ACGME Launches Division of Organizational Assessment and Advancement

Julie Jacob

"See one, do one, teach one" is a common saying among graduate medical educators. In the spirit of first doing yourself what you want to teach others to do, the ACGME has launched a new department, the Office of Assessment and Advancement (OAA). As the ACGME continues its work of assessing and advancing the education of resident physicians, the organization will examine its performance with the goal of facilitating continuous improvement.

The OAA is led by ACGME Executive Director David C. Leach, MD; Director of Field Activities Ingrid Philibert, MHA, MBA; Director of Research Susan Swing, PhD; and Associate Executive Director Cynthia Taradejna, MsED. The department will report to the ACGME Board and Executive Committee. The OAA team will look closely at the responsibilities and functions of the various ACGME departments and gather input from staff members on what is working well and what needs to be improved. They will also work closely with the ACGME's Strategic Initiatives Committee and Board of Directors to develop and refine a strategic plan and a dashboard of strategic indicators, which is a map of concrete measurements to assess how well the ACGME is achieving its goals for improving and streamlining accreditation.

"With the increasing focus on the Outcome Project, it became less defensible not to look at our own outcomes," said Philibert. The OAA will also help to put into action the strategic priorities that are identified and approved by the Board, noted Taradejna. The work of the OAA will help the ACGME become an even better, more efficient organization, she said.

"We all know intuitively that we are doing our jobs well, but we also know that in order to remain a viable, creditable organization, we have to do better than last year's performance, and next year we have to do better than this year's performance," said Taradejna. ∎

Understanding the Requirement for a Final Resident Evaluation

Ingrid Philibert and Douglas Carlson, Esq.

> **Common Program Requirement VII.A.2.:** *Final Evaluation: The program director must provide a final evaluation for each resident who completes the program. The evaluation must include a review of the resident's performance during the final period of education and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.*

In the past months, the ACGME has received a number of questions about the requirement for a final resident evaluation. A few constituents have noted that their institutions' legal experts have expressed reservations about program directors completing a final evaluation stating that the resident is "able to practice competently and independently," citing potential program or sponsoring institutional liability for an "incompetent graduate."

This makes it important that program directors and their legal counsel have an understanding of the scope and intent of this requirement. In verifying that "the resident has demonstrated sufficient professional ability to practice competently and independently," a program director is expected to report on the ability that a resident has demonstrated during his or her residency, particularly in the final months. A program director is not expected to verify the performance after the graduate has completed the program. It is also important to understand that this is a final student evaluation, i.e., it occurs at the end of a formal training program, which makes it different from an evaluation of a fully trained person over a period of time. The verification might be as simple as, *"I verify that, during his/her participation in the residency program in (specialty) sponsored by (sponsoring institution), John/Jane Doe, MD, has demonstrated sufficient professional ability to practice competently and independently in the specialty of _____ ."*

The underlying support for verifying the resident's ability is laid throughout the entire residency, beginning with the selection of the resident, and continuing through the years of training within a formal curriculum and an organized educational program that includes a series of "formative" educational assessments that offer feedback to the resident on his or her performance. This includes end of rotation evaluations, in-service exams, semi-annual written evaluations, and annual decisions on promotion to the next year of residency.

Areas of the resident's performance that require particular attention should be identified and addressed throughout the program. The final evaluation is expected to be a report on whether, during the residency program, the resident has demonstrated sufficient professional ability to practice competently and independently. This evaluation is the culmination of a series of assessments, with the program's leadership and faculty confident that underlying this "summative" verification is a solid foundation in ongoing assessment.

If, at a late point in the normal residency period, deficiencies in performance are identified that result in an inability on the part of the program director to state that the resident has demonstrated sufficient professional ability to practice independently, academic remediation should be initiated that may last beyond the normal residency year, and the resident should be allowed to complete the program upon successful remediation. The ACGME understands that this represents a difficult decision for the program, and has

consequences for the resident, for the residency program, and for the sponsoring institution. However, this decision is critical to the resident's future as a practitioner in his or her specialty, and to the program's and sponsoring institution's accountability to the public to educate the next generation of physicians.

