Alliance for Academic Internal Medicine

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October 28, 2016

Thomas J. Nasca, MD
President and Chief Executive Officer
Accreditation Council for Graduate Medical Education
401 North Michigan Avenue
Suite 2000
Chicago, IL 60611

Dear Dr. Nasca:

On behalf of the Alliance for Academic Internal Medicine (AAIM), thank you for the opportunity to provide feedback regarding sections I-V of the Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements.

AAIM represents department chairs and chiefs; clerkship, residency, and fellowship program directors; division chiefs; and academic and business administrators as well as other faculty and staff in departments of internal medicine and their divisions at medical schools and teaching hospitals in the United States and Canada.

As you requested, AAIM considered the topics in your letter of September 16, 2016, and responses to your questions are attached. Themes include:

- Systems to ensure wellness for residents and fellows
- Infrastructural support
- Service v. Education
- Electronic Medical Records
- Leadership Training

Again, thank you for providing AAIM the opportunity to provide feedback on sections I-V of the Common Program Requirements. If you have questions or need additional information, please contact me at (703) 341-4540 or AAIM@im.org at your convenience.

Sincerely,

D. Craig Brater, MD
President and Chief Executive Officer

Question # 1

What areas currently addressed in Sections I-V should be common across all specialties without the option of additional requirements for individual specialties?

AAIM reviewed all of the instances in Sections I-V that are currently identified with the allowance for additional requirements, “[As further specified by the Review Committee].” With the exception of I.B.2 and II.A.1.a), AAIM agrees that the “[As further specified by the Review Committee]” text should remain as additional requirements (and/or exceptions) may be needed by individual specialties.

Question # 2

What issues or topics that are, or should be, common to all specialties are missing from the current requirements? Please include any specific recommendations you may have regarding how to address these issues/topics in the requirements.

The major themes that emerged from discussion of this question were:

- Wellness
- Support
- Service v. education
- Electronic Medical Records (EMR)
- Inclusion of Osteopathic Residents
- Leadership Training

Wellness

AAIM recommends provision of resources for wellness programs and confidential mental health services. Language should be developed to require program directors to have systems in place to encourage and develop resident wellness and resilience, with a clearly delineated method to identify residents who are in danger of burnout, mental health disorders (e.g., post-traumatic stress disorder, major depressive disorder, adjustment disorder, other anxiety disorders, substance use disorders, etc.), and/or suicide. This system would also include connecting residents to institutional employee assistance programs.
Suggested additions to the requirements include:

- Change IV.A.5.f).(5) to “work in interprofessional teams to enhance patient safety, improve patient care quality, and facilitate workplace engagement (i.e., prevent burnout) when managing complex patients and complicated situations using teams; and”

Wellness for Fellows
AAIM recommends the addition of requirements to monitor the demands of call, including call at the hospital and at home, and to adjust schedules as necessary to encourage wellness and promote the energy needed for the cognitive and performance-based activities of the fellowship. Calls from home are “work” and should be counted as work. Schedules must be set up to allow for sufficient time to rest from these activities.

Support

There should be specific language requiring infrastructural support—including financial, administrative, personnel, and technological—for the program director and core faculty. Dedicated administrative support personnel must have the qualifications, knowledge of ACGME regulations/ milestones, and adequate relevant experience to promote program efficacy and reporting. Technological support should include systems to facilitate and manage the collection and storage of data for competency-based learner assessments and ACGME subcompetency reporting.

AAIM recognizes that it would be difficult to calculate an appropriate minimum number of hours per week support, especially for small fellowship programs (e.g., one to three fellows). Size-based charts,

such as those in the ACGME Program Requirements for GME in Internal Medicine (I.A.2.), may be useful, but proscriptive requirements may prove problematic for some programs.

Service v. Education

The introduction to the Common Program Requirements clearly states the importance of service learning – that physicians hone their knowledge, skills, and attitudes by performing authentic physician duties and working in patient care and academic settings. Unfortunately, the annual resident survey has framed questions about the learning environment in terms of "service versus education," thereby creating a false dichotomy. While this verbiage is not found specifically in the Common Program Requirements, it has become engrained in the minds of residents and faculty members. It would be helpful to expand upon the theme of service learning (as in performance of authentic physician duties) in subsequent portions of the requirements.

The requirements should indicate that the institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. Currently, only the program director is so charged. Residents and fellows should perform work that is commensurate with their level of training and it should be expected that activities such as scheduling, returning routine calls that do not require the level of training of a provider (e.g., calling in medications or telling a patient the time of an appointment), and clerical activities (e.g., forms with routine check lists, faxing, scanning documents) should be delegated to other members of the health care team.

Electronic Medical Records

Add a new requirement [IV.a.5.d).(6).] to indicate the need for proficiency in the use of electronic medical records (EMR) to maintain accuracy and efficiency. An exception can be allowed if the institution or program does not have an EMR.

