

# Residency Review Committee for Internal Medicine (RRC-IM) Update

Dennis Boulware, MD, Chair, RRC-IM

Jerry Vasilias, PhD, Executive Director, RRC-IM



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# RRC Composition

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- 3 appointing organizations - ABIM, ACP, AMA
- Currently 19 voting members
- 6 year terms -- except resident (2 years)
- **Generalists and subspecialists**  
*Cardiology, Critical Care Medicine, Endocrinology, Gastroenterology, General Internal Medicine, Geriatric Medicine, Hematology-Oncology, Infectious Diseases, Medicine-Pediatrics, Nephrology, Pulmonology/Critical Care Medicine, Sleep Medicine, Rheumatology, Transplant Hep*
- ***Geographic Distribution***  
*AZ, CA, CT, DC, HI, IN, MA, NY, NM, PA, RI, SC, TX, WA, WI*
- Ex-officio members from each appointing organization (non-voting)



# Who is the RRC-IM?

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- **Committee Members**

Dennis Boulware – Chair

Eileen Reynolds – Vice Chair

James A. Arrighi, MD

Beverly M.K. Biller, MD

*Heather Brislen, MD \**

*Steffanie R. Campbell, MD \**

E. Benjamin Clyburn, MD \*

John Fisher, MD \*

John Fitzgibbons, MD

John G. Frohna, MD

Andrew S. Gersoff, MD \*

Sara J. Grethlein, MD \*

Lynne M. Kirk, MD

Susan Murin, MD \*

Victor J. Navarro, MD \*

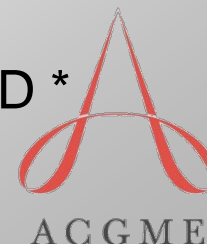
Stuart F. Quan, MD

Andrea Reid, MD \*

Stephen M. Salerno, MD

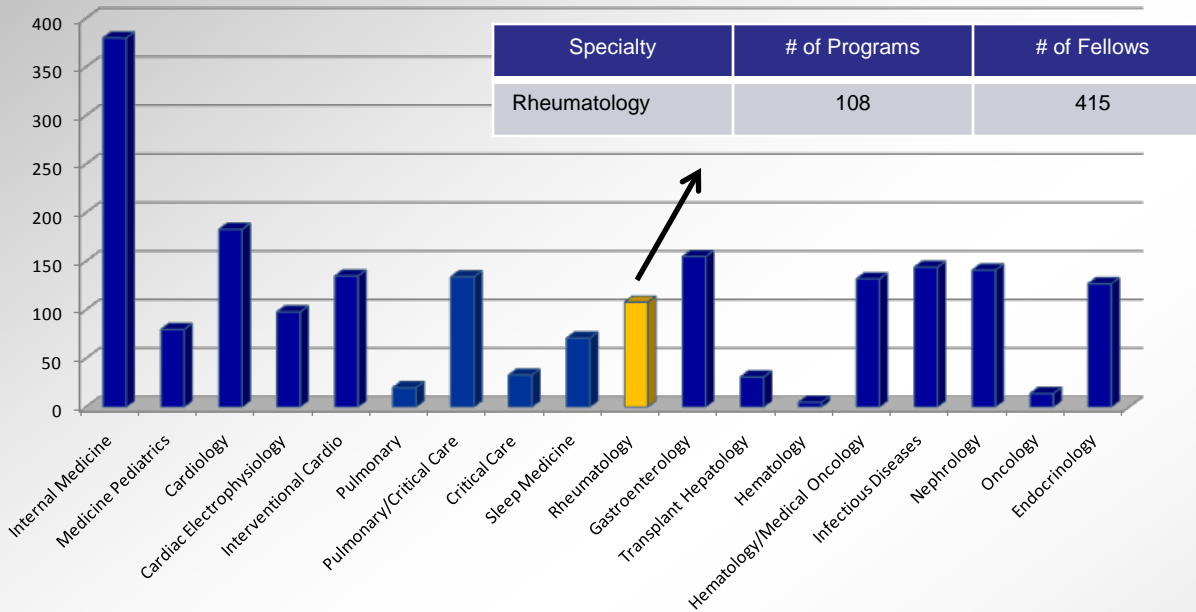