A related matter is the requirement that a permanent record be kept of the final evaluation. The nation's experience with Hurricane Katrina has shown that neither electronic nor paper-based records are completely safe in the face of a major local disaster. The ACGME suggests that for maintaining a record of the final evaluation, programs should follow their sponsoring institution's protocol for maintaining other vital, permanent records related to patient care and other institutional matters. Many institutions likely will re-examine these protocols in the interest of learning from the experience of the institutions affected by Katrina.

In summary, the final evaluation of each resident represents an important component of the responsibilities of the program director. On occasion, ACGME has cited programs for failing to provide a final evaluation consistent with the requirement. Program directors may want to consult with their legal counsel, but it is important to accept that the requirement addresses performance during the course of the residency program, not predictions of performance after the resident leaves the program. Based on past performance, others may deduce future performance, but the program's job solely involves reporting on past performance. ∎

ACGME Institutes E-Mail Notification of Institutional Review Committee and Residency Review Committee Actions

Jeanne Heard, MD, PhD

Recently, ACGME's Department of Accreditation Committees began to test a new system for notifying program directors about the results of RRC program reviews. About one week following the RRC's meeting, the program director receives an email informing him/her of the accreditation status. The exception is that the e-mail notification is not sent for a proposed adverse action or adverse action. Because feedback about this timely notification has been very positive and in support of the ACGME's efforts to provide greater communication with program directors and DIOs, ACGME has decided to extend this function to all Review Committees – RRCs, TYRC and Institutional Review Committee.

Beginning October 1, 2005, approximately two weeks following a Review Committee meeting an e-mail notification is sent to the following individuals:

1. For the results of a specialty program review, notification is sent to the program director with a copy to the DIO of the sponsoring institution;

2. For the results of the review of a dependent subspecialty, notification is sent to its program director, and copies are sent to the core specialty program director and the DIO;

3. For the results of an institutional review, notification is sent to the DIO.

The email will contain the following elements:

- New Accreditation Status
- Length of Program
- Effective Date
- Information about resident complement (if applicable)
- Decisions (e.g., request for progress report, acknowledgment of progress report)
- New Survey Date (if applicable)

Six to eight weeks after the Review Committee meeting, the program director and DIO will receive hard copies of the full accreditation letter with complete information. The ACGME hopes that program directors and DIOs will find this service helpful in administering their educational programs and in providing oversight by the sponsoring institution. ∎

Revisions to the ACGME *Manual of Policies and Procedures* and *Glossary*

Doris Stoll, PhD

The ACGME Board of Directors approved the revisions to the ACGME *Manual of Policies and Procedures* and the ACGME *Glossary,* which became effective July 1, 2005. This approval is the result of more than a year of intensive work by the ACGME Committee on Requirements and staff to reorganize, simplify, and streamline those policies and procedures that form the basis for the ACGME accreditation system. The ACGME *Manual of Policies and Procedures* and the ACGME *Glossary* are among the definitive documents by which the ACGME provides transparency in its accreditation and policy-making process.

In particular, we recommend that program and institutional leaders read the introductory section of the *Policies* in Section I. A–D, which describes the ACGME mission, purpose, and definition of accreditation to reinforce their knowledge about accreditation. Some may comment that the technical procedures, such as how the ACGME monitors the work of its committees, formulates policy, approves revisions of requirements, or conducts meetings of the RRC Chairs and Residents' Councils (Sections I. F–H) do not make exciting reading. These details are important, because not only do they define the ACGME, they exemplify the care the organization takes to adhere to its stated purposes and achieve constituency in its actions.

