

Accreditation Council
for Graduate Medical
Education



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The ACGME Bulletin is distributed free of charge to over 12,000 individuals involved in graduate medical education.

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Executive Director's Column:




David C. Leach, M.D.

On Saturday, February 20, 1999 the American Medical Association (AMA) sponsored an open hearing at the Westin O'Hare Hotel to allow interested parties to offer testimony on a series of recommendations proposed by the Federation of State Medical Boards (FSMB) regarding resident physician licensure. The following constitutes a summary of my brief remarks to the group.

"The ACGME has not taken a position on the Federation's recommendations. At the same time, the Council would like to offer itself as a forum for dialogue on this and other issues of importance to graduate medical education.

The ACGME had no prior knowledge of the recommendations and could have substantively contributed to the development of proposals that might have served the compelling agenda of protecting the public, yet done so in a way that was less disruptive to quality education programs. The ACGME has established Institutional Requirements that must be met for an institution to conduct any graduate medical educational programs accredited by our organization, and periodically reviews each training institution to ensure that it meets these requirements.

They include such things as policies and procedures for the recruitment and selection of residents and criteria for resident eligibility. It is clearly stated in the requirements that "enrollment of non-eligible residents may be a cause for withdrawal of accreditation of the involved program." Additionally, the criteria for resident selection include things like preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity.

We believe the Federation's proposals would be strengthened by input from the ACGME. For example, the Federation's proposal requiring passage of USMLE 2 prior to entering the match would compromise the student's preparation for this exam. Yet both society and the educational program might be well served by mandating passage of USMLE 2 by the end of the first year of GME. We welcome the opportunity to contribute to this open hearing and welcome further dialogue with the Federation to accomplish the crucial mission of protecting the public and improving educational programs." 

AMA Sponsors

Hearing on FSMB

Recommendations

HCFA New York Demonstration Project Finishes Second Year

An interview with Tim Johnson, Greater New York Hospital Association.

In January 1997, the Health Care Financing Administration (HCFA) approved a demonstration project to provide transition payments to New York teaching hospitals that agreed to reduce their resident counts by a prescribed amount. Hospitals that reduced their resident numbers by 20 or 25 percent, while maintaining or increasing their percentage of primary care residents, would be paid a declining percentage of the Medicare reimbursement they would have received for each resident position that had been cut.

The payments would decline over the life of the demonstration, and would disappear after the sixth year. At the start of the project in 1997, nearly two-thirds of New York's 68 teaching hospitals signed up. As of March 15, 1999, 23 hospitals are remaining in the demonstration.

The following is an interview with Tim Johnson, Director of Health Finance and Physician Policy at Greater New York Hospital Association (GNYHA). GNYHA assisted in the development of the demonstration project, and has been acting as an administrative liaison between the demonstration hospitals and HCFA.

What factors were responsible for the development of the New York Demonstration Project?

Tim Johnson: One reason was that leaders at several New York institutions had identified difficulties with reducing their number of residents. A major difficulty in hospitals' efforts to reduce the size of their graduate medical education (GME) programs was that reducing the number of residents at the institution resulted in an immediate loss of all reimbursement associated with those residents, and the hospitals did not have adequate time to adjust to the reimbursement loss. The transition payments were thought to be a partial solution to that difficulty.

There were several reasons why New York was an attractive site for a HCFA demonstration project on resident reductions. New York trains 15 percent of the nation's residents. Since reducing the number of residents was going to save the Medicare program money in the long run, the more residents were reduced, the better it was for HCFA. In addition,

many institutions in New York's urban areas, as in other states, rely on residents to help provide needed patient care services. This made New York an ideal learning laboratory to test whether transition payments could adequately assist institutions in reducing their reliance on residents. Also, sizable reductions in Medicare GME payments were being debated in 1996, and many New York teaching institutions were interested in reducing residents in anticipation of these cuts. Finally, there were concerns that impending legislation might severely curb or eliminate payments for international medical graduates (IMGs). A large percentage of the trainees in New York's teaching hospitals are IMGs, so any payment cut that targeted IMGs would have a disproportionate effect on New York's teaching hospitals.

What caused the majority of New York teaching institutions to sign up for the demonstration project in 1996?

Today, why are some institutions dropping out and others are remaining in the demonstration?

Tim Johnson: The large number of institutions' interest was not anticipated. GNYHA expected that less than ten institutions would sign up, not the 42 that entered the project at the start.

