Review Committee for Internal Medicine Update

ACOI 2019 Annual Congress on Medical Education

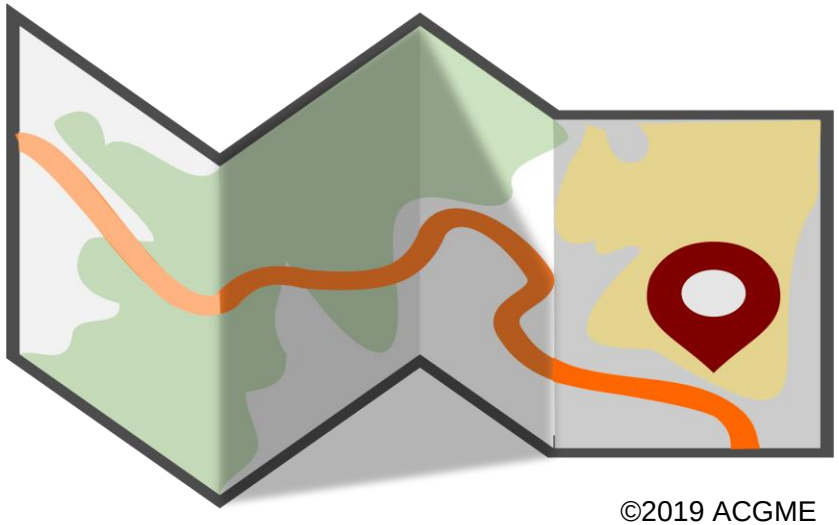
Friday, May 10, 2019

Jerry Vasilias, PhD, Executive Director
Review Committee for Internal Medicine

Disclosures

No conflicts to disclose

General Information: What does RC do?
Actions and Citations for SingleGME Applications/Programs
Change to Requirements
NAS 101
NAS Lessons Learned from Self-Study/10-year visits
RC Members and Staff



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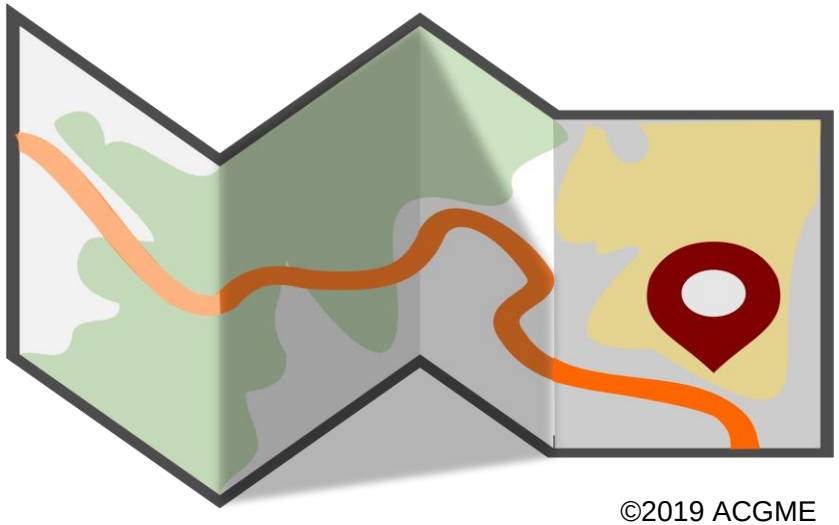


What does the RC do?

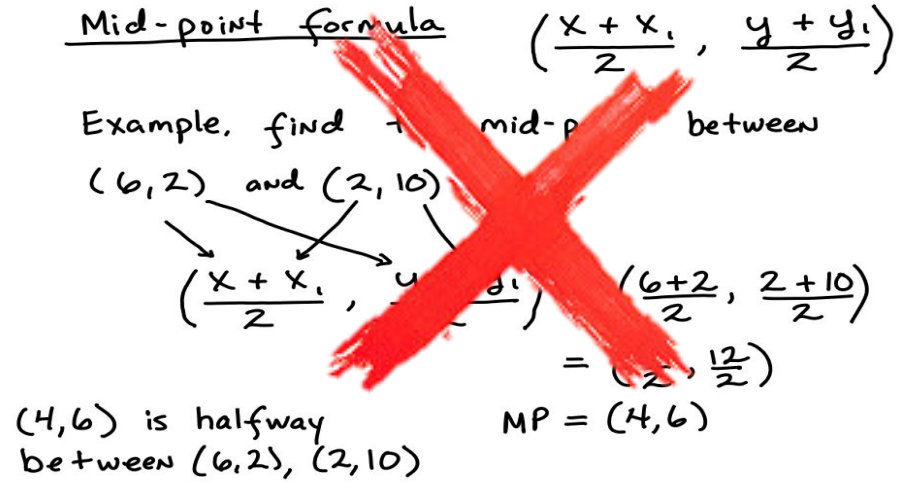
- Reviews programs with regards to common and specialty PRs
- Determines accreditation status for programs
- Proposes revisions to PRs
- Discusses matters of policy and issues relevant to the specialty
- Recommends changes in policy, procedures and requirements to the ACGME Council of Review Committee Chairs.

How does it review programs?

- RC reviews programs to determine *substantial compliance* with minimum requirements
- Areas of noncompliance may be identified
- *Substantial compliance* can be achieved even with areas of non-compliance

QUESTION: what's the "tipping point"? What combination of citations leads to an *adverse action (warning, probation, or withdrawal)*?

There is no formula.
This a *peer* review process



"Areas of noncompliance"?

RC communicates noncompliance with requirements via…

Citations

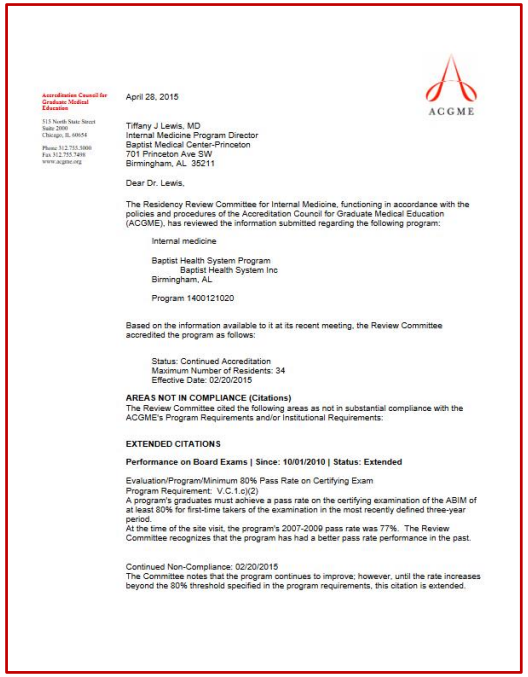
- Require response in ADS
- Citations are typically weightier than AFIs.

AFI = "Areas for Improvement"

- AFIs do not require specific response in ADS.
- RC assumes the program and institution will address AFIs.
- Will draw further scrutiny (possibly become citation) if the trend continues

What happens after the RC reviews the application/program?

- PD + DIO will receive an email with RC's decision within *5 business days* of the RC meeting.
- A letter of notification follows approximately 8 weeks later that will detail areas of noncompliance, if any.



Accreditation Council for Graduate Medical Education
515 North State Street
Suite 2000
Chicago, IL 60654
Phone: 312.755.5000
Fax: 312.755.7498
www.acgme.org

April 28, 2015

ACGME

Tiffany J Lewis, MD
Internal Medicine Program Director
Baptist Medical Center-Princeton
701 Princeton Ave SW
Birmingham, AL 35211

Dear Dr. Lewis,

The Residency Review Committee for Internal Medicine, functioning in accordance with the policies and procedures of the Accreditation Council for Graduate Medical Education (ACGME), has reviewed the information submitted regarding the following program:

Internal medicine

Baptist Health System Program
Baptist Health System Inc
Birmingham, AL

Program 1400121020

Based on the information available to it at its recent meeting, the Review Committee accredited the program as follows:

Status: Continued Accreditation
Maximum Number of Residents: 34
Effective Date: 02/20/2015

AREAS NOT IN COMPLIANCE (Citations)
The Review Committee cited the following areas as not in substantial compliance with the ACGME's Program Requirements and/or Institutional Requirements:

EXTENDED CITATIONS

Performance on Board Exams | Since: 10/01/2010 | Status: Extended

Evaluation/Program/Minimum 80% Pass Rate on Certifying Exam
Program Requirement: V.C.1.c)(2)
A program's graduates must achieve a pass rate on the certifying examination of the ABIM of at least 80% for first-time takers of the examination in the most recently defined three-year period.
At the time of the site visit, the program's 2007-2009 pass rate was 77%. The Review Committee recognizes that the program has had a better pass rate performance in the past.

Continued Non-Compliance: 02/20/2015
The Committee notes that the program continues to improve; however, until the rate increases beyond the 80% threshold specified in the program requirements, this citation is extended.

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Changes to Requirements

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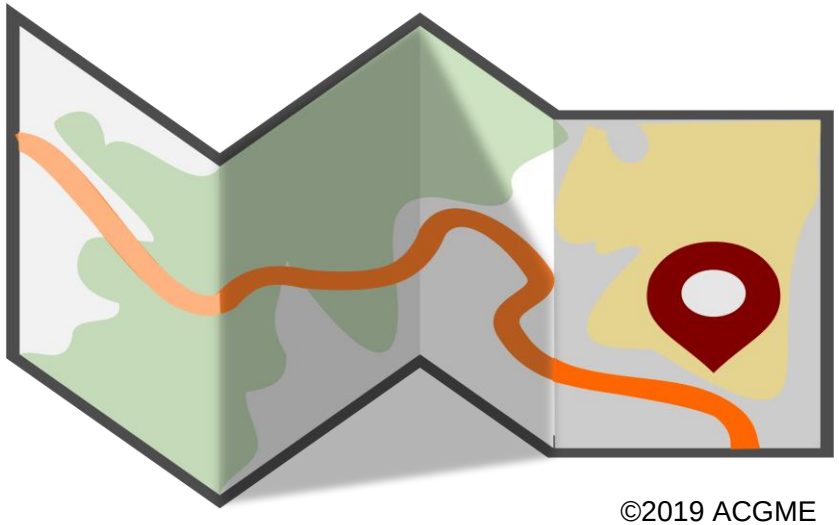
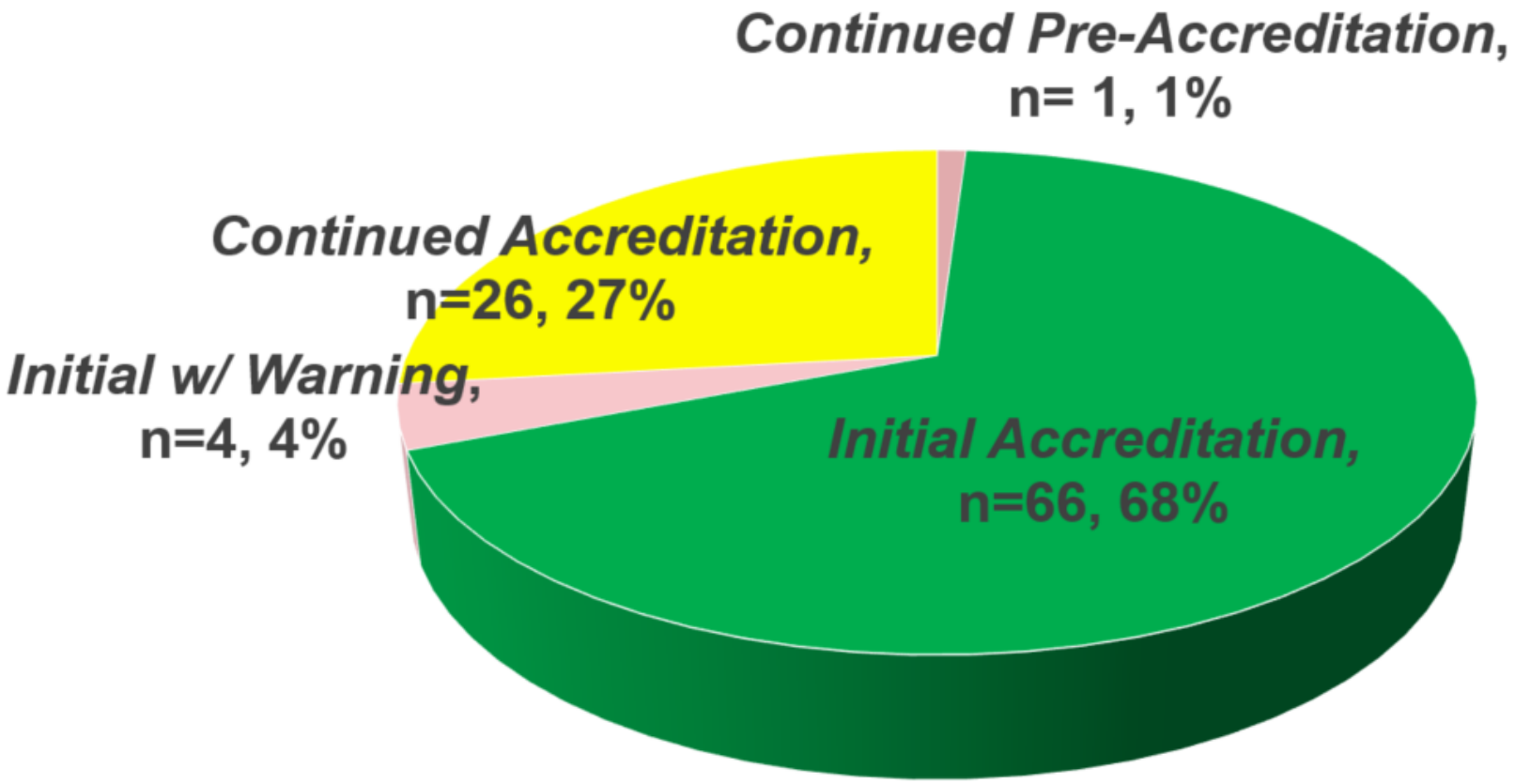