Guidance Regarding Inclusion of Osteopathic Residents

The requirements should provide more guidance on how residency programs should handle transfers from osteopathic programs (especially completion of the traditional rotating internship), osteopathic-trained graduates of American Osteopathic Association accredited programs, and the "grandfathering in" of these residents when applying for fellowship programs.

Many areas in the requirements will need changes to be made to address the Single Accreditation System. For example, in II.A.3., the program director should have qualifications in his/her specialty, but if the program is a dual program, and the program director does not have qualifications in the other half of the program, then, the associate program director should have these qualifications.

Leadership Training

The concept of leadership training should be added to the requirements (Section IV) to ensure residents develop skills in interpersonal communication, professionalism, and systems-based practice in preparation for independence.

Question # 3

Should the ACGME develop a truncated set of Common Program Requirements that would be applied to all fellowship programs? Please include any specific recommendations you may have regarding how Common Program Requirements for fellowships might differ from the existing Common Program Requirements.

AAIM does not support developing a truncated set of Common Program Requirements applicable for all fellowship programs. As currently structured, the Common Program Requirements are applicable for both residency programs and fellowship programs, and includes appropriate delineation of where there may be differences between a fellowship and a residency. The emphasis that a fellow remains a trainee, just as a resident is a trainee in a medical environment should be followed; essentially, a fellow is a "resident" in a subspecialty.

Improvements to the current Common Program Requirements can be made to facilitate its continued application for residency and fellowship:

- As mentioned in question 2 under "wellness," a statement on appropriate "work" should be added to the existing Common Program Requirements to delineate how fellows take call from home. Recognizing this effort as "work" for fellows and scheduling it into their activities is different from that of a residency program.

- The layout of the existing Common Program Requirements could be improved. For example, color-coding could be used to emphasize requirements that are specific to residents or fellows.

Question # 4

Any other comments or suggestions you have related to Sections I-V of the Common Program Requirements.

AAIM identified the following areas addressed in the current requirements which need further clarification and has suggested changes when possible:

- Scholarship
- Evaluating Milestones in Fellowship Eligibility Exception
- Appointment of Fellows and Other Learners
- Practice-Based Learning and Improvement
- High Value Care in Systems-Based Practice
- Clinical Competency Committee Composition
- Faculty Evaluation
- Defining Teaching Faculty

Scholarship
In II.B.5.b), ACGME should clarify whether this requirement pertains to core faculty versus any faculty members. In addition, guidance is needed on whether scholarship also includes work in quality improvement/performance improvement and curriculum development. AAIM supports a broader definition of scholarship.

Clarification is needed in IV.B.2 to indicate whether the goal is increasing scholarly activities or increasing scholarship. ACGME should better define whether quality improvement, educational curriculum development, and developing a researched lecture count as scholarly activity. These efforts take additional time and resources for residents and programs, especially for smaller programs. This area can be better defined for fellowship programs – as there is a stronger emphasis on a narrow definition of scholarship – rather than residency, where a broader definition may be better suited.

Evaluating Milestones in Fellowship Eligibility Exception
AAIM is concerned that six weeks does not provide sufficient time for milestones evaluations [III.A.2.b).(5)] in Fellow Eligibility Exception. ACGME should eliminate the requirement or extend the timeframe to up to three to six months. III.A.2.b).(5).(a) and all of III.A.2.c) should no longer be needed.

Appointment of Fellows and Other Learners
The requirement (III.D.1) for program directors to report the presence of other learners to the designated institutional official and graduate medical education committee is too detailed. It is very difficult (especially at the fellowship level) for program directors to know of all of the learners who may be present in large programs with multiple participating sites.

Practice-Based Learning and Improvement
In IV.A.5.c).(4) and IV.A.5.c).(7), programs should be allowed to confirm that requirements (such as quality improvement) have been achieved through verification of milestones from prior training programs.

High Value Care in Systems-Based Practice

ACGME should encourage implementation of a high value care curriculum (similar to AAIM-American College of Physicians (ACP) High Value Care Fellowship Curriculum and ACP-AAIM High Value Care Curriculum for Residents) to help programs meet the requirement in IV.A.5.f).(3).

Clinical Competency Committee

V.A.1.a) requires the clinical competency committee (CCC) to be composed of, at a minimum, three members of the program faculty. Also, consideration should be given to the use of Advanced Practice Providers to help those smaller fellowships.

Faculty Evaluation

Section V.B. should be changed to be consistent with resident and fellowship evaluations. These evaluations of faculty should be competency-based, just as they are for residents and fellows.

Defining Teaching Faculty

In the past, internal medicine has had core or key clinical faculty. In a given program, there may be over 100 teaching faculty, but each of these may have limited interactions with residents. V.C.3.a) indicates the Program Evaluation Committee (PEC) action plan should be reviewed and approved by the teaching faculty and documented in the meeting minutes. A definition of teaching faculty would be helpful.