Jennifer C. Thompson, MD \*

\* New to RRC since July 2009



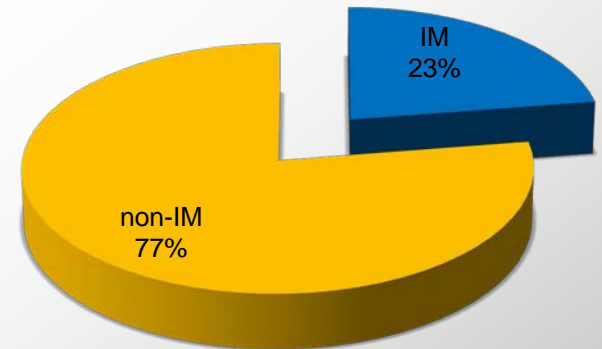
# RRC-IM Oversight

Total Number of Programs



Specialty	# of Programs	# of Fellows
Rheumatology	108	415

% of IM Programs Relative to All Accredited Programs



# Summary of Activities in 2010

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- The RRC meets three times a year – January, May, and September
  - A fourth summer meeting is a business/policy meeting
- The Committee reviewed 546 programs
  - Average per meeting:
    - 20 core
    - 140 subspecialty programs
    - 20 interim reports  
(*progress & duty hours reports*)

## Types of Reviews

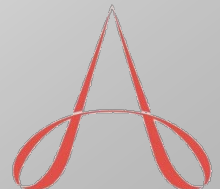
11% 11%

78%

core

subs

interim



ACGME

# Summary of Actions in 2010

## *Subspecialty Programs*

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<b>Number of <i>Subspecialty</i> Programs Reviewed</b>	<b>474</b>
Initial Accreditation	29
Continued Accreditation	347
Proposed Withhold	15
Withhold	4
Voluntary Withdrawal	32
Progress Reports	45
Duty Hour Reports	2

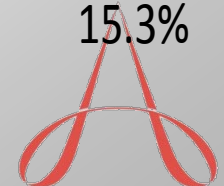
1 year  
3.5%

2 years  
11.5%

3 years  
17.0%

5 years  
52.7%

4 years  
15.3%



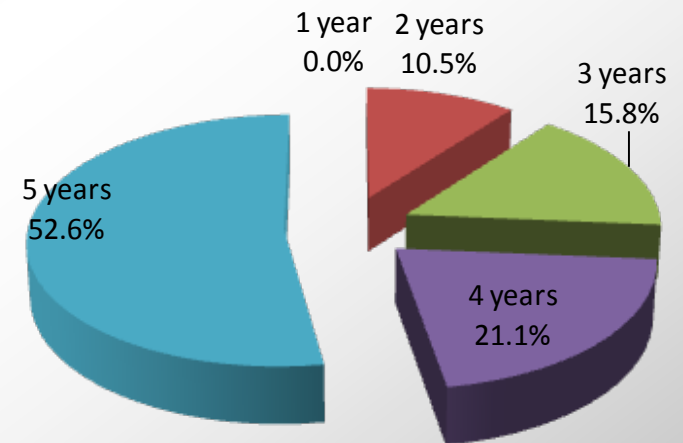
ACGME

# Summary of Actions in 2010

## *Rheumatology Programs*

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<b>Number of <u>Rheumatology</u> Programs Reviewed</b>	<b>21</b>
Initial Accreditation	1
Continued Accreditation	19
Proposed Withhold	1