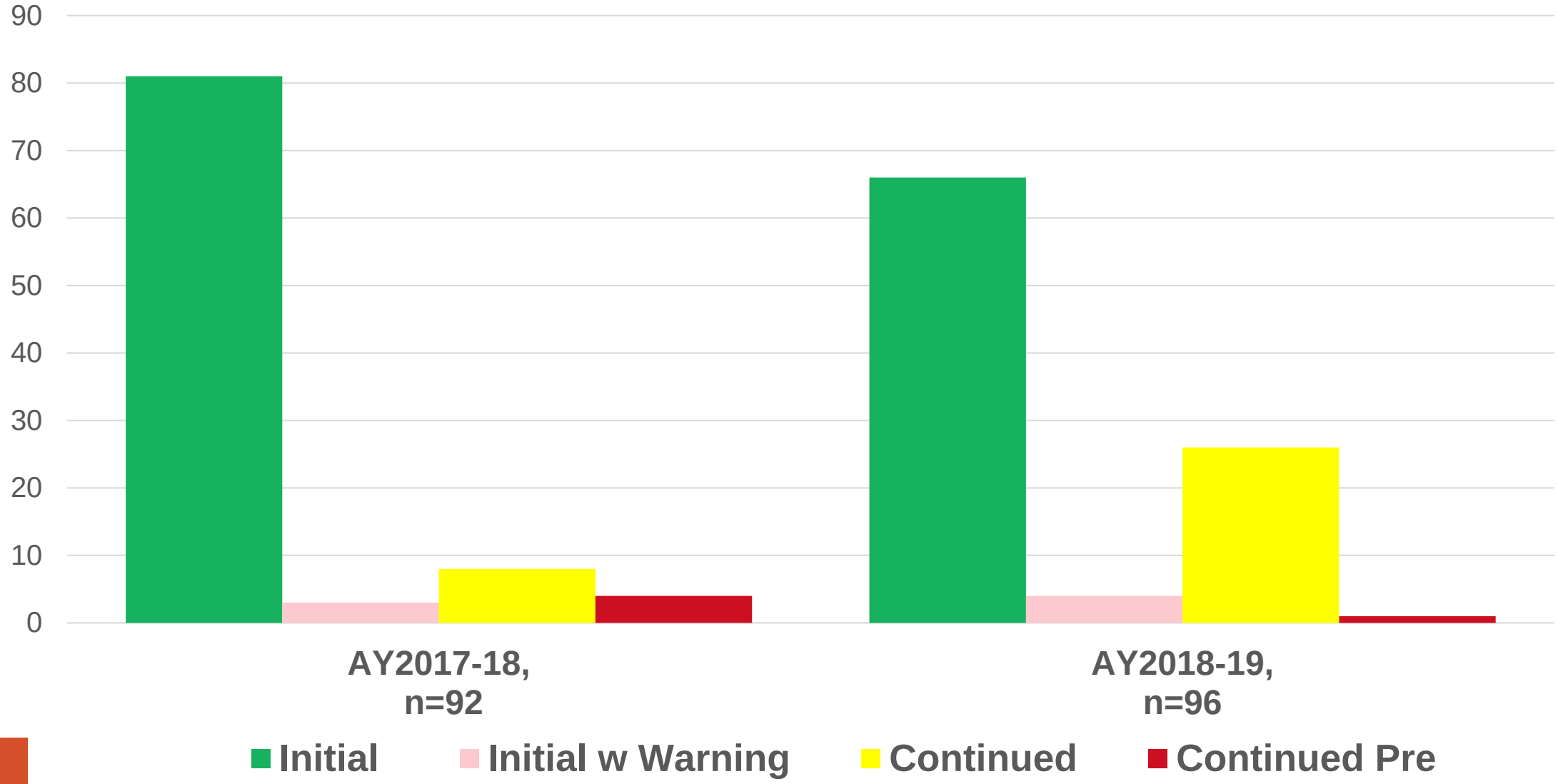
Actions for SingleGME CORE IM Programs

From beginning through recent RC meeting



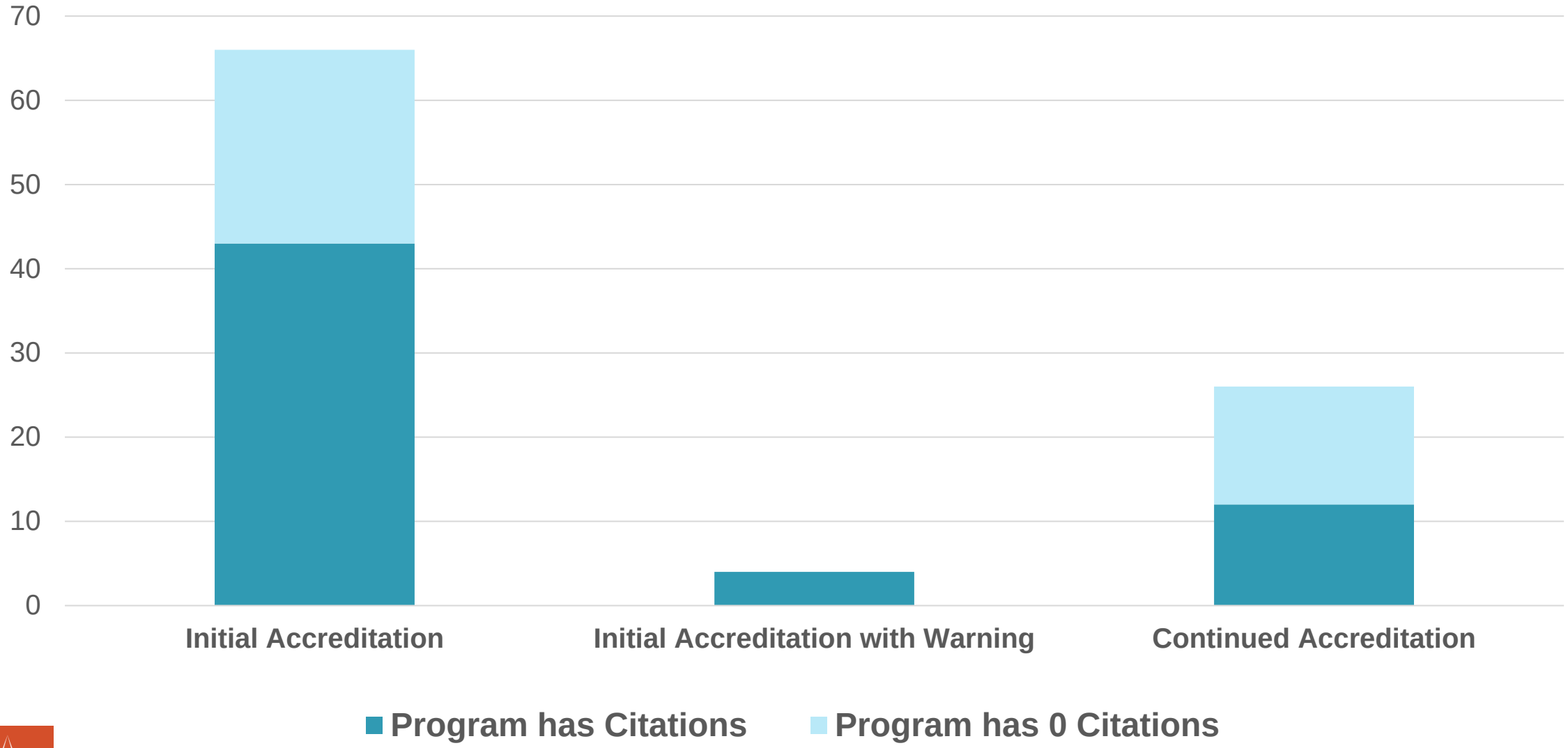
Accreditation Status Decisions x Academic Year

CORE programs



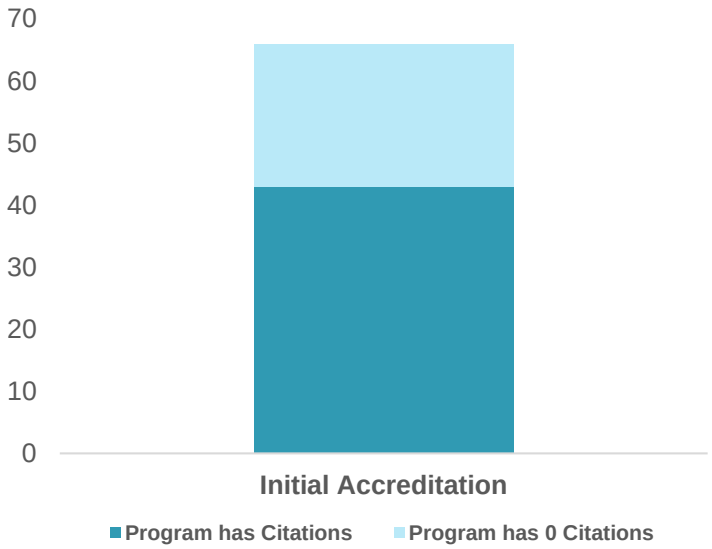
Distribution of citations x Accreditation Status

