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ACGME Bulletin



Accreditation Council for Graduate Medical Education

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Editor's Note

The e-Bulletin returns after a hiatus of nearly a year. Plans call for publishing three times per year in follow-up to meetings of the ACGME Board of Directors and provide updates and information items as well as practical guidance on aspects of the accreditation process.

Funding Source for Patient Centered Improvement and Education Projects

Letters of Intent for the 2011 Picker Foundation GME Challenge Grants are due *March 14 2011*. The Picker Institute/Gold Foundation Challenge Grant Program provides annual grants to support research and development of innovative projects in the area of patient-centered care and education that facilitate successful patient-centered care initiatives and best practices in the education of physicians. The current Request for Proposal (RFP) solicits proposals for projects that will run from August 1, 2011 through August 1, 2012. All awards will be made on a matching grant basis. Applicants who pass the LOI evaluation process will be invited, by March 21, 2011, to submit a full proposal, due on or before May 6, 2011. GME Challenge Grants will be announced on July 1, 2011.

Past projects have included the development of a curriculum to help physicians understand the special needs of young patients with chronic illness as they transition from pediatric to adult care; the design of a patient simulator to objectively assess a resident's ability to practice the principles of patient-centered care as they are embodied in the ACGME's core competencies; and development of a curriculum designed to raise resident awareness of their patients' cultural and spiritual needs

For additional information, consult the detailed challenge grant documents through the link on the *Journal of Graduate Medical Education's* home page (http://www.jgme.org/userimages/ContentEditor/1298392560474/Picker_GME_Challenge_Grant_RFP.pdf).

ACGME Approves Specialty-Specific Elements of the 2010 Duty Hour Requirements

At the February meeting of the Board of Directors, the ACGME approved added specialty-specific elements for the 2010 duty hour standards. These added standards address eight areas:

- 1) guidance on whether residents may be supervised by licensed independent practitioners;
- 2) RRC definitions of the competencies under which PGY-1 residents may progress to be supervised indirectly, with direct supervision available;
- 3) limits on workload and clinical responsibilities for residents;
- 4) establishing definitions of “team” for the new standard on teamwork;
- 5) defining the years of training that constitute “intermediate-level residents” for the purpose of setting a minimum rest period;
- 6) defining the years of training that constitute “residents in their final years of training” for the purpose of setting a minimum rest period;
- 7) describing the special circumstances under which residents may stay on duty or return to the hospital with fewer than eight hours off; and
- 8) establishing the maximum number of consecutive nights of night float.

Supervision by Licensed Independent Practitioners

Seven RRCs defined the licensed independent practitioners that may have ultimate responsibility for patient care and may supervise residents (***Family Medicine, Obstetrics and Gynecology, Orthopaedic Surgery, Pathology, Pediatrics, Physical Medicine and Rehabilitation and Psychiatry***). The requirements for Pediatrics defined the specific settings where licensed independent practitioners may supervise residents, including school-based health centers, child development clinics and the NICU. Family Medicine stipulated oversight by a faculty physician. Several RRCs noted that state statutes may not allow non-physicians to supervise physicians.

Competencies to Allow PGY-1 Residents to Progress to Indirect Supervision

Six RRCs (***Family Medicine, Neurological Surgery, Otolaryngology, Pathology, Psychiatry, Child Psychiatry and Surgery***) defined the competencies that must be demonstrated before a PGY-1 resident may progress to indirect supervision with supervision available. The RRC specifications focus on attained competencies (Family Medicine, Psychiatry and Child Psychiatry), and/or list specific procedures and patient care tasks that can be performed (Pathology), or ask programs to define the tasks that must have direct supervision until residents have demonstrated competence (Otolaryngology, Surgery). Added guidance by the RRC for Otolaryngology specified that programs must maintain records of the attainment of competence. The Question and Answer section for Neurological Surgery note that programs must document that residents had structured education in a list of procedures, such as the education offered through the Society of Neurological Surgeons’ “boot camps.”

Optimal Clinical Workload

Six RRCs (***Dermatology, Family Medicine, Medical Genetics, Otolaryngology, Pediatrics and Surgery***) defined residents’ optimal clinical workload. Family Medicine and Pediatrics

placed the responsibility for setting clinical workload with the program. Dermatology defined the limits on clinical workload for PGY-2 and -3 as a percentage of the workload for PGY-4 residents. Medical Genetics was the only specialty that established numeric limits (no more than four patients with a confirmed diagnosis of an inborn error of intermediary metabolism in an ICU setting, or six patients with a confirmed diagnosis of an inborn error of intermediary metabolism in a non-ICU setting for an entry-level resident). This is in addition to the RRC for Internal Medicine maintaining its existing requirements that limit residents' clinical work load.