# Most Frequent Citations in 2010

## *Subspecialty Programs*

**474 Subspecialty Programs Reviewed**  
**Total of 1,027 Citations = 2.2 citations/program**

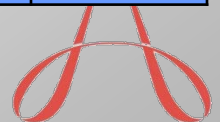
Name and Description of Citations	times cited	% of total
<b>1. Evaluation of Fellows</b> - semiannual evaluation not documented; faculty do not routinely provide verbal feedback at the end of rotation; inadequate multi-source evaluation; fellow's performance in continuity clinic not documented; appropriate evaluation methods not used to evaluate the fellow's achievement of the competencies; Inadequate procedure logs; no summative evaluation	187	18.2%
<b>2. Didactic Components</b> - fellows not educated to recognize the signs of fatigue and sleep deprivation; no regularly-scheduled or -attended research conference; five hours of teaching rounds per week does not occur; instruction for basic sciences not provided	135	13.1%
<b>3. Evaluation of the Program</b> - program evaluation did not address all required elements; does not monitor and track program quality; no written improvement plan	92	9.0%
<b>4. Patient Care Experience</b> - Inadequate continuity clinic experience and/or continuity clinic patient volume; panel of patients does not include 25% of each gender; inadequate procedural experience(s)	75	7.3%
<b>5. Responsibilities of the Program Director</b> - does not oversee/ensure the quality of training at all participating sites; unapproved changes in complement; no CME for the program director; inaccurate PIF; unfamiliar with the ACGME policies and procedures; no reporting relationship with the IM program director; program director not at primary site; place undesirable stress on fellows	70	6.8%
<b>6. Goals and Objectives</b> - no evidence of level-specific and competency based goals and objectives for each assignment	64	6.2%
<b>7. Institutional Support</b> - internal review did not occur mid-cycle; inadequate faculty support; Inadequate faculty, facilities, and/or resources; No PLA; incomplete internal review committee	58	5.6%
<b>8. Evaluation of Faculty</b> - faculty evaluation by the fellows is not confidential; faculty are not evaluated at the end of each rotation/assignment; faculty are not evaluated semi-annually and/or annually	40	3.9%
<b>9. Responsibilities of Faculty</b> - inadequate faculty research; insufficient time devoted to the program; faculty do not routinely participate in conferences; faculty are not ABIM certified	32	3.1%
<b>10. Performance Improvement (PI) Activities</b> – no evidence of ongoing PI activity	29	2.8%

# Most Frequent Citations in 2010

## *Rheumatology Programs*

21 Programs Reviewed  
72 Total of Citations = 3.4 citations/program

Name and Description of Citations	times cited	% of total
<b>1. Didactic Components</b> – inadequate conferences; Fellows do not have formal instruction, clinical experience, and demonstrate competence in required procedures;	14	19%
<b>2. Evaluation of Fellows</b> – no evaluation in continuity clinic; don't use direct observation tool; doesn't evaluate fellows at the end of each rotation/assignment; inadequate logbooks	14	19%
<b>3. Evaluation of Program</b> – no annual program review; no written improvement plan;	13	18%
<b>4. Goals and Objectives</b> – not competency-based; not level-specific; not for each assignment; not reviewed with the fellows	5	7%
<b>5. Responsibilities of the Faculty</b> – faculty don't devote sufficient time to the program; faculty do not participate in scholarly activity;	4	6%



# Site Visit Pilot

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Recent announcement in ACGME's e-Communication related to site visits:

## **ACGME Department of Field Activities (DFA) Continues Pilot to Increase Resident Input During the Site Visit**

The DFA is extending, through June 2011, a pilot effort for obtaining more resident input. In this program, residents in programs undergoing a site visit are asked to submit a consensus list of five program strengths and opportunities for improvement directly to the assigned field staff representative. Programs are given detailed information on the pilot program before the site visit. The ACGME will evaluate the results in summer 2011.



# ACGME:

## *Assisting PDs with Common Reqs*

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- PD Guide to the Common Requirements:  
[http://www.acgme.org/acWebsite/navPages/nav\\_com\\_monpr.asp](http://www.acgme.org/acWebsite/navPages/nav_com_monpr.asp)
- Provides PDs:
  - Explanations of the intent of most of the common requirements (particularly competency-based)
  - Suggestions for implementing requirements and types of documentation expected.

# RRC Communications

## *FAQs*

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- General Subspecialty FAQs posted to website  
[http://www.acgme.org/acWebsite/RRC\\_140/General\\_Subspecialty\\_Fellowship\\_FAQs.pdf](http://www.acgme.org/acWebsite/RRC_140/General_Subspecialty_Fellowship_FAQs.pdf)

# RRC Communications

## *Newsletter*

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- Communication tool to provide updates on RRC and ACGME initiatives
- Sent to all core, med-peds and subspecialty program directors, coordinators, and designated institutional officials
- Annual newsletter
- Newsletter postings announced in the weekly e-communications email



# RRC Communications

## *Highlights from August 2010 Newsletter*

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- August 2010 newsletter:  
[http://www.acgme.org/acWebsite/RRC\\_140\\_news/Internal\\_Medicine\\_Newsletter\\_Aug10.pdf](http://www.acgme.org/acWebsite/RRC_140_news/Internal_Medicine_Newsletter_Aug10.pdf)
- Re-interpretation of expectations for Scholarship for Subs
- New Core and Subs FAQs
- Summary of RRC-IM Activities
- Updates on Program Requirements Revisions



# RRC Communications

## *Highlights from August 2010 Newsletter (continued)*

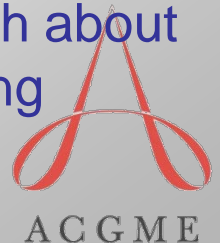
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As of January 1, 2011, all IM subspecialty programs will be expected to document that patients are used in the multi-source evaluation of fellows.