Since one of the ACGME functions is to provide a fair and equitable evaluation of institutions and programs, the *Policies* in Section I. H and I. L. 4 outline how the members of the ACGME Board of Directors, its Review Committees and its Councils are required to uphold their fiduciary duty to the ACGME, avoid conflicts of interest in decision making, and adhere to confidentiality of information.

The procedure in Section I. K describes how each Review Committee functions under delegated authority by the ACGME Board of Directors and also describes how the Review Committees are not autonomous, but are subject to Board oversight and activities. Individuals with an interest in serving as

a member of a Review Committee may want to read Sections I. L. 3 and 4, which describe the specific duties, appointment, qualifications and terms of the Review Committee members, as well as the expectations for member performance.

Section I. M of the document has been amplified to describe the accreditation process itself and the inner workings of an RRC meeting. Because accreditation actions are by their nature conducted in closed session, the public tends to question procedural clarity and *what really occurs when the door is closed.* We hope this section is helpful as it outlines ACGME expectations.

The ACGME announced earlier this year that it had granted the Institutional Review Committee (IRC) accreditation authority for sponsoring institutions. To create consistency in designations, all ACGME committees that accredit, i.e., the Residency Review Committees (RRC), the Transitional Year Review Committee (TYRC) and the Institutional Review Committee (IRC) are now named *Review Committees (RCs).* Except for a few minor variations in policy between institutional and specialty review, all RCs now use the same procedures. In the few instances of difference, e.g., expedited withdrawal of accreditation and the appeals procedures, the document specifies either the Residency Review Committees (RRCs) or the Institutional Review Committee (IRC).

Two major revisions should be noted in Section II describing the accreditation actions:

1. The status of *provisional accreditation was deleted* because the larger community of interest, including primary stakeholders, has for many years confused provisional (the designation for the first, or initial accreditation status) and probation (an adverse action). Instead, we are using the term *initial accreditation* rather than provisional accreditation to describe this status. This change should clarify the designation for the first stage of accreditation.

2. The status of *inactive accreditation was deleted.* A relatively recent addition to our procedures, it did not prove helpful to the stakeholders or to our process.

Positive accreditation actions, i.e., those identifying substantial compliance with the Requirements for programs and institutions, are *initial accreditation* and *continued accreditation.* Adverse actions still include: *withheld accreditation* for applications of programs and institutions not demonstrating substantial compliance with requirements; *probation, withdrawal of accreditation,* and *expedited withdrawal of accreditation* for accredited programs and institutions not demonstrating substantial compliance with the requirements; and *decrease in resident complement* for those specialties that set resident complement.

Consistent with prior policies, a Review Committee must first propose an adverse action, providing the institution or program with due process. Each proposed action remains confidential, or unannounced, as in the past. However, the timeline for an *expedited withdrawal* of a program remains compressed, but has been revised to provide for an expedited appeals process. The appeals processes have been differentiated for institutions and programs representing the difference in nature of each, as noted above.

A graphic *schema* for the accreditation process has been inserted. The ACGME has used this document for a number of years in the orientation of Board and Review Committee members. We hope this single page provides a ready and quick reference guide. Note here that the *total lengths* of the accreditation cycles of two statuses have been decreased: for initial accreditation, 4 years; and for probation, 3 years.

Administrative actions have been updated and reorganized to include deferral of accreditation and progress reports, and to provide general guidelines for institution and complement changes. (Definitive policies by specialty for institution changes and complement changes may be found in the given RRC's section of the ACGME website). Other policies of interest include those for granting duty hour exceptions and those for receiving complaints about the conduct of programs.

We invite you to review the entire document on the ACGME website and to contact the ACGME staff for clarification of these policies and procedures in relation to your institution or program. The *Manual of Policies and Procedure* and the *Glossary* can be found on the ACGME's website under http://www.acgme.org/acWebsite/about/ab_ACGMEpolicyProceed07_05.pdf and http://www.acgme.org/acWebsite/about/ab_ACGMEglossary07_05.pdf. ∎

Clarifying the Matter of Dependent and Independent Subspecialties

William Rodak, PhD and Steve Nestler, PhD

The ACGME defines core specialties to be those with a dedicated Residency Review Committee, and where residents are eligible to complete primary board certification by a member Board of the American Board of Medical Specialties. There are 25 core specialties, as well as the Transitional Year. All other accredited programs are in a subspecialty of these core specialties. Subspecialties can be organized as dependent or independent from their core program.