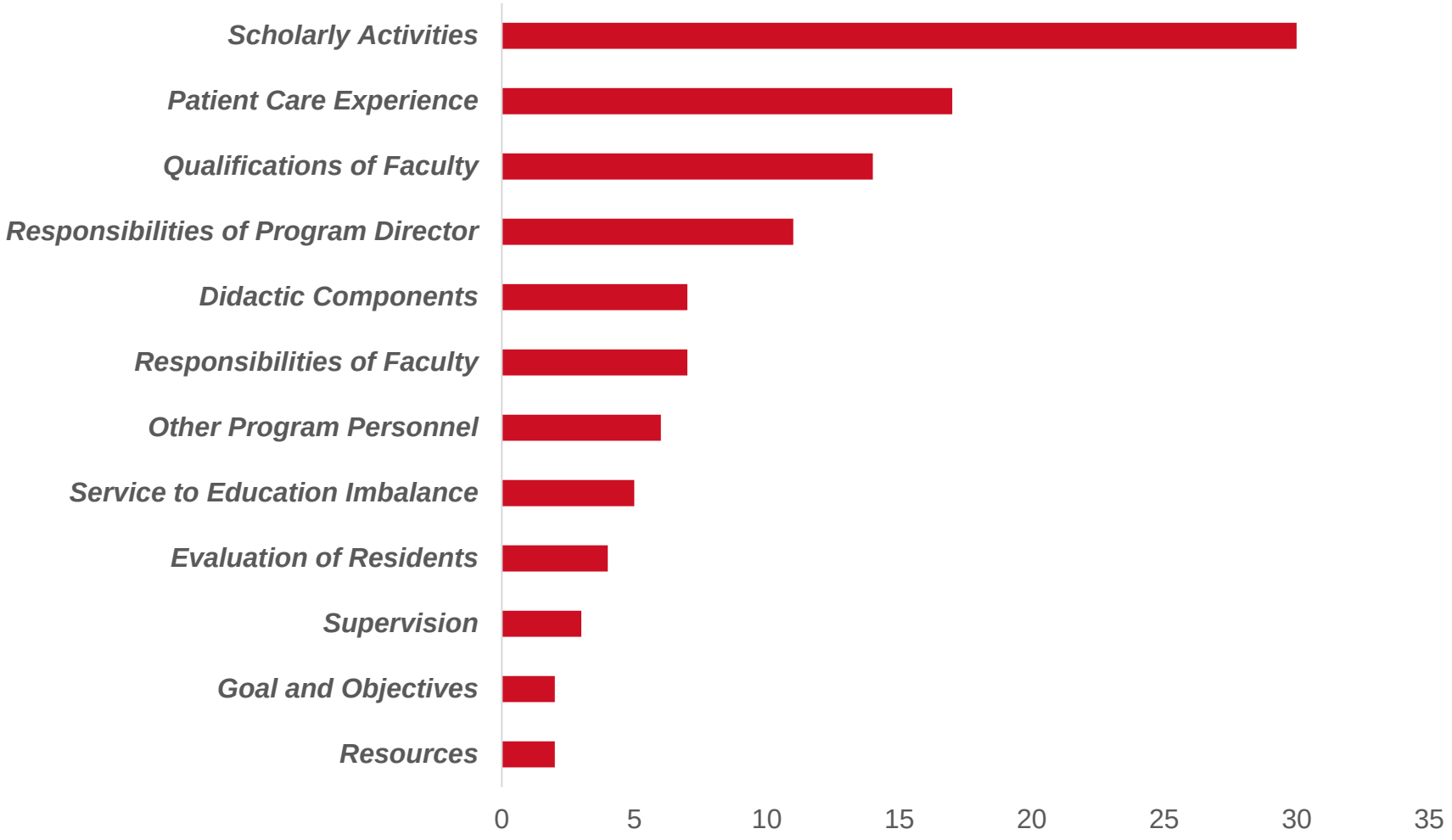
CORE programs



Programs at Initial Accreditation, n=66

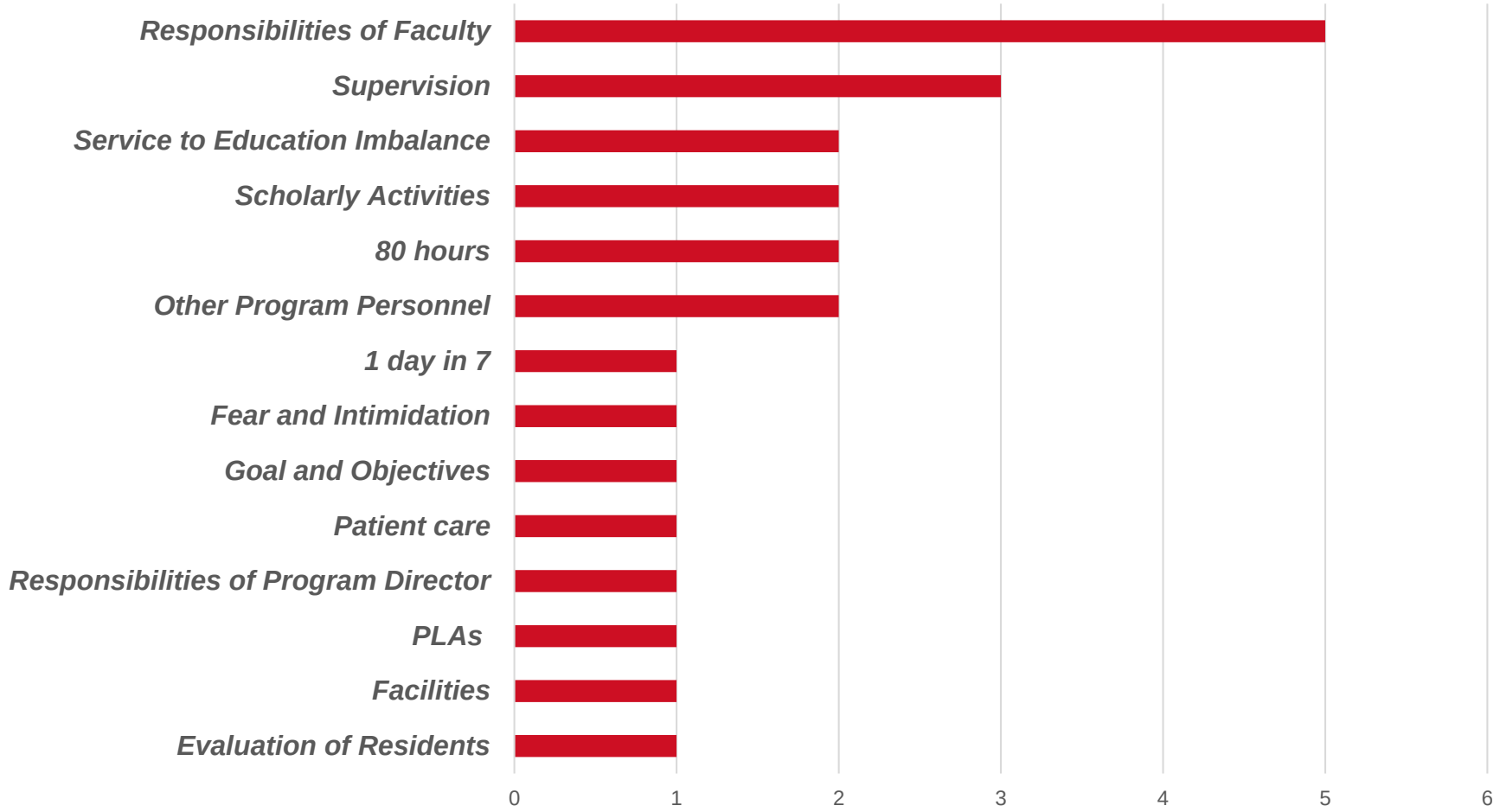
- **Of programs at Initial Accreditation (n=66), 23 do *not* have a citation.**
- **If have citations, have 2-3 citations.**





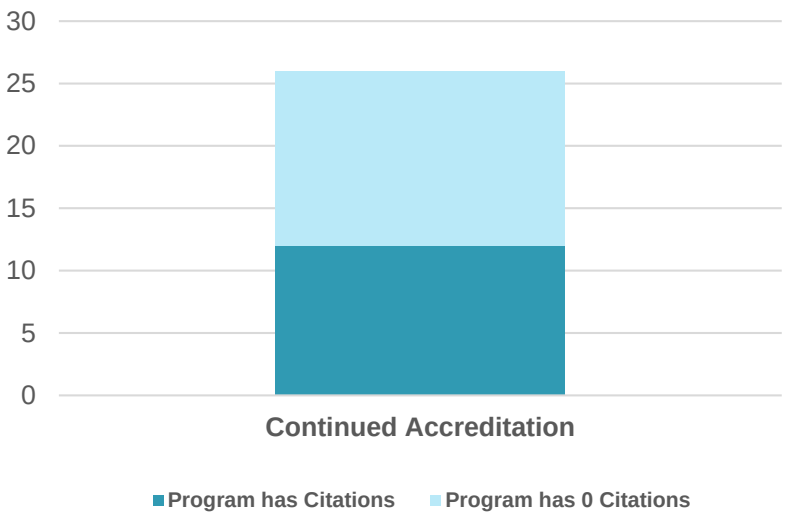
Programs at Initial Accreditation w Warning, n=4

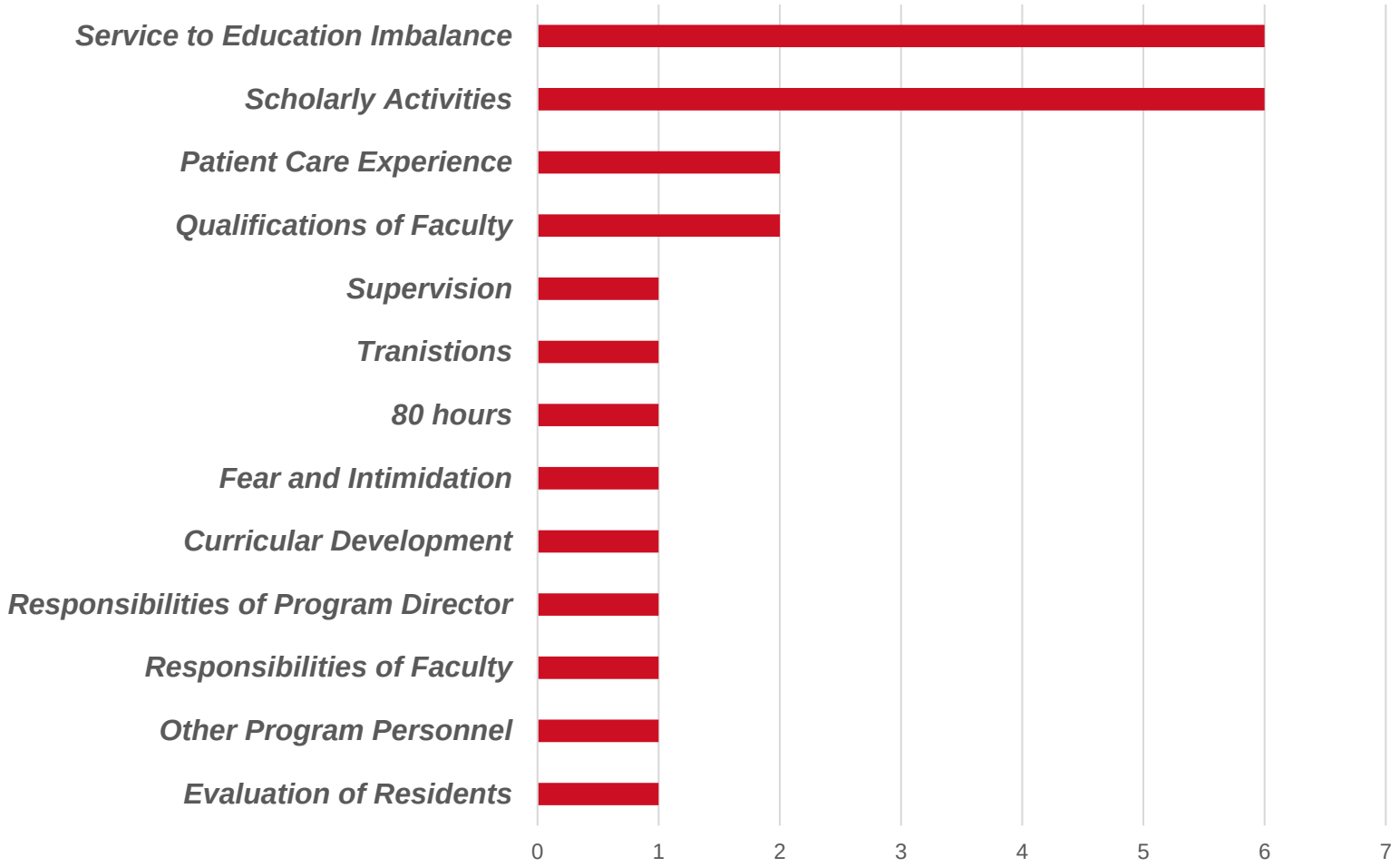
- All 4 programs at Initial w Warning have citations.
- Each program has approximately 6 citations.



Programs at Continued Accreditation, n=26

- **Most programs at Continued Accreditation are without citations; 14 of 26 do *not* have citations.**
- **If have citations, have about 2.**



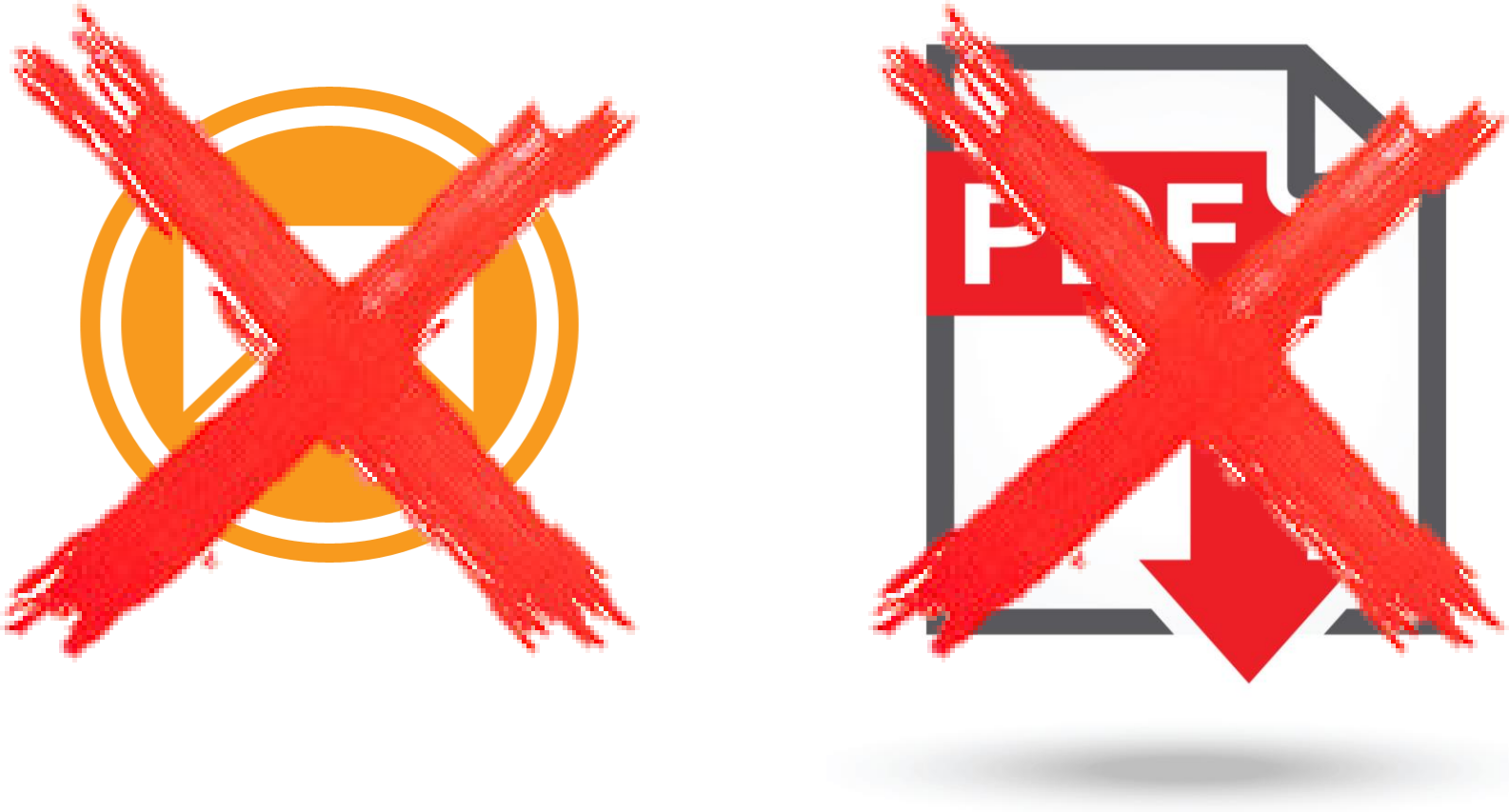


If you receive a citation…

- Respond to the citation in *ADS*
  - Be specific
  - Be concise
- If you believe citation is an error, clarify misunderstanding
- If citation is a “work in progress,” document the progress/action plan made thus far

- If program is at…
  - ***Initial Accreditation*** – responses to citations will be verified by site visitor at time of site visit, typically 2 years after Initial review
  - ***Continued Accreditation*** – responses will be reviewed annually, typically at the January RC meeting

If you get a citation, do <u>not</u>…



Pointers for responding to citations

https://www.acgme.org/Program-Directors-and-Coordinators/Avoiding-Common-Errors-in-the-ADS-Annual-Update

Responding to Citations Video

Total Viewing Time: 8 minutes

Note: if you experience any delay loading this video, use this direct link

ACGME

Example Citation Responses

This document contains examples of responses to citations. The first and third examples show well-written responses along with details on why the response is effective. The second and fourth examples depict poorly written responses and provide feedback on what could be improved to make the response better. This handout can be used as a reference for programs when responding to citations to ensure that they clearly and accurately address the Committees concerns.