*Question: What is expected for the multi-source?*

Answer:

- Multi-source evaluations are important in the assessment for several competencies.
- The goal is to obtain feedback from multiple evaluators who interact with the resident being assessed. These must include at least patients, peers, and non-physician team members (nurses, clerical staff, therapists, etc.).
- Forms distributed to these individuals do not have to ask each about the same items, but should reflect the general domain(s) being assessed (e.g., interpersonal and communication skills, professionalism, systems-based practice).



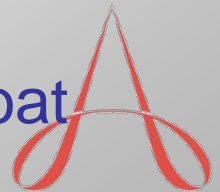
# New Common Requirements

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New Duty Hour and Supervision PRs that go into effect ***July 1, 2011***

RCs asked to add language in following sections:

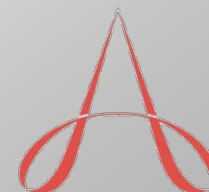
1. Define licensed independent practitioners
2. PGY-1: direct supervision available
3. Specify optimal clinical workload
4. Define elements of teamwork
5. Define intermediate and residents in final years
6. Define circumstances with 8 hours duty free
7. Consecutive weeks and annual cap of night float



# 1. Define licensed independent practitioners

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In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician [or licensed independent practitioner as approved by each Review Committee] who is ultimately responsible for that patient's care.

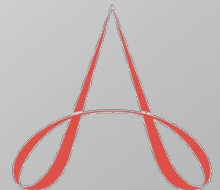


# Define licensed independent practitioners

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## *RRC-IM action:*

1. *No new language.*
2. *A licensed independent practitioner as a resident supervisor is addressed in two existing FAQs.*
  - a. *Allowed: specialized outpatient settings for specific learning experiences (i.e., GYN clinic, STD clinic, wound care clinic, home visits, nursing homes, etc.).*
  - b. *Not allowed: inpatients, continuity clinics, subspecialty or general medicine clinics.*



## 2. PGY-1: direct supervision available

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In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.]

*RRC-IM Action:*

*1. No new language added. Does not affect fellowship programs. Fellows considered to be “in final years of education.”*



# 3. Specify optimal clinical workload

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The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. [Optimal clinical workload will be further specified by each Review Committee.]

*RRC-IM Action:*

- 1. No new language added.*
- 2. The existing program requirements address limitations on admissions, ongoing care, and available support services.*

# 4. Define elements of teamwork

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Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty. [Each Review Committee will define the elements that must be present in each specialty.]

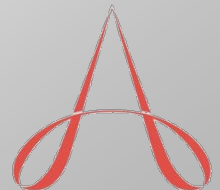


# 4. Define elements of teamwork

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*RRC-IM Action:*

- 1. No new language.*
- 2. The existing program requirements address residents working in multidisciplinary and interdisciplinary teams.*



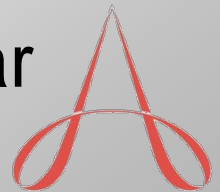
ACGME

# 5. Define “intermediate” and “residents in final years”

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Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.



# 5. Define “intermediate” and “residents in final years”

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## *RRC-IM Action:*

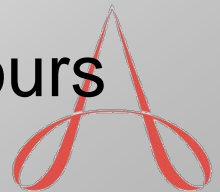
- 1. No new language added. Fellows considered to be “in final years of education.”*

# 6. Define circumstances with 8 hours duty free

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Applies to resident in final years of training:

This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

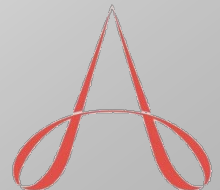


# 6. Define circumstances with 8 hours duty free

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## *RRC-IM Action:*

- 1. Adopted language that appears earlier in document related to breaches in 24 hours.*
- 2. Allows for unusual and rare circumstances (care for severely ill, learning opportunity, humanitarian, etc) that are initiated by the resident with reporting and tracking by the program director.*

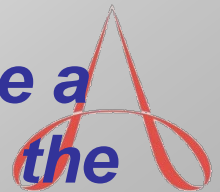


## 6. Define circumstances with 8 hours duty free (1 of 2)

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*In unusual circumstances, residents may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family.*

