IN-TRAINING EXAM 2012

Last month the ABFM administered the 2012 In-Training Examination (ITE) to more than 10,000 examinees. This year we had over 93% of all residents participate online, which is the highest participation rate for online testing since we introduced the option in 2006. The results of the 2012 ITE will be available in mid-December through the Resident Training Management (RTM) for the residency program to access, and residents will be able to access online in their physician portfolio at www.theabfm.org.

Next year the only delivery method for the In-Training Examination will be online. We will no longer provide the printed ITE booklets. We are currently evaluating the exam feedback from both residents and the programs. We received higher marks regarding the exam experience this year over last year and continue to do everything we can to improve the online examination. The number one comment regarding the online examination was the viewing of images in the exam. We are working with the examination vendor to look at ways we can improve the images for the 2013 examination as well as other improvements.

IMPROVING ITE RESULTS REPORTING

The ABFM is working to make ITE reports available in a ruler-based format for this year’s Resident 2012 Item Performance Report. In this format, the less difficult questions are found in the lower portion of the content area column and more difficult items are higher up. Questions answered correctly are in green and questions answered incorrectly are in bold red. The zone of transition from green to red graphically represents the resident’s ability level. Instances in which a resident answered a question correctly or incorrectly will also be easier to see.

When the ITE results are released, please review this report and tell us what you think. This format is the intended format for two fully customizable reports under development for RTM, the program diagnostics report and the resident diagnostics report. We would like these reports to be as informative and easy to use as possible upon first release, so your feedback is very important. Please send your feedback via email to Dr. O’Neill at toneill@theabfm.org.
USING SAMs as a COMPONENT of RESIDENT EDUCATION

Newly introduced resident requirements for initial certification will include participation in MC-FP. The first group of residents who will be required to participate in this new process will be those entering family medicine residencies on or after June 1, 2012, including those residents who receive advanced placement credit for prior training in another specialty. Residents must meet the following requirements before they will be able to sit for the examination.

MCFP requirements for residents who begin training on or after June 1, 2012:
Completion of fifty (50) MC-FP points prior to the MC-FP Examination, which must include:
• Minimum of one (1) Self-Assessment Module (Part II)
• Minimum of one (1) Performance in Practice Module (Part IV) with data from a patient population (or an ABFM approved alternative Part IV activity with patient population data)

As the MC-FP requirements for initial certification take effect, residencies are finding ways to integrate MC-FP modules into resident education. The following offers two examples of how residencies are incorporating MC-FP modules into their teaching process. As always, the MC-FP activities are free to all residents.

Cabarrus Family Medicine Residency Program
The Cabarrus Family Medicine Residency in Concord, NC found several valuable reasons to use the SAMs for resident teaching, including the fact that the SAMs are evidence-based, readily available, and fulfill several competencies like medical knowledge, systems-based practice, and patient care (via the ClinSim portion of the SAM). Since the ABFM made the initial availability to the SAMs for residents, PGY3 residents in this program are required to complete a SAM of their choice, both the question and the patient simulation sections in order to graduate from the program.

This residency program is also using the SAMs in two different ways, using small groups of mixed PGYs to facilitate the exchange of ideas/information, reasoning, and problem-solving that is sometimes less accessible in a large-group teaching model.

SAM questions for team-based learning
A Faculty-Intern pair presents guidelines on pre-chosen chronic diseases (e.g. COPD, Asthma, CHF, etc.) during conference. The purpose is to ensure transmission of basic evidence-based medical knowledge for better patient care and the fulfillment of federal quality measures. The faculty member composes a test comprised of case-based board-type questions using the SAMs, AAFP board review, and possibly questions generated internally. The SAMs questions with multiple correct answers are listed as true/false questions.

The schedule for the 90 minute workshop is as follows:
15 minutes—Individual test. Each resident takes the test created by faculty. The test is scored.
30 minutes—Intern PowerPoint Presentation. A large group reviews the guidelines.
USING SAMs as a COMPONENT of RESIDENT EDUCATION cont.

35-40 minutes—Team Test. Residents in a pre-assigned group with a faculty facilitator answer the same test. The Team Test is scored and a prize awarded to the group with highest score.

**SAM in small groups to aid in teaching chronic disease management**

During conference (4 hours), each of three groups is led by one faculty member who is familiar with navigating the SAMs and together they answer 20 questions (could do 4 groups to answer 15 questions). After each group completes its questions, the faculty members input all answers from the other groups. After all 60 questions are answered, these small groups review the correct and incorrect answers to solidify knowledge. Finally, each group works through the simulated patient in the ClinSim portion of the SAM.

For more information on this program please contact Mark D. Robinson, M.D., Program Director, at mark.robinson@carolinahealthcare.org or Delyse Bright at Delyse.Bright@carolinahealthcare.org or by phone at 704-721-2064.