Example 1—Well-Written Response

Citation: Fellow Evaluations - Multiple Evaluators Program Requirement: V.A.2.b). (2) The program must: use multiple evaluators (e.g. faculty, peers, patients, self, and other professional staff). (Detail)

It is unclear whether the program uses multiple evaluators to evaluate fellow performance. Evaluation forms provided in the updated application materials included a faculty of fellow evaluation and a 360 evaluation. However, the 360 evaluation does not indicate who will be completing the form, so it is unclear who is evaluating the fellows aside from the program faculty.

Program Response: Our program already had a 360 evaluation in place at the time of site visit, which was completed in the past by a medical assistant and by a nurse. This may not have been clear at the time of the site visit but it was already in place and we have the documentation to show this. However, we have recently increased the number of people completing this evaluation to include peers (i.e. the fellows will evaluate each other) and have also increased the number of medical assistants completing the evaluation to two, as well as adding a second nurse and one to two clinic ATCs, so we will receive more 360 evaluations for each fellow each year.

Comments: A citation may occur based on the information available to the committee, which may be incomplete or misunderstood. This response is concise and describes the program that was in place previously, and then adds detail about how it has been enhanced. It provides a clear description rather than merely reporting that the citation has been addressed.

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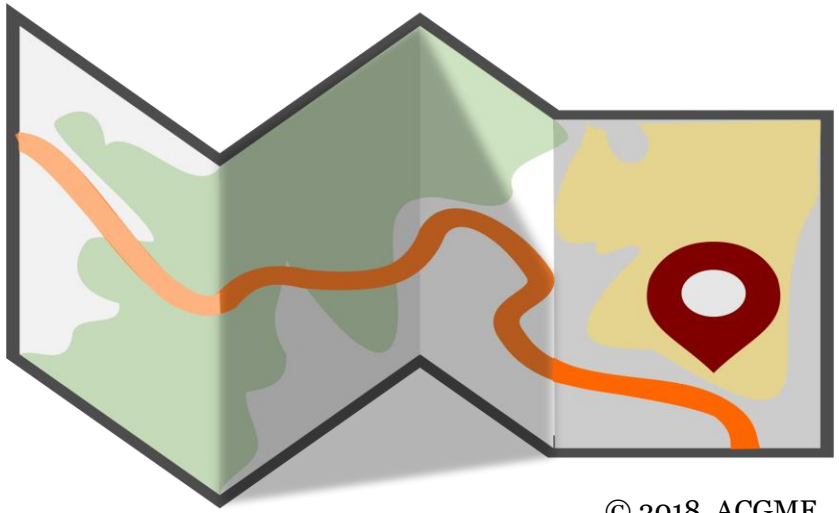


Types of Program Requirements (PRs)

Introduction

Int.A. **Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.**

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Common PRs

Int.B. Internal medicine is a discipline encompassing the study and practice of health promotion, disease prevention, diagnosis, care, and treatment of men and women from adolescence to old age, during health and all stages of illness. Intrinsic to the discipline are scientific knowledge, the scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values.

Specialty PRs

Summary of new Common PRs (CPRs), Sections I-IV

- **New CPRs go into effect *July 1, 2019***
- **Biggies include…**
  - Mostly “core” PRs
  - 3 sets – residency, fellowship, and 1-year CPRs*
  - *Mission* and *aims* baked into CPRs
  - Some former CPRs deleted/transferred to under-construction PD Guide
  - AOA certification acceptable for physician faculty
  - “Core Faculty” is in CPRs and broader (can be non-physician)
  - .5 FTE Coordinator support in residency CPRs
  - Scholarly Activity (SA) overhauled
  - More language on faculty development
  - More language on Annual Program Evaluations
  - New certification exam CPRs
  - Fewer sub-competencies for fellows

**** Approved at the Feb 2019 ACGME Board meeting***

Program Requirement Revisions

1. Focused
2. Major

Focused Revisions to date…

- **Focus of focused revisions = to accommodate new CPRs**
  - Edit current PRs to remove redundancies/conflicts
  - Clarify RC's expectation for new CPRs by adding new PR language

- **Focused revisions for IM, PCCM, H/O, H and O vetted in March**
  - Will be reviewed at June Committee on Requirements (CoR) meeting
  - Once approved will be posted before July 1, 2019
  - Remaining subspecialty focused revisions are coming soon

Focused Revisions

Clarifications/new language for *RESIDENCY* PRs…

- New CPRs now use ‘core’ faculty - physicians + non-physicians. RC needed to clarify it still expects min # of core *INTERNIST* faculty
  - Certified by ABIM or *AOBIM* certified
- Expectation for scholarly activity remains broad – do not expect publication
- Hours devoted to program were removed because new CPRs do not allow, will create specialty-specific Background and Intent:

The residency program must have a minimum number of ABIM- or AOBIM-certified core faculty who devote significant time to teaching, supervising and advising residents, and working closely with the program director and associate program directors. One way these core internist faculty members can demonstrate that they are devoting a significant portion of their effort to resident education is by dedicating an average of 15 hours a week per year to the residency program.

Focused Revisions

Clarifications/new language for *FELLOWSHIP* PRs…

- New CPRs use “core” faculty—physicians *and* non-physicians. RC cannot continue to use “key clinical faculty,” so will clarify it still expects a minimum # of core *subspecialty-certified physician* faculty
  - Certified in the subspecialty by ABIM *or AOBIM*
- Re-categorizing PD support 20-50% as “*core*” instead of “detail”
- CPR for fellows to practice independently in specialty will *not* appear in IM subs
  - But *will* be in multidisciplinary Clinical Informatics, at community’s request
- Expectation for scholarly activity remains broad
  - No expectation for a peer-reviewed publication
  - 50% of graduates must have engaged in more than one SA from long list
  - 50% of faculty must engage annually in a variety of SA from long list

Focused Revisions …

- Focused revisions for **IM, PCCM, H/O, H** and **O** vetted in March
  - Will be reviewed at June Committee on Requirements (CoR) meeting
  - Once approved will be posted on website, by July 1, 2019

- The remaining subspecialty requirements will undergo two step revision process…
  1. **Focused revision that is *editorial* to harmonize sub PRs with CPRs**
     - Incorporate CPRs and remove redundancies and conflicts

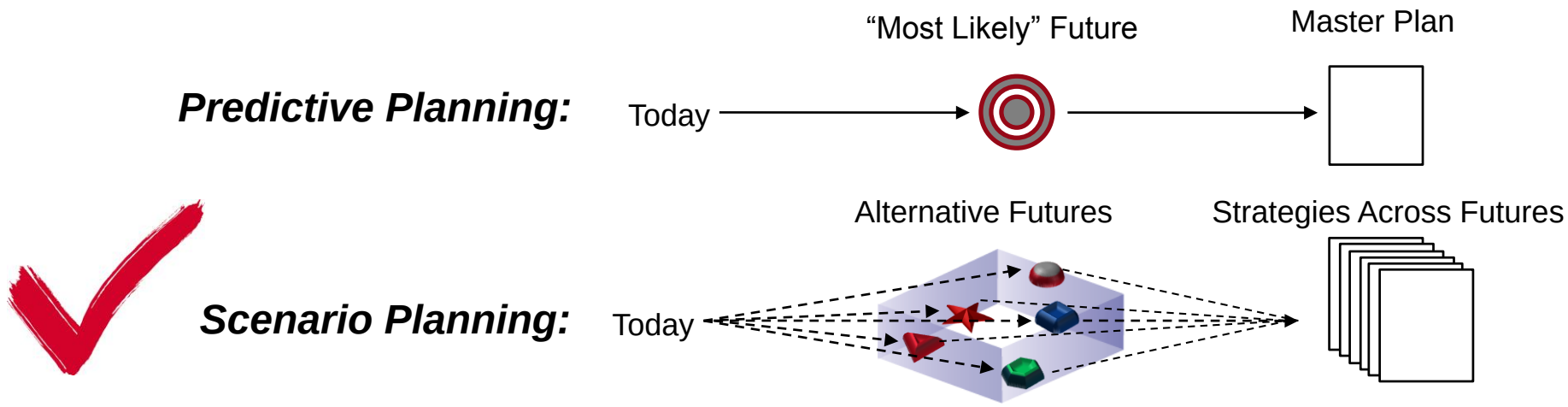
  2. **Focused revision *to add new PR language***
     - To allow RC to clarify expectations for new CPRs
     - Not many, but some – previous slide lists new PRs to be added

EXAMPLE: Geriatric Medicine (GM)

- *On July 1, 2019, the GM PRs will have new CPRs, but no new PR language*
- *In fall of 2019, RC will vet GM PRs with the clarifications/new language from earlier slide*

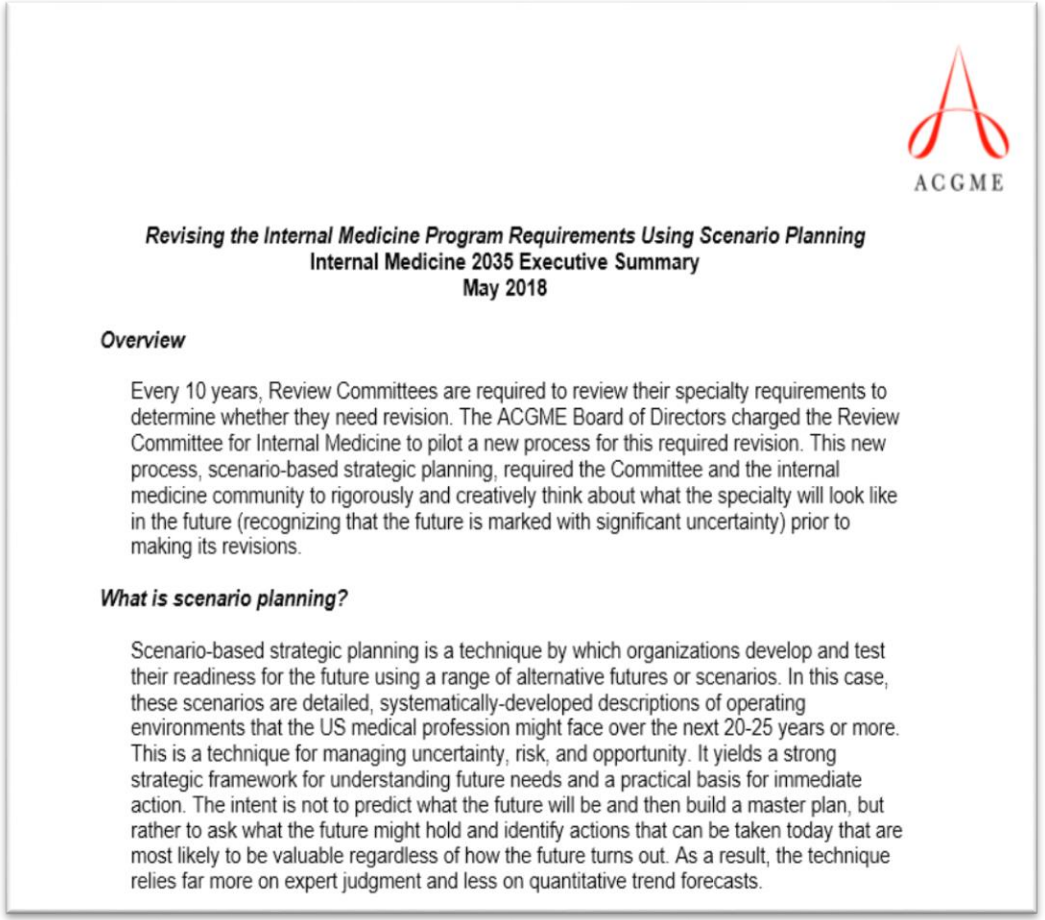
Major Revision

- Current IM PRs in effect since 2009. RCs do major revisions every 10 years.
- For this major revision, ACGME asked RC to pilot *scenario-planning*.
- Intent of *scenario-planning*: not to predict the future and then build a master plan, but rather to *ask what might future hold* and *identify actions today that are most likely to be valuable regardless of how the future turns out*.



