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### Proposal for Accelerated Residency Program Denied

In the fall of 2008, the Residency Review Committee reviewed a proposal for accelerated residency education which would combine the fourth year of medical school with the first year of residency. Allowing such an arrangement would require a waiver of the institutional requirement that all U.S. applicants to ACGME-accredited programs must be graduates of LCME- or AOA-accredited medical schools (Institutional Requirements II.A.1). In accordance with ACGME policy, the Committee forwarded the proposal to the ACGME Board of Directors for consideration. At its February 9, 2009 meeting, the Board reviewed the proposal and upheld the Institutional Review Committee's recommendation to deny the waiver of the institutional requirement. The request for a waiver was denied on the grounds that the institutional requirement was a fundamental and important standard.

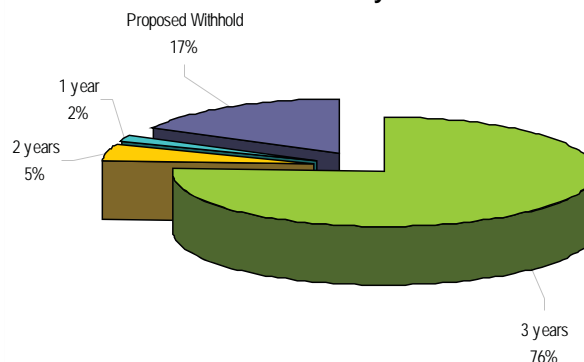
### National Data Reports

The family medicine national reports based on data submitted for the reporting year 2007-2008 are now available in ADS. To view this newest report, along with previous year's reports, program directors may log into ADS, select the "Family Medicine Specialty Data" menu and click on the "Family Medicine National Report" link. DIOs may also view the report. The Committee has collected three years worth of data using this system. Upcoming newsletters will compare data across years.

### Update on Accreditation of Hospice and Palliative Medicine (HPM) Programs

The Committee reviewed all the HPM applications it received by the summer 2008 deadline (n=58). The HPM advisory group made recommendations to the Committee regarding compliance relative to the HPM requirements. Then, the Committee reviewed all aspects of the application and made the accreditation decisions. While most applications received initial accreditation with a three-year cycle, there were ten for which the Committee recommended withholding accreditation.

Hospice and Palliative Medicine Applications  
January 2009



Some of the more frequent citations for applications that received proposed withholding of accreditation include:

- No evidence that the program director is certified in hospice and palliative medicine (by either the applicable ABMS board of the American Board of Hospice and Palliative Medicine);
- No evidence that the program will have the requisite number of faculty certified in HPM;
- The application was not well prepared or complete making it difficult for the Committee to determine compliance with requirements;
- Inadequate inpatient experience (e.g., no evidence of being four months in length; not done in an acute care hospital);
- No evidence of a multi-disciplinary environment with faculty from other disciplines (see clarification in “Clarification of HPM Program Requirements” in the next column);
- The application lacked evidence of key clinical components (e.g., no evidence of ambulatory experience but expected in the future; no evidence of pediatric experience, but expected; etc.).

Responses to proposed withholds will be reviewed at the May and September 2009 Committee meetings.

### **Procedures for Processing HPM Applications/ Programs**

As noted in the 2008 RRC newsletters, the Committee will review and accredit all HPM programs, regardless of the specialty with which the HPM program is aligned. This is a new/different accreditation model than what has been done in the past with other multidisciplinary subspecialties (e.g., sleep and sports medicine). An advantage to this model is that one Committee develops expertise with HPM. This model also helps avoid the possibility of one or two specialties accrediting a very small number of programs in this area. A recent ACGME e-communication provided details on how HPM applications and programs will be handled by ACGME. The link to the PDF is located here: [http://www.acgme.org/acWebsite/RRC\\_120/ProcessingHPMPrograms\\_FM\\_SA\\_032009.pdf](http://www.acgme.org/acWebsite/RRC_120/ProcessingHPMPrograms_FM_SA_032009.pdf).