One reason so many may have signed up is that doing so did not involve any up-front cost or risk, and that hospitals had only one month to decide whether to apply. The fact that there was no cost to joining allowed hospitals to take time to analyze whether they would benefit from the transition payments. There still is no penalty associated with withdrawing from the project. To date, hospitals have not received 'transition funds' and thus no payback of dollars is required when a hospital resigns from the project.

Hospitals that have dropped out of the demonstration have done so for different reasons. In general, hospitals have found that the cost of replacing the service component of residency training is not close to being offset by increased efficiency and the expected transition payments. Some hospitals have been unable to work within the project's inflexible design. For example, if a hospital decided it needed seven years to make a 25 percent reduction, the hospital would not be able to remain in the demonstration.

Also, Medicare's approach to calculating the reduction 'glide path' involves counting all residents on-site, both

those sponsored by the institution and rotating residents from other sponsors. The fact that the reductions must take into account both groups of residents was causing some hospitals to have difficulties.

Some hospitals serve as the only local or regional training site for selected specialties and accept rotators from a number of programs. The demonstration effectively required them to either not allow residents to rotate in or to make deeper cuts in their sponsored programs.

Some institutions have been able to work well within the design of the project. The particular mix of training programs that a hospital has can increase that institution's ability to reduce residents in the manner required for the demonstration. For example, cutting an internal medicine training program by 50 percent requires a different approach and has a different impact than eliminating a pathology or anesthesiology program. At the same time, as the project enters its third year, the cumulative effect of the reductions is being felt by all participants. Institutions find it difficult to replace residents in their patient care role, in large part because these are bright, highly skilled, versatile, energetic individuals.

Were there unexpected benefits for the institutions participating in the demonstration project?

Tim Johnson: One benefit was that the institutions in the project performed a thorough assessment of their GME programs. This gave them added insight into the scope of their training programs, the institutions used for rotations, and the quality of the individuals recruited into residency. There is no clear evidence to date that participation in the project enhanced the quality of education. However, use of National Resident Matching Program (NRMP) fill rates in targeting programs for reduction has focused interest and potentially resources on the factors that positively affect 'match' performance at the institutional level. In addition to the Federal demonstration project, New York State, through the Health Care Reform Act of 1996 (HCRA), provides \$54 million in added incentive payments to teaching hospitals and GME consortia that meet certain State policy goals. Minimum requirements for receiving HCRA incentive pool funds include a 2 percent reduction in non-primary care residents, and having 95 percent of the institution's residents training in accredited programs.

What was the environmental context in which the demonstration project was initiated?

Have major changes occurred in the environment over the past two and one-half years?

Tim Johnson: The major environmental factors that made the demonstration attractive were the deregulation of the hospital financing system that began in January 1997, and increased managed care enrollment. The end of the rate-setting system meant that the level of competitiveness among hospitals increased such that teaching hospitals were unsure whether they could support the number of residents they had while competing for managed care contracts. In addition, there were expectations that the inpatient census at many hospitals would drop and that teaching hospitals would not be able to offer the requisite number of "experiences" to residents to maintain their programs' accreditation. In some hospitals, the census did drop, but in many others, it did not and those hospitals found it extremely difficult to replace the service component that their residents provide in a cost-effective manner.

Also, a provision in the Federal Balanced Budget Act of 1997 that reimburses teaching hospitals for their residents on the basis of a three-year rolling average effectively created a form of transition payment for modest reductions. This offered teaching hospitals that were interested in paring down their resident complement another option for doing so.

Is the New York demonstration project as valid as it was in 1997?

Tim Johnson: While institutions have dropped out of the project, the current level of participation still exceeds initial expectations. In general, it is important to remember that this is a demonstration project. Irrespective of the number of institutions that will ultimately complete the demonstration, the information the demonstration project will yield for HCFA will be invaluable in the design of future programs that seek to use Medicare payments to bring about changes in the size and mix of GME programs.

If at the end of the demonstration, HCFA determines that structured payments allowed some hospitals to reduce residents, while this did not work for others, the project will have been worthwhile. Future federal payment plans may then take into account what was learned from the

New York demonstration — that certain institutions may need more time or programmatic flexibility in order to be successful, and that there may be barriers to making reductions that transition payments cannot overcome.