Key insights from the scenario planning workshops

- Executive summary from the workshops RC held in June and September of 2017, ***https://www.acgme.org/Portals/0/PFAssets/ProgramResources/IM2035ExSummary.pdf?ver=2018-08-16-133452-567***



ACGME

Revising the Internal Medicine Program Requirements Using Scenario Planning
Internal Medicine 2035 Executive Summary
May 2018

Overview

Every 10 years, Review Committees are required to review their specialty requirements to determine whether they need revision. The ACGME Board of Directors charged the Review Committee for Internal Medicine to pilot a new process for this required revision. This new process, scenario-based strategic planning, required the Committee and the internal medicine community to rigorously and creatively think about what the specialty will look like in the future (recognizing that the future is marked with significant uncertainty) prior to making its revisions.

What is scenario planning?

Scenario-based strategic planning is a technique by which organizations develop and test their readiness for the future using a range of alternative futures or scenarios. In this case, these scenarios are detailed, systematically-developed descriptions of operating environments that the US medical profession might face over the next 20-25 years or more. This is a technique for managing uncertainty, risk, and opportunity. It yields a strong strategic framework for understanding future needs and a practical basis for immediate action. The intent is not to predict what the future will be and then build a master plan, but rather to ask what the future might hold and identify actions that can be taken today that are most likely to be valuable regardless of how the future turns out. As a result, the technique relies far more on expert judgment and less on quantitative trend forecasts.

Key insights from the scenario planning workshops

Excerpts from the report:

What residency programs should do to prepare internal medicine programs to practice in 2035:

- The Program Requirements will need to be flexible to allow programs to individualize residents' experience, depending on interests and post-residency plans.
    - Requirements and programs will need to ensure that those residents who want more subspecialty experiences can have it. Residents will have more subspecialty experiences as the delineation between general medicine and subspecialty education and training blurs, general internists take on some current subspecialty responsibilities, AI-based knowledge systems support immediate access to medical information, and residents pursue Master Clinician positions.
    - Requirements and programs will need to allow residents interested in crossing medicine with traditionally non-clinical/non-medicine areas (like public policy, business administration, and law) the option of doing so.
    - Requirements and programs will need to allow residents interested primarily in either an inpatient/hospital or an outpatient/ambulatory setting to have significant portions of their education occur in that setting during residency.
    - New subspecialties will develop, some in response to technological advancements (bio-sensor stress or tech-related anxieties/disorders), others in response to global changes (climate-change medicine), and programs will need to allow residents to pursue such options.

Major Revision

June 2017
IM2035 Workshop #1
IM & non-IM discuss IM in 2035

Sept 2017
IM2035 Workshop #2
RC & non-RC

Jan 2018 RC Meeting
Review Report from IM2035 Workshops + SI2025
Identify Chair of PR Writing Group + members

Feb/March 2018
CEO & RC Chair at AEC and APDIM
Discuss use of scenario planning for PR revision

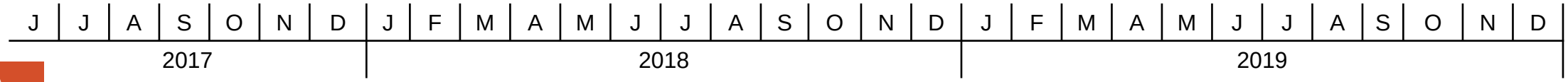
May 2018
Solicit input from PDs
Make IM2035 report available to PDs
Conduct Literature Review

September 2018
IM2035 Writing Group Meeting #1

November 2018
IM2035 Writing Group Meeting #2

April 2019
IM2035 Writing Group Meeting #3

June/July 2019, TBD
IM2035 Writing Group Meeting #4



Major Revision – Updated Timeline

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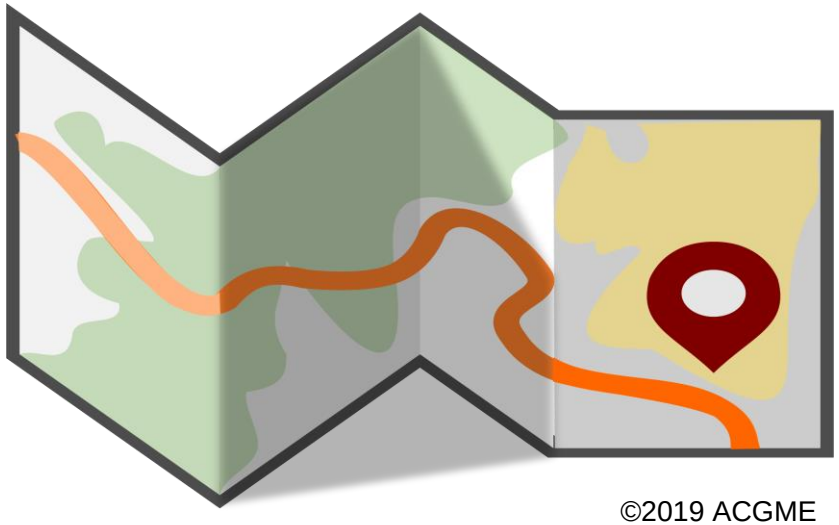
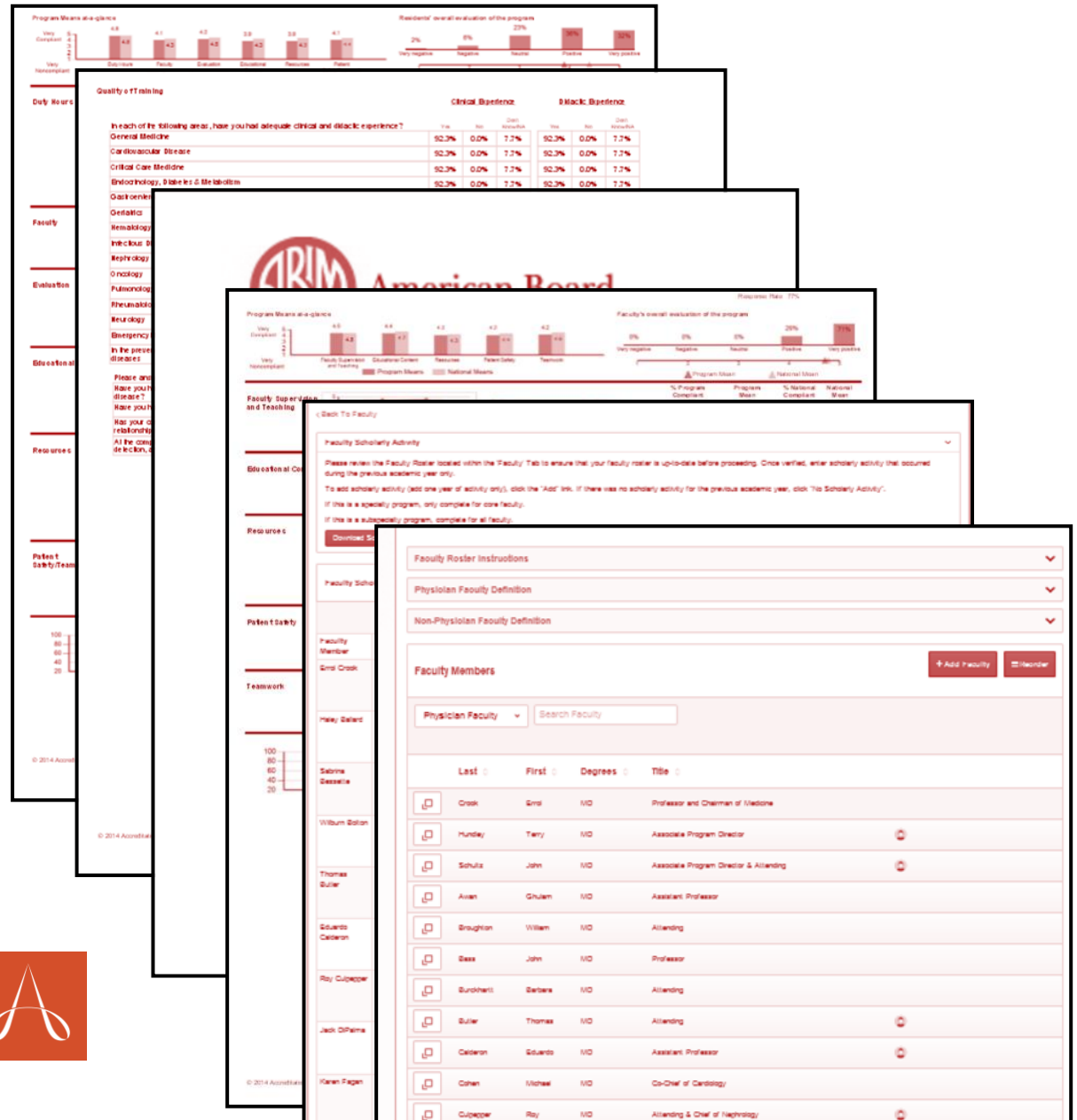


~~*Let's get NAS-ty*~~ ***What is NAS?***

- Next Accreditation System
- Better to call it *NOW Accreditation System*
- RC reviews every established programs (at Continued Accreditation) program *annually* using screening tools

NAS: Programs are reviewed annually using…



Data Elements

- Resident/Fellow Survey
- Clinical Experience
- ABIM/AOBIM Pass Rate
- Faculty Survey
- Scholarly Activity
- Attrition/Changes/Ratio
- Performance of sub
- Omission of Data

NAS: What happens with “outliers”?

1. Programs with Citations
    - *Is the program addressing the citations?*
    - *Are there positive outcomes?*
    - *Is there enough information?*

2. Programs flagged on NAS data elements
    - *Just because program flagged, does not mean it is an outlier*
    - *RC needs to consider…*
        - *Are there multiple elements flagged?*
        - *Which elements were flagged?*
        - *Are there trends?*
        - *Is there enough information?*

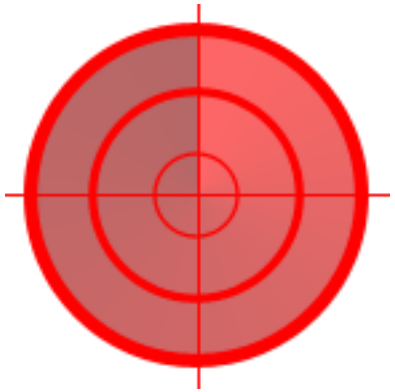
NAS: What happens with "outliers"?

- If there is not enough information or there is concern, RC may request a site visit.

- Request for site visit is a rare event
  - *This year, only 15 programs got a site visit (total 2,200 programs)*

Use "Major Changes and Other Updates" in ADS

- Be proactive
- Provide context
- Describe outcomes



Major Changes and Other Updates

Major changes to the training program since the last academic year, including changes in leadership. This may also include improvements and/or innovations implemented to address potential issues identified during the annual program review.

[Enter text here]

*Resident Survey is *one* data element*

- Resident survey (RS) can be sensitive, so if flagged, we ask:

  "Is this a ***signal***, or is it ***noise***?"

- Considerations:
  - How many sections are flagged? One, two, more?
  - Which sections?
  - Degree of non-compliance? 50% of *what size* program?
  - How long has RS been flagged? First time? Multiple years?
  - What is *overall impression of the program*?
  - Did other NAS data elements flag?
  - Has an AFI already been issued?
  - Did program provide justification in "major changes and other updates"

Let's talk about the survey some more…

QUESTION at APDIM a couple of years back:

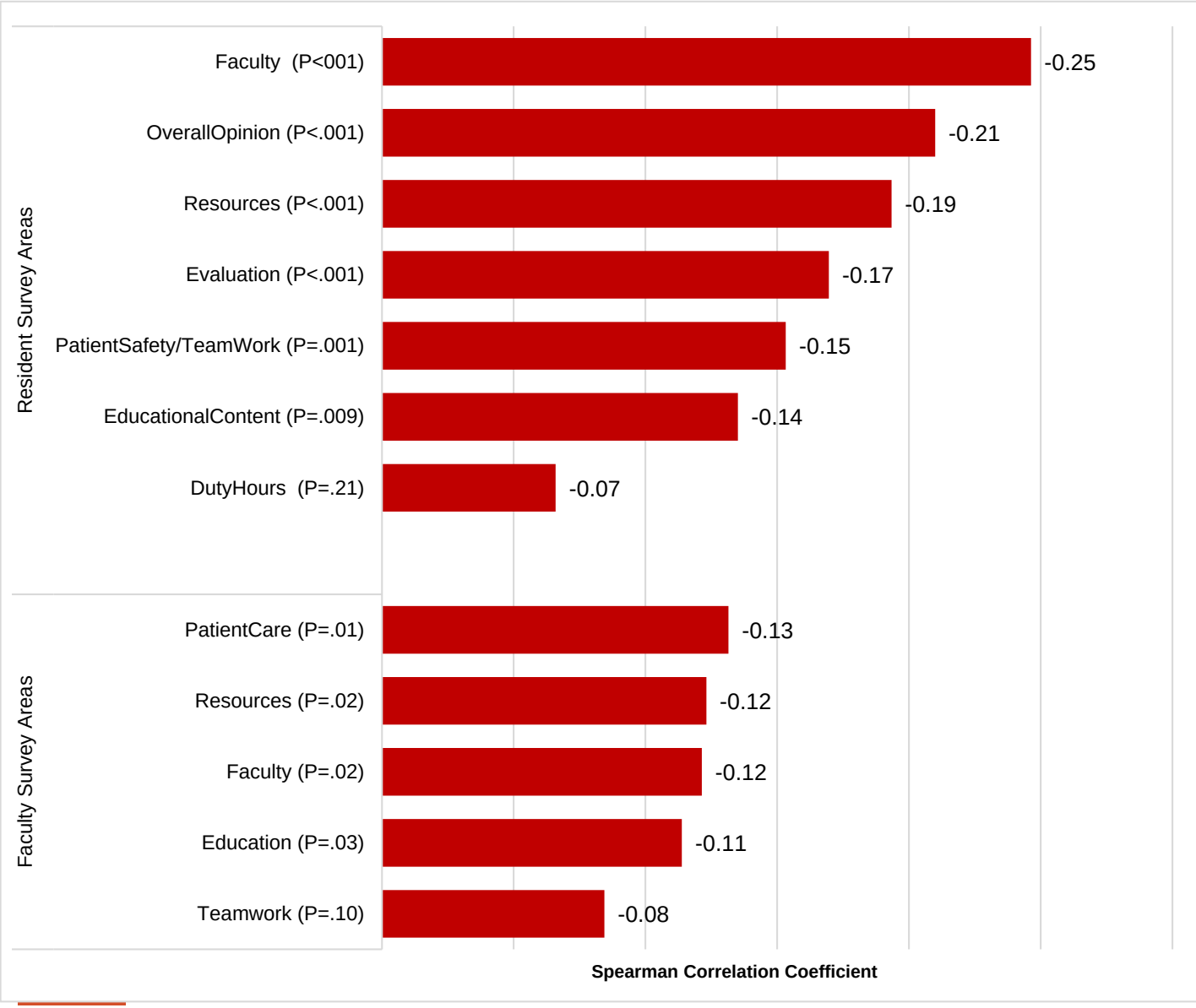
Is there a relationship between the resident survey and the certification exam pass rate?

