

## Accreditation Council for Graduate Medical Education

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## Preparing for the Accreditation Site Visit: Advice for New and Seasoned Program Directors

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In the past year, nearly 2,000 programs and sponsoring institutions underwent an ACGME accreditation visit. The goal is clear to most – assessing compliance with the program or institutional requirements – but the process remains a mystery to some. To increase new program directors' awareness, and to update seasoned ones on changes since their last site visit, this article offers insight into what to expect in 2005, along with practical suggestions for how to prepare.

### Preparing the Program Information Form (PIF)

An important requisite is a thorough understanding of the requirements, which is equally important to day-to-day compliance and to the preparation of the program information form (PIF). Program directors filling out their PIF should understand that it is a self-study document that describes how the program meets the accreditation requirements. The site visit and the review by the Residency Review Committee (RRC) are based on this document, and the site visitor's role is to verify and clarify the information in the PIF.

The site visit announcement letter sent by the ACGME (also see below) contains information and instructions to assist in preparing for the visit to ensure that it goes smoothly. Program directors should particularly note the bulleted instructions that detail the documents that need to be prepared for the visit, including the Competency Assessment Form that collects information on the six general competencies. The ACGME and RRC team are eager to provide information and assistance to programs regarding any aspect of preparation. For new program directors, RRC newsletters and information compiled by program director organizations can also be helpful by providing specialty-specific information. Some general, practical "Do's and Don'ts" are shown below.

#### **Do**

- Begin with a review of the current program and institutional requirements. Both are available from the ACGME's Website (<http://www.acgme.org>). Look for the verb "document" in the requirements, because these are the areas where the site visit will entail review of files, policies and procedures and other documents provided by the program.
- Allow sufficient time to gather the data needed for completing the PIF.
- Describe your residency program accurately, completely and truthfully. Be clear and concise.
- Call the RRC staff if you are unclear about how to answer a question in the PIF. If you have a technical problem, contact the ACGME Help Desk at 312 755-7464.

- Keep in mind the RRC will appreciate clear, concise information about the specifics of your program.
- Complete the competency addendum on the ACGME's Accreditation Data System (ADS).
- Send one copy of the completed PIF to the site visitor a minimum of 14 days before the site visit date. Retain three copies to give to the site visitor, to be sent to the ACGME and used for the review.

### ***Don't***

- Leave any PIF questions unanswered, or submit information not requested, such as recruitment materials or public relations materials.
- Staple or bind the PIF. Rubber bands should be placed around each copy.
- Forget to include the Letter of Report from your sponsoring institution's most recent institutional review. If you do not have a copy, contact your GME office.
- Rely on the site visitor to convey information to the RRC that was not included in the PIF.
- Make changes to the PIF after you sent the site visitor his/her copy. Minor corrections may be made on the day of the review and the revised pages substituted in the copies to be sent to the ACGME.

Whether the program director completes the PIF or delegates parts to others, a third party should read the document for consistency, accuracy and clarity. You may also want to have your residents read the PIF. The final step is review and sign-off by the designated institutional official (DIO).

### **The day of the visit**

To make things go well on the day of the visit, keep in mind that site visitors appreciate directions and arrangements for a specified meeting place. The visit should take place in one conference room with a table to allow the site visitor to do his or her work. Program staff should be flexible, as the day's schedule may change to accommodate collection of additional information.

The visit begins with the program director and the site visitor conducting a thorough review of the PIF, to begin the process of verifying and clarifying the information. This is followed by interviews with faculty, institutional and departmental representatives, ending with the resident interview. The site visitor seeks consensus among all participants. When this cannot be achieved, differing views are reported, while maintaining the confidentiality of the reporters, especially that of resident participants. In many programs, the interviews are followed by a tour of selected facilities. A final meeting with the program director, to resolve ambiguities discovered throughout the day, completes the visit. Most program directors know that the ACGME site visitors cannot provide feedback on how the program is performing. Though they are experts, often having seen hundreds of programs both good and bad, they are not the decision-makers. That responsibility rests with the RRC, in keeping with the ACGME's peer review process. Program leadership may still find this interview useful.

### After the visit

Following the visit, the site visitor completes the report. When the document has been written, edited and transmitted to the ACGME, the site visitor's job is completed. The report is forwarded to the RRC, where one or more reviewers review the PIF, the site visitor's report and, frequently other information such as operative log data or information from resident surveys collected with or in parallel to the PIF. At the RRC meeting, after the primary reviewer presents the program, the RRC as a whole decides on citations, the accreditation status and the time interval until the next scheduled visit.

