

During the Key Stakeholders' session at the APPD Spring meeting, many questions were posed to the ABP and the ACGME both at the open microphones and via written cards. We collected all of those questions and posed them to our representatives (ACGME-Caroline Fisher and Mary Lieh-Lai; ABP-Gail McGuinness). Their responses are below. We hope that you find this useful. Thank you for your active engagement with the APPD.

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ACGME and ABP Answers/Questions Follow-up from Key Stakeholders Plenary Session 2014 APPD Annual Spring Meeting

ACGME

CORE Faculty and other faculty issues:

- For the subspecialty faculty survey, what constitutes “core faculty”?
 - *The definition for “Core” faculty only applies to specialty programs (i.e. Pediatrics). Faculty, from the subspecialty division, who devote significant time to the subspecialty program were identified to participate in the faculty survey. The ACGME will review the criteria for participation in the survey, once the results of this year’s survey have been analyzed.*
- Is there a specific %time devoted to education?
 - *See above.*
- Is there an opportunity to remediate if the faculty survey is not done?
 - *No, once the reporting window is closed, the survey cannot be completed.*
- RE: ACGME “Core” faculty: for example, pediatrics genetics faculty in small programs, some faculty do not teach learners every month, but when they do have a learner they are highly engaged teachers (40 hours a week). Is this person a Core faculty member even though the average may be <15 hours a week if you include months with no learners.
 - *Programs may calculate the average hours faculty devote to residency education per week based on the academic/calendar year or if faculty do not teach residents each month, it may be based on only the months the faculty spend teaching.*
- How should we report “recent” for those faculty in MOC?
 - *The faculty board certification section is being updated to include an option for participating in MOC.*

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- Should a subspecialty program with multiple sites, some of which have no fellows resident/working at that location, but the faculty is in the same division, be included in the roster?
 - *Faculty in the division who are not involved in the education/supervision/research mentoring of fellows should not be included on the faculty roster.*

Resident Survey:

- Why doesn't the ACGME publish a complete, verbatim set of the resident survey questions on the website?
- Failing the above, is there any prohibition against a PD asking a resident to print a blank copy of the questions and giving it to the PD?
 - The ACGME does not want to publish a complete, verbatim set of the resident survey question in order to avoid instances where program directors dictate the residents' responses to the survey questions.
- Can the ACGME provide us with comparable data on the PL-3 "comfort level" with procedures?
 - *National data on the specialty specific questions of the resident survey will be provided along with the national data of the standard survey questions later this year.*
- Delay of release of resident survey results to mid-June is really horrible! Especially since I am also a TYPD. Please fix this!
 - *The ACGME realizes the drawbacks to program directors in delaying the release of the survey results and is reviewing how to make the results available sooner for the next year.*

Accreditation notification:

- In the notification letter, there is no listing of new-extended-resolved citations for the core program, only for the associated subspecialties?
 - *The new departmental letter will be revised to only show the accreditation status for the core program and each of the dependent subspecialty programs. Any changes in citations will be reflected in a separate notification letter for the individual program.*

Program Requirements:

- *Do you have advice re: the liaison for small programs that don't always have a PGY-4 Chief? Can the liaison be a non-MD, i.e. nurse educator or social worker?*
 - *No, the liaison may be a senior resident, chief resident or junior faculty member.*
- For the 3 additional subspecialties in the new requirements, can they be a repeat of the 4 key subspecialty requirements or must they be unique (ie-7 unique subspec EUs)?
 - *The intent was for there to be 7 different subspecialty experiences.*
- Program reqs-CC: Will there be a companion document? Do residents need to track panel patients?

