Graduate Medical Education: Institutional and Common Program Requirements

Armando D. Meza M.D.
Associate Dean GME
Texas Tech El Paso
Pop Quiz: What is the ACGME?

A) Institution for the accreditation of trainees
B) An agency of the federal government
C) It is the funding source for residency and fellowship programs
D) A branch of the LCME for medical school accreditation
E) Program accreditation body
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Accreditation Council for Graduate Medical Education

- Founded in 1981
- 103 employees
  - Administrative role
- Headquarters in Chicago
- Private, non profit
- Voluntary membership by training programs
- Participating annual fee
- Oversees post graduate education and training for MD’s and now DO’s
  - 10,217 programs
  - 129,247 on-duty residents
- Member organizations: ABMS, AHA, AMA, AAMC, CMSS.
2017 ACGME Annual Educational Conference Registration is Open!

Join others passionate about igniting the sparks of innovation at one of the largest gatherings of GME educators in the world.

WHAT'S NEW

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>DEC 15 2016</td>
<td>ACGME Joins National Academy of Medicine's 'Action Collaborative' to Promote Physician Well-Being</td>
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<tr>
<td>DEC 9 2016</td>
<td>December 2016 Issue of Journal of Graduate Medical Education (JGME) Focuses on Well-Being</td>
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<td>DEC 1 2016</td>
<td>ACGME, AFSP, and Mayo Clinic aim to reduce suicides by physicians, medical trainees</td>
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<td>NOV 4 2016</td>
<td>ACGME CEO Addresses Proposed Revisions to Common Program Elements</td>
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Accreditation Council for Graduate Medical Education *Mission*:

“To improve health care by assessing and advancing the quality of resident physicians' education through *accreditation.*"
Accreditation Council for Graduate Medical Education Operational Structure

- ACGME delegates authority for accreditation of programs to the Residency Review Committees (RRC)
  - **RRC members** appointed by the ACGME Board
    - 6 year term
    - Variable size (6-20)
    - Chair, vice-chair
    - ACGME Staff: Executive Director, Associate Director(s), others
  - **26 RRC’s** for each specialty and 1 for the transitional program
    - Subspecialties are included in the core
  - Consists of a group of volunteers
    - Physicians selected for their specialty and GME experience
      - There is a resident member

- ACGME delegates authority for accreditation of institutions to the Institutional Review Committee (IRC)
## Institutional Review Documents and Resources

### Common Resources

- ACGME Glossary of Terms
- Sample Program Letters of Agreement
- Duty Hour FAQs and Resources
- CLER
- Common Program Requirements (includes General Competencies)
- Notable Practices
- Review and Comment
- Selection Process - Review Committee
- Resident/Fellow Eligibility
- Webinars

### Contact Us:

- Executive Director, Institutional Review Committee
  - Paul Foster Johnson, MFA
  - pjohnson@acgme.org
  - 312.755.5005

- Senior Accreditation Administrator, Institutional Accreditation
  - Victoria Shaffer
  - vshaffer@acgme.org
  - 312.755.5011

- Executive Assistant to the Senior Vice President, Institutional Accreditation
  - Keisha Billups
  - kbillups@acgme.org
  - 312.755.7421
Accreditation
Accreditation

- Each program is reviewed annually
- NAS is a continuous process
- Annual data supplemented by:
  - Reports of self study visits
  - Progress reports (when requested)
  - Reports of site visits (as necessary)
- Cycle lengths not used
- Feedback given to program annually
Ten Year Self-Study Visit

Self-Study Process

Yr 0
Yr 1
Yr 2
Yr 3
Yr 4
Yr 5
Yr 6
Yr 7
Yr 8
Yr 9
Yr 10

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ACGME Requirements
Requirements: General Guidelines

• Requirements
  – Core
    • Define essential elements to every GME program
    • “Must” is often used with these requirements
    • “Should” has been largely eliminated
  – Detail
    • Describe elements to achieve core requirements but alternative approaches may be used
  – Outcome
    • Specify expected measurable or observable attributes of residents
ACGME Requirements

Institutional Requirements

- Institutional Program Requirements (IPR)
  - Latest version effective since 2014

Common Program Requirements (bold font)

- Effective since 2013
- Major revision to section VI proposed
  - Once approved by the ACGME Board will become effective July 1st 2017

Specific Program Requirements (regular font)

» Stem of these is the CPR for all specialties
  - Specific to each program
  - Established by each Residency Review Committee (RRC)
ACGME Program Requirements for Graduate Medical Education in Internal Medicine

Common Program Requirements are in BOLD

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.