ANSWER:

As a matter of fact, there is. Programs with higher noncompliance on the resident and faculty surveys tend to have lower board pass rates.

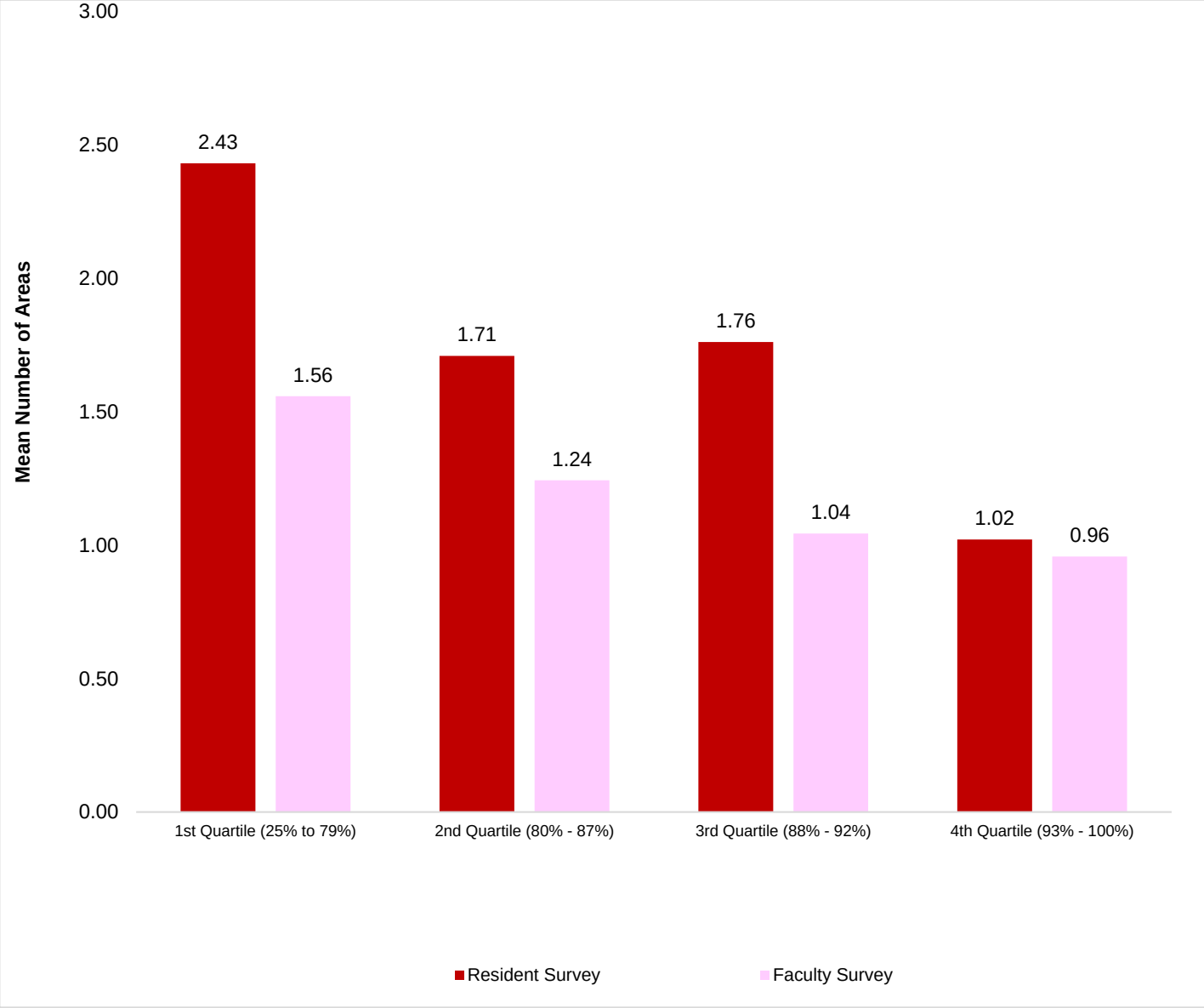
https://journals.lww.com/academicmedicine/Abstract/2018/08000/Relationships_Between_the_ACGME_Resident_and.35.aspx

Takeaway Point #1



- High non-compliance on the Resident and Faculty Surveys is correlated with lower board pass rate

Takeaway Point #2



- Programs in lowest BPR quartile (BPR below 80%) had more survey sections flagged as non-compliant than programs in the highest BPR quartile (BPR 93% or higher)

The surveys will be changing…

- New CPRs means resident and faculty surveys will need to be updated
- Survey experts have been hired to revise & update
- Requested input on survey items
- Committed to keeping as many current items that are clear unchanged, to allow for trend analysis
- Will go live in early spring of 2020

ACGME

Accreditation Council for Graduate Medical Education

e-Communication

March 13, 2019

Dear Colleauges,

The ACGME seeks participants to help evaluate new and existing questions in its annual Resident/Fellow and Faculty Surveys. These surveys are used to help monitor graduate medical education and measure compliance with accreditation requirements.

Assisted by the non-profit research institute, RTI International, the ACGME is recruiting interested participants for 90-minute interviews about survey questions designed to assess residents' and fellows' clinical and educational experiences. These interviews will also help inform development of future questions. All interview participants will receive $200 for their time. If interested in participating in the survey design, please visit **this website**.

To be eligible for the interviews, participants must:

- be a current resident, fellow, or faculty member in an ACGME-accredited program
- have access to a computer and web camera
- have ability to participate in an uninterrupted 90-minute session

E-mail questions to **GMEsurveys@rti.org**.

Information on the Resident/Fellow and Faculty Surveys

Thank you,

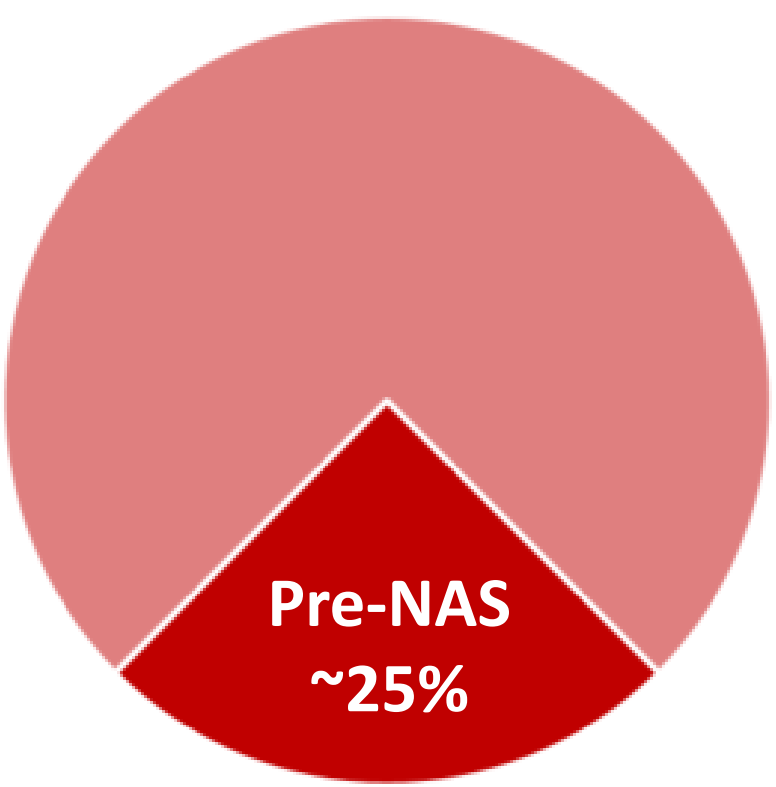
Survey Task Force
ACGME and RTI International

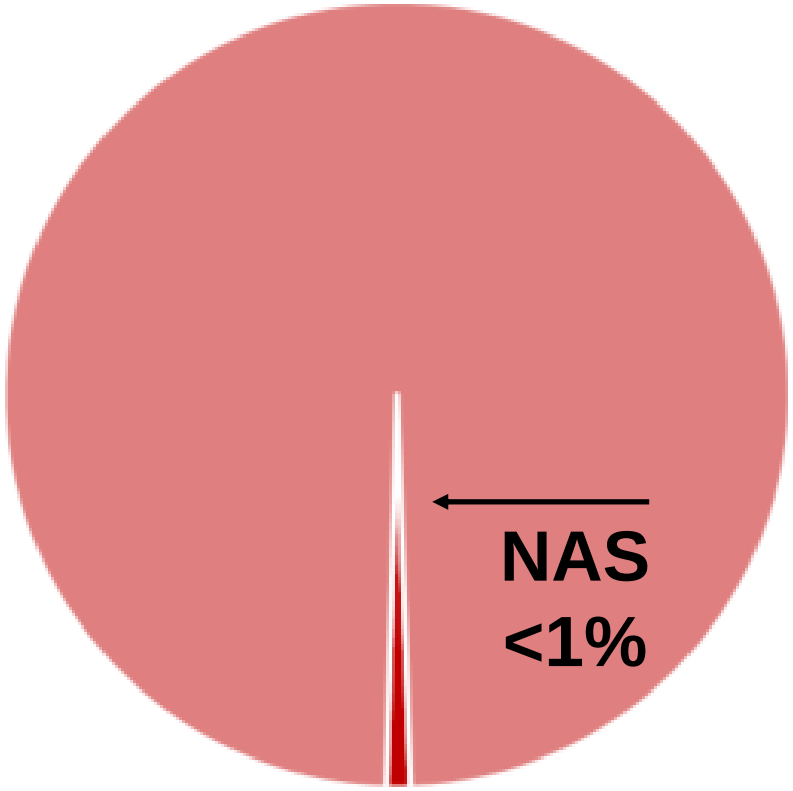
Also, ADS will be changing…

- ADS will also be updated as a result of new CPRs
- Edits being made with a mindfulness to burden
- Some new questions will be added…some current items will be removed