Members of the Interprofessional Team

For eight core specialties (*Dermatology, Emergency Medicine, Family Medicine, Otolaryngology, Surgery, Psychiatry, Radiation Oncology and Urology*) and for the subspecialties of *Molecular Genetic Pathology, Pediatrics and Sleep Medicine* the RRCs defined the membership of the interprofessional team for the new standard on teamwork. In the Question and Answer section, the RRC for Pediatrics indicated that members of the interprofessional team include nurses, physician assistants, advanced practice providers, pharmacists, social workers, child-life specialists, physical and occupational therapists, speech and language pathologists, audiologists, respiratory therapists, psychologists, and nutritionists.

Definitions of Resident Levels for Establishing the Minimum Rest Period

Table 1 shows the definitions of intermediate residents and residents in their final years of training for the purpose of establishing the minimum rest period between duty periods.

Table 1

Definitions of “Intermediate Residents” and “Residents in Their Final Years of Training”

Allergy and Immunology

First-year allergy and immunology residents should be able to function as residents in the final years of education. However, some may come to residency with a specialized education scheduled, and may only be at the PGY-2 or PGY-3 level. These residents should be monitored as “intermediate” residents for one year.

Anesthesiology

Intermediate-level residents have completed all goals and objectives of the CBY and CA-1 year and have progressed to the CA-2 year.

Residents in the final years of education have achieved the goals and objectives of all core rotations and fulfilled all minimum case requirements.

Colon and Rectal Surgery

Colon and rectal surgery residents are considered to be in the final years of education.

Dermatology

First-year (PGY-2) and second-year (PGY-3) residents are considered to be at the intermediate-level.

Third-year (PGY-4) residents are considered to be in the final years of education.

Emergency Medicine

PGY-2 residents are considered to be at the intermediate-level.

Residents who are in the PGY-3 or beyond are considered to be in the final years of education.

Family Medicine

PGY-2 residents are considered to be at the intermediate-level.

PGY-3 residents are considered to be in the final years of education.

Medical Genetics

Residents in the first year of the program (MG-1) are considered to be at the intermediate level.

Residents in the second (final) year of the program (MG-2) are considered to be in the final year(s) of education.

Definitions of “Intermediate Residents” and “Residents in Their Final Years of Training” (cont.)

Internal Medicine

No residents will be designated as being at the intermediate level.
PGY-2 and PGY-3 residents are considered to be in the final years of education.

Internal Medicine - Pediatrics

PGY-2 residents are considered intermediate level.
PGY-3 and PGY-4 residents are considered to be in the final years of education.

Neurological Surgery

PGY-2 residents are considered to be at the intermediate level.
Residents at the PGY-3 level and beyond are considered to be in the final years of education.

Neurology

PGY-2 residents are considered to be at the intermediate level.
PGY-3 and PGY-4 residents are considered to be in the final years of education.

Neurology-Child

R1 residents are considered to be at the intermediate level.
R2 and R3 residents are considered to be in the final years of education.

Neurology-Neurodevelopment Disabilities

R1 and R2 residents are considered to be at the intermediate level.
R3 and R4 residents are considered to be in the final years of education.

Nuclear Medicine

NM-1 and NM-2 residents are considered to be at the intermediate level.
NM-3 level residents are considered to be in the final years of education.

Obstetrics and Gynecology

PGY-2 residents are considered to be at the intermediate level.
PGY-3 and PGY-4 residents are considered to be in the final years of education.

Ophthalmology

PGY-3 residents are considered to be at the intermediate level.
PGY-4 residents are considered to be in the final years of education.

Orthopaedic Surgery

PGY-2 and PGY-3 residents are considered to be at the intermediate level.
PGY-4 and PGY-5 residents, and fellows (PGY-6 and above) are considered to be in the final years of education.

Otolaryngology

PGY-2 and PGY-3 residents are considered to be at the intermediate level.
PGY-4 and PGY-5 residents are considered to be in the final years of education.

Pathology

PGY-2 residents are considered to be at the intermediate level.
Residents in the final two years of the program (PGY-3 and PGY-4) are considered to be in the final years of education.

Pediatrics

PGY-2 residents are considered to be at the intermediate level.
PGY-3 residents are considered to be in the final years of education.

Physical Medicine and Rehabilitation

PGY-2 and PGY-3 residents are considered to be at the intermediate level.
PGY-4 residents are considered to be in the final years of education.

Plastic Surgery

For independent programs, Y-1-3 residents are considered to be in the final years of education.
For integrated programs, Y-2 and -3 residents are considered to be at the intermediate level.
For independent programs, Y-1-3 residents are considered to be in the final years of education.
For integrated programs, Y-4, -5 and -6 residents are considered to be in the final years of education.

Preventive Medicine

PM-1 residents are considered to be at the intermediate level.
PM-2 residents are considered to be in the final years of education.

Psychiatry

PGY-2 residents are considered to be at the intermediate level.
Residents at the PGY-3 level or beyond are considered to be in the final years of education.

Definitions of “Intermediate Residents” and “Residents in Their Final Years of Training” (cont.)

Psychiatry-Child

PGY-2 residents are considered to be at the intermediate level.
Residents at the PGY-3 level or beyond are considered to be in the final years of education.

