782 out of 9,529 residents) indicate highly engaged learning between faculty and residents.

- Questions pertaining to FACULTY (Q1-6) had an average compliant response rate of 93.5% and ranged from 86.3% (Q5) to 96.8% (Q2).
- Questions pertaining to EVALUATION (Q7-8, Q11-12, Q15) averaged 96.8% compliance and ranged from 95.3% (Q8) to 99.3% (Q12).
- Questions pertaining to the EDUCATIONAL CONTENT (Q9-10, Q13-14) averaged 96.6% compliance and ranged from 92.1% (Q13) to 98.7% (Q9). Additional educational content Question 19a and 19b had compliant responses of “extremely often” or “very often” 90.3% (Q19a) and “never” or “rarely” 71.6% (Q19b).
- The questions regarding RESOURCES (Q16, 17a) had compliant response rates of 81.7% and 92.4% respectively. An additional resources questions (Q17b) had a compliant response of “extremely satisfied” or “very satisfied” 78.0%. The remaining resources question (Q18) had a compliant response rate of 90.8% for “at all times”.
- DUTY HOUR compliant responses (“extremely often” or “very often”) for questions 20a-20f on ranged from 93.8% (Q20f) to 98.1% (Q20b). Responses marked “not applicable” averaged 1.1%. Additional duty hour questions (Q20g-20i) had compliant responses (“extremely often” or “very often”) with an average of 68.0%. Responses marked “not applicable” for Q20g-20i averaged 29.7%. For duty hour Q21 – “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 (12.2%), Within My Specialty (9.6%), Both (5.4%), N/A (72.8%). Noncompliant responses (sometimes, rarely, or never) for questions on duty hours (Q20a-20i) ranged from 1.5% to 4.9%.

The table that follows highlights select Resident Survey questions where non-compliant responses from Family medicine are greater than all specialty programs combined (national normative data), OR if non-compliant Family medicine responses are greater than 10%.

(continued on p.10)

Table 1: 2010 Resident Survey Response Data

	Family Medicine Specialty-Specific Non-Compliant Response Data	National Normative Non-Compliant Response Data
Survey Items		
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?	18.3%	17.5%
Q17b – How satisfied are you with your program’s process to deal confidentially with problems or concerns you might have?	22.0%	20.6%
Q19a – How often do your rotations and other major assignments provide an appropriate balance between clinical education and other demands, such as service obligations?	16.1%	16.8%
Q19b – How often has your clinical education been compromised by excessive service obligations?	28.5%	29.1%
	FM Specialty-Specific Questions – Percentage of Yes Responses	
1.A. Have you personally delivered care to one of your family medicine patients in at least 3 different settings?	Overall: 84.0% Year 1: 69.4% Year 2: 89.6% Year 3: 93.2%	
1.B. Has this occurred more than 3 times in the preceding 6 months?	Overall: 54.0% Year 1: 41.2% Year 2: 59.9% Year 3: 61.9%	
2.A. Have you personally called and directed a family meeting for any reason?	Overall: 90.3% Year 1: 82.2% Year 2: 92.9% Year 3: 95.7%	
2.B. Has this occurred more than 2 times in the preceding 6 months?	Overall: 69.6% Year 1: 64.4% Year 2: 71.1% Year 3: 73.2%	
3.A. Have you personally provided a comprehensive service for one of your patients for any reason?	Overall: 93.9% Year 1: 88.4% Year 2: 96.6% Year 3: 96.6%	
3.B. Has this occurred more than 2 times in the preceding 6 months?	Overall: 81.0% Year 1: 71.8% Year 2: 85.4% Year 3: 85.8%	
4.A. Have you personally helped one of your patients by being supportive, making suggestions, and were you an important part of the healing for the patient?	Overall: 97.9% Year 1: 96.3% Year 2: 98.5% Year 3: 98.7%	
4.B. Has this occurred more than 2 times in the preceding 6 months?	Overall: 91.3% Year 1: 88.2% Year 2: 92.2% Year 3: 93.3%	