Six years in NAS…

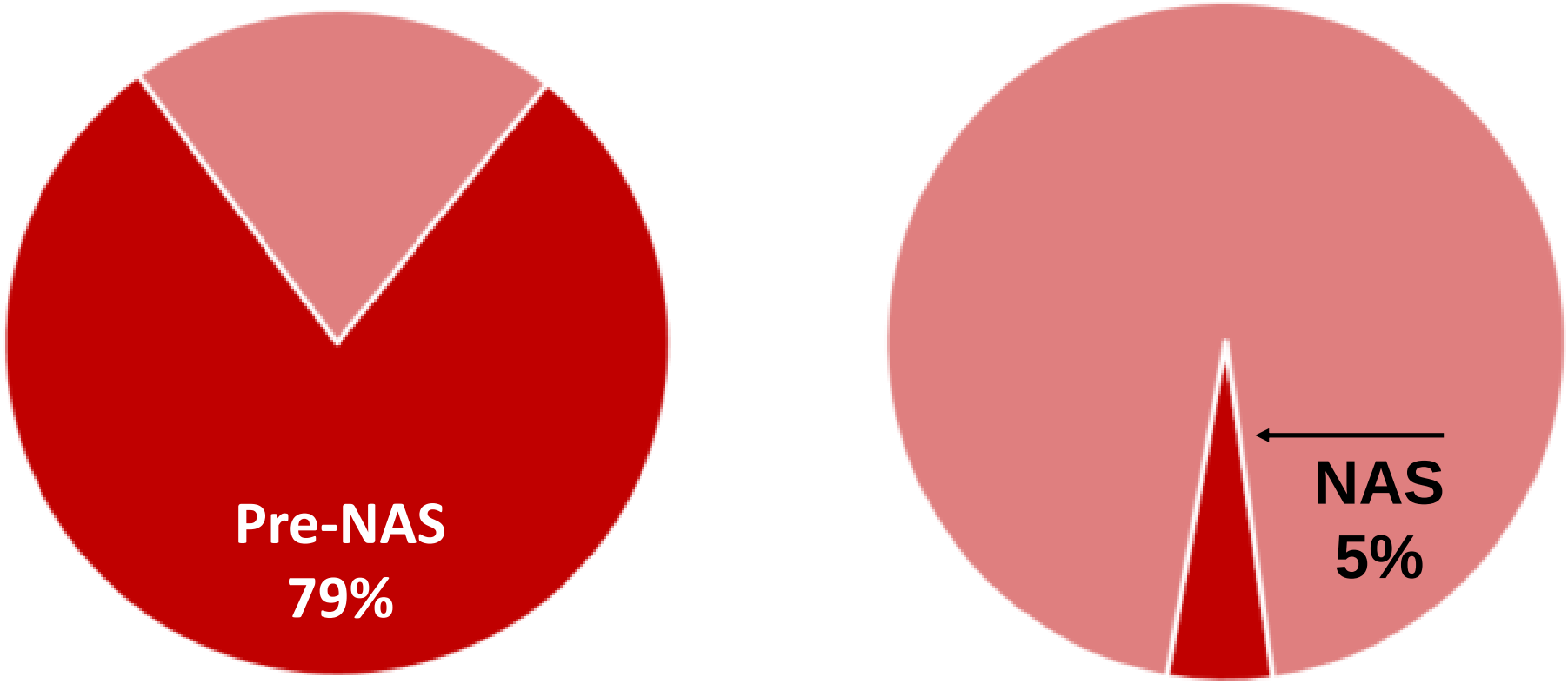
NAS: Fewer Site Visits





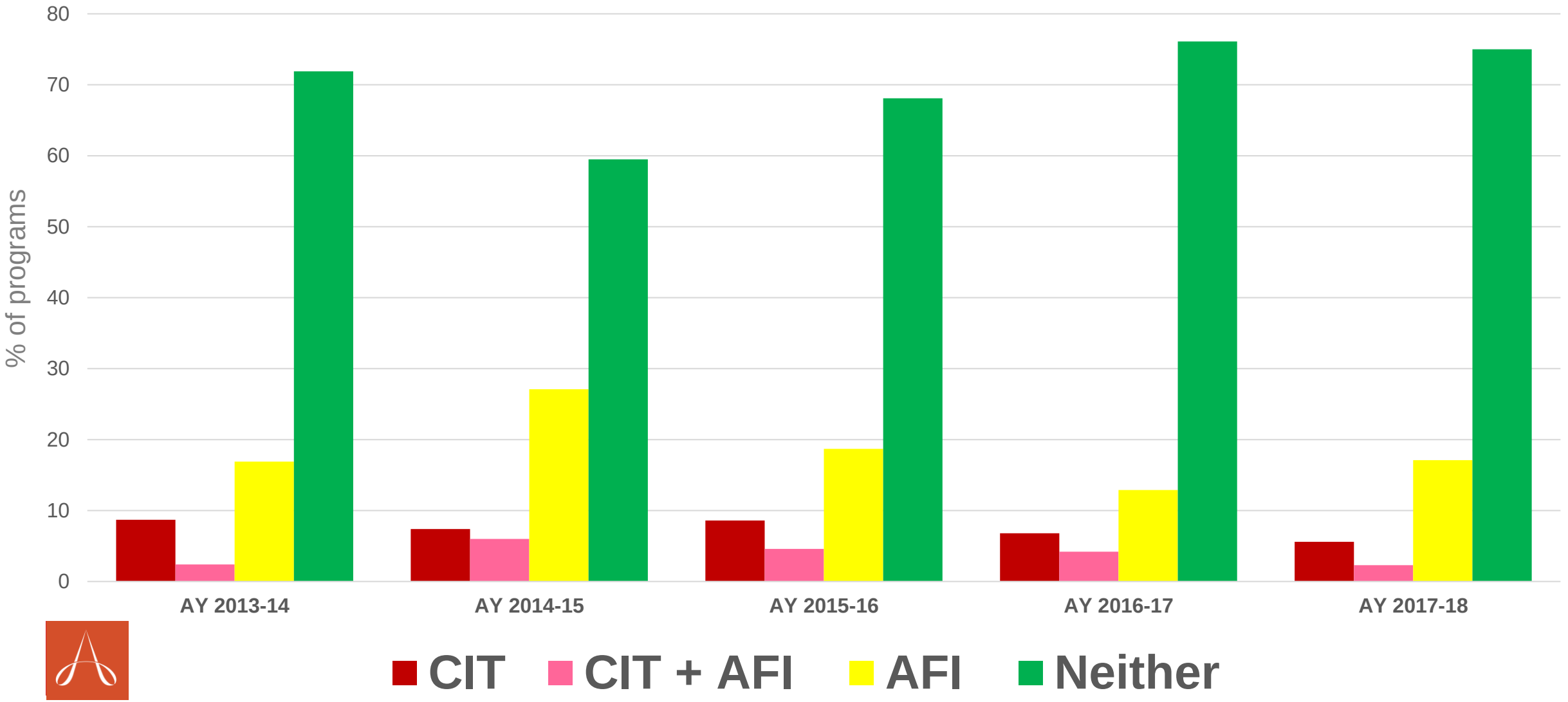
% of IM programs (core and sub) with site visits per year

NAS: Few programs have citations



% of IM programs (core and sub) with citations

NAS: Few core programs have citations

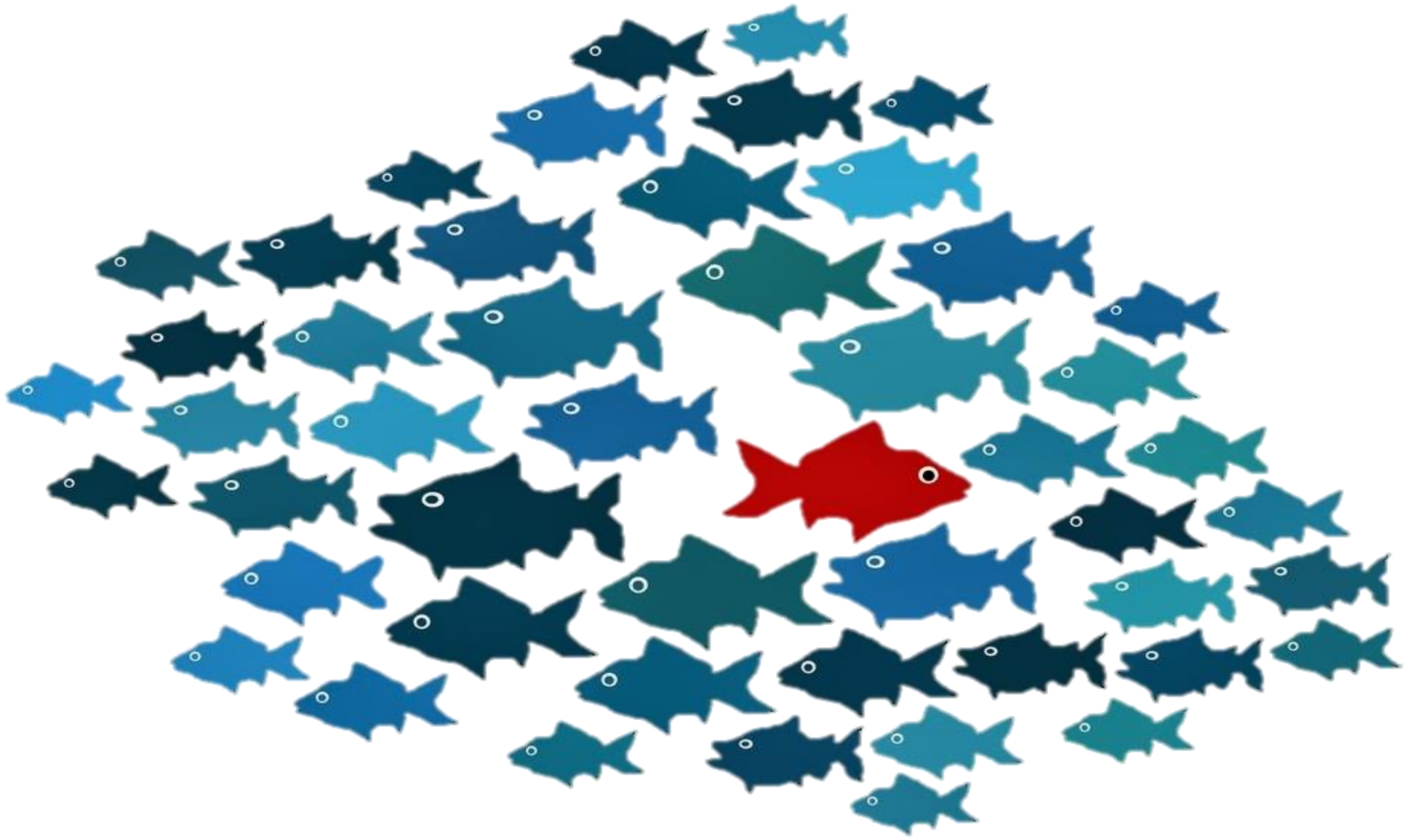


NAS Process: Continuous Improvement

- **Annual** Data Submission
- **Annual** ACGME Review
- **Annual** Program Evaluation (PEC)

Self-Study / 10-year Site Visit

NAS = Innovation

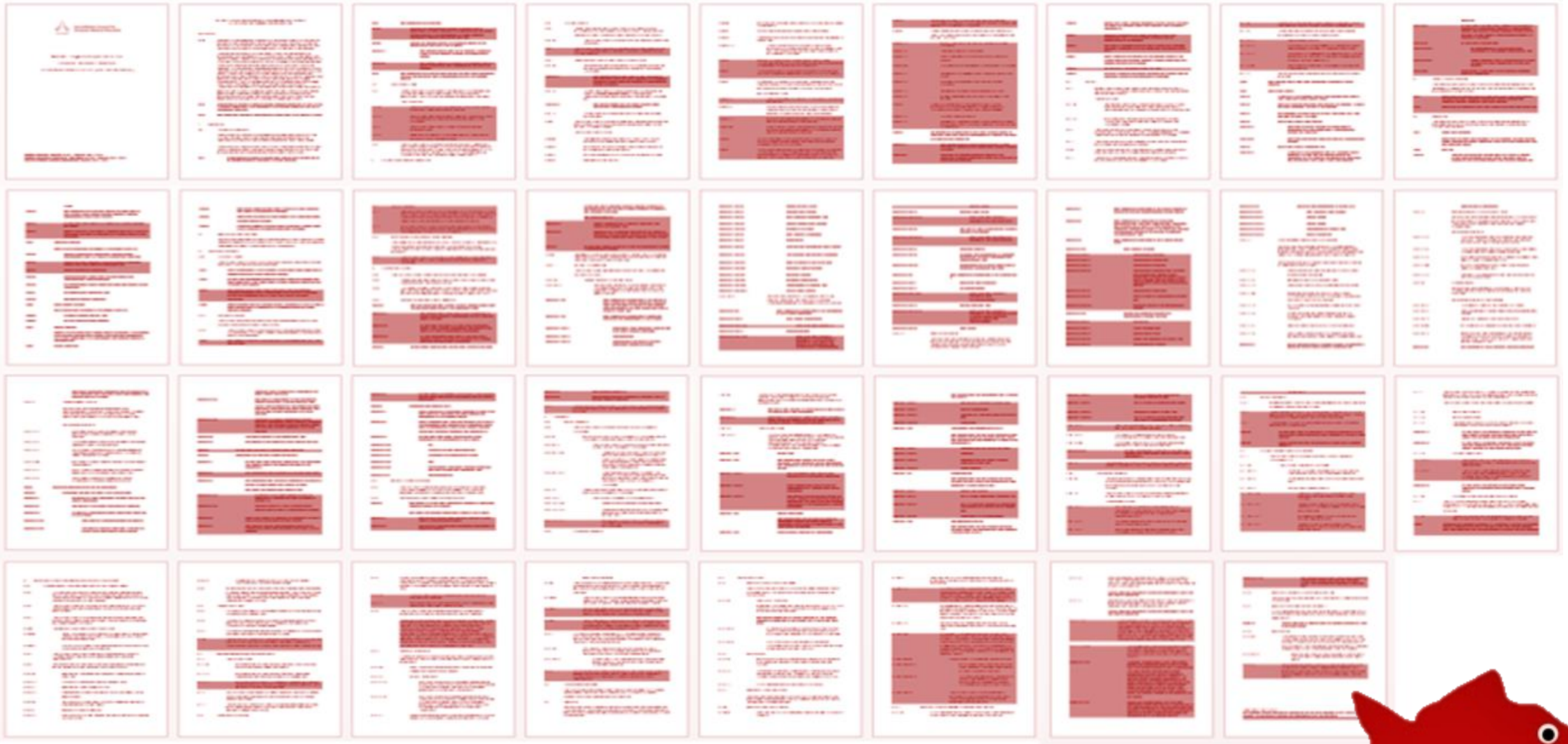


How does NAS promote innovation?