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.
Institutional Requirements
Institutional Requirements

I. Structure for Educational Oversight
II. Institutional Resources
III. Resident/Fellow Learning and Working Environment
IV. Institutional GME Policies and Procedures
Institutional Requirements: Structure for Educational Oversight

- Designated Institutional Official (DIO)
  - It can be held by the associate dean for GME or other individual as assigned by the institution
- Graduate Medical Education Committee (GMEC)
  - The governing body
  - The chair can be the DIO
  - Needs representation by all relevant GME components including residents
Institutional Program Requirements: Institutional Resources

• Financial support
  – It’s an institutional responsibility

• Resident/Fellow forum
  – To openly discuss and voice their concerns

• Resident salary and benefits
  – To assure it meets the trainee needs
    • AAMC resident salary report

• Resident educational tools
  – Library
  – Simulation
Institutional Program Requirements:
Resident/Fellow Learning and Working Environment

• The institution must provide an environment in which residents can raise concerns and provide feedback without intimidation or retaliation and in a confidential manner

• CLER focus areas
Institutional GME Policies and Procedures

• Recruitment
  – **Consistent** and clear criteria

• Promotion, appointment renewal and dismissal
  – **Critical** for PD’s to be familiar with before taking disciplinary action

• Grievances
  – Institutional policy

• Benefits
  – **Health insurance** included

• Vacation and leaves of absence
  – Keep in mind the **30 day time period**

• Resident services
  – Residents Assistance Program (**RAP**)

• Supervision
  – **Direct and indirect**

• Duty hours
  – **Upcoming changes**

• Closures and reductions
  – Of programs will need **GMEC approval**
Common Program Requirements
Common Program Requirements: Sections

I. Institutions
II. Program Personnel and Resources
III. Resident Appointments
IV. Educational Program
V. Evaluation

VI. Resident Hours in the Learning and Working Environment
**Common Program Requirements: Institutions**

- Sponsoring institution
  - Only one
- Program Director protected time
  - 50% for the larger programs
  - Free of financial responsibility
- Affiliation Agreement
  - Document **between institutions**
- Program Letter of Agreement
  - Document **between programs**
- Participating sites
  - Each has to have and AA And PLA for each rotation
Common Program Requirements: Program Personnel and Resources

• Program Director/APD qualifications and functions
  – Qualifications
    • GME experience
    • Board certification
    • Be approved the GMEC and the ACGME
      – Major challenge is scholarly activity
  – Functions
    • Administrative
    • Oversight
    • Carry the ultimate authority and responsibility over the program

• Faculty
  – Core
    • The only one that should be listed in WebADS
    • Can participate in the educational committees
    • Need to have a productive scholarly activity

• Resources
Common Program Requirements: Resident Appointments

• Eligibility
  – MD or DO
  – USMLE

• Number of residents
  – Based on the educational resources capacity not the service needs

• Resident transfers
  – Verification of training document
  – Milestones report after selection has taken place
Common Program Requirements: Educational Program

• Curriculum content and structure
  – The six competencies
    • Patient care and procedural skills
    • Medical knowledge
    • Practice based learning and improvement
    • Interpersonal and communication skills
    • Professionalism
    • Systems based practice
<table>
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<tr>
<th>Specialty</th>
<th>Specialty-specific Program Requirements</th>
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<td>II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)</td>
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<td>II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Detail)</td>
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<td>II.B.5.c) Faculty should encourage and support residents in scholarly activities. (Core)</td>
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<td>II.B.7.e). (2) At least 50% of the KCF must demonstrate evidence of productivity in scholarship, specifically, peer-reviewed funding; publication of original research, review articles, editorials, or case reports in peer-reviewed journals; or chapters in textbooks. (Detail)</td>
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Clinical Research During Internal Medicine Residency: A Practical Guide