ACGME's *Manual of Policies and Procedures* states, "Dependent subspecialty programs are required to function in conjunction with an accredited specialty program, and are usually reviewed conjointly with the specialty program. The continued accreditation of the subspecialty program is dependent on the core specialty program maintaining its accreditation." What this means to a dependent subspecialty residency is that if the core specialty receives a two-year review cycle, the related subspecialty usually receives the same cycle. If the core is placed on probation, the subspecialty is warned that its accreditation may be administratively withdrawn if the specialty program remains on probation. If the core specialty's accreditation is withdrawn, the subspecialty accreditation is administratively withdrawn, without appeal.

The *Manual* also states, "The dependent specialty program must be sponsored by the same ACGME-accredited sponsoring institution, and should be geographically proximate." What this means for the subspecialty training program is that the subspecialty which is linked to the core specialty, must be under the same sponsorship as the core and use the same Graduate Medical Education Committee. In addition, the location of the primary training site for the subspecialty must be geographically close to the core residency to allow interaction of subspecialty's faculty members and fellows with core faculty and residents.

The ACGME has made an exception for the special case of "pediatric-oriented" subspecialties, such as Pediatric Anesthesiology, Pediatric Radiology and Child Neurology. With permission from the team for the relevant RRC, these subspecialties may be sponsored by a children's specialty hospital that operates in close affiliation with the institution sponsoring the core specialty program.

"Independent" subspecialty programs are not required to function in conjunction with an accredited specialty program. As a result, the site visit scheduling and RRC review of independent subspecialty programs is identical to that of core specialty programs, and they are eligible for the same accreditation status designations as core programs. ■

Change Is Good: The 2005 Annual "Report from the Field"

Marianne Gideon, PhD

Dr. Gideon's "Report from the Field," which aggregates the perceptions of the ACGME Field Representatives and other staff, was presented at the September meeting of the ACGME Board of Directors.

When I told our friends that my husband and I were moving from the beautiful Jersey shore to Des Moines Iowa, most of them seemed to be stunned and their first word was "WHAT?" But one friend paused and then said, "Change is good!" His unique response struck me as a good theme for this year's report to the ACGME, so this summer I asked program directors, residents, RRC Executive Directors and fellow members of the Field Staff if the changes the ACGME instituted in the areas of duty hours, competencies, the Accreditation Data System (ADS) and program information forms (PIFs) have been good.

The consensus is that duty hour limits are basically good. Residents are more rested. Other health care providers are picking up more of the repetitive, non-educational work – they have to, as the residents are not around as much as they were prior to the institution of the limits. Hospitals and departments who can afford it have hired physician assistants, nurse practitioners, hospitalists and "nocturnalists" to fill in the gaps. Work hour restrictions are reported to be contributing to better team work. Surgical chief residents say they're now awake in the OR instead of being all but asleep on their feet.

Programs have rescheduled rounds and conferences so residents can get to them and still go home on time post call, and more attending physicians can get to the earlier conferences and rounds before office hours. Several programs report that a night float system provides better continuity of care with the same house staff team in the hospital five nights in a row. A Family Medicine program director said when he started night float several years ago, the divorce rate among his residents went down. Perhaps these findings should be published. One drawback is that residents see night float mostly as a service obligation, unless faculty are in house or arrive early enough in the morning to provide meaningful teaching before the night float residents have to leave.

A group of New York surgeons, who have more than a decade of experience in dealing with duty hour limits, noted that residents no longer provide the primary safety net for patients. In their place, they, as faculty, have assumed this responsibility. One attending told me he really likes the duty hour limits, because he gets to tell his residents about how tough it was when he was a resident.

