

# ACGME NUCLEAR MEDICINE RRC UPDATE

## ACNP Annual Meeting

### February 16, 2007

As the new Chair of the Accreditation Council of Graduate Medical Education (ACGME) Nuclear Medicine Residency Review Committee (RRC), I will present a brief update on current and upcoming activities of the committee and the ACGME.

My presentation will have the following learning objectives:

1. List the primary functions of the ACGME and the Nuclear Medicine RRC.
2. Describe the relationship of the RRC to the American Board of Nuclear Medicine (ABNM).
3. Understand the ACGME Outcomes Project, Phase III (7/1/06)
4. Review the program changes effective 7/1/07: program length and changes in CT and radiation oncology & oncology training
5. Present suggested components of a Resident's Learning Portfolio.

#### **ACGME and the Nuclear Medicine RRC:**

Established in 1981, the ACGME is a private non-profit organization that evaluates and accredits approximately 8,000 allopathic graduate medical education programs in the US. The mission of the ACGME is to improve health care by assessing and advancing the quality of resident physicians' education through accreditation. This is performed through the 27 residency review committees or RRCs, one for each medical specialty and an institutional review committee. A RRC consists of representatives appointed by the American Medical Association, the appropriate specialty board, and in some cases a national specialty organization.

The Nuclear Medicine RRC consists of 6 nuclear medicine physicians and 1 resident member. Each member is a representative from one of the 3 founding organizations: American Medical Association (2 members), American Board of Nuclear Medicine (2 members) and the Society of Nuclear Medicine (2 members). A commitment term is for 3 years, with the option of a second term and a maximum service of 6 years.

The primary duties of the Nuclear Medicine RRC are:

- (1) **sets the standards for residency training in nuclear medicine with periodic review and revision of the Nuclear Medicine program requirements** (generally every 4-5 years; last revised 2006). Program requirements target the education of a resident so that at the conclusion of a resident's education he/she will be able to practice competently and independently in the specialty of Nuclear Medicine. The ACGME, however, also contribute to the overall resident's educational format through institutional and common program requirements (i.e., duty hours, 6 core competencies).
- (2) **evaluate and accredit** all nuclear medicine residency programs through ACGME site visits which determine whether a program is in substantial compliance with the institutional, common and specialty program

requirements for resident education. If the program is found to be in compliance, it is granted a satisfactory status, full ACGME accreditation and a maximum survey cycle of 5 years. If there is/are deficiencies, a citation is given requesting a follow up progress report to be reviewed at the next RRC meeting. If the deficiencies are substantial, accreditation may be deferred or the program placed on probation with a final accreditation decision to be made pending review of the progress report. A shorter survey cycle may also be requested.

Nuclear Medicine programs and progress reports are reviewed by the Nuclear Medicine RRC on a biannual basis (May and November).

### **The Nuclear Medicine RRC and the American Board of Nuclear Medicine:**

In 1971 the American Board of Nuclear Medicine was the 1<sup>st</sup> conjoint board established under the American Board of Medical Specialties. It was sponsored by the American Board of Internal Medicine, the American Board of Pathology and the American Board of Radiology. In 1985 with the continued support of these original sponsors the ABNM was designated as a primary Board

The ABNM was created to establish educational requirements for training and to evaluate physician competency in Nuclear Medicine. It is responsible for developing the certification requirements, conducting certification examinations and issuing certificates to those who fulfill these requirements. As of 2004, the ABNM had issued 4,869 certifications.

If the ABNM was not created until 1971 and the ACGME in 1981, how were Nuclear Medicine training programs evaluated before 1971?

Prior to 1971 Nuclear Medicine programs were not regulated resulting in residencies of varied duration and content. In the early 1970's, residency approval was through 2 American Medical Association (AMA) committees: the Liaison Committee for Graduate Medical Education and the Nuclear Medicine Residency Review Committee (RRC).

In 1981, the ACGME took over the task of regulating requirements and accrediting programs. To ensure that the training requirements of the RRC matched the requirements for board eligibility and certification by the ABNM, there had to be a tight co-ordination between these 2 groups. This was accomplished through the membership in the RRC. As previously noted, the representatives of the sponsoring organizations are the AMA, ABNM and the SNM.