Kendal L. Hamann, MD, a,b Tonya L. Fancher, MD, MPH, a Sanjay Saint, MD, MPH, c,d Mark C. Henderson, MD a

aDepartment of Internal Medicine, University of California, Davis Medical Center; bSacramento Mather VA Medical Center, Mather, Calif; cAnn Arbor VA Medical Center; dDepartment of Internal Medicine, University of Michigan School of Medicine, Ann Arbor, Mich.

The American Journal of Medicine, Vol 119, No 3, March 2006
Common Program Requirements: Evaluation

- Resident evaluation
  - Clinical Competency Committee
    - Milestones assessment
      - From multiple evaluation tools
  - Formative
    - Immediate
  - Summative
    - At the end of the rotation

- Faculty evaluation
  - By the program on multiple areas

- Program evaluation
  - Program evaluation committee (PEC)
    - To generate the Annual Program Evaluation
      - SWOT
      - PDSA
Section VI.

Resident Hours in the Learning and Working Environment

- VI.A. Professionalism, Personal Responsibility and Patient Safety
- VI.B. Transitions of Care
- VI.C. Alertness Management/Fatigue Mitigation
- VI.D. Supervision of Residents
- VI.E Clinical Responsibilities
- VI.F Teamwork
- VI.G. Resident Duty Hours
Section VI Major Changes Justification

• To Improve Patient Care
  – 80 hour rule remains
  – Elimination of the 16 hour rule for PGY-1’s
  – limit Improvement
  – Clinical service hours minor modifications
  – Transitions of care
  – QI/PI

• To improve the educational experience of the trainee
  – Burnout, depression, suicides
  – Promotion well-being
  – QI/PI Education
Association of End-of-Rotation Resident Transitions and Patient Mortality

Figure. Risk of Hospital Mortality in End-of-Rotation Transition vs Control by Hospital Site

A Unadjusted risk of hospital mortality

B Adjusted risk of hospital mortality

Error bars indicate 95% CIs for each odds ratio. Adjustments included age, sex, race/ethnicity, length of stay (outliers >99% excluded), calendar month, calendar year, hospital site, and Elixhauser comorbidity index.
Percentage of CLEs with Hand-off Processes that were Standardized across Programs, Based on Direct Observations

- No standardization, 68.5%
- Some standardization, 20.4%
- All standardized, 11.1%

Figure 11
Percentage of Residents and Fellows Who Reported Experiencing an Adverse Event, Near Miss/Close Call, or Unsafe Condition and Submitting a Report Themselves, by Specialty Group

- Medical: 51.0%
- Surgical: 46.4%
- Hospital-based: 36.9%

Figure 3
Percentage of CLEs by Proportion of Resident and Fellow Knowledge of Basic Quality Improvement Concepts

- Few residents and fellows had a working knowledge, 59.1%
- Some had a working knowledge, 23.4%
- Most had a working knowledge, 17.5%

**Figure 6**
VI. The Learning and Working Environment

• **Intent of the Revision:**
  
  – Emphasize that GME are designed to provide professional education rather than vocational training
  
  – To incorporate **best available evidence**
  
  – To support the philosophy of
    
    • Excellence in **safety and quality**
    
    • Excellence in **professionalism**
    
    • **Commitment to the well-being** of residents, faculty, students and all members of the health care team
CPR VI Section A
Patient Safety, Supervision and Accountability

• VI.A.1
• Patient Safety and Quality Improvement
  – Shared responsibility
  – Highest level of clinical care
  – Patients have the right to be cared for by residents who are:
    • Appropriately supervised
    • Have the knowledge, skills and abilities
    • Understand their limits
    • Seek assistance as required
  – Residents should demonstrate:
    • Ability to analyze the care they provide
    • Understand their roles within coordinated healthcare teams
    • Play an active role in system improvement process
CPR VI Section A
Patient Safety, Supervision and Accountability

