The Residency Assistance Program: 1,000+ Opportunities and 30 Years of Experience Promoting Excellence in Family Medicine Education

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Historical Development

The Residency Assistance Program (RAP) was established in 1975 in response to a demonstrated need. In the first 6 years following the creation of the specialty of family medicine, more than 250 residency programs were initiated. Not only did this rapid growth challenge the nation’s medical education system, it also challenged the available resources to accommodate it. Many family medicine educators of that time were comfortable teaching the clinical skills of the discipline, but there was a recognized need for consultative assistance regarding the organization and administrative aspects of building and operating postgraduate training programs.

This demand for consultative support quickly outstripped the available resources of the American Academy of Family Physicians (AAFP) Division of Medical Education, and a need for a different approach was identified. In 1975, with a 3-year development grant by the W.K. Kellogg Foundation and with the collaborative support of the AAFP, the Society of Teachers of Family Medicine (STFM), the American Board of Family Practice (ABFP) (now the American Board of Family Medicine), and the Family Health Foundation of America (which evolved into the AAFP Foundation in 1989), RAP was created. Financial and in-kind support were provided by the original supporting organizations, and in 1990, a grant from the Upjohn Company supported RAP’s consultative activities for the development of new family medicine residency programs.

Governance

The original oversight body to RAP consisted of a project board with representatives from the AAFP, AAFP Foundation, ABFP, and STFM. In 1988, the AAFP assumed administrative and financial responsibility for RAP, and, in 1991, the project board was expanded to include representation from the Association of Departments of Family Medicine (ADFM) and the Association of Family Practice Residency Directors (AFPRD) (now known as the Association of Family Medicine Residency Directors). The RAP Project Board provides representation for the interests of the various constituencies in family medicine, as well as policy oversight and liaison functions. The RAP project director manages the day-to-day decision making regarding development and maintenance of the program.

Consultants

The original 30 RAP consultants were selected in 1975 by the Project Board from a pool of family medicine educators and practicing physicians. All RAP consultants are appointed for a 1-year renewable term, and it is common for experienced consultants to be reappointed annually as long as they maintain an active role in family medicine education and perform well as consultants. Over the years, it has become necessary to replace consultants, and the Project Board has issued a national call for nominations 11 times since the original panel was formed in 1975. All consultants are experienced family medicine educators representing expertise in community, university, and military programs. Since the inception of the RAP project, a total of 125 family physicians have been appointed to the RAP Panel of Consultants. All five of the RAP project directors have also been directors of the AAFP Division of Medical Education.

Family medicine was the first specialty to create such a consultative service and to formally train its consultants. All RAP consultants, following initial training, participate in two educational sessions per year to
ensure that they have the most up-to-date knowledge and support resources to carry out the consultative process. Initially, the consultants’ role reflected that of mentors in visiting family medicine residency programs. They looked for areas that needed to be upgraded, provided advice to strengthen areas of concern, and made recommendations to improve programs to achieve a standard of excellence. More recently, however, rapid changes in graduate medical education and the legislative initiatives that affect it have evolved the role of consultant to be more of an “expert” bringing to training programs special knowledge gained from ongoing national experience and unique resources. They assist programs in coping with the rapidly changing and increasingly demanding environment of graduate medical education.

The consultative process of RAP is peer based, confidential, nonpunitive, and entirely voluntary. These qualities are carefully guarded, and they enhance the information sharing and collaborative problem-solving nature of the consultative process.

**RAP Criteria for Excellence**

In its early years, the criteria used by RAP in evaluating residencies were developed by consensus among the panel of consultants. In 1978, these criteria were collated into a document titled “The Residency Assistance Program Criteria for Excellence in a Family Practice Residency Program.” The RAP criteria have been subsequently revised on five different occasions, with the most recent revision being distributed in 2003.

Each revision has been the collective work of the RAP panel of consultants, drawing on their collective observations and experiences and are approved by the RAP Project Board. Each time, too, the Criteria for Excellence have integrated the most advanced strategies and perspectives with graduate medical education. As an example, because the RAP panel was involved in the Future of Family Medicine project, many of the subsequent recommendations from that project have found their way into the RAP criteria.