Thus, the ACGME Nuclear Medicine RRC and the ABNM set mutual program training requirements for board certification. The Nuclear Medicine RRC is responsible for reviewing and accrediting the training programs and periodically reviewing and revising the program requirements. The ABNM is responsible for creating and administering the board certifying exam and issuing the appropriate certificates.

### **The ACGME 6 Core Competencies:**

In the 1990's the ACGME, American Board of Medical Specialties and other stakeholders in GME came to a mutual agreement that certain common clinical competencies spanned the

education of all medical physicians. Hence through joint meetings, the 6 clinical competencies were developed and in 1999 they were endorsed by the ACGME. Programs were then expected to implement the education of these concepts by providing knowledge, skills and the experience to adequately demonstrate and utilize these competencies to the level of a new practitioner.

As part of the ACGME Outcomes Project, beginning in July 2001 (**Phase 1 forming an INITIAL response to changes in the requirements**), and growing in July 2002 (**Phase 2 sharpening the FOCUS & definition of the competencies and assessment tools**), the ACGME required all ACGME-accredited residency programs to be responsible for providing training and evaluation in the 6 clinical competencies of: patient care, medical knowledge, professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice. . **Since 2003 the RRC has been assessing these 6 competencies at a fairly lenient level.**

**Beginning 7/1/06, the ACGME began Phase 3 of the Outcomes Project: full INTEGRATION of the competencies and their assessment with learning and clinical care.** This phase expects residencies to have fully integrated the 6 clinical competencies. The RRC will now expect programs to identify their competency-based objectives, their competency-based assessment tools, and demonstrate how the program uses this data to provide continuous improvement in their resident and program performance.

“Programs are expected to show evidence of how they use educational outcomes data to improve individual resident and overall program performance.” As of July, 2006, the ACGME has begun to increase their emphasis on educational outcomes in their accreditation of training programs.

What does this mean?

**A program needs to develop learning objectives and outcomes that reflect the competencies.**

Why now?

Over the last 2 decades, the quality of health care has come under intense public scrutiny. In the 1980's the US Department of Education spearheaded a project to look at outcomes assessment in the accreditation process. In 1999 the President's Advisory Committee on Consumer Protection and Quality in the Health Care Industry published the report “Quality 1<sup>st</sup> Better Health Care for All Americans” and recommended steps to develop a national committee to improve health care. In 2000 the Institute of Medicine (IOM) published a report “To Err is Human.” which looked at 2 studies and suggested that ~ 44,000-98,000 US deaths/yr occur because of medical error. Thus making medical error the 8<sup>th</sup> leading cause of death in the country! In 2001 the IOM published “Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century.” This urged the need for basic changes to occur to close the quality gap.

Other groups have also advocated for improved patient care. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Committee on Quality Assurance are actively advocating this initiative. Third party insurance payers are also interested in rewarding quality initiatives with increased reimbursements (i.e., Pay 4 Performance) and the Federation of State Medical Boards is also considering MOC activities for maintaining current licensures.

So what does this all mean?

Medical education is supported by public funding. With a greater emphasis on accountability, the needs of the public (i.e., currently patient safety) and the concern of training well qualified new physicians in a cost-effective way are at the forefront of the public “eye” and policy-maker’s “table.” Thus, the change of educational emphasis from the STRUCTURE and PROCESS to the PRODUCT or OUTCOME. The policy makers and the public are becoming increasingly focused on medical education and in particular patient safety. To maintain the privilege of self-regulation, we must evaluate and improve the process of our medical education to develop and maintain public confidence in our profession.

In conclusion, the ACGME states: “It is incumbent upon us as medical educators to demonstrate the effectiveness of our educational programs and to be held accountable for our work. The ACGME Outcomes Project is dedicated to achieving that purpose.”