- *Companion documents no longer exist. The “tracking” of the experience should be based on the needs of the program in monitoring the curriculum of the longitudinal outpatient experience.*
- Will there ever be established procedure minimums written into the Peds Program reqs or FAQs? This would help with competency assessment.
 - *The ACGME does not have data on the number of procedures that must be performed before a resident is deemed competent. Until such data are available, the ACGME will rely on the Program Director to determine when the resident is competent to perform procedures without supervision.*
- With minor fluctuations in the #s of residents, a “typical” or “average” block schedule may change year to year. Assuming you always meet minimum requirements for Ed. Units for a given area, will these minor changes be red flags for the RRC? (E.g.-total NICU time goes from 2EU to 2.5 EU to 2EU?)
 - *The “program changes” that are monitored as a data element in the Accreditation Data System (ADS) do not include changes to the block diagram. Changes to the curriculum are not a “red flag”, as long as the minimum program requirements are being met.*

CCC:

- Our 4th year chiefs are still fully funded through GME \$s, can they be on the CCC?
- Can a chief resident be a member of the CCC? The ACGME may be giving the impression that chiefs should not be members of the CCC.
- Please explain the rationale for excluding coordinators from being participating members of the CCC? They are often able to assess subcompetencies in the professionalism domain and provide an important “public” perspective on resident performance.
- I think the ACGME is making assumptions about coordinator skill sets. As a coordinator with a PhD in Adult Education, I believe that I could contribute to the assessment of resident teaching abilities and communication competence. Further, I have formally researched the supports of implementation of competency-based curriculum, yet I am being told that my skill sets are not valued. Why? Why should I not be a full member of the CCC?
 - *Please refer to the e-Communication of April 17, 2014. Proposed requirements related to the composition of the CCC will be posted for review and comment within the next couple of months. Any feedback provided to the proposed revision of the requirements will be taken into consideration by the ACGME Board of Directors when it approves the final language at its September meeting.*

Milestones reporting:

- In prior meetings the RRC stated that Milestones reporting would not be used in the accreditation process. If so, why will the results be reviewed at

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- the time of the RRC meeting, other than whether a program has reported or not?
- *Just as with any new data element (resident survey, faculty survey) that the RC reviews, it will need to be validated. No accreditation decision will be based on any one data element that the program provides. The RC will be looking at the milestones data in conjunction with other data elements to determine if further information is needed before making an accreditation decision.*
 - RE: Milestone reporting and security: We have already reported Milestones in December 2013. What is being done to keep it secure?
 - *Internal Medicine or Pediatrics programs were not required to enter Milestones data during the reporting period of November 1 – December 31, 2013. Therefore any milestones data entered during this period were considered a “test”, and have been discarded.*
 - *Milestones data, as well as all other data submitted through ADS, is kept on a secure, encrypted site.*
 - *The ACGME is exploring other means of Milestones identification such as National Provider Identification (NPI) numbers.*
 - Are they domains of competence of competencies? Are they competencies or subcompetencies? People are using terms in interchangeable ways, which is confusing.
 - *The ACGME has defined 6 domains of competence (or competency, they are interchangeable terms), each of which has several areas of subcompetence (or subcompetency), a total of 48 subcompetencies. Each of the subcompetencies has defined sets of developmental Milestones.*
 - The same subcompetency for pediatrics and subspecialty peds now have different numbers. How should we proceed with data collection and comparison?
 - Are there plans to reassign Milestone numbers so that resident and subspecialty are in alignment?
 - *Competencies are defined by descriptors. Those descriptors have not changed (much) and should be the focus of assessment and reporting. Updated documents mapping the subcompetency areas on which programs must report milestone levels to the original milestones document will be posted to the ACGME website in the upcoming weeks. However, the reporting will take place with the ACGME’s numbering.*

Resident Scholarly Activity:

- One problem we had with ADS reporting was the 1 year window for scholarly activity and only for PL-3s, so no way to report any scholarship done during the 1st and 2nd years of training.
- Resident scholarly activity in ADS asks only for 3rd year residents only the last 12 months of scholarly activity, so this misses 2 years of activity. Will this change in the future, or is there a particular reason for this restriction?

