ACGME Review Committee – Family Medicine

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Early Impressions of the CLER visits to Smaller Sponsoring Institutions: Creating Conversations, Effecting Change

Baretta R. Casey, MD, MPH
Regional Vice President
Smaller Sponsoring Institutions
ACGME CLER Program

Baretta R. Casey, MD, MPH

- Disclosures
- I do not have any conflicts of interest to report

Objectives

- At the conclusion of this session, the participants will be able to:

- Describe the preliminary impressions of CLER site visits of Smaller Program Sponsoring Institutions.

- Engage in discussions to improve the integration of GME into the teaching hospital/medical centers infrastructure in the six focus areas.

Three Components to the CLER Program

- **Site Visit** – Provides sites with formative feedback to assist with development in the six focus areas.

  - Larger SI finishing second set of visits, Small SI middle of first set of visits

- **National Data** – Tracks aggregated data over time - map the forward progress along each CLER pathway toward achieving optimal engagement.

  - First National Report of Findings published in May 2016

- **Learning Community** – In collaboration with key organizations, ACGME develops resources to educate and support faculty and executive leadership across six focus areas.

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Site Visits

- Six Focus Areas

  - Patient Safety

  - Health Care Quality

    - Health Care Disparities

  - Care Transitions

  - Supervision

  - Duty Hours/Fatigue Management & Mitigation

  Professionalism

- Key Points

  - Two days; small group meetings and walking rounds

  - Includes CEO/DIO/senior leaders, quality/safety leaders, residents, faculty, PDs

  - Formative feedback

  - Learning before, during and after the visit

  - "Prep" of individuals is not necessary and may be counter-productive

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- Creating Conversations as Levers for Change

National Report of Findings

- National Report of Findings, published May 2016
- Data from the first round of site visits from Larger Sponsoring institutions
- More detailed information on each focus area is being shared in Issue Briefs
- All available on the ACGME website

The CLER 2016 National Report of Findings

- Foreword: John Duval
- Introduction: Tom Nasca
- Overview of the Program
- Overarching Themes
- Challenges and Opportunities in the Six Focus Areas
- Detailed Findings and Methods
- Technical Appendices, Selected tables, graphs, and figures

Summary of overarching themes from initial National Report of Findings

1. Clinical Learning Environments (CLEs) vary in approaches to patient safety and health care quality and the degree of engagement of residents and fellows in addressing those areas.

2. CLEs vary in the approach of implementing GME within the organization.

3. CLEs vary in the investment of teaching and engaging faculty and program directors on system-based initiatives

4. CLEs vary in the degree of coordination of educational resources across professions.

Larger vs Smaller Sponsoring Institutions

- Larger SIs first set of visits
  - June 2012 – March 2015
  - 297 Sponsoring Institutions
  - All sites with 3 or more core programs, may have multiple fellowships

- Smaller SIs first set of visits
  - September 2015 – 2018 (projected late spring)
  - Total of 354 Sponsoring Institutions
  - 128 Sponsoring Institutions visited so far
  - All sites with 2 or fewer core programs, may have multiple fellowships

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Larger SIs – Smaller SIs

- Larger SIs first set of visits
- 297 SIs visited
- 8,755 residents, 7,740 faculty, 5,599 PDs
- Cycle 2 will be complete this summer

- Smaller Sis as of March 8, 2017
  - 144 SIs with 289 programs visited
  - About 70% have included FM programs, 50% were a single FM program
  - Approximately 800 residents, 800 faculty, 235 PDs interviewed so far

Numerous hospital administrators, quality and safety leaders, nurses, and other health professionals are also interviewed at each site.