- In NAS PRs are categorized as *Outcome, Core* and *Detail*
  - *Outcome = specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents at key stages of their GME*
  - *Core = define structure, resource, or process elements essential to program.*
  - *Detail - describe a specific structure, resource, or process, for achieving compliance with a Core PR. Programs in substantial compliance with the Outcome PRs may use alternative or innovative approaches to meet Core PRs.*

- Programs in substantial compliance with *Outcome* and *Core* and PRs can innovate with *Detail* PRs.
  - *Detail* PRs do not go away, but PDs do not need to demonstrate compliance them, unless it becomes evident that *Outcome* or *Core* PRs are not being met.

“Detail” PRs



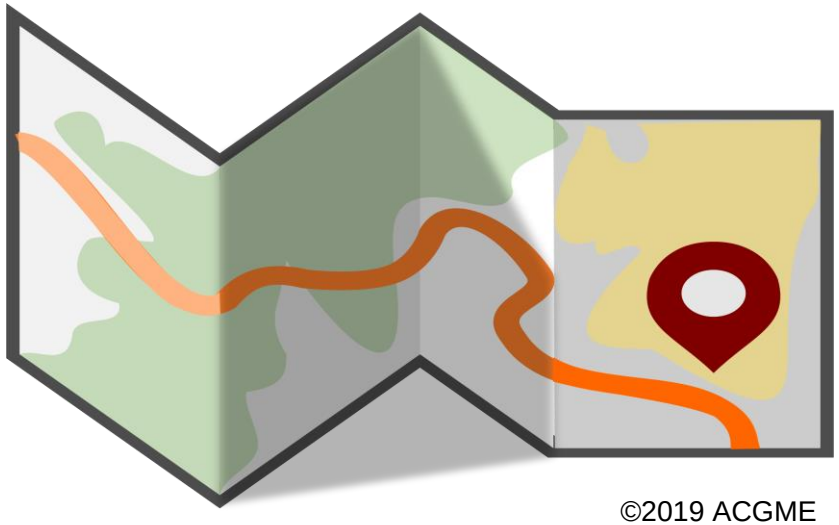
When can I innovate ?

- Applications and new programs at *Initial Accreditation* are expected to comply with all PRs.

- Innovation is a privilege of demonstrating substantial compliance with PRs over time → *Good Standing (continued accreditation and no/few citations)*

- *Take away message…*
  - *Something to consider in the future, and,*
  - *There are different types of PRs*

General Information: What does RC do?
Actions/Citations for SingleGME Applications/Programs
Changes to Requirements
NAS 101
NAS Lessons Learned from Self-Study/10-year visits
RC Members and Staff



NAS: Review every year; site visit every decade

- **Annual** Data Submission
- **Annual** ACGME Review
- **Annual** Program Evaluation (PEC)

Self-Study / 10-year Site Visit

RC's decision about self-study report

- At its April 2017 meeting, the RC decided that it will *not* provide programs feedback on their self-study.

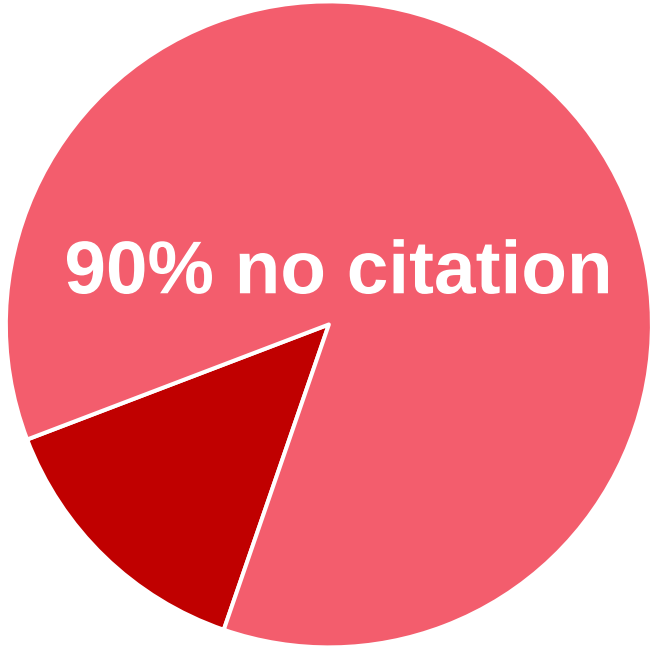
- It will provide feedback on compliance with requirements and allow the Department of Field Activities to provide the programs feedback on the self-study.

Summary of 10-year compliance visits

150 programs

- All programs on Continued Accreditation
- 5 years of mostly/entirely clean NAS screens

Results from 10-year compliance reviews…



If cited, received 1 citation, on average

Lessons learned from 10-year compliance visits

- Annual screening works
  - Multiple years clean NAS → positive accreditation outcomes

- Most programs do not receive any citations
  - If cited, on average, program receives a single citation

General Information: What does RC do?
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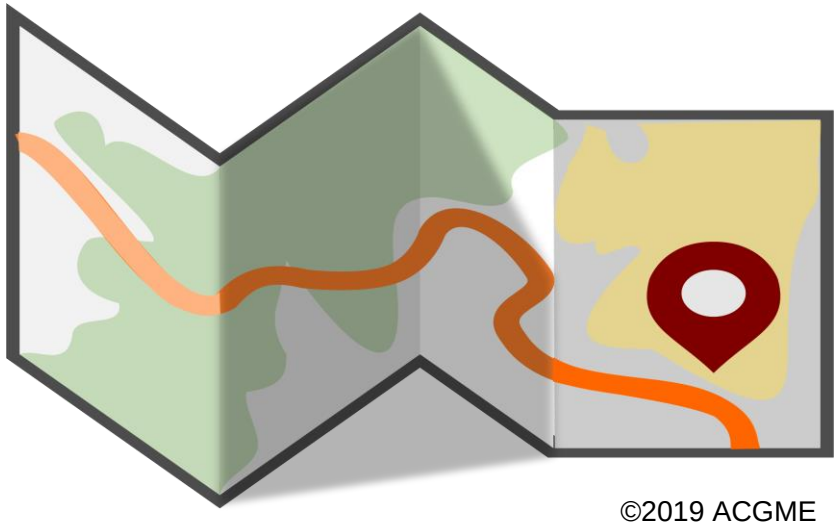
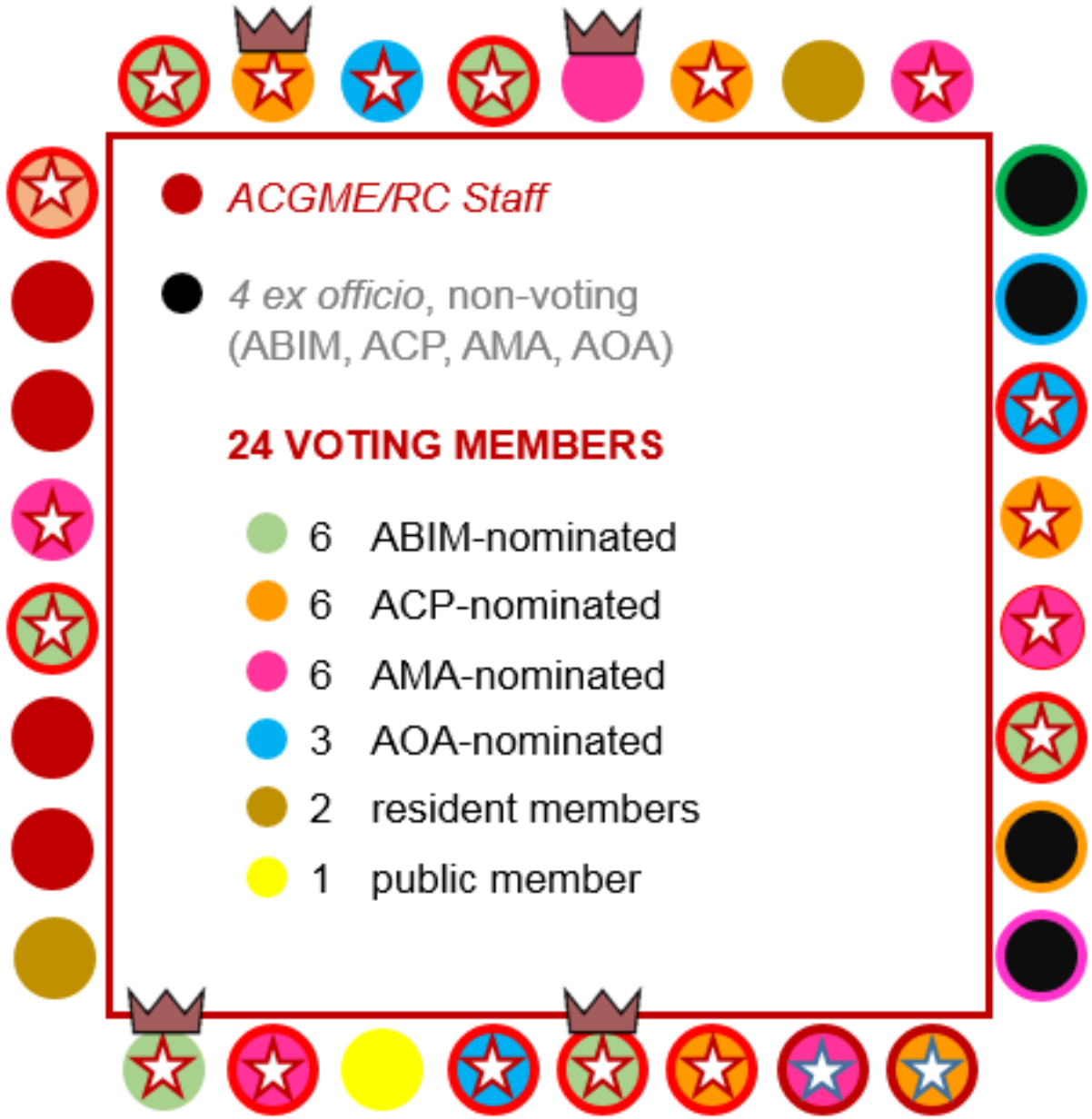


Who is the RC-IM?



Program Director

DIO

Subspecialist

Current Composition of the RC-IM

Chair: Christian Cable, MD *Hematology-Oncology*

Ruth Campbell, MD *Nephrology*

Alan Dalkin, MD *Endocrinology*

Andrew Dentino, MD *Geriatrics/PM*

Sanjay Desai, MD *PCCM*

Sima Desai, MD *GIM* **Chair-Elect**

Jessica Deslauriers, MD **Resident Member**

Oren Fix, MD *Transplant Hepatology*

Christin Giordano McAuliffe, MD **Resident Member**

Russ Kolarik, MD *Med-Peds*

Monica Lypson, MD *GIM*

Vice Chair: Brian Mandell, MD *Rheumatology*

Elaine Muchmore, MD *Hematology-Oncology*

Cheryl O'Malley, MD *GIM*

Amy Oxentenko, MD *GI*

Jill Patton, DO *GIM*

Kristen Patton, MD *CCEP*

David Pizzimenti, DO *GIM*

Donna Polk, MD *Cardiology*

Samuel Snyder, DO *Nephrology*

David Sweet, MD *GIM*

Jacqueline Stocking, RN, PhD **Public Member**

Heather Yun, MD *ID* **Vice Chair-Elect**

Alejandro Aparicio, MD ***ex officio*, AMA**

Davoren Chick, MD ***ex officio*, ACP**

Furman McDonald, MD ***ex officio*, ABIM**

Don Nelinson, PhD ***ex officio*, AOA**

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Ousted, June 2019

As of July 1, 2019: Composition of the RC-IM

Ruth Campbell, MD *Nephrology*

Alan Dalkin, MD *Endocrinology*

Andrew Dentino, MD *Geriatrics/HPM*

Sanjay Desai, MD *PCCM*

Chair: Sima Desai, MD *GIM*

Jessica Deslauriers, MD **Resident Member**

Oren Fix, MD *Transplant Hepatology*

Gerald Fletcher, MD **Resident Member**

Russ Kolarik, MD *Med-Peds*

Monica Lypson, MD *GIM*

Alice Ma, MD *Hematology-Oncology*

Elaine Muchmore, MD *Hematology-Oncology*

Cheryl O'Malley, MD *GIM*

Michael Pillinger, MD *Rheumatology*

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Sheila Tsai, MD *Sleep Medicine*

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Davoren Chick, MD ***ex officio*, ACP**

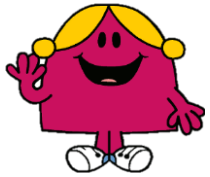
Furman McDonald, MD ***ex officio*, ABIM**

Don Nelinson, PhD ***ex officio*, AOA**

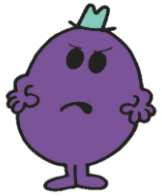
Noobs, July 2019

Questions?
Please contact RC-IM Staff

Christine Gillard *cgillard@acgme.org*
Accreditation Administrator *312.755.7094*

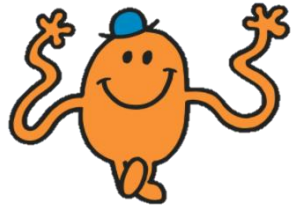


William Hart *whart@acgme.org*
Associate Executive Director *312.755.5002*



Karen Lambert *kll@acgme.org*
Associate Executive Director *312.755.5785*

Jerry Vasilias, PhD *jvasilias@acgme.org*
Executive Director *312.755.7477*



"I'm looking for that special someone to hate."