- Is there an FAQ on what qualifies as scholarly activity? The definitions are not clear on the WebADS system. The resident data is for the final year of residency only, does not capture previous years, why is this?
- I believe the section for resident scholarly activity only lists newly graduated residents. Will this change to include all residents, as scholarly activity may be done in PGY-1 and PGY-2, but not necessarily PGY-3?
- Why does resident scholarly activity limit to the PL-3 during the third year rather than all 3 years of training?
 - *Scholarly activity will now be reported on the current PGY-2 and PGY-3 residents and the immediate graduating class for the previous academic year. Please refer to the descriptions of resident scholarly activity on slide 11 from the RC Update to the AAPD presentation.*
- Scholarly activity: publications with multiple authors, who get credit? Is there credit for posters/presentations?
 - *Publications with multiple faculty authors can be listed for each faculty member. Posters should be counted under conference presentations. Publications authored by one or more residents may be credited for each resident.*
- Can MedEd Portal be added as a scholarly activity in WebADS?
 - *For peer-reviewed articles that are not assigned a PMID number, count the publication as other presentations for faculty or under conference presentations for residents/fellows.*

Questions re: CLER visit:

As CLER focuses on the institution, how does the ACGME emphasize outpatient systems of quality and safety? Or perhaps better worded, how do we as Program Leadership balance educational efforts to include outpatient systems not a part of the institution when we are measured by institutional standards? Our hospital quality committee is insisting that we abandon our outpatient QI project (which is robust and impacting patients) so that all our residents do hospital-based initiatives because “that is what the ACGME says”. Residents are involved in hospital-based initiatives but they lead the outpatient initiatives.

CLER will focus on the clinical learning environment as a whole, though the visit may focus initially on the inpatient services. Outpatient QI efforts are important and it is expected that the ambulatory setting will be included in the CLER process in the near future. A CLER Vice President was hired to specifically address the issue of Clinics and remote outpatient sites such as Family Medicine Practices. The process for CLER visits in these areas is being defined.

Are residents involved in the CLER visit? Are they interviewed? Why or why not?

Yes, residents are interviewed during the CLER visit to get their perspective on their involvement with many aspects of the institutional learning environment including quality and safety efforts.

ABP

Questions about Retraining:

Certification of competence by PD:

- *What is the ABP's interest, if any, in any milestone reports on identified candidates?*
 - At this time, the ABP is not collecting any milestone-specific performance data on trainees. The current reporting for trainee progress and verification of training will remain in place.
- *If a program accepts a physician for retraining, do subsequent attempts on the Certifying Exam count toward the program's overall pass rate?*
 - No. Scores of individuals undergoing additional training will not be reported to ACGME. Only the first-time test takers from that program are counted toward the overall pass rate. See the FAQ's posted on the ABP website.
www.abp.org/abpwebsite/becomecert/timeeligibility.htm)
- *It is quite possible that a pediatrician re-training would not meet competency at the end of a year of training. What options would that person have at that time? Where does that leave the PD?*
 - If the PD believes that the individual is not competent to practice without supervision, the PD should inform the individual. The individual will need to consider further re-training. The PD is not under any obligation to provide such training.
- *It takes 3 years for a PD to declare a trainee competent for independent practice. What are the legal liabilities, if any, to PDs who certify a re-trainee as competent after only 1 year?*
 - The individuals seeking retraining have demonstrated competence to practice independently in the past, and many are currently actively practicing independently. The ABP will rely on the judgment of the PD regarding the individual's competence.
- *If I accept someone to provide additional training, do I need to provide a statement of competence to the ABP?*
 - Yes. Upon receipt of an application for certification, the ABP will send an abbreviated verification of competence form for completion by the PD.
- *How can any program director be expected to retrain a failing test taker and then attest to competence after a year? This is about not passing the test that the ABP owns, develops and sets the criterion for (and a very low pass rate compared to other specialties).*
 - It is not known whether an individual will apply and take a certifying examination at the end of the retraining period. Individuals may seek retraining so they can regain the status of "eligible to sit for the exam" for another seven years – a status that may allow them to be credentialed by their institutions and by insurance providers.

