



**Update from the
Residency Review Committee
for Internal Medicine
March 27, 2010**

**Dennis Boulware, MD
Chair-Elect
Residency Review Committee
for Internal Medicine**

Keys areas to be covered:

- Committee current structure
- **Overview of the committee's 2009 activities**
- Update on the proposed program requirements (PRs)
 - Deleted PRs
 - New and changed PRs
 - PRs of significance
- Questions and answers



Committee Structure

RRC-IM – Members 2009 - 2010

- Rosemarie Fisher (10)
- Thomas Cooney (10)
- Glenn Mills (10)
- Brian Freeman (10)
- Stuart Quan (11)
- Eileen Reynolds (11)
- John Frohna (11)
- Steffanie Campbell (11)
- Jack Fitzgibbons (12)
- Dennis Boulware (13)
- Beverly Biller (13)
- Lynne Kirk (14)
- Steven Salerno (14)
- Ben Clyburn (15)
- Victor Navarro (15)
- James Arrighi (15)
- Jennifer Thompson (15)
- Susan Murin (15)
- Sara Grethlein (15)

RRC-IM Committee Structure

- New Members – July 2010
 - Andrew Gersoff (2016)
 - Heather Breslin (2012)

RRC-IM Committee

- Cardiology
- Critical Care
- Endocrinology
- Gastroenterology
- Geriatrics
- Hematology
- Infectious Diseases
- Internal Medicine
- Medicine-Pediatrics
- Nephrology
- Oncology
- Pulmonary diseases
- Rheumatology
- Sleep Medicine
- Transplantation hepatology
- Resident representation

RRC-IM Committee Structure

Positions to be filled in the near future:

- Cardiology
- Gastroenterology
- General internal medicine
- Hematology and/or oncology
- Medicine-Pediatrics
- Pulmonary/Critical Care Medicine
- Sleep

RRC-IM Ex-Officio

- William Iobst MD
America Board of Internal Medicine
- Paul Rockey MD
American Medical Association
- Steven Weinberger MD
American College of Physicians

RRC – IM Staff

- Jerry Vasilias (ED)
- Karen Lambert (AED)
- Felicia Davis (AED)
- Sharon Walker
- Danny Hart
- Jessalynn Van Ausdall
- Cleo Whitfield
- Betty Cervantes



Committee's Activities 2009

Committee Activities in 2009

- Program reviews
- Policy development and revision
- Revise program requirements
- Collaborate with the American Board of Internal Medicine, American College of Physicians, American Medical Association, etc.
- Manage requests for expedited reviews (complement changes, innovations, etc)

Committee's Activities in 2009

- Four meetings annually: January, May, July, September
- Program reviews at 3 meetings with July meeting for policy and business issues
- Executive committee conference call 1-2 times between meetings
- Full committee conference calls as needed
- Expedited reviews done electronically

Committee Member Activities

- Attend four meetings annually: 13 days (executive committee 16 days)
- Travel time to meetings: 4-8 days annually
- Time to review programs for January, May and September: 30-40 hours each meeting
- Conference calls, electronic reviews, email, non-review preparation: ? Hours
- **TOTAL: 17-24 days plus 100-200 hours preparation time per year**

RRC-IM Oversight

| | Program (N) | No. fellows |
|---------------------------|--------------------|--------------------|
| Internal Medicine | 387 | 22,477 |
| Medicine Pediatrics | 80/40 | 1385 |
| Cardiology | 178 | 2415 |
| Cardiac Electrophysiology | 94 | 170 |
| Interventional cardiology | 135 | 291 |
| Critical Care | 36 | 154 |
| Endocrinology | 125 | 534 |
| Gastroenterology | 156 | 1319 |
| Transplant hepatology | 28 | 19 |

RRC-IM Oversight

| | Program (N) | No. fellows |
|-----------------------------|--------------------|--------------------|
| Hematology | 10 | 38 |
| Hematology/Medical Oncology | 127 | 1392 |
| Infectious Diseases | 150 | 707 |
| Nephrology | 141 | 850 |
| Oncology | 18 | 106 |
| Pulmonary | 21 | 79 |
| Pulmonary/Critical Care | 136 | 1285 |
| Rheumatology | 106 | 397 |
| Sleep | 68/44 | 130 |
| TOTAL | 2040 | 33,748 |

RRC-IM Subspecialties 2009 (2008)

| | |
|---------------------------|------------------|
| • New Applications | 37 (44) |
| • Continued Accreditation | 307 (329) |
| • Warning | 34 (31) |
| • Proposed adverse | 36 (36) |
| • Adverse | 16 (13) |
| • Rescind prob./comp red. | 1 (8) |
| Total | 431 (461) |

http://www.acgme.org/acWebsite/RRC_140/140_stat.asp



Proposed New Requirements

Program Requirements (PRs)

- **Common PRs** are required by ACGME of all programs
- Sections I – VII:
 - I. Institution
 - II. Personnel and resources
 - III. Fellow appointment
 - IV. Educational Program
 - V. Evaluation
 - VI. Duty hours in learning and work environment
 - VII. Experimentation and Innovation

Program Requirements

Important caveats

- Common PRs cannot be changed by the RRC-IM.
- The PRs reflect the minimum threshold.
- The PRs are developed with significant targeted input from the subspecialty societies, the Association of Specialty Professors and Alliance of Academic Internal Medicine.
- Public feedback is solicited and desired.

