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CONT. ON PG. 2

Clarifications of the July 1, 2009 Internal Medicine Program Requirements

I SPONSORING INSTITUTION

I.A.1.c) Sponsoring Institution

The sponsoring institution must: assure implementation of models and schedules for ambulatory training that minimize conflicting inpatient and outpatient responsibilities.

How can programs minimize "conflict" between input and output?

Answer: This requirement was written to encourage programs to be innovative in balancing the inherent conflicts between inpatient and outpatient responsibilities. Methods for doing this include, but are not limited to the following: having an effective handoff process and responsible team member to cover the inpatient service when residents are in their clinics; scheduling blocks with increased continuity clinic when residents are not on inpatient rotations, so that they can have less or no clinic during their inpatient rotations; handling outpatient issues by a member of a resident "firm system" when other members of the team are on busy inpatient rotations.

I.A.2.j) Sponsoring Institution/Simulation

The sponsoring institution and participating sites must: provide residents with access to training using simulation;

What does the committee consider as part of the range of simulation?

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

I.A.2.k) Sponsoring Institution/Electronic Health Record

The sponsoring institution and participating sites must: provide access to an electronic health record. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development, and progress towards its implementation;

MEETING DATES

JULY 17 - 19, 2009

OCTOBER 2 - 5, 2009

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What does the committee consider as examples of electronic medical records?

Answer: Residents must have access to an electronic health record (EHR). An EHR can include electronic notes, orders, and lab reporting. Such a system also facilitates data reporting regarding the care provided to a patient or a panel of patients. It may also include systems for enhancing the quality and safety of patient care. An EHR does not have to be present at all training sites and does not have to be comprehensive. A system that simply reports lab results or radiology results does not meet this definition of an EHR.

II PROGRAM PERSONAL AND RESOURCES

II.C.3 Program Personal and Resources/Other Program Personnel/ Core Faculty

Core Faculty - The residency program must include institutionally based core faculty in addition to the program director and associate program directors. The core faculty are the expert competency evaluators who work closely with the program director and associate program directors, who assist in developing and implementing the evaluation system, and who teach and advise residents. The core faculty must:

- a) **The core faculty must: be ABIM-certified internists who are clinically active, either in direct patient care or in the supervision of patient care;**
- b) **The core faculty must: dedicate an average of at least 15 hours per individual per week throughout the year to residency training;**
- c) **The core faculty must: be specifically trained in the evaluation and assessment of the ACGME competencies;**
- d) **The core faculty must: spend significant time in the evaluation of residents including the observation of residents with patients;**

Who would be considered a competency evaluator?

Answer: The requirements now require an identified group of core faculty, based on the size of the program. An important role for these faculty is to serve as competency evaluators for the program. As described in the requirements, these faculty must be specifically trained in the evaluation and assessment of the ACGME competencies. There must be ongoing faculty development for these evaluators and the program should be able to document that they have been active in the assessment of residents.

IV EDUCATION

IV.A.2.c).(1).(g).(ii).(e) Education/Educational Venue and Strategies

Each resident's longitudinal continuity experience: must include resident participation in coordination of care across health care settings. Residents should be accessible to participate in the management of their continuity panel of patients between outpatient visits. There must be systems of care to provide coverage of urgent problems when a resident is not readily available;

How can programs document accessibility?

Answer: Programs should develop mechanisms to allow residents to participate in the management of their

continuity panel of patients between outpatient visits. These could include: improved communication processes to allow residents to address phone calls on their patients; notification of residents when their patients have been seen by other primary care or subspecialty physicians; notification when a resident's patient is admitted to the hospital.

IV.A.2.c).(1).(f) Education/Educational Venue and Strategies

These experiences must include: a clinical experience in outpatient chronic disease management, preventive health, patient counseling, and common acute ambulatory problems. Overall this experience must include an appropriate distribution of patients of both genders and a diversity of ages.

How will the committee assess gender diversity?

Answer: At the time of a site visit, the committee will examine data related to gender diversity across the ambulatory portion of the training. It is expected that residents will have a minimum of 25% of the patients of each gender.

IV.A.2.c).(1).(g).(ii).(d) Education/Educational Venue and Strategies

Each resident's longitudinal continuity experience: must include evaluation of performance data for each resident's continuity panel of patients relating to both chronic disease management and preventive health care. Residents must receive faculty guidance for developing a data-based action plan and evaluate this plan at least twice a year;

What does the committee accept as details of performance data?

