

## Accreditation Council for Graduate Medical Education

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## Editor's Introduction

This issue of the ACGME-Bulletin includes a brief article about nine “red flags” – tell-tale signs of problems in residency programs, compiled from the observations of the ACGME field representatives. The aim is to assist programs in addressing or avoiding these problems in their ongoing operations and preparation for upcoming site visits.

Two companion articles offer clarification on the requirement for an annual evaluation of the educational quality of the program. Questions from program directors about the annual evaluation of the program have shown that many may not fully understand the goals of this requirement. As a result, programs may miss out on opportunities to conduct a meaningful self-evaluation and use the results in continuous improvement of the curricula, rotations and other aspects of the program. To clarify this requirement, the e-Bulletin includes an excerpt from the new ACGME Program Director Guide to the Common Program Requirements, available on the ACGME web site. It also features practical advice on program self-evaluation by Barbara Bush, PhD, a member of the ACGME accreditation field staff.

The issue also includes several brief updates on topics relevant to the ACGME's accreditation of programs, including an announcement of a virtual handbook for program directors, an exhibit of the current specialty-specific requirements for resident duty hours, and a new online function that streamlines the process for requesting Voluntary Withdrawal of Accreditation.

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## Nine “Red Flags” in Accreditation Site Visits and Reviews

*Barbara Bush, PhD, William Robertson, MD, Ingrid Philibert, MHA, MBA*

The nine “red flags” outlined in this article were compiled from the observations of several members of the ACGME field staff with many years of experience, and were informally validated by a number of RRC and former RRC members. “Red flags” are attributes of programs that are discernible during site visits. This summary offers insight into these attributes, which may raise site visitor and RRC reviewer questions about program quality and compliance with aspects of the program and institutional requirements. One use of this information is for an internal assessment or self-study with the goal of program improvement. The 9th “red flag” relates to preparation for the accreditation review, and may be particularly useful to a program preparing for its site visit.

The attributes are germane to both residency and fellowship programs, and the term “residents” refers to both residents and fellows. The ordering of the nine “red flags” is random and does not reflect any particular importance of the items.

**Red Flag 1: Lack of Program Leadership**

This red flag relates to indications that the program director and key faculty fail to advocate for residents on important education and patient care matters. Signs include insufficient attention or lack of response to concerns residents have raised about aspects of the program and insufficient efforts to correct problems identified by the residents. These deficits may also show up as a failure to address problems with rotations at participating institutions or as insufficient follow-up by the sponsoring institution to problems or concerns requiring institutional interventions. Such issues may contribute to a failure to address areas of prior non-compliance, and may result in repeat citations on a successive review.

In the process of preparing for site visits, insufficient leadership may become apparent as a program's reliance on communication and preparation managed solely by the program coordinator or another staff member, rather than direct involvement of the program director. On the day of the visit the program director may rely entirely on an associate to answer all questions from the site visitor.

**Red Flag 2: Lack of Program Infrastructure for Teaching and Evaluation**

Insufficient clinical or didactic curriculum, including formal didactics, conferences and lectures, or deficiencies in the systems for evaluating residents, faculty and the program may have a negative impact on the residents' educational environment.

**Red Flag 3: Lack of Appropriate Volume and Variety of Patients**

Lack of appropriate patient populations to ensure an appropriate depth and breadth of clinical education is characterized by insufficient volume or balance of patients (diagnoses, clinical problems, acuity and demographics), disputes with other disciplines that affect the number and type of patients available to a particular program, or too many residents, fellows and other learners competing for the same patient populations.

**Red Flag 4: Problems with Resident Recruitment and/or Retention**

Reduced ability of a program to recruit or retain residents may be due to geographic location, program or institutional reputation, reduced interest in the specialty, or program-level problems that induce residents to leave prior to graduation. Signs of this difficulty are evident from unfilled resident positions or a high resident turn-over. As a result, poorly qualified residents may require intensive remedial teaching and evaluation, creating an added burden on the program director and faculty. Problems with resident recruitment may also contribute to a poor record for graduates in sitting for and passing their board examination.

**Red Flag 5: Lack of Dedicated Teachers**

This red flag involves the faculty's unwillingness or inability to devote the added time required for effective teaching (at the bedside and in the operating room, or during conferences, rounds and other didactic activities). On some occasions, this problem may be evident in low numbers of board-certified faculty or a key faculty component that is not adequate to teach the number of residents in the program. Causes may include problems with faculty recruitment, high faculty turnover or faculty attrition.

Lack of effective faculty teaching also may manifest as too much or too little supervision, or the faculty's not turning over cases or giving hands-on responsibility to residents, not allowing sufficient autonomy for decision-making with appropriate oversight, not offering progressive responsibility and not providing meaningful evaluation and feedback to the residents. During the site visit, residents may report over-reliance on fellows to teach, or competition between residents and fellows for attending physicians' teaching time.

