



Review Committee/ACGME Update

ACOI 2018 Annual Congress on Medical Education

Friday, April 27

Jerry Vasilias, PhD

Executive Director, Review Committee for Internal Medicine

No conflicts to disclose



Plan for Session

General Information Related to Work of the Review Committee

Update on Actions for IM Applications

Update on Actions for SUBSPECIALTY Applications

RC-IM's Position on SingleGME

New Requirements

NAS 101

RC Members and Staff



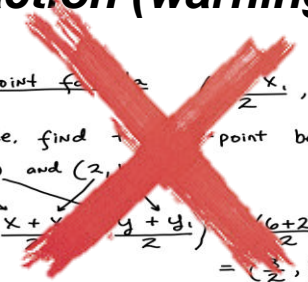
What does the RC do?

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



What does the RC review?

- RC reviews applications and programs to determine **substantial compliance** with minimum PRs
- Areas of non-compliance may be identified
 - **Substantial compliance** even with areas of non-compliance
- The big question...
 - **What's the "tipping point"? What combination of citations leads to an undesirable (continued pre-accreditation) or adverse action (warning, probation, or withdrawal)?**
 - There is no formula: **peer review process**



Mid-point formula: $\left(\frac{x_1 + x_2}{2}, \frac{y_1 + y_2}{2} \right)$

Example, find the mid-point between $(6, 2)$ and $(2, 10)$

$$\left(\frac{x_1 + x_2}{2}, \frac{y_1 + y_2}{2} \right) = \left(\frac{6+2}{2}, \frac{2+10}{2} \right)$$
$$= \left(\frac{8}{2}, \frac{12}{2} \right)$$
$$= (4, 6)$$

$(4, 6)$ is halfway between $(6, 2)$, $(2, 10)$



“Areas of non-compliance”?

RC communicates noncompliance with requirements via...

Citations

- **Require response in ADS**

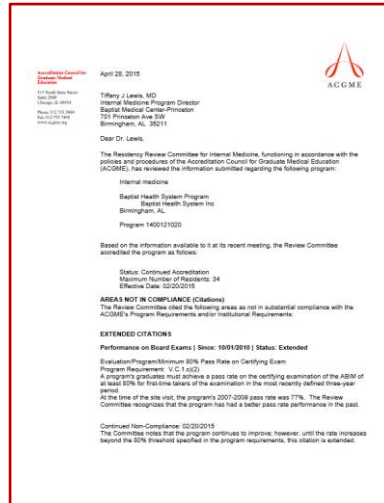
AFI = “Areas for Improvement”

- **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?

- PD + DIO will receive an email w/ RC's decision w/in 3-5 *business days* of the RC meeting.
- A letter of notification follows 6-8 weeks later that will detail areas of non-compliance, if any.



When can a subspecialty application be submitted?

- Subs are considered *dependent*.
- Subs must be associated with core program in same sponsoring institution.
- A sub application can be initiated after the core program has received *Pre-Accreditation*.
- A sub application cannot be submitted in ADS until its core receives *Initial Accreditation*.



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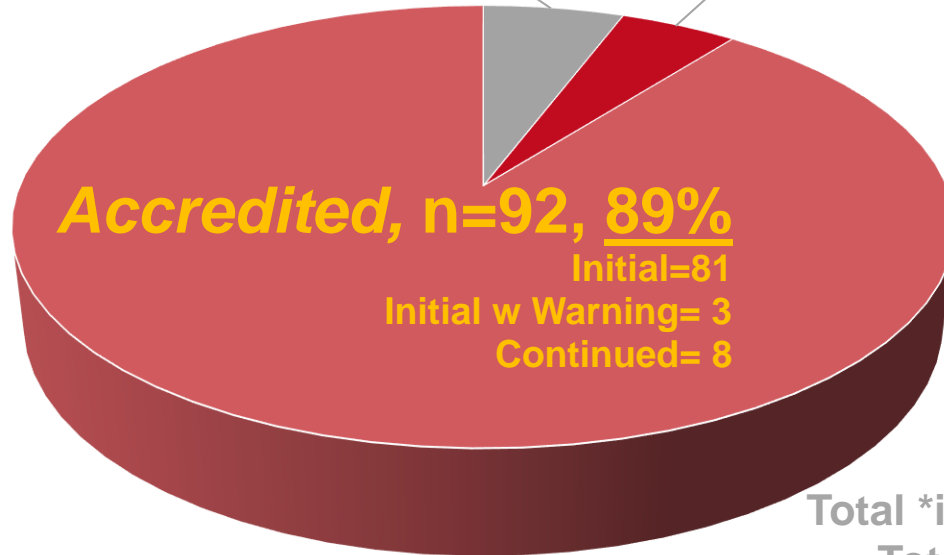


Actions for SingleGME CORE programs

From beginning through recent RC meeting

Expected to Apply, n=6, 6%
“Working on app”= 5
Open app in ADS=1

Applied, n=5, 5%
Pre-Accred=1
Cont-Pre=4



99%
in

Total *in* + Expected to Apply = 103

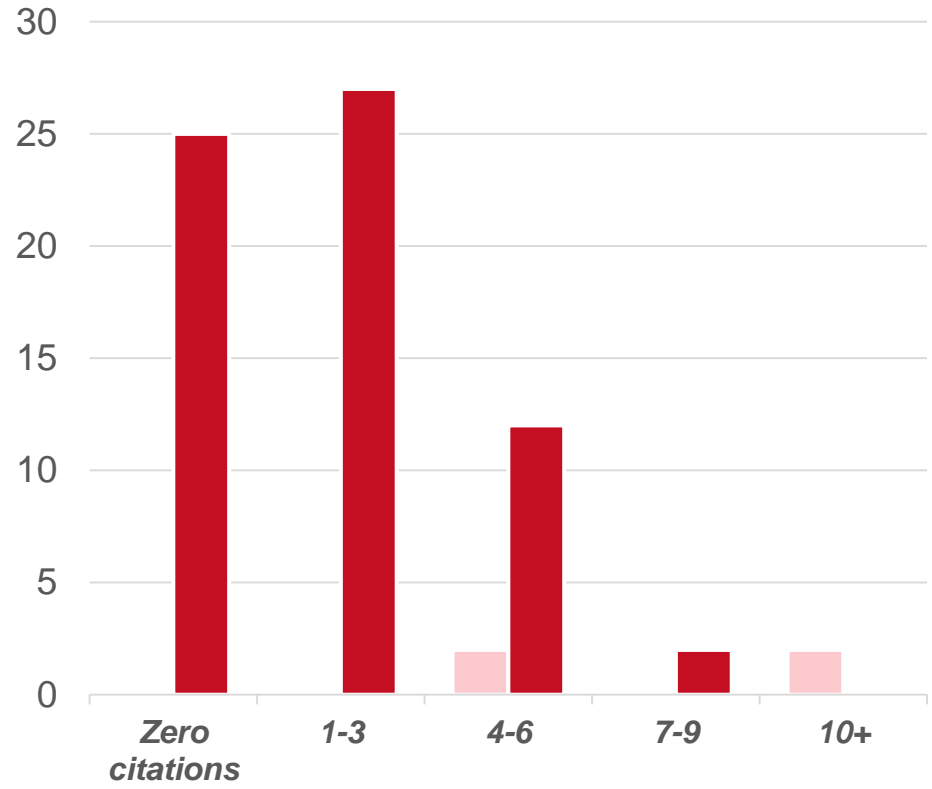
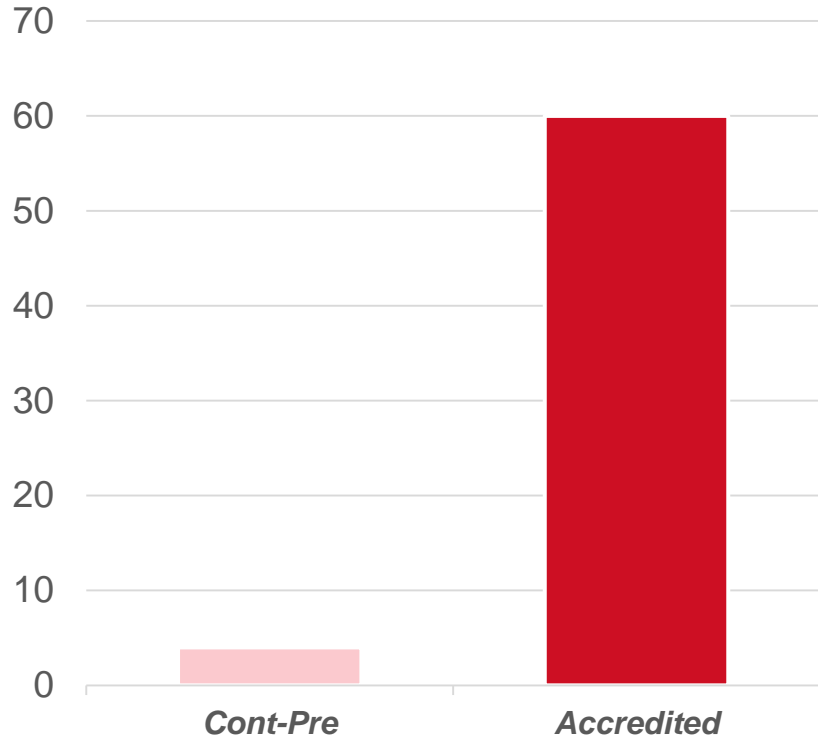
Total Not expected to apply = 46