### **Changes in the Nuclear Medicine Program Requirements (7/1/07):**

<b>1. Program Length:</b>	<b><u>Years</u></b>
• completion of 1 yr accredited program in fundamental clinical education	3
• completion of an accredited patient care specialty program	2
• completion of an accredited program in Diagnostic Radiology	1

### **2. Training in CT and radiation oncology/oncology:**

(1) **CT training requirement:** “a minimum of 4 months of CT experience that may be combined with rotations that include PET/CT and/or SPECT/CT, although rotation on a CT service is desirable for part of the training.”

This training must:

- emphasize anatomic CT correlation with the PET or SPECT
- acquire sufficient proficiency in CT to accurately correlate the CT associated with the PET or SPECT and to be able to supervise the CT portion of the exam.

(2) **Experience in radiation oncology and oncology.** A 1 month rotation or an equivalent experience through participation in patient management conferences or clinics will be required.

### **Resident Learning Portfolio:**

With the increasing emphasis on the clinical competencies and the inevitable professional requirement in maintenance of certification, a resident learning portfolio can be a valuable documentation of compliance.

The **portfolio can be organized** into the 6 competencies (or in other ways that make sense for the program):

1. Professionalism:
  - (1) Official documents: resident contract, state board physician in-training permit, medical license (state, DEA, DPS)
  - (2) Certification documents: copy of board certification/recertification, BCLS/ACLS, MOC
  - (3) Organized medicine: membership in organized professional societies, activities in organized professional societies (i.e., committees)
  - (4) Ethics: CME, "physician charter"
  - (5) Assessments: 360 surveys, self
2. Medical Knowledge:
  - (1) Test scores: in-service, mock exams, ABNM
  - (2) MOC: certificates in SAMs and LLASP, CME
  - (3) Presentations: invited lectureships, resident presentations, case conference
  - (4) Publications
  - (5) Conference and journal club: attendance
  - (6) Learning plan: reading plan
3. Interpersonal and Communication Skills:
  - (1) Others assessments: faculty evaluation, rotation evaluation, 360 surveys
  - (2) Self assessment: self evaluation
4. Patient Care:
  - (1) Case logs
  - (2) 360 surveys: patient assessment
  - (3) Patient follow up: multi-specialty conference attendance, written case follow up
5. Practice-based Learning and Improvement
  - (1) Peer review: 360 survey, peer review
  - (2) Self-reflective review: performance self-review, self-reflective project, individualized learning plan & progress review
  - (3) Clinical performance review: M&M, multi-specialty conference attendance
  - (4) Project: QA project
6. Systems-based Practice
  - (1) Systems meetings: QA (departmental, hospital, institutional), GME internal review participant, risk management
  - (2) Systems project: QA project, root cause analysis, adverse outcomes case-based assessment
  - (3) Systems methods: billing and coding activities, insurance seminar or workshop, legal seminar

It is suggested that program leaders review the **new competency questions**, being included in all specialties' PIFs, for specific guidance regarding items to be included in the portfolio – at the time of this writing these questions had not been incorporated into the NM PIF, but they can be reviewed in other specialties' PIFs (e.g., Pediatrics).

## SUMMARY

In summary, we have reviewed several items as they relate to resident education.

The first involved the ACGME and the Nuclear Medicine RRC. We have reviewed the RRC member composition and explained its 1<sup>o</sup> duties:

- 1) review and accredit all nuclear medicine residency programs and
- 2) to perform periodic review and revision of the NM program requirements.

We explained the relationship of the RRC to the ABNM where the ABNM develops and administers the certifying exam and issues certificates. To ensure that the training requirements mirror the board certification requirements there is a tight co-ordination between these 2 groups.

We have reviewed the 6 competencies and the ACGME Outcomes Project in respect to Phase III. This latter began in 7/06 and emphasizes the need to look at a program's educational outcomes to improve resident and program performance.

We have reviewed the upcoming program changes beginning in July, 2007 affecting program length, CT training and experiences in radiation oncology and oncology.

And lastly, the Resident Learning Portfolio is being utilized to document compliance in the competencies and in the process of MOC. I have proposed suggested components of a competency-based portfolio.

Thank you for your attention.