The ACGME strives to get each program reviewed in a timely fashion, and all RRCs meet two or more times per year. Yet a visit 90 days ahead of a meeting date does not guarantee the program will be considered. Many RRCs close out the agenda well ahead of the meeting, to give their members time to complete the reviews. The schedule of RRC meetings is published on the ACGME Web site. Program directors also may contact the RRC team to find out whether their program will be reviewed at a given meeting. After the RRC has met, the program is notified in writing of the accreditation decision. Many RRCs now offer an initial summary of accreditation status and cycle length via fax or email within three to four days of the meeting. These early notifications will not provide citations or other details from the review.

In closing, the suggestions above and the information on the web site and in the announcement letter should contribute to making the site visit go smoothly. At the same time, the best guarantee for a successful site visit is ongoing attention to the quality of resident education, to ensure that the program provides the best possible education experience. ■

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## Responding to Enhanced DIO Oversight

The ACGME Institutional Requirements specify that the Designated Institutional Official (DIO) or a designee review and cosign "all program information forms and any correspondence or document submitted to the ACGME by the program directors that either addresses program citations or requests changes in the programs that would have significant impact, including financial, on the program or institution." In addition, the institution's graduate medical education committee (GMEC) must review and approve applications for new programs; changes in resident complement; major changes in program structure; additions and deletions of participating institutions and appointments of new program directors. The ACGME is in the process of transitioning to electronic submission of these requests to RRCs through the Accreditation Data System (ADS). In final development is a systems improvement that will provide periodic electronic updates to the DIO of any changes programs under his or her purview have submitted to ADS. The goal is to increase DIO awareness of these changes and to facilitate follow-up with programs as needed. ■

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## ACGME Extends Site Visit Announcement to 110 Days to Facilitate DIO Review of the PIF

Beginning in January 2005, the ACGME will send its announcement letters for accreditation site visits 110 days prior to the date of the visit, extending it from the current 90 days of advance notice. This change was instituted in response to requests from programs and designated institutional officials (DIOs), with the goal of allowing added time for review and sign-off of the program information form (PIF) by the DIO, which ACGME considers an important aspect of institutional oversight.

In specialties in which "Part 1" of the PIF is generated by the Accreditation Data System (ADS), a space for the DIO signature is provided on the first page. This currently encompasses all core programs with the exception of Preventive Medicine and Internal Medicine, and several subspecialties. Other specialties are scheduled to be added in the coming months. In specialties that do not yet use ADS, programs should add a space for the DIO to sign on the first page of the manually prepared PIF.

It is worth noting that, just like the prior 90-day period, the current advance notice period of 110 days is a guideline. Occasionally, announcements may be made within a shorter time frame, especially when a program is being substituted for a visit that needed to be postponed. Should the assigned date present a major conflict, the program should contact the ACGME within 14 days of the receipt of the announcement letter. ■

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## Expectations for Documentation in Resident Files

The growing use of electronic evaluation and data management and refinements in the standards make it advisable to clarify ACGME's expectation for documentation in resident files. The ACGME site visitors are required to look for evidence of documentation of resident selection, resident evaluation and verification of prior training for transfer residents. Site visitors do this by reviewing a sample of residents' files. This summary seeks to provide helpful advice on what they expect to see.

### Documentation of prior training for transfer residents

The common program requirements require the program director to "receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program." A companion requirement stipulates that the director of the resident's former program must provide this verification upon request. The intent of these standards is to allow the program accepting the transfer resident to prepare an appropriate education plan, and to allow forwarding of the documentation to the pertinent ABMS-member board to confirm board eligibility once the resident completes training.

The expectation for documentation of prior training also applies to residents who complete a preliminary or transitional year, and to residents entering fellowship training at the completion of a core program. In all cases, the RRCs expect documentation of prior training to be included in residents' files, and the ACGME site visitors will look for this in their sampling of these files. Finally, the ACGME also looks for documentation of undergraduate medical education, and for the presence of current ECFMG certificates in the files of international medical graduates.

### Use of electronic resident evaluation systems

A growing number of programs use electronic evaluation systems or data management “suites” for collection, aggregation and presentation of a variety of data related to the administration of residency programs. The ACGME and the RRC Council of Chairs have clarified the expectation for information that should be available during the site visit, with the goal of allowing site visitors to verify the existence of a functioning evaluation process, including discussion of the evaluations with the residents. Evidence of this can be offered either via traditional paper-based evaluation forms or print-outs of electronic evaluations, and evidence these evaluations were reviewed with the resident, such as the residents’ signatures.