Deleted Program Requirements

- **Current “general requirements”** were deleted and combine with individual subspecialty program requirements.
- Death reviews and autopsy reports.
- Specifics of the written curriculum (teaching methods, reading lists, disease mix, etc).
- Teaching rounds of five hours a week.
- Conference specificity (types and numbers of conferences per month)
- Others

Important New or Changed PRs

I. Institution

- Electronic health record
- Simulation

II. Personnel and Resources

- PD salary support
- Associate PD
- KCF numbers
- KCF scholarship
- KCF evaluator

Important New or Changed PRs

IV. Educational Program

- Conference format
- Practice management education

V. Evaluation

- Validated formative assessment method
- Multisource evaluation
- 80% of takers should pass ABIM

Major revisions or new PRs

Impact Statement

- 1) impacts the quality and safety of patient care;
- 2) improves the quality of fellow education;
- 3) affects the way the fellow, the service, and the staff provide patients with continuing care;
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact;
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution; and
- 6) impacts residency education in other specialties.

Electronic Health Record

*"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: Residents must have access to an electronic health record (EHR). 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 training sites and does not have to be comprehensive. A system that simply reports lab results or radiology results does not meet this definition of an EHR.

Simulation

"Fellows must have access to training using simulation;"

FAQ: The 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

“The sponsoring institution must: *ensure that the program director is provided with adequate salary support for the administrative activities of the fellowship program. 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, depending on the size of the program.”*

Impact Statement: The change from a “suggested” to a “should”, should not have any financial impact. 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

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

FAQ (to be developed): This is not mandatory, but done in response to a suggestion from many program director groups to allow the many responsibilities of a PD of a large program to delegate some of those responsibilities.

KCF numbers: Some fellowships

"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 that will benefit from the need to have a second KCF and will continue to provide a ratio of 1:1.5.

KCF Scholarship

***"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."*

FAQ (to be developed): This is a current requirement for KCF research productivity; however, the proposed change from **"majority" to 50%** is intended to clarify the RRC-IM's standard and to allow flexibility in meeting the standard. It is recognized that evidence of productivity could take many forms depending upon the particular strengths, program size, and faculty composition of individual programs.

KCF Evaluator

*“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 (to be developed): 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 must have ongoing training in these areas.

Conference Format

*"The core curriculum must include a didactic program based upon the core knowledge content as defined in the subspecialty. The program must afford each fellow an opportunity to learn all of the core curriculum topics. 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 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 (1 of 2)

Fellows must be instructed in 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.

Practice Management (2 of 2)

Proposed revision: Fellows must receive instruction in practice management relevant to their subspecialty which may include: personnel and business management, scheduling, billing and coding procedures, telephone and telemedicine management, and maintenance of an appropriate confidential patient record system.

Validated Formative Assessment

"(Medical Knowledge) The program must use an objective validated formative assessment method, e.g., in-service training examination or chart stimulated recall. The same formative assessment method must be administered at least twice during the program."

Proposed revision: The program must use an objective formative assessment method. The same formative assessment method must be administered at least twice during the program.

Multisource Evaluation

*"The program must use both direct observation and multi-source evaluation including patients, peers and non-physician team members, to assess fellow performance in: (Communication, Professionalism and System-**Based Practice**)"*

FAQ (to be developed): The multi-source evaluation is separate from the faculty evaluation and the numbers and types of evaluators will be defined.

ABIM take and pass rate

"A program's graduates should achieve a pass rate on the certifying examination of the ABIM of at least 80% for first-time takers in the past five years."

Proposed revision: The take rate will remain, but the pass rate will be deleted.



Program Requirements of Frequent Significance

Current and Future

PRs of Frequent Consequence

- ABIM certification: program director, key clinical faculty
- KCF: number of qualified KCF
- Faculty scholarship
- Evaluation: Annual program evaluation, evaluation of faculty, confidentiality of evaluations, multisource evaluations.

New Subspecialty Program Requirements

Thank you to the ACR, all the subspecialty societies and ASP for participating in this process

Who to contact?

Jerry Vasilias PhD, Executive Director

(312) 755-7477

jvasilias@acgme.org

Karen Lambert, Associate ED

(312) 755-5785

kl@acgme.org

Felicia Davis, Associate ED

(312) 755-7445

fdavis@acgme.org



Questions???



**Update from the
Residency Review Committee
for Internal Medicine
March 27, 2010**

**Dennis Boulware, MD
Chair-Elect
Residency Review Committee
for Internal Medicine**