Answer: Each program should identify appropriate measures that will be reported to and acted upon by the residents. These could include measures of patient satisfaction, data regarding chronic medical problems (diabetes, hypertension, coronary artery disease, etc.), and information about preventive health care (immunization rates, cancer screening rates, etc.). The evaluation of these performance data can also occur through the use of the ABIM PIMs or through chart reviews.

IV.A.2.c).(1).(g).(ii) Education/Educational Venue and Strategies

Each resident's longitudinal continuity

experience:

(b) should not be interrupted by more than a month, not inclusive of vacation;

(c) must include a minimum of 130 distinct half-day outpatient sessions, extending at least over a 30-month period, devoted to longitudinal care of the residents' panel of patients;

How does the committee define 130 continuity clinic sessions?

Answer: The 130 continuity clinic sessions should be distinct half-day sessions in which the residents provide longitudinal care to their panel of patients. This will generally occur in a single setting. Time spent in this clinical setting in which the resident does not provide care to their panel of patients does not count toward the 130 sessions, but can be included in the broader ambulatory time. Urgent care visits by patients who are part of the resident's panel or who are part of the practice panel to which the resident belongs will count towards the 130 clinic sessions. It should be emphasized that time spent in a general urgent care clinic where unassigned patients or patients with physicians who are not part of the practice panel will not count towards the 130 clinic sessions. While home visits and group visits are encouraged, these also do not count toward the 130 sessions.

In certain circumstances, sessions from two well-integrated continuity clinics (two sites) could be counted toward the 130 sessions. Both sites would have to consider the resident as part of their continuity practice and the resident would have to be accessible to patients in both sites and meet all of the other requirements outlined in this section.

How should programs count the 30-month period?

Answer: The 30-month time frame was established to assure a minimum duration of time in which residents would provide care to their panel of patients while allowing flexibility for programs to start clinic further into the PG-1 year. The time begins when the residents see their first patient in clinic and ends 30 months later. The clinic does not have to occur weekly to allow for flexibility in scheduling. However, the longitudinal experience cannot be interrupted by more than a month, not inclusive of vacation.

Extending the Term of Chair

At its February 2009 meeting, the ACGME Board of

Directors approved revisions to the Manual of Policies and Procedures that included changing the name of the ACGME Council of Review Committee Chairs to the ACGME Council of Review Committees (CRC) and extending the term length of Review Committee Chairs from two years to three years (Manual, pg 36), including endorsement of the implementation of the transition plan. The term of the current chair of the Internal Medicine RRC, Rosemarie Fisher, MD, will end on June 30, 2010.

The primary rationale for these changes is to facilitate greater interaction and improved communication with the ACGME Board of Directors by helping ensure institutional memory as the Council undertakes its initiatives through the coming years. Under the scope of its redesign, the CRC also structured three subcommittees: Standardization, Innovation, and Common Program Requirements and identified three specialty groups – Surgical, Medical, Hospital-based and Ancillary. These subcommittees and sections will become pivotal to the CRC in accomplishing its work.

2010 ACGME Annual Educational Conference

The 2010 ACGME Annual Educational Conference will be held March 4-7 at the Gaylord Opryland in Nashville, Tenn.

Useful ACGME Website Links

Virtual PD handbook: <http://www.acgme.org/acWebsite/home/PDVirtualHandbook.asp>

ACGME Data book: https://www.acgme.org/acWebsite/dataBook/dat_index.asp.

Frequency of Accreditation Statuses by Specialty and Average Cycle Length by Accreditation Status and by Specialty: <http://www.acgme.org/adspublic/>. Click on Search programs and sponsors.

Resident Survey National Data Report: available in ADS for Program Directors. Log into ADS, click Resident/Fellow Survey, click National Data; DIOs select Reporting Tools, click Resident Survey National Data Overall.

Resident Survey Institutional Data Report for each sponsoring institution's programs available in ADS for DIOs: log into ADS, select Reporting Tools, click Institution Level Resident Survey Results

Faculty development resources for competency-based education contains a series of four PowerPoint presentations with facilitator's manuals (introduction

to competency-based resident education, practical implementation of the competencies, developing an assessment system, developing a competency-based curriculum): <http://www.acgme.org/outcome/e-learn/e-powerpoint.asp>