**Red Flag 6: Lack of Meaningful Didactics (Rounds, Conferences and Lectures)**

A didactic component that does not cover the essential body of knowledge (basic science and clinical) of the specialty, frequent cancellation of conferences, lack of sufficient faculty attendance at or participation in conferences, and an over-reliance on residents or fellows to organize and present at conferences reflect insufficiencies in the program's organized curriculum.

**Red Flag 7: Lack of Financial and Human Resources**

A lack of financial and human resources at the program or institutional level may be apparent in inadequate or outdated facilities, or excessive clinical demands on faculty, including the program director. Other ways in which this may become apparent include insufficient support services for patient care that affect residents and faculty, or excessive service needs, with residents needing to "cover" too many hospitals. Issues with adequate support of the program also may show as inadequate numbers administrative and ancillary staff for the size of the program, or a lack of adequate institutional support or funding for the program.

**Red Flag 8: Service has a Higher Priority than Education**

Evidence of undue reliance on residents to provide service includes clinical services that cannot run without the presence of residents, frequent instances of residents being pulled from one rotation to cover another service, and duty hour violations affecting a significant percentage of the residents in the program. Another example is a resident's being required to provide coverage or cross-coverage on inpatient units during their ambulatory, subspecialty or research rotations.

**Red Flag 9: Lack of Preparation for the Accreditation Process**

In the ongoing management of the program, deficiencies may present themselves as inadequate attention to selected requirements. In the preparation for the accreditation site visit, one sign of this may be a poorly prepared program information form (PIF). Examples include PIFs with obvious errors, inconsistencies or failure to follow the instructions; missing documents; or a PIF that arrives after the specified date, which is set to allow the site visitor adequate time to review the documents.

On the day of the visit, a program leader who does not understand or argues about the standards may be evidence of inadequate attention to the accreditation process. Knowledge deficits related to the accreditation standards, or lack of "buy-in" for all or selected accreditation requirements (institutional, program and common requirements, including the competencies and duty hours) on the part of program leaders and faculty may contribute to this.

Other potential "red flags" were considered, but ultimately rejected because they related to program elements important only in selected specialties and subspecialties. Two deserve specific mention:

1) lack of faculty and/or resident scholarship; and 2) excessive focus on research at the program level that may prevent faculty from providing clinical and didactic instruction to their residents.

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## Program Evaluation and Improvement: Two Practical Perspectives on a Common Program Requirement

### An Explanation of Requirement V. C. “Formal Systematic Evaluation of the Curriculum”<sup>1</sup>

*Pamela Derstine, PhD*

A requirement in the Evaluation Section (V. C.) of the Common Program Requirements specifies a “formal, systematic evaluation of the curriculum” conducted at least annually. To meet this requirement, program directors should lead an ongoing effort to monitor and improve the quality and effectiveness of the program. This evaluation is unrelated to the internal review of the program by the institution's Graduate Medical Education Committee (GMEC), which takes place at the mid-point of the accreditation cycle. However, results of the internal review may become part of the annual program evaluation, and some data from the annual evaluation may be useful to the internal review. Programs should develop approaches to collect the data elements specified in the requirement: resident performance; faculty development; graduate performance; and program quality. To broadly assess program quality, the requirement also directs program directors to solicit confidential evaluations from residents and faculty.

The goal of this requirement is for the program to have an ongoing effort to monitor and improve the quality and effectiveness of the program. A written plan for program evaluation and improvement will help to assure that a systematic evaluation takes place annually, that results are used to identify what is working well and what needs to be improved, and that improvements are implemented.

More information clarifying this and other Common Program Requirements can be found in the ACGME's Program Director Guide to the Common Program Requirements, [http://www.acgme.org/acWebsite/navPages/nav\\_commonpr.asp](http://www.acgme.org/acWebsite/navPages/nav_commonpr.asp)

<sup>1</sup>Adapted from the Program Director Guide to the Common Program Requirements, <http://www.acgme.org/acWebsite/home/PDVirtualHandbook.asp>.

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## Strategies for Program Evaluation: Examples from the Field

*Barbara H. Bush, PhD*

Many program directors have acknowledged that addressing program evaluation at the monthly faculty meeting is insufficient. While there may be time for brief updates, the monthly meeting does not allow the program to conduct a “formal, systematic review of the curriculum,” as specified in the Common Program Requirements. When site visitors review the minutes of faculty meetings, these rarely reflect discussions on program quality and efforts to improve it.

A growing number of programs are beginning to organize annual half- to full-day program evaluation meetings for key faculty from their major participating sites. Often, several residents or fellows are included in all or some portions of those meetings. Other faculty and residents cover the services to protect the time of the participants. The Common Program Requirements state that, “At a minimum,

methods must be developed and implemented for systematically collecting and analyzing data in the following areas: resident performance, faculty development, graduate performance, and program quality.” As such, there must be ongoing data collection in these areas (discussed in more detail in the Program Evaluation and Improvement Section of the “Program Director Guide to the Common Program Requirements,” see above). The goal of the program evaluation meeting is to analyze the results of these data, make assessments and set goals for improvement.