For those programs that cannot or choose not to change the time of rounds, shorter work hours without night float create a problem in continuity of care and education because the resident who needs the teaching that occurs on rounds has gone home post call. I also sensed some faculty physicians are lonely with no one to teach on afternoon cases in the OR.

Some residents say they now do the same amount of work, but feel rushed and unsure whether they have completed everything before leaving. There also are faculty members concerned that the system is training a generation of doctors who drop everything including patients when the clock strikes. And how will they do that once they are in practice? One of the members of the field staff says the focus on duty hours has resulted in more residents thinking that even 50 to 60 hours a week is too much.

The Competencies movement has given value to other attributes in addition to knowledge and clinical volume. The six general competencies have provided structure, and have forced faculty and others to think in new ways when evaluating residents. Competency-based evaluations ensure that faculty are paying attention to interpersonal and communication skills, and professionalism. More focused observation is occurring. Some have noted that the competencies have helped faculty define or label what they have been doing for a long time.

Programs also use the competencies to evaluate faculty, and a number of programs appear to be making efforts to "rehabilitate" faculty that receive poor evaluations, rather then just removing them from the teaching staff. Sometimes the improvement program is framed according to one or more of the general competencies. More programs are reporting successful remediation. With fewer physicians willing to devote added time to teaching, residency programs need all the attending physicians they can keep.

One member of the Field Staff reported that programs are finding entering residents already knowledgeable about the competencies, because they encountered them during their medical student clerkship rotations for the past two years. At the same time, many program directors are still struggling with the competencies and keep waiting for their specialty society or another expert group to come up with a master plan including goals and objectives, instruction outlines and evaluation tools. Some program staff has voiced their distaste for the paper work generated by the competencies, especially in disciplines where RRCs pay less attention to them or provide little guidance. One faculty asked when the ACGME will move to "Evidenced-Based Paperwork."

With the increasing use of computer programs for logging evaluations, conference attendance, and procedures, program directors are able to monitor trainees in "real time" and give more frequent feedback. Due to the use of the procedural logs, residents are more aware of "targets" (numbers of procedures, conference attendance), and where they stand. They appear to be more proactive about meeting these targets. The paper trail offered by the ACGME's web-based logs also makes it easier for program directors to monitor individual residents and adjust assignments if necessary and to prepare for site visits and internal reviews. Faculty has stated that the need to verify their residents' acquisition of skills and procedures makes them take responsibility in ways they did not do previously.

Could it be that program directors will start to ask for their own duty hour limits? One program director said he needed two days for a site visit, noting that with all the improvements in the system and in his program, it would be difficult to present the program in one day, and difficult for the surveyor to get the real flavor of his program and institution. His DIO also wants more frequent *ACGME Bulletins* which he finds quite useful, and the program director and DIO both want more instruction from the RRCs or ACGME on learning how to teach.

One person I spoke with – both a DIO and teaching attending – said looking at the changes from both perspectives she sees both good and bad in the changes, but that the good outweighs the bad by a long shot. In summary, most program directors, residents, DIOs and faculty agree – some more enthusiastically than others, "Change is good." ∎

Call for Abstracts

2006 ACGME Annual Educational Conference
March 3–5, 2006
The Marvin R. Dunn Poster Session

Advancing Competency in Graduate Medical Education

The Accreditation Council for Graduate Medical Education (ACGME) invites proposals for poster presentations at its annual conference on March 3–5, 2006 at the Gaylord Palms Resort and Convention Center in Kissimmee, Florida. Program directors, faculty, administrators and residents interested or involved in graduate medical education (GME) are encouraged to submit proposals.