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Early Impressions

- Patient Safety
  - Variability in resident knowledge of when, what, and how to report
- Health Care Quality
  - Degree of resident participation in QI varies across programs
  - Variable alignment with the clinical sites' priorities
  - Disparities initiatives focus on access; little attention to measuring variability or impact

Early Impressions

- Transitions in Care
  - To date, most residents report following a standardized process for hand-offs within their program or inpatient service
  - Variability in oversight of resident hand-offs and process for transitioning to independence in handoffs
- Supervision
  - To date, most residents report adequate supervision

Early Impressions

- Duty Hours/Fatigue Management/Burnout
  - Consistent reporting of fatigue education
  - Variability in evidence of effective management strategies
- Professionalism
  - Variability in monitoring by participating site

Additional Thoughts

- We have found multiple models of GME oversight, with variability in administrative support (financial or otherwise)

- Significant variability in participating site's leadership view of the strategic value and role of GME in advancing patient safety and health care quality improvement

The Clinical Learning Environment

- *"The term CLE means any and all such clinical settings where residents and fellows learn to care for patients. The CLE is much more than a set of places and resources. It also includes the people, their values, and the sense of dedication to team and community."*

- CLER National Report of Findings 2016

Future Revisions

- The Duty Hours/Fatigue management focus area is being transitioned to Physician Wellbeing and should be published soon

Available Resources

- CLER website at ACGME.org
  - CLER Pathways to Excellence:
    - Guidance document, not intended to be prescriptive or a set of requirements, currently being edited to include Well-Being
  - National Report of Findings, full version and executive summary:
    - May 2016 publication of data and themes from the initial set of LPSI visits
  - National Report of Findings Issue Briefs:
    - PS, QI, Health Care Disparities have been published, webinars on each are available; future issues on other focus areas
  - Pursuing Excellence Initiative:
    - Collaboration with 21 national organizations to develop and share innovations in the CLER focus areas
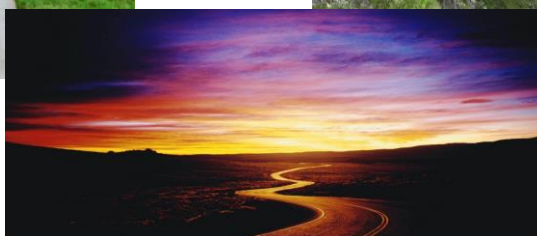
Clinical Learning Environment Review
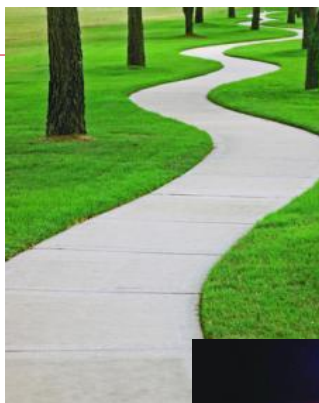
A journey

Common Program Requirements Section VI*

Mary W. Lieh-Lai, MD, FAAP, FCCP
Senior Vice President for Medical Accreditation

*Approved by the ACGME Board of Directors February 2017

Disclosures

- Recovered pediatric intensivist and DIO
  - Out of rehab
- Recovering:
  - Program director
- No financial disclosures

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Background

- A deliberate process: CPR Phase I Task Force
- Literature review: over 1000 relevant references
- ACGME Congress: testimonies
- Written comments from the GME community and the public

http://www.acgme.org/Portals/0/PDFs/Nasca-Community/Section-VI-Memo-3-10-17.pdf

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Bottom Line

- Graduate Medical Education programs are designed to provide *professional* education, *NOT* vocational training

The Learning and Working Environment

- Excellence in the safety and quality of care rendered to patients by residents today

- Excellence in the safety and quality of care rendered to patients by today's residents in their future practice

- Excellence in professionalism through faculty modeling of:

  - The effacement of self-interest in a humanistic environment that supports the professional development of physicians

  - The joy of curiosity, problem-solving, intellectual rigor and discovery

- Commitment to the well-being of the students, residents, faculty members, and all members of the health care team

Why should we care?
JAMA. 2009:302(12): 1277-1283

Physicians are only as good as their training – this effect is durable

Evaluating Obstetrical Residency Programs Using Patient Outcomes

David A. Asch, MD, MBA
Sean Nicholson, PhD
Sindhu Srinivas, MD, MSCE

Context Patient outcomes have been used to assess the performance of hospitals and physicians; in contrast, residency programs have been compared based on non-clinical measures.

"Women treated by obstetricians trained in residency programs in the bottom quintile for risk-standardized major maternal complication rates had a complication rate approximately 1/3 higher than those treated by obstetricians from programs in the top quintile"

tested. This information could be useful in at least 2 different ways.[1] First, identifying which training programs pre

than the 10.3% adjusted rate for women treated by obstetricians from programs in the top quintile (absolute difference, 3.3%; 95% confidence interval, 2.8%-3.8%). The rankings of residency programs based on each of the 9 measures were similar.