Closing or closed = 14

Dual or merging = 32



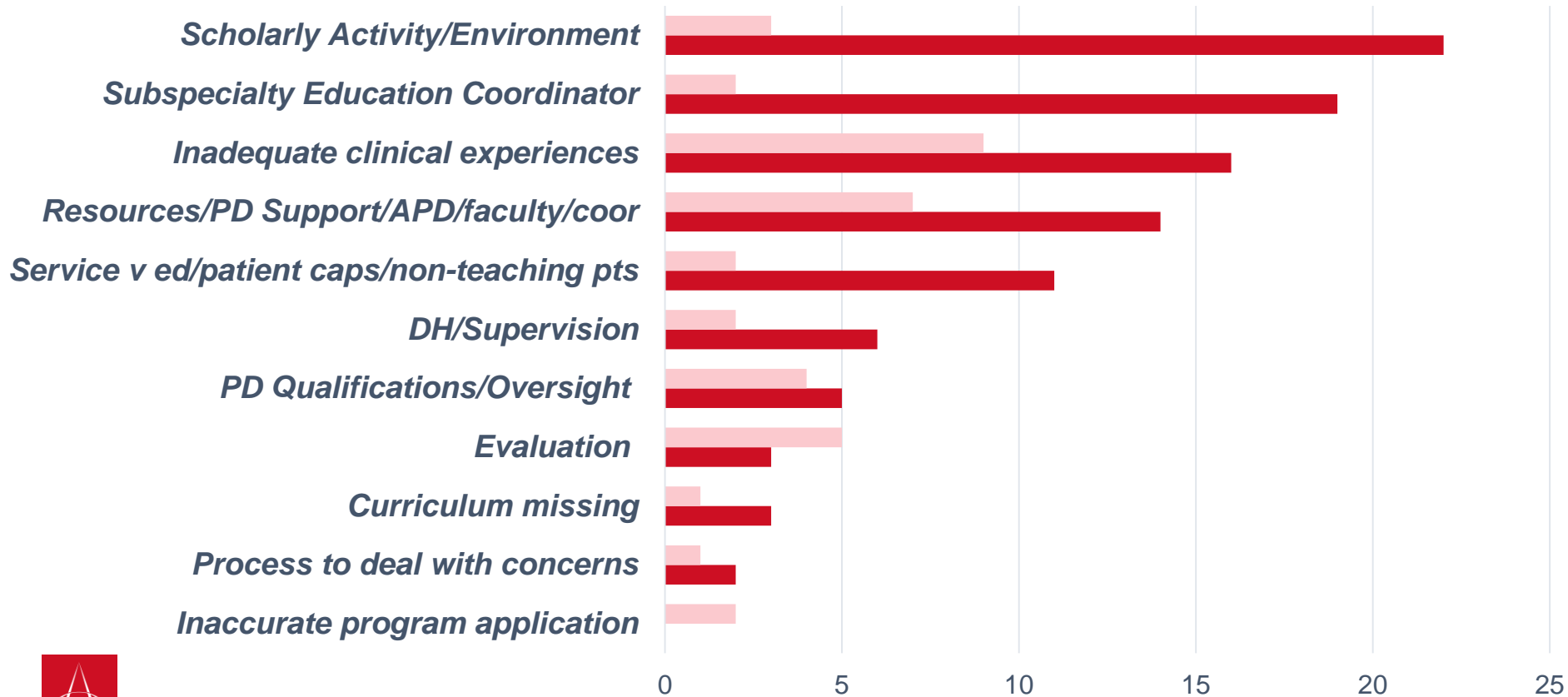
of citations for core applications AY17-18: Accredited vs Cont-Pre



total # of programs x status

of citations x status

Core programs in AY17-18: types of citations



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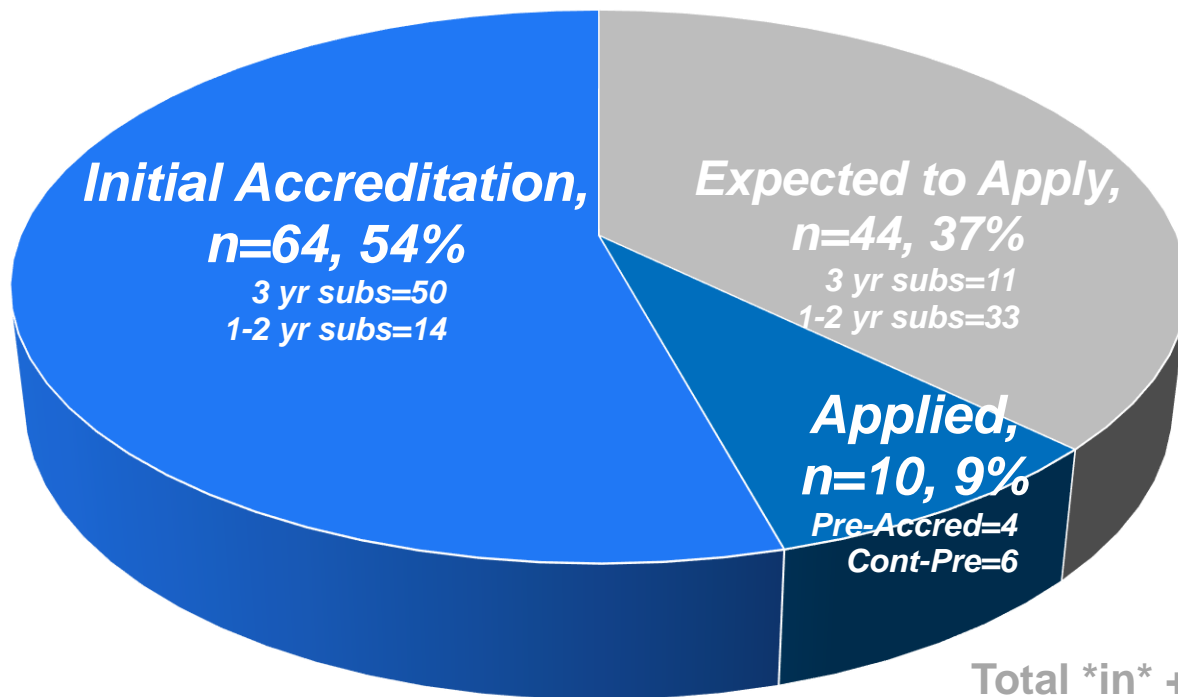
NAS 101