Over time, the RAP criteria have evolved as new challenges and demands were presented to family medicine education. Their focus on excellence has resulted in the RAP criteria guiding the evolution of the program requirements for residency accreditation in family medicine by the Accreditation Council for Graduate Medical Education (ACGME) and the Residency Review Committee for Family Practice (RRC-FP) (now known as the Residency Review Committee for Family Medicine). Over the past 25 years, with each revision of the program requirements by the RRC-FM, recommendations from the then-current RAP Criteria for Excellence were incorporated. Thus, RAP has led change in family medicine residencies through most of its history. The newest set of criteria, approved in 2003, is the first to include specific quality benchmarks for family medicine training programs, and, with the assistance of the Association of Family Medicine Residency Directors (AFMRD), copies of these criteria have been provided to all of the nation’s family medicine residency programs.

The RAP criteria are used in many different ways. Family medicine residency programs use them to guide their efforts to develop and evolve their curricula, and they are used extensively by programs to help respond to curricular deficiencies. Through the incorporation of performance benchmarks in the most recent edition of the RAP Criteria for Excellence, residencies can now use them to measure the program’s performance against nationally referenced standards. This is particularly advantageous with today’s focus on identifying metrics of quality in educational programs.

**Consulting for Excellence**

Since the project was initiated in 1975, RAP has provided consultative support to the nation’s family medicine residencies (Figure 1). To date, more than 1,025 of these consultative conferences have been provided. Collectively, 81% of family medicine residencies have had at least one consultation, more than one third have had three or more consultations, and some have had as many as six consultations during their history (Figure 2). A 2004 study of 35 family medicine residencies that have closed since the 2000–2001 academic year demonstrated that only 60% had ever had a RAP consultation, at an average of more than 10 years ago (Figure 3). In the past, consultations were requested primarily to assist in the development of new programs or to improve curriculum. In recent years, RAP consultations have been increasingly requested to assist in the addressing of operational challenges that threaten the residency in some manner.

A RAP consultation may be requested by the residency program director, department chair, medical school dean, or hospital chief executive officer (CEO). Historically, the vast majority of consultations have been requested by residency program directors. The consultation report is a confidential document and, in addition to the copy that goes to the residency program director, only one other is provided to the department chair, medical school dean, or hospital CEO and only if that individual specifically requested the consultation in the first place.

To provide the consultant with essential background information, all RAP consultations begin with the completion of a pre-site visit questionnaire about the training program and specific questions regarding the targeted objectives for the consultation itself. The consultations themselves take place over a 2-day period and are scheduled for the convenience of both the consultant and the requesting program. The RAP consult-
The consultant collects additional information about the program through interviews with faculty, staff, and residents, as well as through meetings and other conversations with key institutional individuals. Comparative data with other resources is also brought to bear during the consultation process, and this collaborative information-sharing relationship between the RAP consultant and the program director provides an almost ideal combination of internal and external perspectives related to the program.

When the consultation visit is completed, RAP consultants will typically provide a verbal report on their findings and recommendations to the residency program director and other individuals whom the director feels will benefit from the information. Following the consultant’s visit, a comprehensive written consultation report is prepared, carefully edited for consistency of style and accuracy of information, and submitted to the requesting entity within approximately 4 weeks of the consultation visit. On occasion, accompanying the written report will be reference material pertinent to the unique...
needs of the program under review. Where appropriate, consultation reports will not only identify strengths and weaknesses of the training program but also recommend strategies for implementing change in affirmative directions.

Meeting the Needs for Consultations

The original RAP consultations focused on the residency program’s educational curriculum from a global perspective. Time and the changing health care environment have necessitated the creation of “focused consultations” to meet programs’ specific needs. One of the earliest focused consultations was for institutions in the early stages of developing a family medicine residency program. Focused consultations developed since then include those paying particular attention to the operations of the family medicine center, the fiscal operation of the residency program, and focused attention on specific curricular elements such as geriatrics curricula, women’s health, and sports medicine.

In recent years, RAP has developed new products to meet the evolving needs of the training programs and their leadership. For example, in 2001, following the publication of reference resources, including a family medicine residency financial model and a taxonomy for categorizing the benefits of a residency program to its trainees, sponsoring institution, and community, the “Program Impact Consultation” (PIC) was initiated. This unique consultation is specifically designed to assist family medicine residency programs in “justifying their existence” to their sponsoring institutions during times of critical appraisal of the direct, indirect, and intangible benefits of institutional programs and products.