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The Learning and Working Environment

• It is not just about ~~duty hours~~…..

VI.A: Patient Safety and Quality Improvement

VI.B: Professionalism

VI.C: Well-Being

VI.D: Fatigue Mitigation

VI.E: Clinical Responsibilities, Teamwork, and Transitions of Care

VI.F: Clinical Experience and Education (includes work hours)

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CPR VI.A.

- Patient Safety, Supervision and Accountability
  - Patient Safety: culture, education, safety events, QI
  - Supervision and accountability:
    - Levels of supervision
    - Progressive authority

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CPR VI B

- Professionalism
  - Professional responsibilities
  - NOTE: Service vs education: routine reliance on residents to fulfill non-physician obligations increases work compression for residents and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital, routine blood drawing for laboratory tests, routine monitoring of patients when off the ward, and clerical duties, such as scheduling. While it is understood that residents may be expected to do any of these things on occasion when the need arises, these activities should not be performed by residents routinely and must be kept to a minimum to optimize resident education

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Service vs Education

- Catalanotti JS, Amin AN, Caverzagie K et al: Balancing Service and Education: An AAIM Consensus Statement

  - Service is authentic to the role of a physician and a part of practicing medicine

    - Knowing how to start an IV line can be life-saving

    - Helping with paperwork for discharge planning is essential

  - Deliberate practice in provision of patient care is crucial to active learning

  - Excessive reliance on residents for nonphysician activities may detract from education

CPR VI.B.

- Culture of professionalism that supports patient safety and personal responsibility

- Assurance of their fitness for work

  - Management of time before, during and after clinical assignments

  - Recognition of impairment

- Responsiveness to patient needs that supersedes self-interest

- Environment free from mistreatment, abuse or coercion…

CPR VI.C.

- Well-Being: in the current health environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Programs in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to ensure other aspects of resident competence.

CPR VI.D.

- VI.D. Fatigue Mitigation
  - Education
  - Policies and procedures
- VI.E. Clinical Responsibilities, Teamwork and Transitions of Care

CPR VI.F.

- The Learning and Working Environment
  - Clinical Experience and education
  - Hours
  - Exceptions
  - Moonlighting
  - In-House Night Float
  - At-Home call

CPR VI.F.

- 16-hour continuous duty for PGY-1 removed
- 24+4
- **80-hour week** averaged
  - Simple math: if you consistently schedule residents to work the max 80 hours each week, there is no room for flexibility

CPR VI

- Effective July 1, 2017........but
  - Some components are citable immediately
    - Supervision
    - Work hours

    We cite these now
  - Other components: AFIs
    - Wellness
    - QI Education

    More resource-intensive

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Review Committee for Family Medicine Update

Stacy Potts, M.D., M.Ed.,

Chair, Review Committee for Family Medicine

Eileen Anthony, RC Executive Director

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Disclosures

- Dr. Potts and Ms. Anthony have nothing to disclose.

Discussion of Topics

- RC-Family Medicine: Who We Are and What We Do

- NAS – Annual Data Review/Accreditation Decisions

- Proposed Focused PR Revisions/New FAQ

- Single GME Accreditation System

RC-Family Medicine Staff

- Eileen Anthony, Executive Director; 312.755.5047; eanthony@acgme.org

- Sandra Benitez, Senior Accreditation Administrator; 312.755.5035; sbenitez@acgme.org

- Luz Barrera, Accreditation Assistant; 312.755.5077; lbarrera@acgme.org

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www.acgme.org

- RC for Family Medicine Webpage (PRs, FAQs, etc., etc.)
- ACGME Glossary of Terms
- Application Instructions
- Site Visit FAQs
- ACGME Policies & Procedures
- Duty Hour FAQs and Resources

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RC-Family Medicine Webpage

The Review Committee meets *three times* a year

Meeting and agenda closing dates on webpage

FAMILY MEDICINE

OVERVIEW

The documents and resources within this section are provided by the Review Committee for Family Medicine and its staff at the ACGME to assist ACGME-accredited programs and those applying for accreditation. Specialty and subspecialty information is found in each of the links listed below, as applicable.