RC Members and Staff



Actions for SingleGME SUBs

From beginning through recent RC meeting



63%
in

Total *in* + Expect to Apply = 118

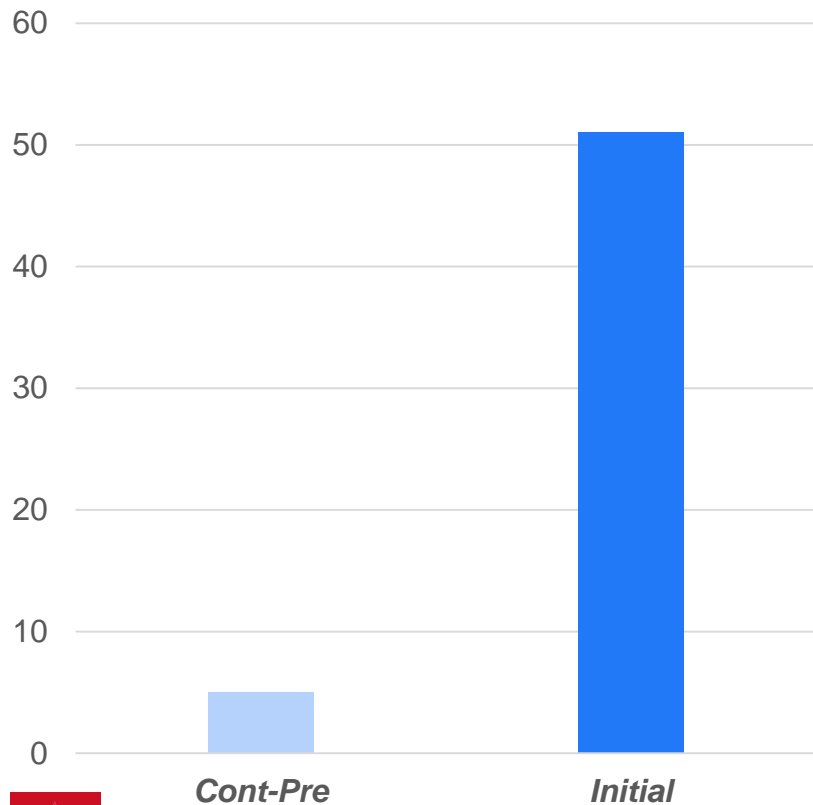
Total Not expected to apply = 55

Closing or closed = 21

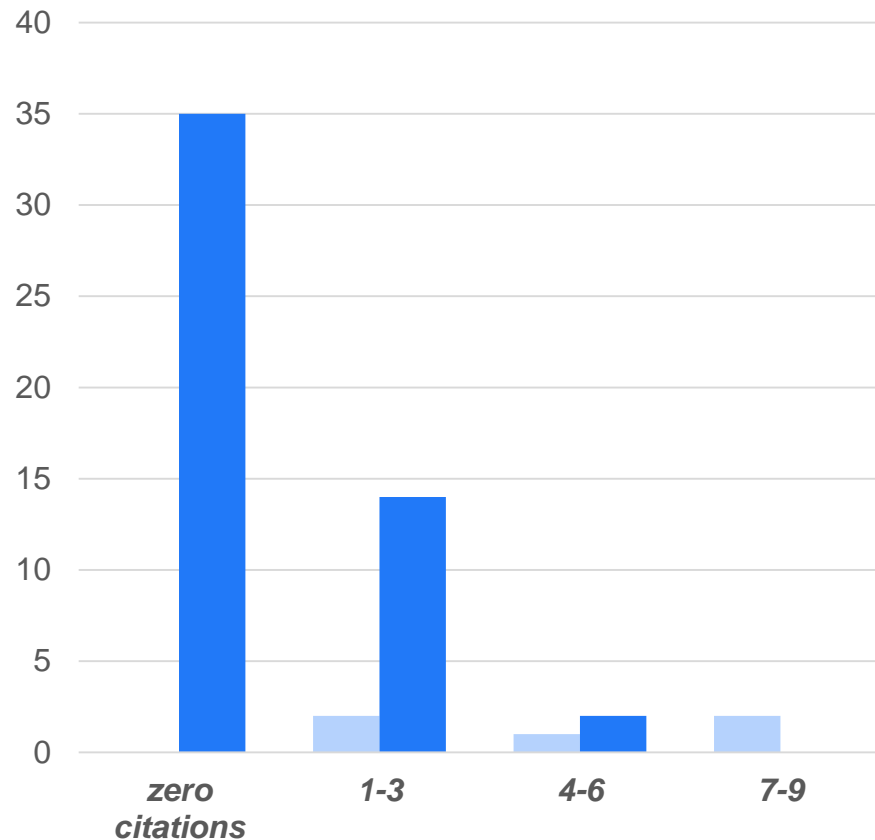
Dual or merging = 34



of citations for sub applications AY17-18: Initial vs Cont-Pre



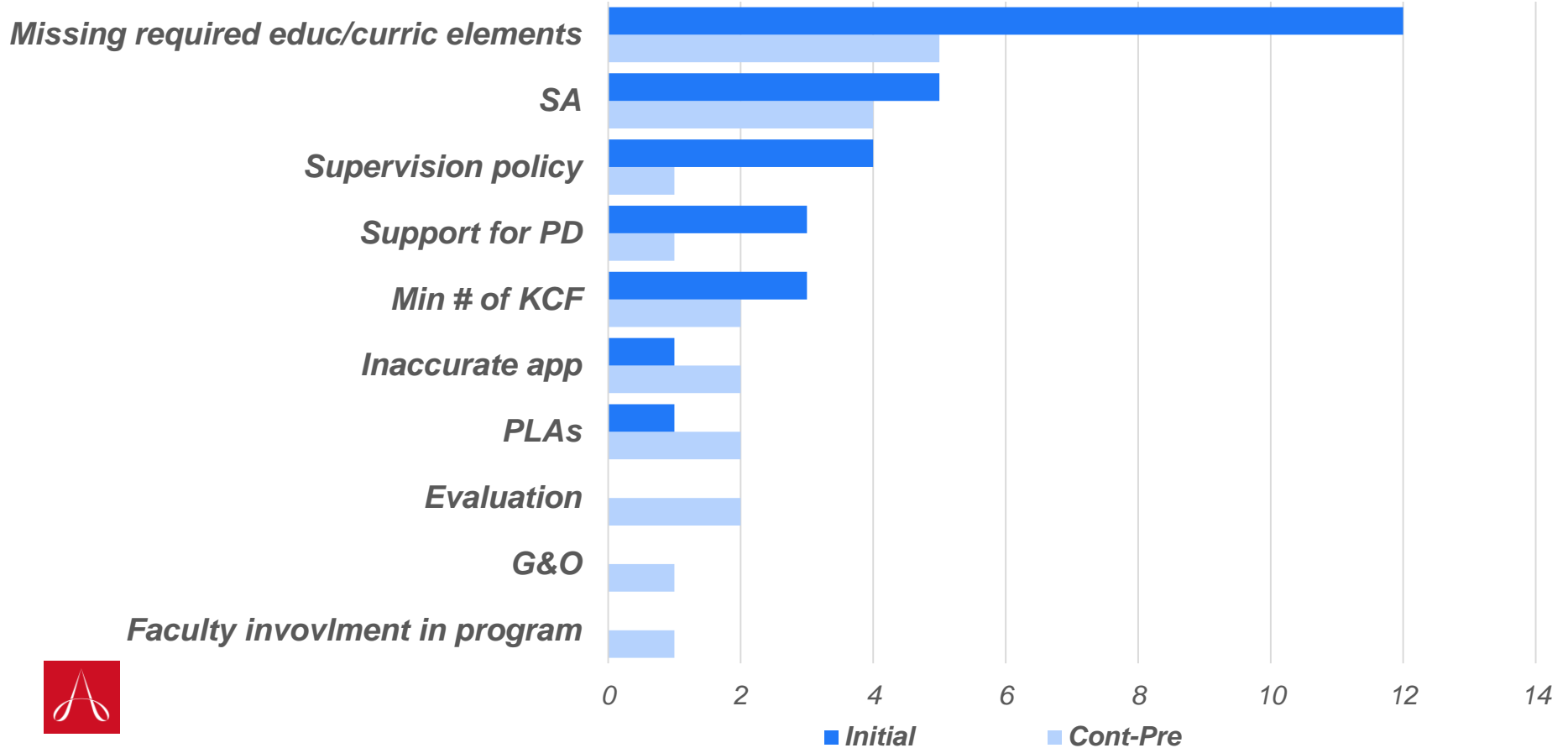
total # of programs x status



of citations x status



Types of citations for subs in AY17-18: Initial vs Cont-Pre



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Expectations for Single GME applications

PD, APD, CF, KCF, SEC...AOA is AOK!



Expectations for non-Single GME applications

PD, APD, CF, KCF, SEC...AOA is AOK!



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Or...Changes to Requirements



PHASE I: Revision of Section VI of CPRs

Vetted in winter of 2016.

Reviewed and approved by ACGME Board in 2/2017; effective 7/2017

The biggies ...