However, the ABP is unable to make a statement regarding regained acceptance for an examination, or eligibility unless the individual submits an application for an examination.

The ABP is not asking PD to assure that these individuals will pass the exam. The ABP is asking PDs to provide a clinical experience, with supervision, that is sufficient to judge competence to practice without supervision.

Cost Issues:

- *Could one charge a tuition fee for retraining?*
 - The ABP has no comment on this issue. It is up to individual institutions and training programs to make this determination.
- *Though I do not want to take advantage of the graduate who hasn't passed the exam, is there anything wrong with charging a fee for the work of the PD/faculty to supervise and organize this training?*
 - See above

Number of affected individuals:

- *How many people will be affected by the time limit issue who may be looking for 1 year positions?*
 - It is impossible to determine how many individuals will be seeking training positions. There are fewer than 1000 whose eligibility has expired who took the examination in 2013.
- *Is there any estimate of the number of individuals not certified by 7 years post-residency?*
 - Yes. There are several thousand individuals who have never become certified over the last several decades. This number includes individuals in their 60's and 70's, many of whom have not taken an examination in recent years.

Timing Issues:

- *Can a person who has been practicing primary care for years get a waiver, for say, 6 months if a faculty member can attest to the individual's competence in outpatient peds so the individual can still work while getting retraining?*
 - It is possible for an individual to continue to work part time while re-training, but the retraining experiences must be balanced and consist of the equivalent of a year of full time training. No waivers can be granted. www.abp.org/abpwebsite/becomecert/timeeligibility.htm
- *Can you provide more detail about the year of retraining? -Fulltime? How many half days per week? Inpatient/out patient?*
 - The curriculum to be covered is outlined on www.abp.org/abpwebsite/becomecert/timeeligibility.htm

- The APPD will post examples of such retraining models that have been approved by the ABP so that the range of the flexible models for managing retraining for full-time and part-time applicants can help programs plan.
- *Please discuss what fulltime means (# of hours per week or month) if the physician wants to work in their current practice part-time but complete retraining in 12 months*
 - As above
- *You said part time is ok for retraining period. Does this mean they can work 2 days/week for 1 year, or work part time but still complete 52 weeks of training over a longer period?*
 - The ABP is willing to review alternative proposals for part time training, but the individual still must complete the equivalent of a year of full time training over an extended period of time.
- *If a board eligible pediatrician, now more than 7 years out performs his year of retraining, does that mean he now is board eligible for another 7 years or some different time frame?*
 - Yes, if the individual is judged as competent to practice without supervision by the Program Director, that individual is now eligible to sit for the board exam for another seven years, even if he/she does not take the exam.

Legal concerns:

- *Current trainee contracts used at your institution may help to guide the agreements for individuals seeking retraining. These agreements and their specifications should be created at the local institutional level. You said that programs are not obligated to take re-training requests. Hypothetically, what would happen if no PD agreed to take on one of these physicians?*
 - If an individual is not able to arrange for a period of retraining, he/she will no longer be eligible to take the ABP Certifying Examination. Exceptions to the requirement for Board eligibility can be made at the hospital or institutional level where one's practice is actually observable.

Other questions for ABP:

- *Why can't Peds-Child Neuro combined trainees take the ITE annually?*
 - The Pediatric-Child Neurology program is not a combined and integrated training program (as Medicine-Pediatrics is, for example). It is sequential training and does not always happen in the same training institution. Therefore, when an individual is engaged in the neurology portion of their training, they are not eligible for testing outside of neurology.
- *Is there any way to get ITE score results sooner than we do? Sooner release would allow programs to identify deficient residents sooner.*

- We are working on this request. The processes around data quality, analysis and preparation of the reports takes a considerable amount of work and the reports are sent as soon as they can be, at this time.