Diagnostic Radiology

R1, R2, and R3 residents are considered to be at the intermediate level.
R4 residents are considered to be in the final years of education.

Radiation Oncology

PGY-2-4 residents are considered to be at the intermediate level.
PGY-5 residents are considered to be in the final years of education.

Surgery

PGY-2 and PGY-3 residents are considered to be at the intermediate level.
Residents at the PGY-4 level and beyond are considered to be in the final years of education.

Thoracic Surgery

For independent programs, Y-1-3 residents are considered to be in the final years of education.
For integrated programs, Y-2 and -3 fellows are considered to be at the intermediate level; Y-4, -5, and -6 level residents are considered to be in the final years of education.

Urology

URO-1 and URO-2 residents are considered to be at the intermediate level.
URO-3 and URO-4 residents are considered to be in the final years of education.

All Subspecialty Programs

Fellows are considered to be in the final years of education.

Circumstances When Residents May Remain or Return in Fewer than Eight Hours

For the definition of circumstances when residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty, the majority of RRCs defined these circumstances as “required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.” The remaining RRCs developed definitions tailored to the particular specialty. The RRC for Internal Medicine requires the program director to review each instance when residents remain or return with fewer than eight hours of rest, and track individual residents’ and program-wide episodes of additional duty. The RRCs for Pediatrics and Psychiatry did not allow for circumstances under which residents may stay with fewer than eight hours off.

RRC Defined Maximum Frequency of In-House Night Float

Fourteen RRCs set a specialty-specific limit on the number of consecutive nights of night float allowed and/or the number of weeks or months in given year that can be devoted to night float. The detailed information is shown in **Table 2**.

Table 2 - RRC Defined Maximum Frequency of In-House Night Float

Family Medicine

Night float experiences must not exceed 50% of a resident’s inpatient experiences.

Neurological Surgery

Night float should be limited to four months per year, and must not exceed six months per year.

Neurology, Child Neurology and Neurodevelopmental Disabilities

Residents should not have more than two consecutive weeks of night float or ½ of a calendar month (maximum 16 days), and no more than six weeks of night float per year.

Medical Genetics

Fellows must not be assigned night float duties.

Table 2 - RRC Defined Maximum Frequency of In-House Night Float (cont.)

Obstetrics and Gynecology

Night float rotations must not be longer than two months in duration, and residents cannot be assigned more than three months of night float per year. There must be at least two months between each night float rotation.

Orthopaedic Surgery

Night float may not exceed three months per year.

Otolaryngology

Night float rotations cannot exceed two months in duration, and residents can have no more than three months of night float assignments per year. There must be at least two months between each night float rotation.

Pediatrics

Residents should not have more than one consecutive week of night float and not more than four total weeks of night float per year.

Physical Medicine & Rehabilitation

Night float cannot exceed more than 18 nights total per year.

Plastic Surgery and Thoracic Surgery

Residents must not have more than four consecutive weeks of night float assignment, and night float cannot exceed one month per year.

Psychiatry

Residents should not be scheduled for more than four consecutive weeks of night float during the required one-year, full-time outpatient psychiatry experience. Residents should not be scheduled for more than a total of eight weeks of night float during the one year of consecutive outpatient experience.

Surgery

Residents must not be scheduled for more than six consecutive nights of night float.

Night float rotations must not exceed two months in duration, and there can be no more than three months of night float per year. There must be at least two months between each night float rotation.

Other Information Items from the February 2011 ACGME Meeting

Approval of Revisions to Requirements for Anesthesiology, Pediatric Rehabilitation Medicine and a Number of Internal Medicine Subspecialties

The Committee on Program Requirements approved Focused Revisions to the Program Requirements for Anesthesiology; and approved Major Revisions to the Program Requirements for Pediatric Rehabilitation Medicine as a subspecialty of Physical Medicine and Rehabilitation, for the Internal Medicine Subspecialty Requirements for Cardiovascular Disease, Clinical Cardiac Electrophysiology, Interventional Cardiology, Hematology, Medical Oncology, Hematology and Medical Oncology, Pulmonary Disease, Pulmonary/Critical Care Medicine, Gastroenterology, Transplant Hepatology, Rheumatology, Endocrinology, Diabetes, and Metabolism, Infectious Diseases, and Nephrology.

ACGME Directors Discuss Next Accreditation System

During a strategic planning session, the Board of Directors also continued discussion of the next accreditation system. As a preliminary step to more focused planning, the Board members discussed elements of the next system. These included longer cycle lengths for high performing programs, “continuous accreditation,” with continuous or at minimum annual data acquisition; increased focus on outcomes and reducing the burden associated with process-based standards, enhanced emphasis on quality and safety of care, and enhanced transparency and public input into standards development. No specific time line was referenced, but it was noted that the move to the new model will be facilitated by the completion of the ACGME’s Milestone Project. The ACGME Board of Directors will continue discussions of a new accreditation model at its upcoming meetings.