- **Eliminated 16 hour rule for PGY1s**
 - ***Holding all residents to same clinical and educational work hours***
- **New sections → patient safety, quality improvement, well-being**
 - ***Effective date of implementation July 1, 2017***
 - ***Assessment of new sections will not be cited until 2019.***
- **Introducing flexibility**
 - ***No longer need to document situations where exceed 24 hours***
- **Potential for burden**
 - ***New PRs related to patient safety, quality improvement and well-being***
 - ***Counting work at home as part of 80 hours***



PHASE II: *Revision of Sections I-V of CPRs*

Accreditation Council for
Graduate Medical Education

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MEMO

DATE: February 6, 2018
FROM: Thomas J. Nasca, MD, MACP, Chief Executive Officer,
Accreditation Council for Graduate Medical Education (ACGME)

The Phase 2 Common Program Requirements Task Force completed its preliminary work on Sections I-V. The proposed Requirements, along with an Impact Statement, are now available for review and comment through Tuesday, March 22, 2018. Based on input received during this public comment period, the Task Force will submit the final proposed requirements to the ACGME Board of Directors for approval, with implementation targeted for July 1, 2019.

This is the second and final phase of the Common Program Requirements review process. The ACGME Board of Directors initiated this periodic review and revision of the Common Program Requirements in the fall of 2015. Phase 1 was completed with ACGME Board approval of revisions to Section VI in February 2017; those changes became effective July 1, 2017 for both residency and fellowship programs.

To address inherent differences in specialty and subspecialty training, the Phase 2 Task Force developed two sets of Common Program Requirements – one specific to residency programs, and a separate set for fellowships. The fellowship version applies to all subspecialty programs, regardless of program length, and will replace the separate One-Year Common Program Requirements. Section VI, previously approved, will remain identical for both residency and fellowship programs.

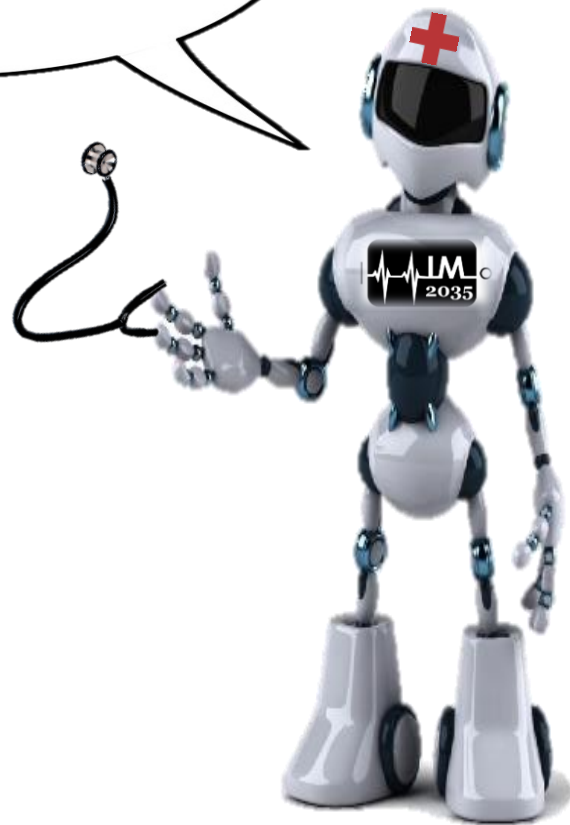
The *biggies* in the proposed revisions in Sections I-V

- Almost all are “core” PRs
- 2 sets – residency and fellowship
- *Mission* and *aims*
- Some CPRs removed to go into to-be-created PD Guide
- **AOA certification acceptable for physician faculty**
- “Core Faculty” is now in the CPRs
- Coordinator support in residency CPRs, 50%FTE
- SA overhauled
- More language in the APE
- New certification exam CPRs

***To be reviewed at June ACGME Board meeting.
If approved, effective July 2019.***



*What will the practice of
medicine look like in 2035?*





Scenario planning...

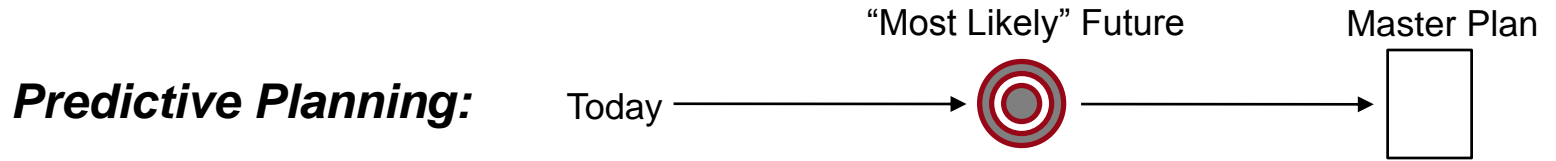
- We are using *scenario planning* to revise the program requirements.
- This is new. The RC-IM is the first RC to do this.
- Scenario planning was used by the ACGME BOD in 2013-14
- Intent is not to predict what the future will be and then build a master plan.
- Intent ...
 - *is to ask what the future might hold, and*
 - *identify the actions that can be taken today that are most likely to be valuable regardless of how the future turns out.*



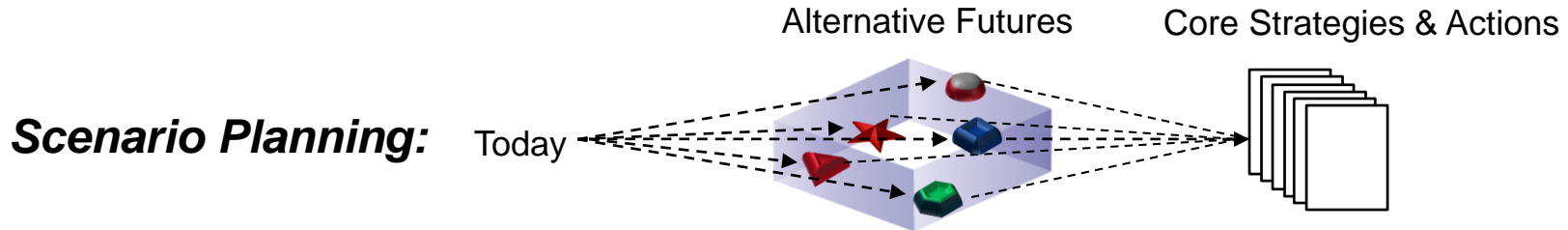
<http://www.jgme.org/doi/pdf/10.4300/JGME-D-14-00740.1>



Scenario planning is about avoiding the “most likely future” trap...



...and building plans on alternative futures

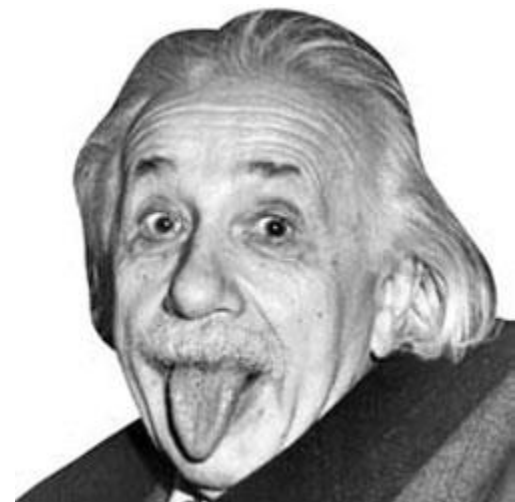
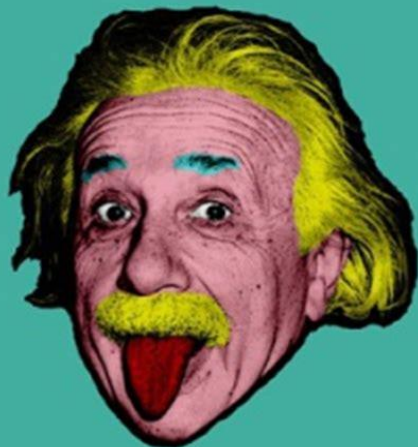




First, we need to imagine the futureS...

“Imagination is more important than knowledge. Knowledge is limited.

***For while knowledge defines all we currently know and understand,
imagination points to all we might yet discover and create.”***





This is a pilot. The RC-IM is the first to use scenario-planning.