The demonstration identified some concrete issues that need to be addressed in GME reduction programs, such as the need to account for residents who are "off cycle." Residents who took maternity or sick leave during their training who need educational time made up at the end of their training throw off a hospital's count from the standpoint of clean program year numbers. In summary, irrespective of whether a teaching hospital ultimately decides to remain in the demonstration, participation produced a wealth of new knowledge

"...the information the demonstration project will yield for HCFA will be invaluable in the design of future programs that seek to use Medicare payments to bring about changes in the size and mix of GME programs."

at the institutional level. It has also focused more institutional attention on the GME programs, which will likely enhance their quality. ♡

ACGME Work on Outcome Assessment Progresses

Susan Swing, Ph.D.

The ACGME outcome assessment initiative has been underway for the past year. The ultimate goal of this long-term project is to put more emphasis on educational outcome assessment in the graduate

medical education (GME) accreditation process. An important aspect of future GME accreditation activities will be to ensure that each residency program has clearly identified learning objectives related to physician competencies for essential patient care and other professional activities. A second major objective will be to ensure that programs' assessments of residents provide sound information regarding the extent to which these competencies have been attained.

The third goal will be to have programs demonstrate use of assessment results to produce improvements. With increased emphasis on educational outcome assessment,

the ACGME wants to gain greater assurance of the overall educational effectiveness of the residency program.

During the initial project year, an outcome assessment work group and staff developed a set of general competencies for resident physicians. The competencies represent fundamental time-honored characteristics of the good physician, including qualities and skills that patients expect of physicians. Among the competencies are those needed for practice in the changing health care delivery system.

At its February meeting, the ACGME endorsed general competencies in the areas of patient care, clinical science, interpersonal skills and communication, professionalism, practice-based learning and improvement, and systems-based practice. To develop the competencies, the team reviewed the literature and received input from various groups, among them content experts, medical educators, residents, health system administrators, physician associates, and societal and patient spokespersons. During the coming years, the ACGME expects the general competencies to be incorporated into accreditation requirements.

With substantial grant funding recently awarded to this effort by the Robert Wood Johnson Foundation, the team will begin work on identifying, developing, and evaluating outcome assessment methods. The goal is to establish a toolkit of measures that residency programs can use to ensure that they obtain sound measures of educational outcomes, including residents' learning and performance. In addition, the team plans to further evolve concepts of how the accreditation process will change to increase emphasis on educational outcome assessment.

The ACGME believes that changes to the accreditation process should serve the purpose of producing better physicians to meet patients' and society's needs. Thus, incorporating input from the major stakeholders and constituents of graduate medical education is an important tenet of our project development philosophy. As the project develops, the team will provide forums such as focus groups and meeting presentations to both share information and receive input from the GME community. Listed below are activities already in progress or being planned in which this input is invited:

Outcome Project Spotlight

The *ACGME Survey of Resident Evaluation Practices and Resources* has been mailed to program directors

in all core specialty areas except preventive medicine and transitional year. Please take the time to complete the survey. Survey responses provide important background information that will be used to direct project development.

Outcome Assessment Method Pilot Projects

Beginning later this year, we will be developing and evaluating outcome assessment methods for potential use by residency programs. To volunteer as a pilot project site or to find out more about the projects, send a message to outcomes@acgme.org or contact Susan Swing Ph.D., Project Director at 312 464-5402.

Outcome Project On-Line Feedback.


Program directors and GME deans and directors are invited to subscribe to the outcome project on-line feedback group. Participants will have the opportunity to provide their perspectives on prospective developments that will affect the residency program. Responses will be summarized and sent back to participants. Project updates will be provided. Thus far, we have asked participants to comment on the general competencies, including status of education activities in the general competency areas and barriers to enhancing education in the general competencies. To subscribe, send a message to outcomes@acgme.org with your name, position, specialty, and institution. Enter "subscribe" on the subject line of your email message.