• VI.A.2

• Supervision and Accountability
  – Responsibility and Accountability:
    • Even though the provision of patient care is a shared endeavor the attending is the ultimately responsible individual
    • Programs should structure, widely communicate and monitor lines of responsibility and accountability for patient care
  – Supervision:
    • Residents should provide safe and effective care to patients
    • Ensures each residents development of the skills, knowledge and attitudes to enter the unsupervised practice of medicine
    • Establish a foundation for continued professional growth
CPR Section VI.B: Professionalism

• VI.B.5
• Residents and faculty should demonstrate responsiveness to patients needs that supersedes self-interest
  – In some cases care should be transitioned to another qualified and rested provider
CLER: Focus Areas

- Patient **Safety**
- Performance **Improvement** (HC disparities)
- Supervision
- Transitions of care
- Duty Hours and Fatigue Mitigation
- Professionalism
CPR Section VI.C: Well-Being

• Recognition that currently residents are at increased risk for burnout and depression

• Psychological, emotional and physical well-being are critical for competent, caring, and resilient physicians

• Self-care is an important component of professionalism and it should be learned and nurtured

• Programs and institutions have the same responsibility in this particular area as with other aspects of resident competence
CPR Section VI.C: Well-Being

• VI.C.1
• Residents must be given the opportunity to attend medical, mental health, and dental care appointments including those during their work hours
  
  * As appropriate considering residents’ individual circumstances
CPR Section VI.C: Well-Being

• VI.C.1
• Provide access to appropriate self-screen tools
• Provide access to confidential affordable mental health counseling and treatment, including access to urgent and emergent care 24 hours a day 7 days a week (core)

*Background and Intent

• To ensure immediate access to the resources:
  • In person, telemedicine or telephonic
  • EM Care should not be the primary or sole means to meet the requirement
  • Cost should not be a barrier
Systematic Review: Raj, JGME 2016, 674

**FIGURE 2**
Focus Areas of Studies Investigating Resident Well-Being
Systematic Review: Raj, JGME 2016, 674

• **Results**
  – Well-being **scores**
    • Lower than population norms in 7 of 8 studies
  – Factors **correlated** with resident well-being
    • Autonomy
    • Competence
    • Social relatedness
    • Sleep
    • Time away from work
    • Spirituality
  – **Predictors** of resident well being
    • Perseverance, “grit”
  – Potential **effects** of resident well being
    • Greater empathy
    • Academic improvement was not observed
    • Others not clearly established
Systematic Review: Raj, JGME 2016, 674

• Results
  – Barriers
    • Women
    • Under age 32
    • Caucasian
  – Others
    – Value perception
    – Access
    – Confidentiality
    – Stigma

• Results
  – Interventions
    • Review of progress, goals, and well-being 2-3 times per year
      – No difference
    • Hospital gym access
    • Strengthening coping mechanism program
CPR Section VI.F: Clinical Experience and Education

• VI.F.4

* Background and Intent
  • Consecutive time on-task
    • 16 hour for PGY-1 conflicted with patient safety, clinical care, continuity of care and resident learning
    • Avoid creating a shift mentality
    • 16 hour-limit for all residents was rejected by the Task Force
CPR Section VI.F: Clinical Experience and Education

• VI.F.4

• Residents may stay after a 24+4 cycle if:
  – Care for a single patient
    • Severely ill or unstable
    • Of academic importance
    • Humanistic attention to patient or family
  – To attend educational events on the residents own initiative
  – It should be counted toward the 80-hour maximum weekly limit
Summary

• ACGME is the largest medical and osteopathic training accreditation body in the US.

• The ACGME has developed a progressively evolving set of guidelines for institutions and their participating training programs to implement.

• The expectations for the ACGME are of minimum substantial compliance be met for continued accreditation status.

• The ultimate goal is to develop physicians that meet the expectations of the public.
End
Questions?