IM2035 Workshop #1 – June 2017

- ***Participants from the IM community and beyond...***
- ***Used 4 scenarios and process ACGME Board used in 2013-14***
- ***Focus of workshop: what does *IM* look like in each of the 4 scenarios?***

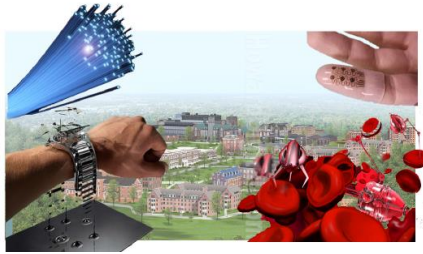
IM2035 Workshop #2 – September 2017

- ***RC members and a subset of participants from June workshop***
- ***Scenarios from June workshop are updated with IM content***
- ***Focus of workshop:***
 - ***What should the RC consider to prepare the internist for each of the 2035 futures?***
 - ***What does the internist of the future look like?***
 - ***What does the internist of the future need to *know*?***



There's an App for That, Too?

U.S. Economy Vitality	The Social Contract	Type of Change	Healthcare as a Percentage of GDP	Globalization
Strong	Broad/Expansive	Revolutionary	Increasing	Increasing



Cloudburst

U.S. Economy Vitality	The Social Contract	Type of Change	Healthcare as a Percentage of GDP	Globalization
Weak	Broad/Inclusive	Revolutionary	Increasing	Decreasing



Boom-doggie

U.S. Economy Vitality	The Social Contract	Type of Change	Healthcare as a Percentage of GDP
Weak	Limited or Exclusive	Evolutionary	Increasing



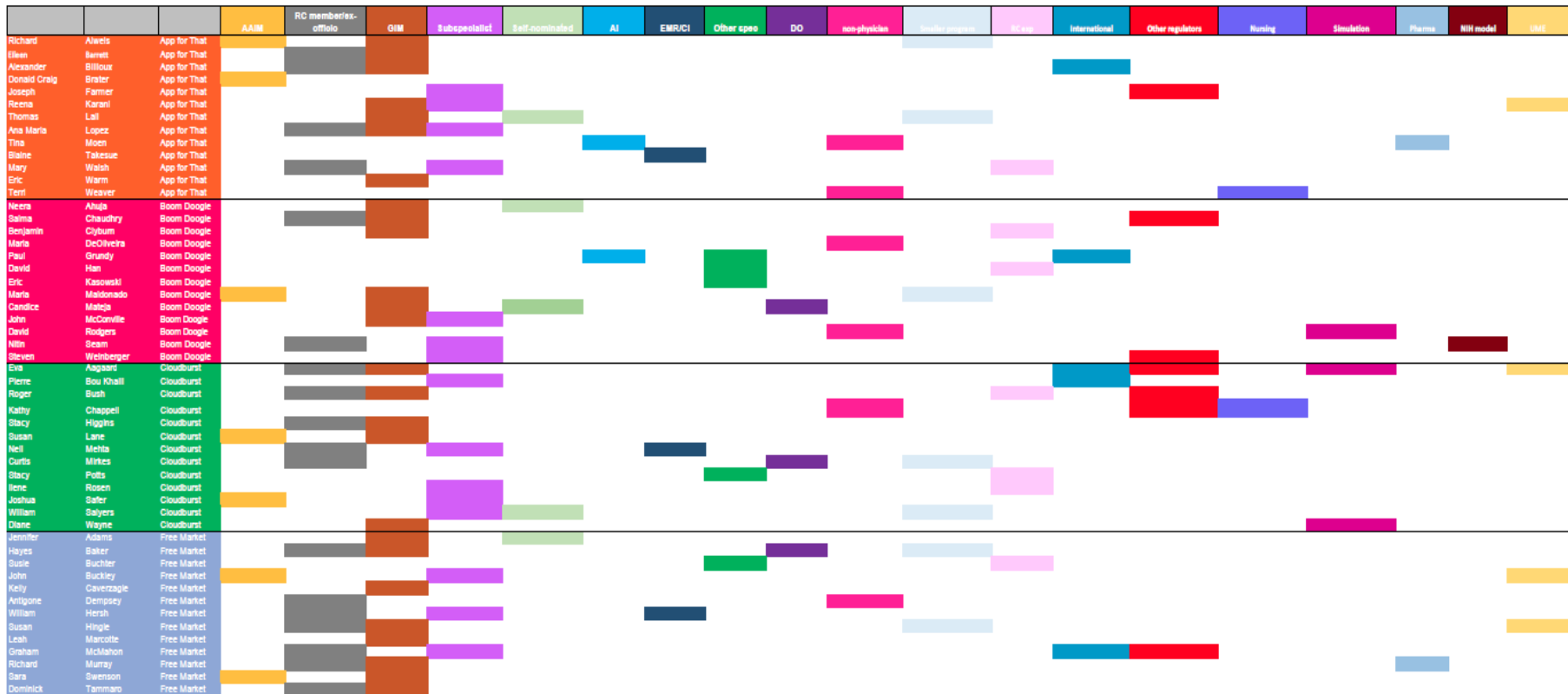
Free Markets Unchained

U.S. Economy Vitality	The Social Contract	Type of Change	Healthcare as a Percentage of GDP	Globalization
Strong	Limited or Exclusive	Revolutionary	Decreasing	Militarily isolationist, but U.S. economy engaged globally





Broad and diverse participants





June Workshop





This is a pilot.

IM2035 Workshop #1 – June 2017

- *Participants from the IM community and beyond...*
- *Used the 4 scenarios and process ACGME Board used in 2013-14*
- *Focus of workshop: what does *IM* look like in each of the 4 scenarios?*

IM2035 Workshop #2 – September 2017

- *RC members and a subset of participants from June workshop*
- *Scenarios from June workshop are updated with IM content*
- *Focus of workshop:*
 - *What should the RC consider to prepare the internist for each of the 2035 futures?*
 - *What does the internist of the future look like?*
 - *What does the internist of the future need to *know*?*

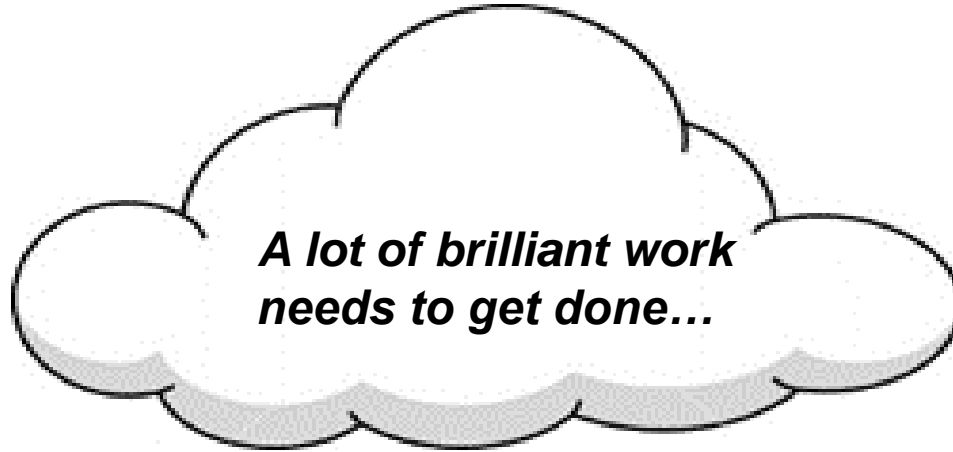


September Workshop





Timeline (circa fall of 2017)