*Such episodes should be rare, must be of the residents own initiative, and need not initiate a new 'off duty period' nor require a change in the scheduled 'off duty period'*



# 6. Define circumstances with 8 hours duty free (2 of 2)

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*Under those circumstances, the resident must:*

*Appropriately hand over the care of all other patients to the team responsible for their continuing care; and document the reasons for remaining or returning to care for the patient in question and submit that documentation in every circumstance to the program director.*

*The program director must review each submission of additional service and track both individual resident and program wide episodes of additional duty.*



# 7. Consecutive weeks and annual cap of night float

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Residents must not be scheduled for more than six consecutive nights of night float. [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

*RRC-IM Action:*

*1. No new language.*



# New Subspecialty Requirements

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- At February ACGME meeting, Board approved revisions to subspecialty requirements in following areas:
  - Cardio, CCEP, IC, Hem, Onc, Hem/Onc, GI, TH, Rheum, Endo, Nephro, ID, Pulm, Pulm/CCM
  - CCM and Sleep Medicine will be reviewed at June ACGME Meeting
- Effective ***July 1, 2012***



# Deleted Program Requirements

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- Current “general requirements” were combined with individual subspecialty program requirements – *so not really deleted.*
- Death reviews and autopsy reports - *deleted.*
- Specifics of the written curriculum (teaching methods, reading lists, disease mix, etc) - *deleted.*
- Teaching rounds of five hours a week - *deleted.*
- Conference specificity (types and numbers of conferences per month) - *deleted*



# Electronic Health Record

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*“Access to an electronic health record should be provided. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development, and progress towards its implementation;”*

*FAQ Question (to be posted): What does the Review Committee consider an example of an electronic health record (EHR)?*

Answer: Fellows are expected to have access to an EHR at least at one site used for clinical training. An EHR can include electronic notes, orders, and lab reporting. Such a system also facilitates data reporting regarding the care provided to a patient or a panel of patients. It may also include systems for enhancing the quality and safety of patient care. An EHR does not have to be present at all participating sites and does not have to be comprehensive. A system that simply reports lab or radiology results does not meet the definition of an EHR.

# Simulation

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*“Fellows must participate in training using simulation.”*

*FAQ Question (to be posted): What does the Review Committee consider as part of the range of simulation?*

Answer: The Review Committee does not expect each program to use a simulator or have a simulation center. Simulation means that learning about patient care occurs in a setting that does not include actual patients. This could include OSCEs, standardized patients, patient simulators, or electronic simulation of codes, procedures, and other clinical scenarios.



# PD salary support

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*“The sponsoring institution must: provide the program director with adequate salary support for the administrative activities of the fellowship. The program director must not be required to generate clinical or other income to provide this administrative support. This support **should** be 25-50% of the program director's salary, or protected time, depending on the size of the program.”*

Rationale: The change is from a “suggested” to a “should” requirement. The RRC-IM has long expected that sponsoring institutions provide adequate salary support for the program director. Adequate salary support for administration of the program enhances the program director’s ability to provide direct advocacy for the fellows’ learning experiences.



# Associate PD

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*“Appointment of one KCF to be an associate program director is suggested.”*

Rationale: This requirement is **not** mandatory; it appears as “is suggested.” It was added in response to suggestions from many program director groups to allow the program directors to delegate some of their many responsibilities to other key members within the program.

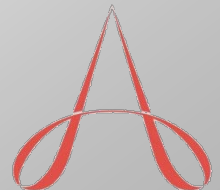


# KCF numbers: Some fellowships

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*“In addition to the program director, each program must have at least one Key Clinical Faculty (KCF). KCF are attending physicians who dedicate, on average, 10 hours per week throughout the year to the program. For programs with more than three fellows, there must be at least one KCF for every 1.5 fellows.”*

FAQ (to be developed): In rheumatology, endocrinology and infectious diseases, a significant percentage of fellowship programs have 3 or less fellow complements. For a complement size of 4 or greater, the program must have a KCF to fellow ratio of 1:1.5.

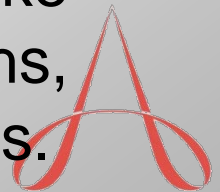


# KCF Scholarship

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*“ 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.”*

Rationale: This is in line with the Committee’s expectation that was highlighted in the RRC-IM’s August 2010 newsletter. This is expected to give programs flexibility. It is recognized that evidence of productivity could take many forms depending upon the particular strengths, size, and faculty composition of individual programs.



