HOD Action: Councilon Medical Education Report 4 adopted and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-A-09

Subject: Protecting Residents During Residency Program Closure

Presented by: Claudette E. Dalton, MD, Chair

Referred to: Reference Committee C
, MD, Chair

This report is a follow-up to Council on Medical Education (CME) Report 7-A-06, Protection Against Delayed Residency Program Closure. The genesis for that report was Resolution 311 (A-05), which was submitted by the American Medical Association (AMA) Resident and Fellow Section and adopted by the AMA House of Delegates.

Resolution 311 was narrowly focused on issues of resident hardship created by programs delaying their closure—either due to voluntary withdrawal or adverse action by the Accreditation Council for Graduate Medical Education (ACGME). However, in August 2005, Hurricane Katrina hit Louisiana and Mississippi, and many graduate medical education (GME) programs in the region were severely disrupted; consequently, CME Report 7-A-06 took on the larger issues created by such exigencies.

Hurricane Katrina rendered it virtually impossible to communicate directly with any of the affected GME leaders and residents in the immediate aftermath of the levee break in New Orleans. Given these circumstances, the ACGME used its Web site as a communications tool to provide information about placement and transfer. In addition, the site provided guidance for designated institutional officials and program directors wishing to accept displaced residents. Further, the ACGME used its authority under the rubric of “alleged egregious or catastrophic events” to initiate immediate site visits to disrupted programs. Through these mechanisms, ACGME staff and Residency Review Committees (RRCs) expedited placement of approximately 1,300 residents during the first two months following the hurricane.

Although the ACGME and RRCs acted rapidly in the aftermath of Katrina, this natural disaster revealed a lack of written ACGME policies that could provide the ACGME and its RRCs with specific authority related to emergency closure of programs and transfer of residents. For this reason, the ACGME began to develop a disaster recovery plan. CME Report 7-A-06 was being written concurrently, and the AMA provided input into the ACGME’s disaster recovery plan, which is now part of both the ACGME Institutional Requirements and its Policies and Procedures:

The Sponsoring Institution must have a policy that addresses administrative support for GME programs and residents in the event of a disaster or interruption in patient care. This policy should include assistance for continuation of resident assignments.
(Institutional Requirements, effective July 1, 2007, I.B.8)

4. Resident Transfers and Program Reconfiguration
Insofar as a program/institution cannot provide at least an adequate educational experience for each of its residents/fellows because of a disaster, it must:

a) arrange temporary transfers to other programs/institutions until such time as the residency/fellowship program can provide an adequate educational experience for each of its residents/fellows, or
b) assist the residents in permanent transfers to other programs/institutions, i.e., enrolling in other ACGME-accredited programs in which they can continue their education.

9. Temporary Resident Transfer
At the outset of a temporary resident/fellow transfer, a program must inform each transferred resident of the minimum duration and the estimated actual duration of his/her temporary transfer, and continue to keep each resident informed of such durations. If and when a program decides that a temporary transfer will continue to and/or through the end of a residency/fellowship year, it must so inform each such transferred resident/fellow.
(ACGME Policies and Procedures, June 9, 2008, "ACGME Plan to Address a Disaster that Significantly Alters the Residency Experience at One or More Residency Programs," pp. 111-114).

Other sections of the Policies and Procedures related to disaster include:

- Definition of Disaster
- ACGME Declaration of a Disaster
- Resident Transfers and Program Reconfiguration *(excerpted above)*
- Communication with ACGME from Disaster Affected Institutions/Programs
- Institutions Offering to Accept Transfers
- Changes in Participating Sites and Resident Complement *(excerpted above)*
- Temporary Resident Transfer
- Site Visits

Members of the Council on Medical Education's graduate medical education subcommittee commented on the development of the disaster response document in a March 28, 2006 memo to the ACGME, which noted, in part: "Subcommittee members agreed that the disaster policy needs further refinement and clarification, to address such issues as the flexibility/portability of CMS-funded slots, and to ensure minimal loss of training time for affected residents/fellows. Also, more examples of what constitutes a disaster are needed." The Council also shared a draft copy of Report 7-A-06, which was instrumental in helping to expand and strengthen the ACGME's proposed disaster policy.

In addition to Council activity, AMA medical education group staff worked closely with ACGME staff to help mitigate the educational impact on residents/fellows affected by Katrina. Furthermore, AMA staff responsible for the National GME Census collected data from programs that received residents displaced by Hurricane Katrina, and made efforts to keep FREIDA Online up-to-date with programs' changing contact information and closure status. AMA staff also advocated for and obtained waivers to transfer residents such that their funding from the Centers for Medicare and Medicaid Services (CMS) would follow them from a closing to the receiving residency program. CMS now permits the transfer of GME slots from a federally designated disaster area via the Emergency Medicare Transfer Affiliation Agreement. This allows the sending program to transfer the funding to follow the resident for the duration of time that the resident is at the receiving facility. Finally, staff contacted the American Board of Medical Specialties (ABMS) to encourage its member certifying boards to develop a mechanism to accommodate discontinuities in training arising from residency closures, including waiving continuity care requirements and granting residents credit for partial years of training.