***A lot of brilliant work
needs to get done...***

June 2017

IM2035 Workshop #1

IM & non-IM discuss IM in 2035

Sept 2017

IM2035 Workshop #2

RC & non-RC

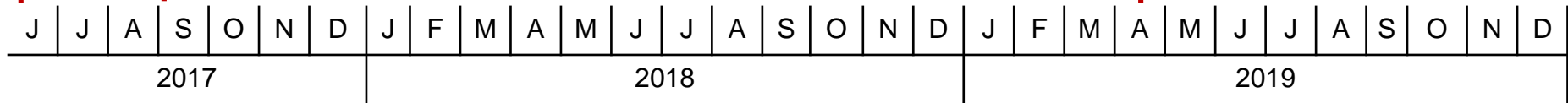
Early 2019

45 day review-and-comment period

Sept 2019

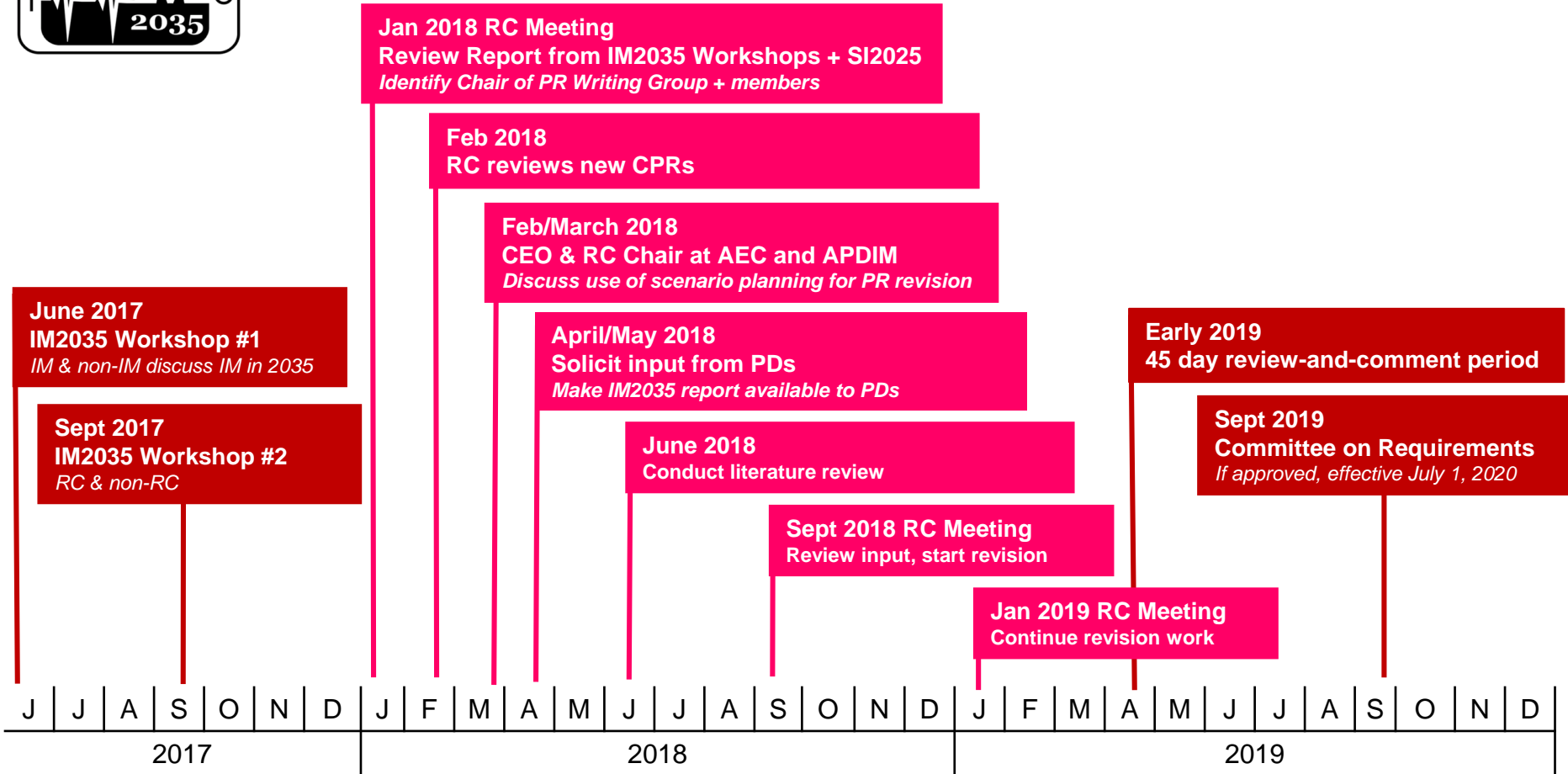
Committee on Requirements

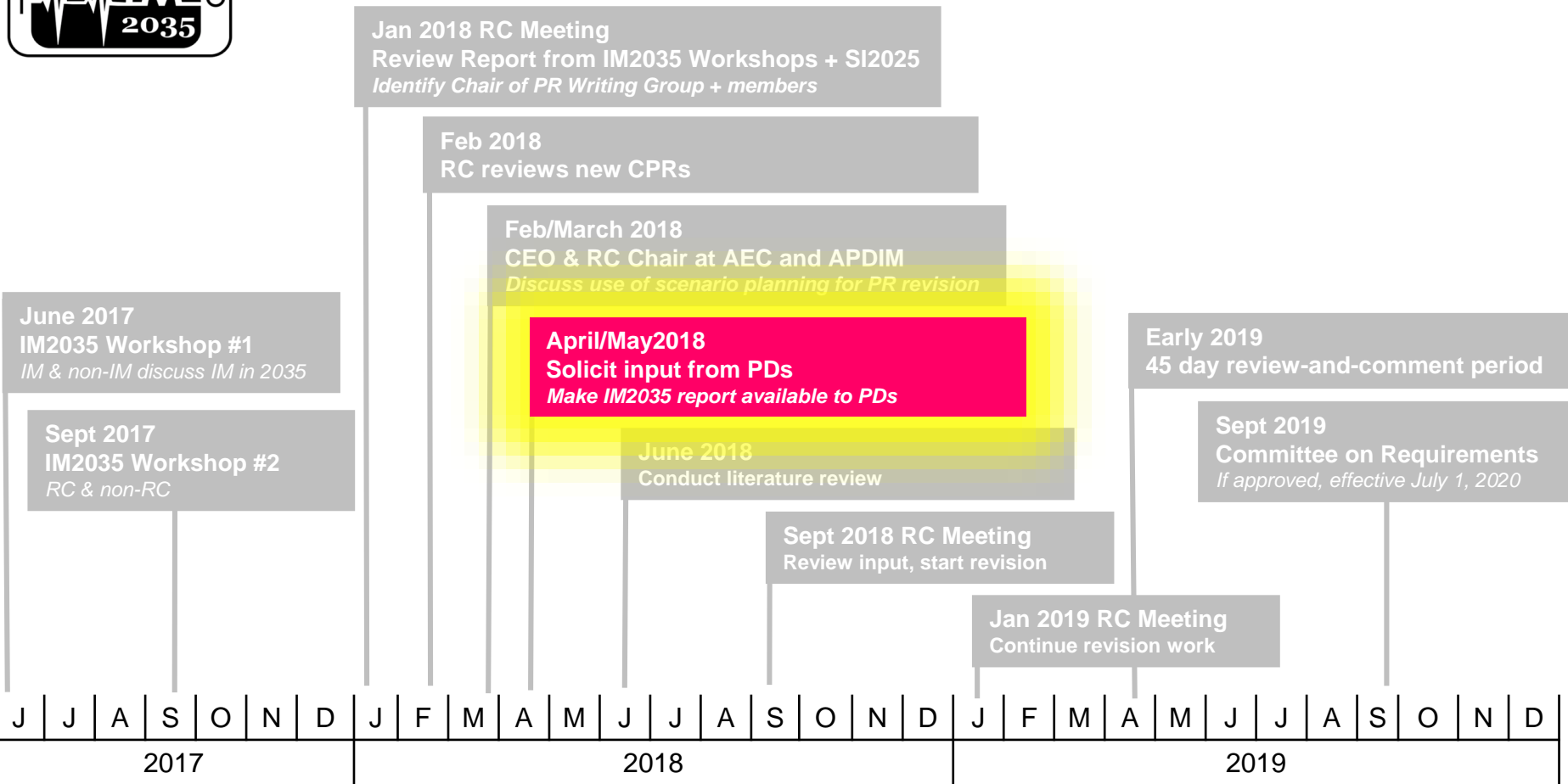
If approved, effective July 1, 2020





More Specific Timeline (as a result of January RC meeting)