# KCF Evaluator

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*“At least one of the KCF must be knowledgeable in the evaluation and assessment of the ACGME competencies; and, spend significant time in the evaluation of fellows including the direct observation of fellows with patients.”*

*FAQ Question (to be posted): What is acceptable education for KCF who will serve as competency evaluators?*

Answer: These faculty must be knowledgeable in the evaluation and assessment of the ACGME competencies. This can be achieved through participation in workshops offered through program director groups, the ABIM, the ACGME, or through local GME faculty development programs that focus on competency assessment. The evaluators are expected to have ongoing training in these areas.



# Conference Format

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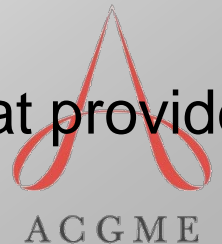
*“The core curriculum must include a didactic program based upon the core knowledge content in rheumatology (as defined in the Educational Program).*

*The program must afford each fellow an opportunity to topics covered in conferences that he or she was unable to attend.*

*Fellows must participate in clinical case conferences, journal clubs, research conferences and morbidity and mortality (or quality improvement) conferences.*

*All required core conferences must have at least one faculty member present and must be scheduled as to ensure peer-peer and peer-faculty interaction.”*

Rationale: Not a new requirement but a modified one that provides programs with more flexibility. Rigid requirements on frequency, numbers of conferences, etc are gone.



# Practice Management

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*“Fellows must receive instruction in practice management relevant to their subspecialty.”*

*FAQ Question (to be posted): What constitutes adequate instruction in practice management?*

Answer: Instruction in practice management includes the organization and financing of clinical practice including personnel and business management, scheduling, billing and coding procedures, telephone and telemedicine management, and maintenance of an appropriate confidential patient record system. Programs can comply with this requirement by developing/implementing a lecture series related to this topic.

# Multisource Evaluation (1 of 3)

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*“The program must use both direct observation and multi-source evaluation, including patients, peers and non-physician team members, to assess fellow performance in: Interpersonal communication, Professionalism and System-Based Practice.”*

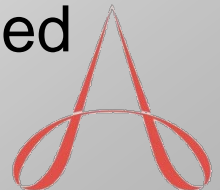


# Multisource Evaluation (2 of 3)

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*FAQ Question: What is expected for multi-source evaluation of fellows?*

Answer: Multi-source evaluations are important in the assessment for several competencies. The goal is to obtain feedback from multiple evaluators who interact with the fellow being assessed. These must include at least patients, peers, and non-physician team members (nurses, clerical staff, therapists, etc.). Forms distributed to these individuals do not have to ask each the same items, but should reflect the same general domain(s) being assessed (e.g., interpersonal and communication skills, professionalism, systems-based practice).

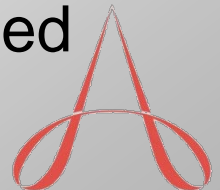


# Multisource Evaluation (3 of 3)

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*FAQ Question: What is expected for multi-source evaluation of fellows?*

Answer: Multi-source evaluations are important in the assessment for several competencies. The goal is to obtain feedback from multiple evaluators who interact with the fellow being assessed. These must include at least patients, peers, and non-physician team members (nurses, clerical staff, therapists, etc.). Forms distributed to these individuals do not have to ask each the same items, but should reflect the same general domain(s) being assessed (e.g., interpersonal and communication skills, professionalism, systems-based practice).



# ABIM take *and* pass rate

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*At least 80 percent of a program's graduating fellows from the most recently defined five-year period who are eligible should take the ABIM certifying examination.*

*Within the most recent five year period, at least 80 percent of a program's graduates taking the ABIM certifying examination for the first time should pass.*

FAQ (to be developed): The Review Committee will take into consideration noticeable changes during this same period. Consideration for programs with small numbers of fellows.