SEPTEMBER 2008: HURRICANE IKE TESTED THE NEW SYSTEM

Just as Katrina served to alert the graduate medical education community to the importance of developing emergency procedures for residency programs closure and transfers of residents, Hurricane Ike—which made landfall at Galveston, Texas on September 13, 2008—proved to be a stringent test of the ACGME's newly enacted policies.

The effectiveness of the ACGME's disaster plan was demonstrated in the ACGME's support to the GME leadership and residents at the University of Texas Medical Branch at Galveston (UTMB) after the devastation of Hurricane Ike. The hurricane was a calamity of unprecedented proportions for UTMB. Subsequently, the hospital laid off 3,000 employees as well as 130 faculty members, including tenured faculty. Tom Blackwell, MD, Associate Dean for GME at UTMB, worked to honor the institution's commitments to both current and future residents. His first priority was to preserve the training of all 597 existing residents/fellows, assuring that they could complete their training on schedule without interruption; this required locating alternative temporary training sites. In addition, significant effort was required to permanently outplace residents into programs that would allow them to continue their training without interruption. Dr. Blackwell also noted that the ACGME was very helpful in assisting in the transfer of residents.

The ACGME provided assistance to GME leadership and residents alike in the wake of the disaster. In addition to disseminating information to all GME constituents through its weekly electronic system and special electronic messages, the ACGME made available to Dr. Blackwell and UTMB program directors and residents a special component of the ACGME's Accreditation Data System (ADS). This mechanism allowed for expediting of all requests for transfer as well as a database with all offers of temporary or permanent resident slots offered by institutions and programs across the country. This entire electronic support system, which automated the processes used during Katrina, can now be launched as a special component of ADS within 24 hours following a disaster.

In addition to electronic support, all RRC executive directors and ACGME staff were available to GME leadership and residents by phone and e-mail to assist with questions and additional guidance. UTMB's GME leadership had 24-hour immediate access to Patricia M. Surdyk, PhD, executive director for the ACGME's Institutional Review Committee.

AMA AND ACGME POLICY IN REGARD TO NON-DISASTER-RELATED CLOSURE OF RESIDENCY PROGRAMS

Aside from the emergency situations, and policies, described above, both the AMA and ACGME have policy on more routine closures of residency programs. Recommendation 1 of the A-06 report, for example, asked that the AMA reaffirm its existing policy related to residency closure:

H-310.943: Closing of Residency Programs (AMA Policy Database)
The AMA: (1) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (2) encourages the ACGME to develop guidelines for the institution to follow in such closings or reductions that provide for adequate notification and out-placement service (such as resource contacts, transfer assistance, and financial assistance); (3) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (4) encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (5) urges residency programs and teaching

hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; and (6) urges institutions that initiate significant reductions in graduate medical education programs (in excess of 20 percent of the trainee complement or in excess of 10 percent of trainees for a given year), or that voluntarily close programs, be requested prior to or at the time of the reduction to file a concise summary of its educational impact with the Accreditation Council for Graduate Medical Education or the relevant Residency Review Committees. (Sub. Res. 328, A-94; Appended by CME Rep. 11, A-98; Reaffirmed CME Rep. 7, A-06).

Similarly, the ACGME Institutional Requirements includes language related to residency program closures that are not caused by disasters:

Closures and Reductions: The Sponsoring Institution must have a written policy that addresses a reduction in size or closure of a residency program or closure of the Institution. The policy must include the following:
a) The Sponsoring Institution must inform the GMEC, the DIO, and the residents as soon as possible when it intends to reduce the size of or close one or more programs, or when the Sponsoring Institution intends to close; and,
b) The Sponsoring Institution must either allow residents already in the program(s) to complete their education or assist the residents in enrolling in an ACGME-accredited program(s) in which they can continue their education.
(Institutional Requirements, effective July 1, 2007, II.D.5).

SUMMARY AND RECOMMENDATIONS

Regardless of whether an impending residency program closure is the result of a natural disaster, a voluntary withdrawal, or an adverse accreditation decision, residents need to transfer to another program efficiently with the least disruption to their training. Furthermore, under such circumstances, individual certification boards should be as flexible as possible in waiving continuity requirements. The A-06 report on this topic served to raise awareness of this issue within the GME community, and the work of the ACGME to develop appropriate policies related especially to emergency closures has laid the groundwork for effective, timely response that better serves the needs of resident physicians and GME programs alike.

The Council on Medical Education recommends that the following be adopted and that the remainder of the report be filed.

1. That our AMA reaffirm the principles of AMA policy D-310.972, Protection Against Delayed Residency Program Closure, which reads:

   Our AMA will:

   (1) Work closely with the Accreditation Council for Graduate Medical Education to contribute to, review and comment on any new ACGME policies related to residency closures, regardless of cause.

   (2) Work with the American Board of Medical Specialties to encourage all its member certifying boards to develop a mechanism to accommodate the discontinuities in training which arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training.

(3) Work with the ACGME to monitor closing programs, including encouraging programs to immediately notify residents of pending closures and to promptly transfer residents to alternate accredited programs as soon as feasible with the least disruption to training; and strongly encourage programs which accept transferred residents to minimize extensions to total training time.

(4) Use the National GME Census and work with the ACGME to assess how much disruption occurred in the training of residents as a result of program closures caused by Hurricane Katrina and report back at the 2009 Annual Meeting with further recommendations.

(5) Work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.

Fiscal Note: $1,000 for staff time.