### **Clarification of HPM Program Requirements**

**Question:** What do HPM programs need to do to document that they are in compliance with the requirement that fellows will receive education in a multi-disciplinary environment?

**Answer:** The requirements state that “because of the interdisciplinary nature of Hospice and Palliative Medicine, physician faculty should include representatives from appropriate medical subspecialties, such as Cardiology, Critical Care Medicine, Geriatric Medicine and Oncology, and from other specialties such as Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, Neurology, Obstetrics and Gynecology, Pediatrics, Physical Medicine and Rehabilitation, Psychiatry, Radiation Oncology, and Surgery.” (Program Requirement II.B.2.a) In order to be in compliance with this requirement, programs will need to document faculty representatives from at least three of the disciplines noted above. For instance, if the faculty roster on the PIF indicates that the program has a faculty member in internal medicine, geriatric medicine, and critical care medicine, who teach and supervise fellows, this would meet the requirement.

**Question:** What is the minimum number of pediatric patients fellows need to see during their fellowship?

**Answer:** The requirements state that “The program must ensure that fellows have access to a patient population adequate to meet the needs of the fellowship program. The population must represent a broad range of diagnoses and palliative care needs, including patients with advanced conditions. The population should include adults and children.” (Program Requirements II.D.1.a) In order to be in compliance with this requirement, programs will need to document that fellows see/provide care for at least five pediatric patients during their fellowship year.

Both of these items will be added to the HPM FAQ that is located on the website at the following address: [http://www.acgme.org/acWebsite/RRC\\_120/62008FAQ\\_HPM\\_AA\\_02012009.pdf](http://www.acgme.org/acWebsite/RRC_120/62008FAQ_HPM_AA_02012009.pdf)

### **Clarification of Expectations Regarding Practice-based Learning and Improvement and Systems-based Practice**

Edwin Zalneraitis, MD and Joseph Gilhooly, MD of the RRC for Pediatrics developed the following FAQs to clarify expectations for two of the more malleable and hard to grasp competencies. The Review Committee for Family Medicine believes that the clarification and

examples could be generalized beyond pediatrics, and these questions and replies are noted below.

**Question:** The requirements for Practice-based Learning and Improvement (PBLI) state that residents must systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement. (IV.A.5.c.4) Does this mean that residents are expected to participate in a quality improvement project?

**Answer:** The program needs to document that residents (working alone or in a practice group) actively participate in an exercise in which they can examine some aspect of their practice to identify an area in need of improvement, and then implement a plan to bring about improvement. An exercise that examines some aspect of their educational activities can be used to meet this requirement if it is related to patient care. Residents will need to be provided instruction in quality improvement methods. This process is learned best when residents are able to work with those skilled in quality improvement.

Here are several examples of clinically based quality improvement projects:

- o **PBLI Example 1:** A group of residents has decided to work on improving how growth in patients in the continuity clinic can be better tracked. First, they document their current tracking percentage; they look at 100 charts. Then, they introduce a reminder system to improve such data. Several months after the change has been implemented, residents check another 100 charts to see if the change has resulted in improved tracking.

- o **PBLI Example 2:** A resident has decided to work on reducing infection rates for a particular procedure. He thinks his rates exceed those of other residents for the procedure. He decides to work on compliance with techniques known to reduce infections associated with the procedure. The resident then introduces a new system of doing the procedure that increases the chance of completing the procedure in the expected way without infection. The resident tracks the technique used and the rate of infection related to the procedure in the future.

Here are two examples of quality improvement projects related to educational activities.

- o **PBLI Example 3:** A resident has studied her sign-outs on the inpatient service and noticed that

the information she often provides has omissions and errors. At the urging of a faculty mentor, she decides to examine her own performance along with that of her colleagues. With the help of the quality improvement department at the hospital, the resident gathers a sample of morning, evening, and weekend sign-outs. The sessions are analyzed for omissions and errors. An SBAR format is implemented and the sign-out template is revised. Residents are taught to use the new format, and omissions and errors are reviewed again two months later. The resident documents improvement in her own performance, as well as reduced errors for all involved in the new approach. Data are used to further modify the sign-out template. Interestingly, this project can be seen as an example of a PBLI or an SBP project. Since the project enhanced and improved individual practice it was framed as a PBLI example, but since it also had a positive affect on the overall system the resident works within, it can also be seen and presented as an example of an SBP project.