Similarly, because many residency programs have specific targeted needs for consultation, RAP has created so-called “mini consults” that pair RAP consultants with program directors and other staff to provide perspective, guidance, and resources for dealing with specific challenges a program may be facing. These mini consultations have become a regular feature at the annual RAP Workshop, the Program Directors’ Workshop, and more recently as part of the training process for the National Institute for Program Director Development.4

The RAP Workshop

In addition to the consultation services, RAP also conducts an annual workshop for faculty and staff of family medicine residency programs. Despite the fiscal challenges faced by most of today’s residency programs, attendance at this meeting has remained high. In addition, the Association of Family Practice Administrators (AFPA) and the Association of Family Practice Residency Nurses (AFPRN) have integrated their annual meetings into the RAP Workshop and identified educational tracks within it for their membership.

Responding to demonstrated needs for the past 2 years, the RAP Workshop has also included a preconference that has allowed concentrated exposure to the RAP consultants and sufficient time for in-depth educational exchange on those topics of most importance to family medicine educators. These include such issues as the ACGME competencies, resident duty hours, and the rapidly changing rules and regulations surrounding state and federal reimbursement for graduate medical education.

Measures of Success

There are four domains that demonstrate the success of RAP. These include the frequency with which programs avail themselves of the consultative resources, the consistently favorable evaluations by program directors using RAP, the role that the RAP Criteria for Excellence have played in the evolution of the discipline of family medicine, and the attempts by other disciplines to duplicate RAP’s services.

At the conclusion of each consultation, the requesting parties are asked to provide a comprehensive evaluation of the consultative process. Throughout its history, RAP has used these evaluations to guide its evolution and training agenda. Satisfaction with RAP consultations remains high, as evidenced by assessment scores routinely exceeding 4 on a 5-point scale (Table 1). Focused consultations and mini consultations have successfully addressed the specific needs of many US family medicine residency programs, as evidenced by the frequency with which they are requested. Nevertheless, the ongoing turnover of family medicine residency directors and faculty necessitates periodic mar-

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**Table 1**

Summary of 2004 Residency Assistance Program (RAP) Consultation Evaluations*

<table>
<thead>
<tr>
<th>Evaluation Criterion</th>
<th>Score (1–5)</th>
<th>Median</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preparation by consultant</td>
<td>5.0</td>
<td>4.50</td>
<td></td>
</tr>
<tr>
<td>2. Pre-consultation meeting with leadership</td>
<td>4.0</td>
<td>4.44</td>
<td></td>
</tr>
<tr>
<td>3. Communication skills</td>
<td>5.0</td>
<td>4.80</td>
<td></td>
</tr>
<tr>
<td>4. Knowledge base of consultant</td>
<td>5.0</td>
<td>4.85</td>
<td></td>
</tr>
<tr>
<td>5. Addressing of problems during consult</td>
<td>5.0</td>
<td>4.48</td>
<td></td>
</tr>
<tr>
<td>6. Program evaluation</td>
<td>5.0</td>
<td>4.53</td>
<td></td>
</tr>
<tr>
<td>7. Problem evaluation</td>
<td>4.3</td>
<td>4.43</td>
<td></td>
</tr>
<tr>
<td>8. Identification of program strengths</td>
<td>5.0</td>
<td>4.55</td>
<td></td>
</tr>
<tr>
<td>9. Plan for program improvement</td>
<td>5.0</td>
<td>4.53</td>
<td></td>
</tr>
<tr>
<td>10. Wrap-up summary session</td>
<td>5.0</td>
<td>4.70</td>
<td></td>
</tr>
<tr>
<td>11. Practicality of recommendations</td>
<td>5.0</td>
<td>4.40</td>
<td></td>
</tr>
<tr>
<td>12. Usefulness of written report</td>
<td>4.0</td>
<td>4.24</td>
<td></td>
</tr>
</tbody>
</table>

* n=20

1—poor, 2—fair, 3—good, 4—very good, 5—excellent
keting of RAP to those individuals who have not yet become familiar with its potential benefits to their institutions.

As noted earlier, recommendations from the RAP Criteria for Excellence have over time consistently found themselves integrated into the revisions of the RRC-FM program requirements for accreditation of family medicine residency programs. In this way, the RAP criteria have “led” the development and evolution of the RRC-FM program requirements and have played a key role in the evolution of the discipline and its training curriculum to best respond to the evolving clinical and educational needs of the nation’s health care system. The more recent integration of quality benchmarks into the RAP Criteria for Excellence will undoubtedly be an affirmative step in driving family medicine residency programs to pay greater attention to their own quality metrics.