If the program uses an electronic system, it should always maintain a paper record of the final evaluation at completion of training. For residents with academic or other performance problems, there should be additional hard-copy records, because the electronic evaluation parameters may not be appropriate or sufficient in cases where remediation, probation, non-renewal or dismissal needs to be documented. ■

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## Summaries of Presentations and Some Practical Advice from the ACGME/IHI Invitational Conference on Medical Knowledge and Practice-based Learning and Improvement

On September 11 and 12, ACGME and the Institute for Healthcare Improvement (IHI) co-sponsored an invitational conference focusing on two general competencies – Medical Knowledge and Practice-based Learning and Improvement. A number of presentations, which showcased the use of these competencies in residency programs, are summarized below, along with three to four important things about the initiative that would be helpful to other programs considering similar efforts to advance the competencies.

In a presentation entitled ***Development of a Competency Assessment Tool for Plastic Surgery Residents***, Lisa J. Gould, MD, PhD, Assistant Program Director, Plastic Surgery, University of Texas Medical Branch, evaluated plastic surgery residents on the six competencies in the context of case presentations. Residents could choose from a list of PGY level-appropriate cases, and the presentations were limited to 15 minutes each for their oral presentations to allow all residents to be evaluated during a two-hour conference. Dr. Gould shared four take-away messages: 1) the format allows the residents to present a “portrait” of a patient from the initial evaluation to the final outcome; 2) residents learn first-hand about aspects of systems-based practice, including billing and coding; 3) residents and faculty demonstrated increased understanding of how to work with the core competencies; and 4) the presentations allow the residents to develop a portfolio of their progress in training.

A second presentation, ***Using the Journal Club as an Approach to Teaching and Assessing Practice-Based Learning and Improvement***, by Andrew G. Lee, MD, Professor of Ophthalmology, Neurology and Neurosurgery, University of Iowa Hospitals and Clinics, showcased the use of a journal club to give ophthalmology residents a better understanding of practice-based learning and improvement. The journal club meets four times per year. Residents are encouraged to apply the knowledge gained during patient care charting and chart rounds, and to incorporate the evidence into their presentations of cases at grand rounds. Dr. Lee added that the most important concepts from this approach are 1) ensure faculty buy-in at the start by explaining the process and offering evidence of its success in other

settings; 2) assign fewer articles and have less frequent meetings, but create a high-quality encounter; 3) combine tools, such as linking the journal club to portfolios or a 6- to 12-month self assessed chart audit to assess change in residents' practice; and 4) measure multiple competencies at once.

Alison S. Clay, MD, Pulmonary/Critical Care Fellow, Department of Pulmonary, Allergy and Critical Care Medicine, Duke University Medical Center, gave a presentation entitled ***Medical Education in Critical Care: Improving Medical Knowledge, Patient Safety and Quality in the Intensive Care Unit.*** This multidisciplinary critical care curriculum, focused on central line placement, resuscitation, consultation to the emergency department and communication with families, is offered to junior residents rotating in the medical and surgical intensive care units. Using a web-based curriculum and a set of "checklists" to measure application of knowledge as tools, the approach identifies strengths and/or gaps in development in the residents. Dr. Clay added this practical advice: 1) evaluation and feedback must be timely, and may be a paradigm shift for some evaluators; 2) educators need instruction to better understand the difference between feedback and evaluation; 3) programs should not underestimate residents' willingness to improve; and 4) the opportunity for self directed improvement/learning may be more powerful than learning mandated by the program.

***A Community Hospital's Collaborative Research Model***, developed by Gino A. Trevisani, MD and Janine M. Sadlik-Carzo, MS, St. Elizabeth Family Medicine Residency Program, Utica, New York, addressed the concern that opportunities for research and scholarly activity may be more limited in community hospital residency programs. Their collaborative research model described links between the residency program and graduate education at State University of New York (SUNY) Institute of Technology, Department of Health Administration to enhance education in epidemiology. Initial collaboration focused on hospital readmissions for patients with a diagnosis of congestive heart failure (CHF). Program faculty and residents collaborated with SUNY faculty and graduate students to develop working hypotheses, a study design, collect and analyze data and present the findings. This contributed to the development of key indicators for patients readmitted with CHF, and ultimately the organization of a CHF clinical pathways team.

***Clinical Profiling in Surgical Education: A Process in Evolution***, by Cheryl I. Anderson, RN, MSA and Carol A. Slomski, MD, Department of Surgery, College of Human Medicine of Michigan State University, assesses surgical patients' experience against the Institute of Medicine's "Six Aims for Patient Safety." Surgical faculty and residents participated in a review of actual or potential patient events, using proven methods that assess the processes of care, including Failure Mode and Effect Analysis and Root Cause Analysis. Ms. Anderson offered the following pointers: 1) ensure the commitment of key leaders; 2) use objective outcome measures linked to evidence; 3) work toward creating a "blameless culture;" and 4) be willing to accept incremental change. ■