ACGME Endorses General Competencies for Residents


At its meeting on February 9, ACGME approved a motion that general competencies in the six areas — patient care, clinical science, interpersonal skills and communication, professionalism, practice-based learning and improvement, and systems-based practice — be incorporated into the Institutional Requirements and the Program Requirements for each specialty. Susan Swing, Ph.D., Director of Research, ACGME, presented on how the general competencies had been identified and distilled to their current format (see **ACGME Work on Outcome Assessment Progresses** on page 4). Future initiatives to make the general competencies an integral part of accreditation will involve the Residency Review Committee Council of Chairs (RRC Council), whose members will address

general competencies at an upcoming meeting on May 8, 1999. A major portion of the meeting will focus on assisting individual RRCs in their efforts to incorporate the competencies into their Requirements, and on discussing ACGME initiatives to assist programs in two areas: (1) implementing education that focuses on the competencies, and (2) evaluating their efforts in this area. The RRC Council also identified operational challenges that will need to be addressed in incorporating the general competencies into education and program accreditation:

- allocating time in the GME curriculum for the general competencies;
- enhancing faculty development and preparedness to teach the general competencies;
- developing effective evaluation and assessment tools; and
- defining which general competencies are the realm of undergraduate medical education, and which should be addressed in residency education.

Future ACGME efforts will focus on further advancing the concept of general competencies for physicians as a vital element of the accreditation process. 

ACGME Bylaws Changes Add Third Public Member and Extend Tenure of Chair


The Council approved a change in the Bylaws to create the position of a third public member to the ACGME, who will serve in addition to Kay Huffman Goodwin and Agnar Pytte, President, Case Western Reserve University, the two existing public members. Paul Friedman, MD, Chair, ACGME noted that the appointment of a third public member will allow for more meaningful involvement of the public members in the ACGME's governance activities, including the various ACGME Committees and the RRC Council of Chairs. The ACGME also approved bylaws revisions that extend the term of the Chair of the ACGME to two years and revise the selection process for the chair and officers of the ACGME to preserve the rotational cycle of the chair position among the five member organizations. The purpose of the revision is "to permit a two-year term of service for the Chair in order to provide more informed participation and better continuity of leadership by the voluntary officers of the ACGME." 

ACGME Defines Procedures for Complaints Against Residency Programs


The ACGME approved revised procedures under which residents and others having knowledge of a program's or institution's failure to comply with ACGME requirements can bring a complaint against the program or institution to the ACGME. The procedures add further to ACGME's systems in place to protect residents by clearly defining the circumstances under which a complaint can be brought before the ACGME and the process to be followed:

- the complaint must result from a failure of a program or institution to comply with ACGME Institutional and/or Program Requirements and the failure must be documented and details provided;
- the individual or group bringing the complaint must have exhausted the program's/institution's options for having the matter addressed;
- complaints must be signed by the complainant and addressed to the Executive Director of the appropriate Residency Review Committee (RRC), 515 N. State Street, Suite 2000, Chicago, Illinois 60610 (a complainant's name will not be disclosed to any party without written consent).

For potentially valid complaints, the RRC may decide to investigate immediately or at the next regularly scheduled site visit and review. The complainant, program director and/or the designated institutional official will be informed of the RRC's decision to proceed.


The complete ACGME Procedures for Dealing with Complaints Against Residency Programs are available on the ACGME Web site (www.acgme.org) and through the ACGME automated Fax System (312-245-9174). 

Program Requirements Approved

At its February 1999 meeting, the ACGME approved revised Program Requirements in the following specialties and subspecialties: Clinical and Laboratory Immunology (effective July 1, 1999); Dermatology and Dermatopathology (both effective July 1, 1999); Ophthalmology (effective July 1, 1999); and Neurological Surgery (effective July 1, 1999). 

ACGME Staff Discusses Accreditation Standards


A recent meeting of the RRC Executive Directors was used as a forum for a discussion with Paul Batalden, MD, Director, Clinical Process Improvement, Dartmouth Hitchcock Medical Center and Jim Roberts, MD, formerly of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), about the process used by the JCAHO a few years ago to revise its standards. The discussion is part of an ongoing dialogue within the ACGME about the substance of accreditation. The presenters noted that, ideally, accreditation should involve the entities being accredited in developing goals for each standard and defining the processes the standard should produce within the unit being accredited. When this process was used at the JCAHO, it resulted in the standards being reduced by one-third. Trimming the standards included removal of standards that were consistently met by every institution and editing the language so standards were clearly stated in ordinary English. Simultaneously, it was possible to 'add muscle' by strengthening the link between the requirement and the desired results at the institutional level.

Dr. Batalden and Dr. Roberts commented that this process requires an active dialogue within the field to explore each standard's leverage in achieving the 'goal' of accreditation — what are the key factors that produce residents who practice well? While it is not exactly known how residency programs produce highly qualified physicians, there is understanding of the processes involved. An active dialogue that is truly industry-wide and not dependent on individual persons or institutions would be a powerful force in advancing both understanding and support of standards. 