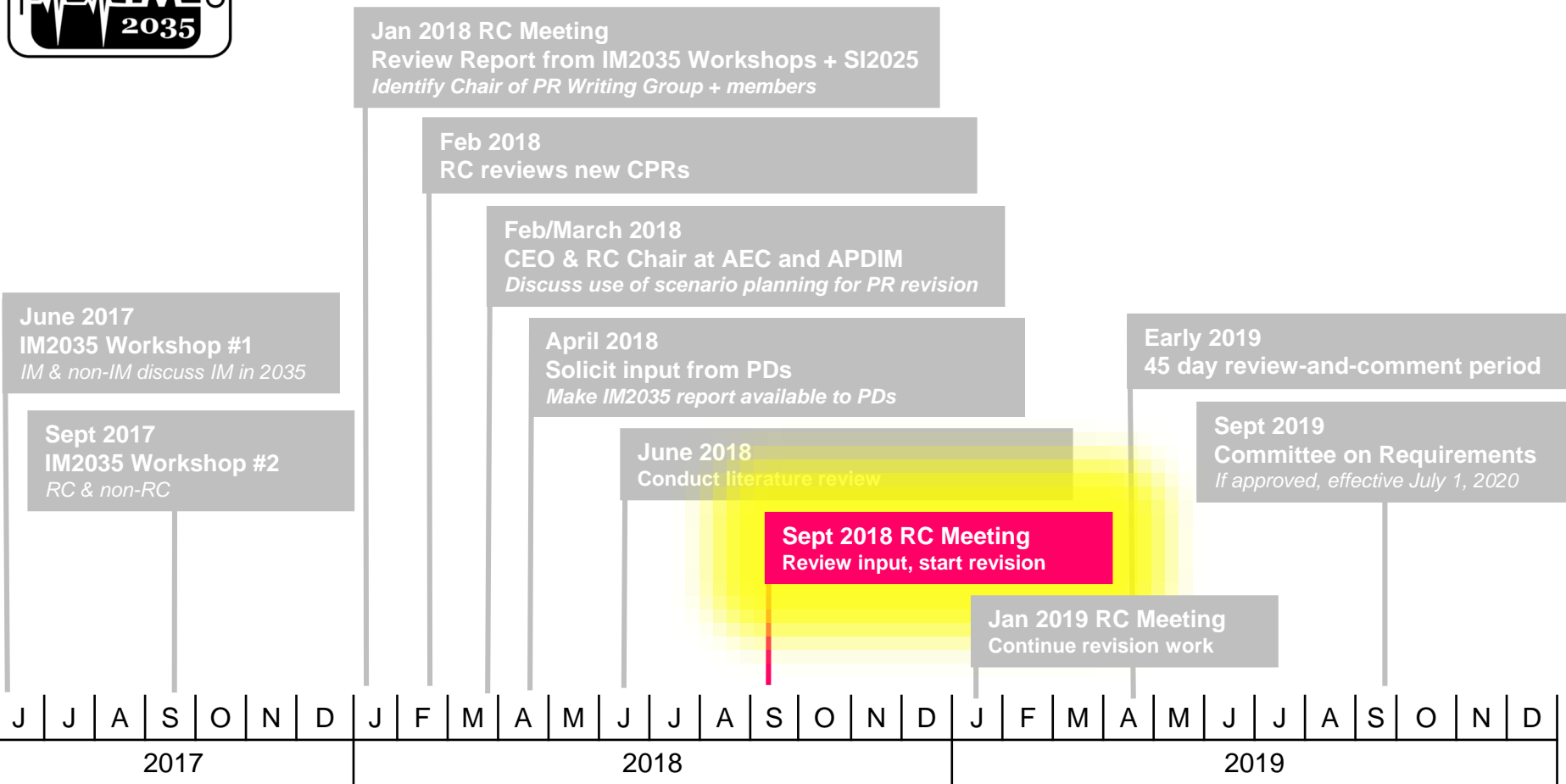






April/May 2018
Solicit input from PDs
Make IM2035 report available to PDs

- In accordance with ACGME policy, the GME community will be invited to comment on *current* IM PRs
 - *Who will be asked?* All major stakeholders. GIM + subspecialists
 - *Comment on?* What should be kept, removed, added, revised...
- Invitation will include *current* IM PRs in *new* CPR format
 - Even though new CPRs will not be approved until June
- IM2035 report will be included
 - To share insights from workshops, and
 - Encourage thinking about the future





Insights from IM2035
+
New CPRs
+
Literature review
+
Community input

Sept 2018 RC Meeting
Review input, start revision

Related to PRs, but not PRs...FAQs



Plan for Session

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NAS 101

RC Members and Staff



What happens when receive “continued accreditation?”

How does RC review established programs?

NAS – ~~Next~~ NOW Accreditation System

RC reviews every established program **annually using data**



How does RC review established programs annually?

The image displays a series of overlapping screenshots from a web-based program review system. The top screenshot shows a 'Quality of Training' dashboard with 'Overall Score' and 'Block Score' sections. Below it, another screenshot shows 'Faculty Roster Instructions' and 'Physician Faculty Definition' sections. The bottom-most screenshot displays a 'Faculty Members' table with columns for Last, First, Degree, and Title, listing various faculty members like Cook, Hurdley, Schultz, etc.

Using these “data elements”

- Resident/Fellow Survey
- Clinical Experience
- Certification Exam Pass Rate
- Faculty Survey
- Scholarly Activity
- Attrition/Changes/Ratio
- Subspecialty Performance
- Omission of Data



How does RC review established programs annually?

1. Programs with Citations

- *Is the program addressing the citations?*
- *Are there positive outcomes?*
- *Is there enough information?*

2. Review program flagged as **outliers** on data elements

- *Are there multiple elements flagged?*
- *Which elements were flagged?*
- *Are there trends?*
- *Is there enough information?*

If there is not enough information...request clarifying information or a site visit.