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# *Use of the Resident Survey in Accreditation*

# Resident Survey (RS) Content: General Information

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- Administered annually Jan-May
- 70% completion rate to see summary report
- Question in RS relate to 5 content areas:  
*Faculty, Educational Content, Evaluation, Resources, Duty Hours*
- In 2009: All core programs and fellowships with 4 or more need to complete survey annually
- In 2010: several difficult questions in RS were modified
- In 2011: RS was revised based on input from residents and survey experts

## RS Question

Category

1. Do the faculty spend sufficient time TEACHING residents/fellows in your program?	Faculty/ Teaching
2. Do the faculty spend sufficient time SUPERVISING the residents/fellows in your program?	Faculty/ Teaching
3. Do your faculty members regularly participate in organized clinical discussions?	Faculty/ Teaching
4. Do your faculty members regularly participate in rounds?	Faculty/ Teaching
5. Do your faculty members regularly participate in journal clubs?	Faculty/ Teaching
6. Do your faculty members regularly participate in conferences?	Faculty/ Teaching
7. Do you have the opportunity to confidentially evaluate your FACULTY, in writing or electronically, at least once a year?	Evaluation
8. Do you have the opportunity to confidentially evaluate your overall PROGRAM, in writing or electronically, at least once a year?	Evaluation
11. Do you receive written or electronic feedback on your performance for each rotation and major assignment?	Evaluation
12. Are you able to review your current and previous performance evaluations upon request?	Evaluation
15. Have residents / fellows had the opportunity to assess the program for the purposes of program improvement?	Evaluation
9. Has your program provided you access to, either by hard copy or electronically, written goals and objectives for the program overall?	Educational Content
10. Has your program provided access to, either by hard copy or electronically, written goals and objectives for each rotation/major assignment?	Educational Content
13. Have you had sufficient education to recognize and counteract the signs of fatigue and sleep deprivation?	Educational Content
14. Does your program offer you the opportunity to participate in research or scholarly activities?	Educational Content
19a. How often do rotations/other major assignments provide an appropriate balance bw clinical education and other demands, such as service obligations?	Educational Content
19b. How often has your clinical education been compromised by excessive service obligations?	Educational Content
16. Has your ability to learn been compromised by the presence of trainees who are not part of your program, such as residents from other specialties, subspecialty fellows, PhD students, or nurse practitioners?	Resources
17a. Does your program provide an environment where residents/fellows can raise problems or concerns without fear of intimidation or fear of retaliation?	Resources
17b. How satisfied are you with your program's process to deal confidentially with problems or concerns you might have?	Resources
18. How often are you able to access, either in print or electronic format, the specialty specific and other reference materials that you need?	Resources
20a. Duty hours must be limited to 80 hours per week (88 for those programs having duty hour exceptions), averaged over a four-week period, inclusive of all in-house call activities.	Duty Hours
20b. Residents / fellows must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over 4-weeks, inclusive of call.	Duty Hours
20c. There should be a 10-hour time period provided between all daily duty periods and after in-house call.	Duty Hours
20d. In-house call must occur no more frequently than every third night, averaged over a four-week period.	Duty Hours
20e. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents and fellows may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care.	Duty Hours
20f. No new patients may be accepted after 24 hours of continuous duty.	Duty Hours
20g. At-home call must not be so frequent as to preclude rest and reasonable personal time for each resident / fellow.	Duty Hours
20h. Residents / fellows taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.	Duty Hours
20i. When residents and fellows are called into the hospital from home, the hours they spend in-house are counted toward the 80-hour limit. (The limit is 88-hours for those programs with duty hour exceptions.)	Duty Hours
21. If you noted any duty hours issues in the section above, would you say issues occurred mostly on rotations to other services outside your specialty?	Duty Hours

# Resident Survey - Outliers

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- 2006: ACGME Board gave Monitoring Committee responsibility to oversee duty hour (DH)
  - Review national reports and recommend to RCs how to handle program outliers = programs with significant non-compliance rates
- 2010: Unlike years past, Mon Com had recommendations for programs w/ high DH non-compliance *and high rates on other parts of the RS.*
  - *Programs non-compliant with DH, or non-compliant w/ multiple other RS areas were either short-cycled or sent letters informing them that they need to improve in 2011.*
  - *Non-compliance defined as extreme outlier = response in content area is 2 standard deviations or greater.*
  - *Of over 2,000 IM fellowship programs, only 3 were short-cycled and 43 received letters.*