Suggested Topics for Submission

This year the ACGME welcomes posters that report on successful initiatives to improve graduate medical education related to: 1) teaching and assessing the general competencies (with a special interest in use of portfolios); 2) using assessment results to drive and guide educational improvement; 3) changing the learning environment or redesigning education and patient care (includes approaches for improving patient safety and reducing resident duty hours); and 4) implementing strategies and methods, including faculty development, to facilitate educational improvement at the institutional or program level.

Submission Process

To be considered for a presentation, your abstract submission must be received electronically by **January 6, 2006.** All submissions will be reviewed and evaluated by the judging panel for relevance, content and clarity. Notification of acceptance for presentation will be e-mailed by **January 13, 2006**. Poster presenters will be required to prepare a poster for the session and be available from 5:00 pm–7:00 pm on the evening of Friday, March 4, 2006 to discuss the poster. Accepted abstract submissions will be printed for distribution to program participants as a part of the workshop agenda. **All presenters are required to register for the workshop.**

Formatting Instructions

Abstracts must be submitted as a single-page document typed in Microsoft Word or Word Perfect format. Margins should be 1-inch on all sides. **Do not** use abbreviations in the abstract title. The abstract title should be typed in ALL CAPS. The title should be brief, but clearly indicate the nature of the project or investigation.

The author(s) name(s) and institutional affiliation(s) should be typed in Title Case (upper and lower letters) on the line after the title. The abstract must be sent to abstracts@acgme.org as an e-mail attachment. The sender of the abstract should be the lead author. All communication will occur with the lead author. Questions regarding the abstracts should also be sent to this electronic address. *Note: Simple graphs or tables may be included if they fit on the single page.*

The text of the abstract must be organized into the sections below (use headings in bold):

1. **Purpose** of investigation or project

2. **Methodology,** including investigation or project design and analysis

3. **Summary of results** (if applicable)

4. **Conclusions**

Abstract Checklist:

1. The abstract must be typed in 10-pt or 12-pt Arial or Times Roman font style; margins must be 1-inch on all sides.

2. The title should be typed in ALL CAPS.

3. Content of abstract should be single-spaced with double-space only between title and author's names.

4. The abstract must not exceed 300 words and must fit on a single page. Not more than three references may be included. If references are used, they must still fit on the single page.

Submission Deadline and Notification

All submissions must be received at the ACGME office no later than **January 6, 2006.** Submissions must be sent electronically according to the format outlined above. No substitutions will be accepted. Authors will receive confirmation of their submission upon its receipt in the ACGME office. The first author will be notified by **January 13, 2006** whether the submission has been accepted for poster presentation. Display specifications and communication guidelines will be provided at the time of acceptance.

Abstracts submitted to other national meetings are acceptable provided they have not been accepted for publication in a peer-reviewed journal prior to the meeting date.

Please note that the ACGME does not endorse any commercial medical education products, and therefore will not accept abstracts promoting the use of these products. ∎

ACGME Seeks Information on Approaches to Facilitate Innovation and Improvement in the Learning Environment

Are there approaches or efforts in your residency program or sponsoring institution that promote excellence and innovation in resident learning or in clinical care in your teaching settings? If your answer is yes, the ACGME Committee on Innovation in the Learning Environment and its work groups would like this information. It will be used in the development of a compendium of ideas that programs and sponsoring institutions can use to facilitate innovation and improvement in the learning environment. With your permission, it will be shared with the education community.

Please send the ACGME a brief description of your approach. It should:

1. Identify the type of initiative/approach at your residency program or institution;

2. Describe the initiative, its goals (e.g., analyzing residents' workflow to reduce "down-time;" instituting rapid response teams for sudden critical illness), and how it meets these goals;

3. Report how many months of experience you have with the innovative approach;

4. Indicate whether the ACGME may share this information with others in the community;

5. Optional, but helpful, discuss the resources required (funds, staff, technology).

Provide the name, address, and e-mail address of a program director, DIO, or project leader who can serve as contact for inquiries.

Send your submissions as an e-mail or an MSWord or WordPerfect attachment to innovation@acgme.org.

Many thanks in advance. ■