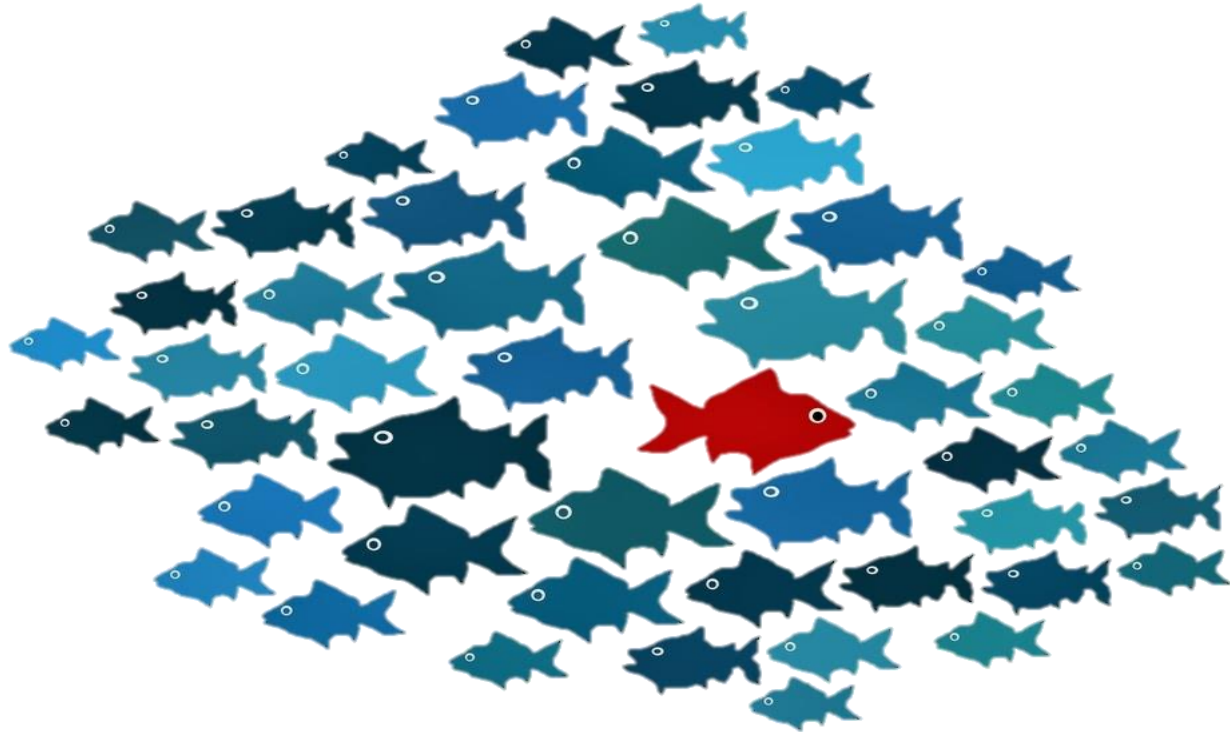
NAS Process: Continuous Improvement

- 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**

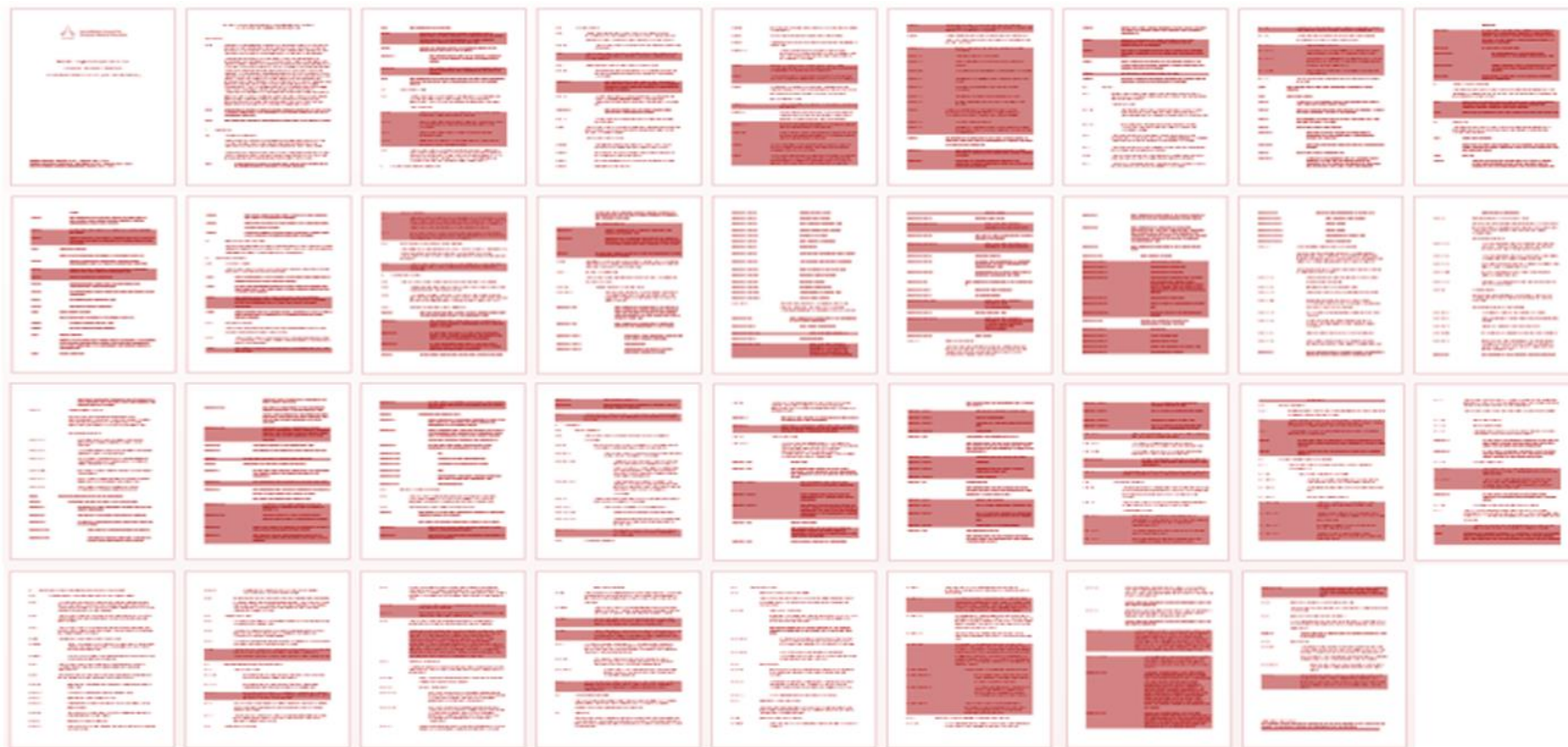
- Outcome = specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents at key stages of their GME
- Core = define structure, resource, or process elements essential to program.
- Detail - describe a specific structure, resource, or process, for achieving 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*

Take away message...

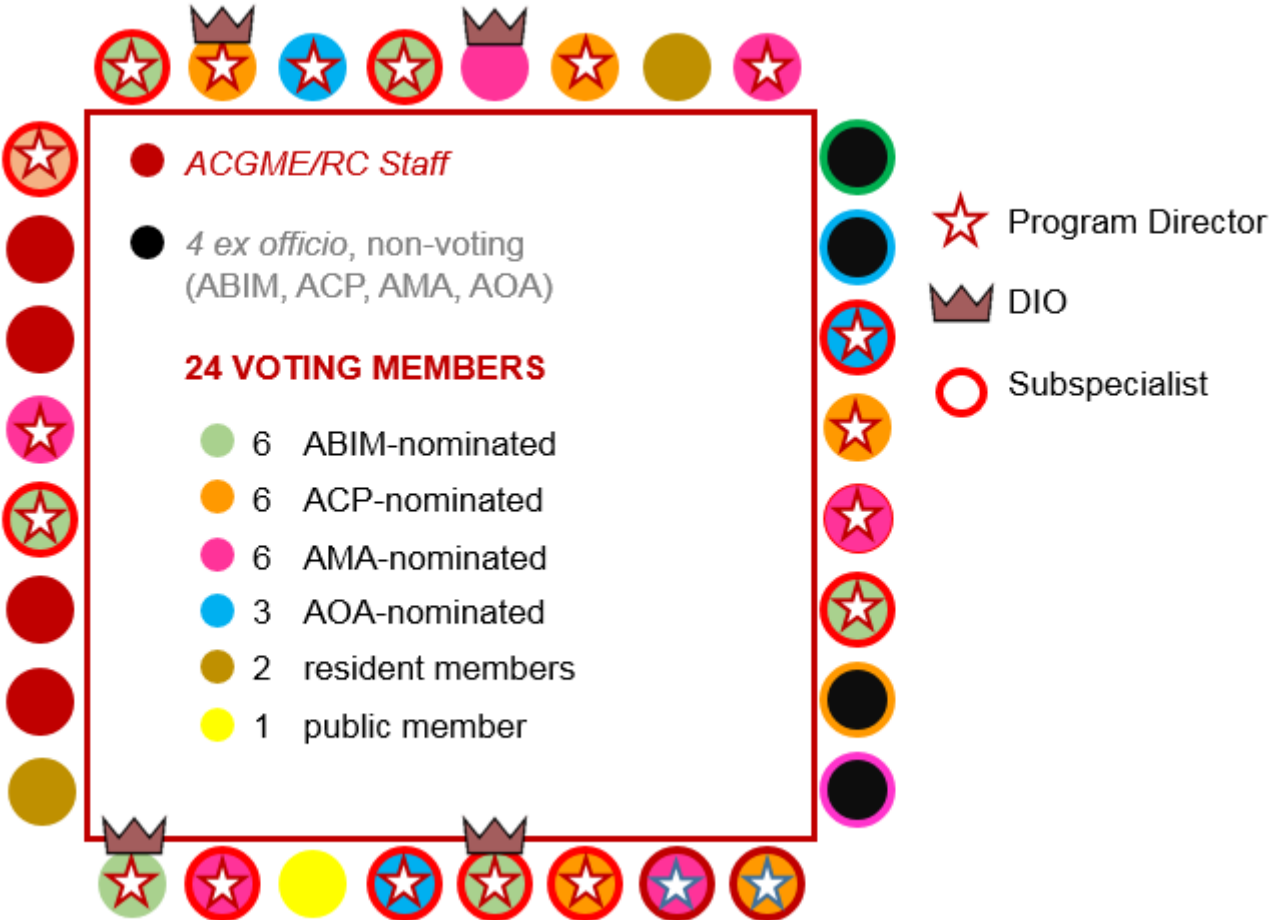
- *Something to consider in the future, and,*
- *There are different types of PRs*



Plan for Session

- General Information Related to Work of the Review Committee
- Accreditation Actions for CORE Applications
- Accreditation Actions for SUB Applications
- RC-IM's Position on Single GME System
- New Requirements and Other New Things
- NAS 101
- ***RC Members and Staff***

Who is the RC-IM?



Current Composition of the RC-IM

Robert Benz, MD

Christian Cable, MD ***Chair***

Alan Dalkin, MD

Andrew Dentino, MD

Sanjay Desai, MD

Sima Desai, MD ***Chair-elect***

Jessica Deslauriers, MD ***resident member***

Oren Fix, MD

Christin Giordano, MD ***resident member***

Russ Kolarik, MD

Monica Lypson, MD

Brian Mandell, MD ***Vice Chair***

Elaine Muchmore, MD

Cheryl O'Malley, MD

Amy Oxentenko, MD

Jill Patton, DO

Kris Patton, MD

David Pizzimenti, DO

Donna Polk, MD

Samuel Snyder, DO

David Sweet, MD

Jacqueline Stocking, RN, PhD ***public member***

Heather Yun, MD ***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***

Please Contact RC Staff

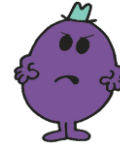
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