# *Final thoughts....*

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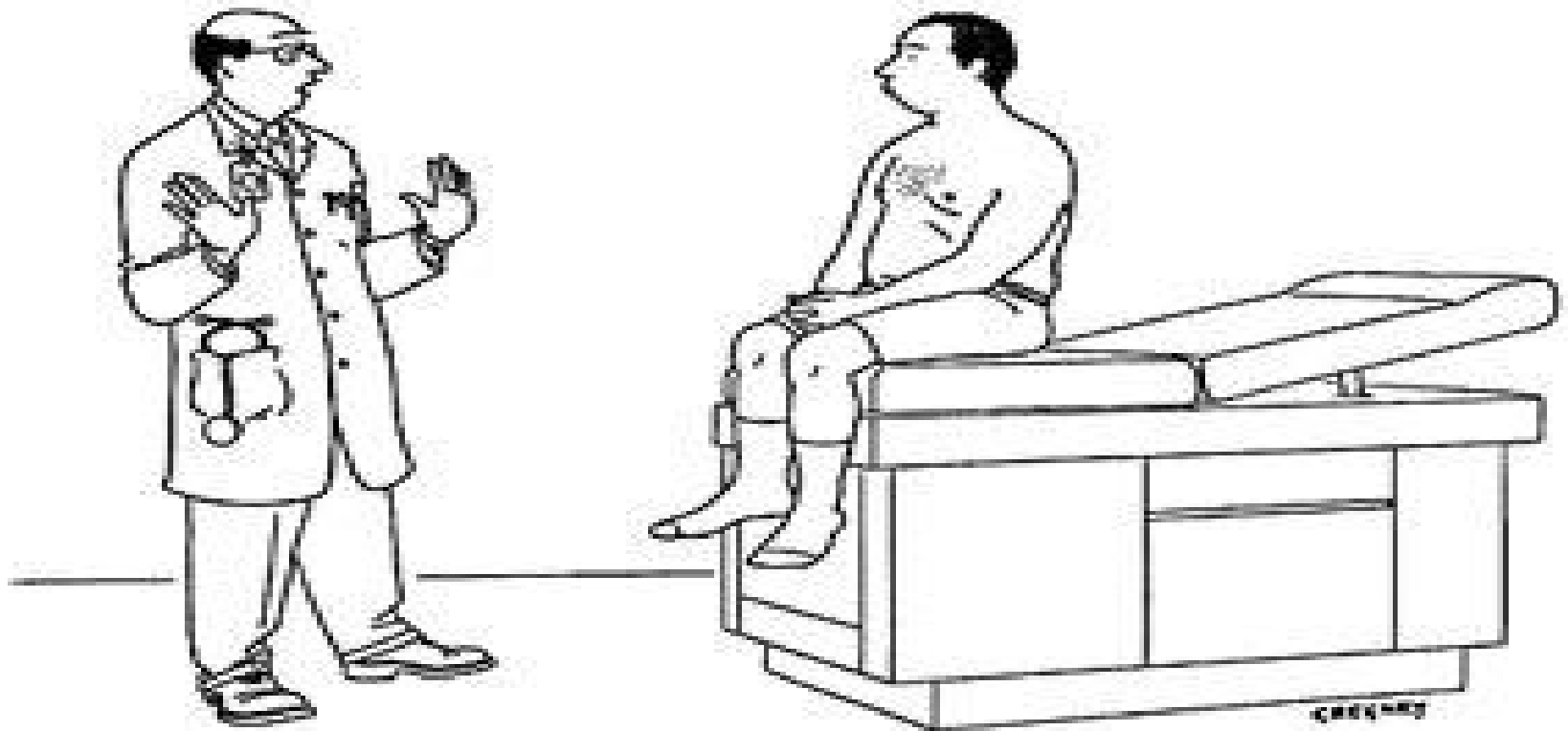
- Resident survey has been revised in 2011
  - [http://www.acgme.org/acWebsite/Resident\\_Survey/General.pdf](http://www.acgme.org/acWebsite/Resident_Survey/General.pdf)
  - Check out FAQ for definitions of scale options for DH questions

# ACGME contacts:

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- Questions related to requirements or notification letter:
  - Jerry Vasilias (312) 755-7477, [jvasilias@acgme.org](mailto:jvasilias@acgme.org)
  - Felicia Davis (312) 755-7445, [fdavis@acgme.org](mailto:fdavis@acgme.org)
  - Karen Lambert (312) 755-5785, [kll@acgme.org](mailto:kll@acgme.org)
- Questions related to PIF content:
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- Questions related to complement increases:
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- Questions related to the ADS/Technical problems with PIF:
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  - Penny Lawrence (312) 755-5014, [pil@acgme.org](mailto:pil@acgme.org)





*"Whoa—way too much information!"*

# Questions?

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