RAP remains unique as a peer-based, criterion-referenced, and entirely confidential consultative process. Attempts to duplicate or mirror RAP have been initiated by multiple disciplines, including obstetrics and gynecology, internal medicine, and surgery. None, however, have successfully created such an in-depth process of continually updated, trained consultants who volunteer their time to assist their peers in achieving excellence in the education of family physicians for the future.

Future Directions

In continuing to support the achievement and maintenance of excellence in family medicine education, RAP has found itself in a supportive role to other members of the family of family medicine organizations. The Association of Departments of Family Medicine (ADFM), for example, has for the last several years been working on a project to bring the benefits of a consultation to support a criterion-referenced, peer-based, confidential consultative process for academic departments of family medicine. In collaboration with ADFM leadership, the RAP director and staff have been working to establish a database of operational benchmarks and to define procedures that will allow departments of family medicine to compare their programmatic and operational efficiency with that of departments in similar settings.

The RAP Criteria for Excellence in family medicine education has over the past several years formed the foundation for assisting generalist physicians in other countries to develop their health care systems from a family medicine perspective. The RAP criteria have been translated into Spanish, Russian, and, in 2004, Japanese. Translations of these criteria have formed the foundation for orienting developing countries with evolving health care systems to the benefits of a health care system built around a base of family physicians.

To this end, the AAFP, with the support and assistance of RAP, initiated the International Family Practice Development Assistance Program (IFPDAP). RAP staff have been central to the development of a curriculum for international consultants, and RAP presently provides ongoing support for this project as it evolves.

More recently, the ACGME has conducted a major revision of its institutional and program requirements, including the application of six new ACGME competencies. They are carefully monitoring the evaluation of these competencies, as well as the new restrictions on resident duty hours. Many residency programs, because of these multiple new requirements, have found themselves struggling to adequately prepare for accreditation site visits.

As a direct response to this perceived need, a new RAP consultation framework has been developed, and, with the approval of the RAP Project Board in January 2004, a new “Comprehensive Accreditation Process” (CAP) consultation was created. This new consultation provides residency programs the opportunity to experience an in-depth evaluation just like an ACGME accreditation site visit in the “no-risk” environment of a RAP consultation. Playing the role of an accreditation site visitor, RAP consultants can essentially walk a training program, its director, and faculty through the process of an ACGME accreditation site visit, help that program identify areas for potential improvement, and gain a familiarity with the processes they are likely to experience during a site visit encounter. Once again, RAP responds to an identified need by family medicine training programs with a product specifically tailored to meet those needs as efficiently and expertly as possible.

In Development

In development are more initiatives of RAP with the objective of making RAP more useful to the discipline of family medicine. For example, recent trends in student interest are prompting training programs to critically address how they present themselves to applicants. RAP has both the depth of expertise and the breadth of experience to help. At the same time, there is a growing recognition among graduate medical education programs of the need for faculty development to support the conversion of residency curricula from time- and process-based training to competency-based education. The RAP consultants’ training over the past 2 years has included an emphasis on group facilitation skills to support the increasing requests for RAP to conduct faculty development retreats and strategic planning workshops. Similarly, as the new model of family medicine becomes clarified by the Future of Family Medicine (FFM) project, residency programs will be challenged into translating those practice changes into the educational setting. The RAP consultants are currently un-
dertaking focused training to prepare them to help lead that change.

Conclusions
The RAP project is an adaptive one, evolving along with the discipline and the health care environment. In 2004, the findings and recommendations of the FFM project are being rolled out and disseminated among the various constituencies of family medicine. With its 30-year history of leadership in the discipline of family medicine, RAP will play an integral role in the facilitation and implementation of those FFM recommendations.

Since the prior report on RAP and its activities, much has changed. RAP has diversified itself into offering a wide (and growing) array of products and services in response to the changing needs of training programs in the evolving health care and graduate medical education systems. Even the RAP Criteria for Excellence have changed to be more responsive to the environment’s need for metrics of quality. What does the future hold for RAP? Only time will tell, but whatever RAP’s response will be can be confidently assumed to be built on a history of innovation and a foundation of excellence. RAP, its consultative process, its annual workshop, its ongoing influence in the evolution of the discipline’s training programs, and its capacity to develop resources and products to meet training programs’ needs as they evolve will continue to be of unique value to the discipline of family medicine for the foreseeable future.

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REFERENCES