Program directors have discovered some group process approaches that have led to more productive evaluation meetings. Some examples follow:

- One residency program distributed program evaluation questionnaires to the residents and the faculty, containing common questions about certain aspects of the program, such as the conferences and the residents’ scholarly activity. The goal was to compare the perspectives of each group on these aspects of the program. Each questionnaire also had faculty-specific questions (such as questions about faculty development) or resident-specific questions (such as questions about the adequacy of supervision). The questionnaire data were summarized and presented at the annual evaluation meeting, with other relevant data provided by the program director.
- Another program organized a full-day retreat. During the morning all residents met privately for a structured evaluation discussion, using a list of aspects of the program (such as rotations, continuity clinics and conferences) that had been developed specifically for this purpose. One of the residents recorded the discussion. Concurrently, key faculty met in a similar session, which was recorded by a faculty scribe. In the afternoon both groups meet collectively to summarize their assessments and review additional data provided by the program director.
- One fellowship program paired six key faculty members and six fellows, and assigned each of these dyads a different component of the program for review over a four-week period. For this program, the components being investigated included clinical rotations at three sites (with each dyad responsible for one site), along with clinics, conferences and fellow research. The program director provided each dyad with data relevant to the program component they were asked to evaluate. All participants met for an evaluation meeting, at which each fellow-faculty dyad formally presented its findings to the entire group.

In all three of the above examples, program evaluation meetings were attended by key faculty and some or all of the residents/fellows. The meetings encompassed presentation of information, followed by analysis, problem-solving and the development of an action plan. During their site visits all three programs were able to provide significant documentation that they had completed formal, systematic reviews of the curriculum and had prepared and begun to implement plans to improve their programs.

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## Requests for Voluntary Withdrawal Must Use the ACGME Accreditation Data System (ADS)

According to ACGME policy, a program may request voluntary withdrawal of accreditation when a decision has been made to close the program. Beginning immediately, programs will enter requests to voluntarily withdraw accreditation using the Accreditation Data System (ADS). Review Committee staff will no longer accept letters requesting this action sent directly to them. The program director initiates the request within ADS by answering a series of questions, including the proposed effective date and the reason for program closure, and presenting a plan to place all active residents in other programs. Once submitted, the DIO is automatically sent an email requesting approval through ADS. After the DIO/GMEC approves the request, a member of the review committee staff is notified and places the request on the next review committee meeting agenda. The program director and DIO receive official notification, and the accreditation status is changed to voluntary withdrawal after the RC makes a final decision to accept the withdrawal.

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## Timing of Availability of Letters of Notification

In 2006 the ACGME changed its process from mailing hard copies of accreditation notification letters to posting the letters to the ACGME Accreditation Data System (ADS) as PDF files. Program directors and Designated Institutional Officials (DIOs) were notified by email that the letters would be posted by the next business day. Recently, the ACGME revised the process so that program directors and DIOs will receive the email after the letters are available in ADS.

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## ACGME Develops Program Directors (PD) “Virtual Handbook”

Program directors and coordinators have great responsibility to develop, oversee and improve residency or fellowship educational programs, implement changes based on the current accreditation standards and prepare for accreditation site visits and review by the ACGME review committees (RRC). To assist with obtaining information related to these endeavors, ACGME has developed a ‘Virtual Handbook’, which contains links to sections of the ACGME website that are very relevant to the work. The Virtual Handbook can be accessed from the program directors & coordinators page or any of the review committee pages at [www.acgme.org](http://www.acgme.org) with links to the ACGME Manual of Policies and Procedures, staff contact information, key to the standard letter of notification, site visit, data collection systems and meeting information.

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## ACGME Updates Summary of Specialty-Specific Duty Hour Language

The ACGME recently updated its summary of specialty-specific duty hour requirements, such as the Emergency Medicine requirement that limits resident duty hours for emergency medicine rotations to 72 weekly hours overall, of which no more than 60 hours may be devoted to patient care. It also includes specialty-specific definitions of “new patient” in the context of the 24 hour (plus up to 6 hours) limit on continuous duty. Several specialties, such as Anesthesiology and Family Medicine further limit residents’ activities during the post-call hours. For example, anesthesiology residents may not administer anesthesia in the operating room for a new operative case or manage new admissions to the ICU.

Seven Residency Review Committees (Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, Neurology, Pediatrics and Diagnostic Radiology) and the Transitional Year Review Committee will not grant an exception that allows a program to extend the 80-hour weekly limit by 10% (the only exception to the Common Duty Hour Standards that is granted by the ACGME).

The summary of specialty-specific duty hour requirements can be found on the ACGME web site at: [http://www.acgme.org/acWebsite/dutyHours/ACGMEApprovedSpecialtySpecificDutyHourLanguage\\_AS\\_ED\\_01\\_16\\_2008.pdf](http://www.acgme.org/acWebsite/dutyHours/ACGMEApprovedSpecialtySpecificDutyHourLanguage_AS_ED_01_16_2008.pdf)