ACGME Holds First Juried Poster Session


The workshop Mastering the Accreditation Process, held March 4-5, 1999 in Chicago, featured a the first ACGME juried poster session entitled "Adapting to Change: Innovative Approaches to Accreditation." Fifteen posters were submitted and exhibited. The intent was to showcase good practices and facilitate the dissemination of new ideas. The presentations were evaluated by a panel of judges, and a prize was awarded to the winning poster — "Core Curriculum Development Through

Postgraduate Education" by James Alan Morgan, MD, LTC, and David Manthey, MD, Maj., Brooke Army Medical Center, San Antonio, Texas. This poster was selected for its innovative use of an outcome measure — peer and self-evaluation of the practice performance of program graduates — as a tool to focus the curriculum in an emergency medicine training program. A follow-up survey of graduates' performance in several areas that include patient evaluation, technical skills, teaching ability and consult utilization is conducted six months and one year after they enter practice. Residents also complete self-evaluations on these parameters. This information is used to identify areas where the curriculum can be enhanced. It has to date resulted in the addition of a neurology rotation, deletion of a trauma rotation, and greater emphasis placed on administration, outpatients pediatrics, and diagnostic ultrasound.

Second place was awarded to the poster "Competency-Based Evaluation Forms" by David G. Kemp, MD FACP, Easton Hospital, Easton, and a third place was awarded to the presentation "Faculty Development: A Continuous Quality Improvement Model" by Karen E. Heiser, PhD, David Dawdy, MD, and David J Fisher, MD, Children's Institute for Pediatric Education, Ohio State University, Columbus, Ohio. 

ACGME Staffing Changes

Several changes in the ACGME's staff have occurred since the beginning of 1999. Mary Ambler, MD and Robert Friedlander, MD both retired from the ACGME field staff in January. Dr. Ambler, a neuropathologist, served on the field staff since 1993. Dr. Friedlander, whose specialty is obstetrics-gynecology, was a member of the field staff since 1994. Three new members joined the field staff in January and February of 1999. Donald Lackey, MD, a graduate of the University of California, Irvine, College of Medicine, is a board-certified pediatrician. He has served most recently as the vice president for medical affairs at the Southern Regional Medical Center, Riverdale, Georgia. Dr. Terry Myers obtained his PhD in molecular genetics at Florida State University and his MD at the University of Virginia. He is board certified in clinical genetics, and served as the regional chairman of pediatrics and associate dean for clinical affairs and medical director for the Texas Tech University health science campus at Amarillo, Texas. E Lee Taylor, MD, graduated from the University of Alabama at Birmingham School of

Medicine, and received his graduate training in family practice. His prior appointments have included Chairman of the Department of Family and Community medicine at the University of Alabama, and Regional Dean of Texas Tech University Medical Center School of Medicine at Amarillo, Texas. 

AMA Releases 1999-2000 GME Directory

The American Medical Association (AMA) recently released the 1999-2000 GME Directory. The Directory includes information on over 7,800 ACGME-accredited and combined specialty programs and 1,600 teaching institutions. Also included are ACGME Institutional and Program Requirements for more than 100 specialties/subspecialties; medical specialty board certification requirements; a list of U.S. medical schools; and a specialty/subspecialty taxonomy with accredited program length and availability of post-graduate year-1 positions. The electronic version of the Directory, Graduate Medical Education Directory on CD-ROM, offers improved search capabilities and includes data not shown in the paper edition of the Directory, including application deadlines, number of applications received, and program start dates. For ordering information contact the AMA at 1-800-621-8335.

Other information resources related to graduate medical education, published by the AMA, include the Graduate Medical Education Directory Supplement, which features information on programs offering shared residency positions and programs offering multiple start dates; and State-level Data for Accredited Graduate Medical Education Programs in the US, which provides information by state and specialty on a number of parameters. Characteristics of Graduate Medical Education Programs and Resident Physicians by Specialty offers information on numbers and characteristics of resident physicians; percentage of resident physicians completing all required training for a given specialty and going on for subspecialization; and faculty and educational features of GME programs by specialty.



- Also: Program Requirements Approved; Accreditation Standards Discussed; First Juried Poster Session; Staffing Changes; and AMA Release of 1999-2000 Directory.
- ACGME Defines Procedures for Complaints Against Residency Programs
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