- o **PBLI Example 4:** A resident feels that her shift assignments in the ED are too long. She is convinced that after eight hours, she works slower and is more likely to make errors. She works with the faculty member in the ED to identify ways to track the patients seen by resident providers. All medication errors are tracked through the EMR. After obtaining IRB approval, the resident and faculty work to randomly assign residents to either 8-hour shifts or 10-hour shifts. The resident reviews and compares her own performance relative to performance errors, and reports are generated across all residents. Results are presented at the annual program evaluation and an action plan is determined. This example can also be seen from either a PBLI or SBP perspective. Because this was conceived of and implemented by an individual resident to improve her work, it is a PBLI example. However, because the project had an impact on the overall system it is also an example of an SBP project.

**Question:** The requirements for Systems-based Practice (SBP) state that residents must participate in identifying systems errors and implementing potential systems solutions. (IV.A.5.f.6). What are residents expected to do to meet this requirement?

**Answer:** The program needs to document that residents have actively participated in identifying systems issues that increase the risk or occurrence of errors and implement a plan to correct these issues. This can be accomplished by an individual resident or by a group of residents and healthcare team

members.

Here are two examples:

o **SBP Example 1:** Residents notice that the wrong size bag and mask is at the bedside when they are called to provide care to an infant in respiratory distress. The residents work with other healthcare team providers and those skilled in evaluating and addressing systems problems to analyze how often errors occur. An intervention is implemented to reduce such errors. The residents monitor error incidence rates after the intervention has been made.

o **SBP Example 2:** A resident is concerned with the lack of proper patient monitoring after undergoing a procedure. Working with those skilled in evaluating and addressing systems problems, she determines the frequency and consequences of this problem, and tries to compare it to rates of occurrence elsewhere. She studies possible interventions and implements one. She then tracks the frequency of improper monitoring and/or its consequences as a result of the intervention.

**Question:** What is the difference between a practice-based quality improvement project and a systems-based practice project?

**Answer:** The practice-based learning and quality improvement project involves residents in improving their own individual practice outcomes. The systems-based practice project is one aimed at identifying systems issues that increase the occurrence of errors. A systems-based practice project would have the goal of creating changes to improve all providers' work environment. However, as noted in several of the examples above, a project can be seen as either a PBLI or SBP project, depending on how it is planned, implemented, and presented.

### **Accreditation and Innovation**

Program directors interested in having the Committee review an experimental or innovative proposal are encouraged to complete the ACGME's form for such proposals, and submit it to the Executive Director for review by the Committee. The form can be found at the following location on the ACGME's website: [http://www.acgme.org/acWebsite/navpages/nav\\_program\\_experimentation.asp](http://www.acgme.org/acWebsite/navpages/nav_program_experimentation.asp)

### **Featured Program**

During its September 2008 meeting, the RRC reviewed and accredited an application from the

Loma Linda University (Hanford) Rural Program. The Committee commended the program for the longitudinal structure of the curriculum and thought that the curriculum could serve as a model for other rural programs. The program director and his staff have agreed to make themselves available to share information with those who are interested in learning more about their curriculum. Should you wish to contact them for more information please contact Tracy Belsan, [belsante@ah.org](mailto:belsante@ah.org), 559-583-2106.

### **RRC Meeting and Agenda Closing Date**

Meeting: May 18 - 20, 2009

Agenda Closing: March 17, 2009

Meeting: September 23 - 25, 2009

Agenda Closing: July 21, 2009

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### **Feedback**

We welcome your comments and suggestions about this newsletter: [dbraun@acgme.org](mailto:dbraun@acgme.org).