**Swedish Medical Center Residency Program—Cherry Hill**

The Swedish Medical Center Cherry Hill campus in Seattle, WA completed an 18-month process to discover if the use of SAMs as a teaching tool within its residency program would benefit its residents. During a faculty retreat, the idea of incorporating the SAMs into various rotations was discussed. The faculty approved the concept, but wanted input from the Residents. The topic was presented during a subsequent Faculty-Resident meeting. The use of SAMs as a training tool to be incorporated into existing rotations was unanimously approved by the entire residency community. Beginning this academic year, the program has been fully implemented. While it has been a bit of a challenge to determine the proper placement of each SAM within the rotation, the Swedish Cherry Hill program has settled on the following placement:

- Diabetes: R1/GenSurg
- Hypertension: R2/AdultEmerMed
- Congestive Heart Failure: R1/FamMedService
- Coronary Artery Disease: R3/Cardiology
- Cerebrovascular Disease: R3/Neuro
- Well Child Care: R1/PedsOutpt
- Asthma: R2/PedEmergRm2
- Childhood Illness: R2/PedEmergRm2
- Maternity Care: R1/Obsterics
- Depression: R2/Behav/Science rotation
- Health Behavior: R3/AddictionMed rotation
- Care of Vulnerable Elderly: R3/Geri
- Pain Management: R2/AddictionMed rotation
- Preventive Care: R1/CommMed rotation

For more information on this program please contact Sam Cullison, MD, Program Director, at Sam.Cullison@swedish.org or 206-320-2233.
Case 5—Completion of Training—Leave of Absence

Dr. Ina Pickle has completed an on-line application for the ABFM November examination. The residency program has indicated that residency training will be completed on September 7, 2012. A review of the application and information contained in the Resident Training Management (RTM) system indicates the following:

- Dr. Pickle began training as a PGY-1 resident in the Meniere Family Medicine Residency in Ogden, Utah on June 29, 2009, and successfully completed the first year of training on June 26, 2010.
- She was promoted to the PGY-2 year and began training on June 28, 2010; she completed the second year on June 25, 2011.
- Dr. Pickle began the PGY-3 year on June 27, 2011. On December 12, 2011 she began a leave of absence due to a fractured ankle in a skiing accident. Her recovery went well, and she returned to training on March 12, 2012. The duration of the leave was 13 weeks, and two weeks of her excused absence time (vacation) was incorporated into the leave. Dr. Pickle is shown to have completed the third year on September 7, 2012.

What policies of the ABFM are pertinent to this case, and what was the likely ruling by staff?

Policy: DURATION OF TRAINING
In accordance with the ACGME Program Requirements for Residency Education in Family Medicine, (Int. A., Duration of Training), “Residencies in family medicine must offer three years of training after graduation from medical school. Residencies must be structured so that a coherent, integrated, and progressive educational program with progressive resident responsibility is ensured.”

Decision: Dr. Pickle’s total residency training, exclusive of the leave of absence time, was less than the three years required by the ACGME. The first and second years of training were each one day short of 12 months—the Sunday preceding the start of the academic year. The third year was 53 weeks in duration. While Dr. Pickle’s residency was technically two days short of the required 36 months, it is highly unlikely that residency completion and eligibility for certification would be denied.
Policy: **LONG-TERM ABSENCE**

1. Absence from residency education in excess of one month within the academic year (G-1, G-2 or G-3 year) must be made up before the resident advances to the next training level, and the time must be added to the projected date of completion of the required 36 months of education.

2. Absence from the residency, exclusive of the one month vacation/sick time, may interrupt continuity of patient care for a maximum of three (3) months in each of the G-2 and G-3 years of education. Leave time may be interspersed throughout the year or taken as a three-month block. Residents will be permitted to take vacation time immediately prior to or subsequent to a leave of absence.

3. Following a leave of absence of three months or less, the resident is expected to return to the program and maintain care of his or her panel of patients for a minimum of two months before any subsequent leave.

4. Program Directors are expected to inform the Board promptly by electronic mail of the date of departure and expected return date in cases in which a resident is granted a leave of absence by the program, or must be away because of illness or injury. It should be understood that the resident may not return to the program at a level beyond that which was attained at the time of departure. All time away from training in excess of the allocated time for vacation and illness must be recorded in the RTM system.

5. Leaves of absence in excess of three months are considered a violation of the continuity of care requirement. Programs must be aware that the Board may require the resident to complete additional continuity of care time requirements beyond what is normally required to be eligible for certification.

**Decision:** Dr. Pickle's leave of absence of 13 weeks exceeded the three month limitation as shown in #5, above. However, since two weeks of annual excused absence time was applied, the net duration of the leave of absence was actually 11 weeks and did not violate the policy. Dr. Pickle's return to training at the point of departure was judged to be appropriate on the basis of the ABFM Policy on Hardship. For the purpose of calculating training time completed, the two weeks of excused absence time was applied February 27 – March 11, 2012.
Bayesian Test Score Predictor Utility

ABFM is creating a Bayesian Test Score Predictor utility to aid in identifying residents at risk for failing the certification examination and to facilitate conversations between program directors and residents regarding what the ITE scores imply. We hope to make the Bayesian Test Score Predictor utility available through RTM in the near future. After using this utility, end users at your residency program should feel free to contact Dr. O’Neill via email at toneill@theabfm.org to share their thoughts on what works well and what does not, especially as regards the user interface.

The utility starts out by presenting the typical distribution of PGY1, PGY2, PGY3, and certification exam scores. The user merely clicks on the score that represents what the resident under consideration actually scored. In this case, a PGY2 score of 410 was observed. The utility then adjusts the distribution of PGY3 scores to reflect the scores that are likely considering that the resident earned a 410 in PGY2. Consequently, this then provides the adjusted distribution of scores on the certification exam considering the revised distribution of PGY3 scores, producing a revised probability of passing.

Please note that for this utility to make reasonable predictions, the residents should try to do their best on the test and observe the same rules for testing as would be required on the certification examination. Residents who do not try their best, who work on the test collaboratively with others, or who seriously deviate from the standardized administration conditions cannot expect the utility to accurately predict their results on the certification examination.

We would also like to include USMLE scores as a predictor of PGY1 scores. Some program directors have suggested that such scores could be useful in evaluating residents during the matching process. We hope to be able to start collecting this data in the future, so your assistance in helping us collect these scores will be much appreciated.
Bayesian Test Score Predictor Utility

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