FAMILY MEDICINE SUBSPECIALTIES

Clinical Informatics
Geriatric Medicine
Hospice and Palliative Medicine
Sports Medicine

SPECIALTY AND SUBSPECIALTY LINKS

Program Requirements and FAQs and Applications »
Milestones »
Documents and Resources »
Review Committee Members and Staff »

OTHER ACCREDITATION RESOURCES

Clinical Experience and Education (formerly Duty Hours)	»
Common Program Requirements	»
Osteopathic Recognition	»
Review and Comment	»
Self-Study and Site Visit	»
Single GME Accreditation System	»
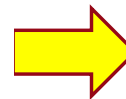
REVIEW COMMITTEE AGENDA CLOSING AND MEETING DATES

DEC 5 2016 — Agenda Closing Date
JAN - FEB 30 - 1 2017 — Meeting Date
FEB 27 2017 — Agenda Closing Date
APR 24 - 25 2017 — Meeting Date
AUG 21 2017 — Agenda Closing Date
OCT 16 - 17 2017 — Meeting Date

RC-Family Medicine Composition

- 4 appointing organizations – AAFP, ABFM, AMA *and* AOA
- One public member
- 14 voting members
- Ex-officio member from AAFP and ABFM (non-voting)
- 6 year terms - except resident (2 years)

- Program Directors, Chairs, Faculty, and Public Representation
- Geographic Distribution
  - AZ, CA, GA, IL, KS, MA, MO, NJ, NY, NC, PA, VA

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Review Committee Members

- John R. Bucholtz, DO

- Gary Buckholz, MD (HPM)

- Paul Callaway, MD - Vice Chair

- Colleen Cagno, MD

- Robert Danoff, DO

- Grant Hoekzema, MD

- Sam Jones, MD

- Martha Lansing, MD

- Harald Lausen, DO

- Joseph Mazzola, DO

- Timothy Munzing, MD

- Stacy Potts, MD, M.Ed - *Chair*

- Amanda Ashcraft Pannu, MD - *Resident*

- Allison Smith, MPH, BA, BSN, RN - *Public member*

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The Work of the RC

- Reviews programs with regards to Common and Specialty Program Requirements

- Determines accreditation status for programs

- Proposes revisions to Program Requirements

- Discusses matters of policy, issues relevant to the specialty

- Recommends changes in policy, procedures and requirements to the ACGME Council of Review Committee Chairs

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ADS Annual Updates

- Annually: programs required to enter data into ADS:

- Faculty information

- Resident/Fellow information

- Block diagrams/curricular information

- Scholarly activity (PD, Faculty, Residents) information

- Participating site information

- Responses to previous citations

- Duty Hour, Patient Safety and Learning Environment information

- Evaluation information

- Reporting of major changes in the program

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ADS Annual Updates

- Data elements for Annual Review, but <u>not</u> entered directly by the program:

- Resident Survey

- Faculty Survey

- Milestone data

- Certification examination performance (*provided by certifying Boards*)

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ADS Annual Updates

- "Traditionally" coordinator's job
  - Now speaks directly to the Review Committee
- Program Director
  - Responsible for information entered
  - Should assure entries are timely, accurate, complete

Omission of Data

- If it is not listed, it isn't so/didn't happen
- Common omissions:
  - Faculty credentials (degree, certification)
  - Participating sites
  - Complete scholarly activity
  - Updated response to citation(s)
  - Complete block diagram

Common Mistakes in Annual Data Collection

- Inaccurate scholarly activity (*e.g., not listing ALL physician specialty faculty and only the FM physician faculty*)
- Program director provides inaccurate and incomplete data (*if not there, the Committee cannot determine compliance and may cite the program*)
- Inaccurate physician faculty credentials (*MOC, board certification)*
- Identification of **core FM** faculty (*per FM PR II.B.6.a).1*)

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Role of the RC in the Accreditation Process

- **Determine** accreditation status based on data review that involves:

  - Reviewing the program's responses to PREVIOUS citations to determine if issues are corrected

  - Reviewing program data to determine substantial compliance with the requirements

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Role of the RC in the Accreditation Process

- **Request** additional information from program
  - Clarifying information
  - Full or focused site visit
- **Change/Continue** accreditation status based upon data review

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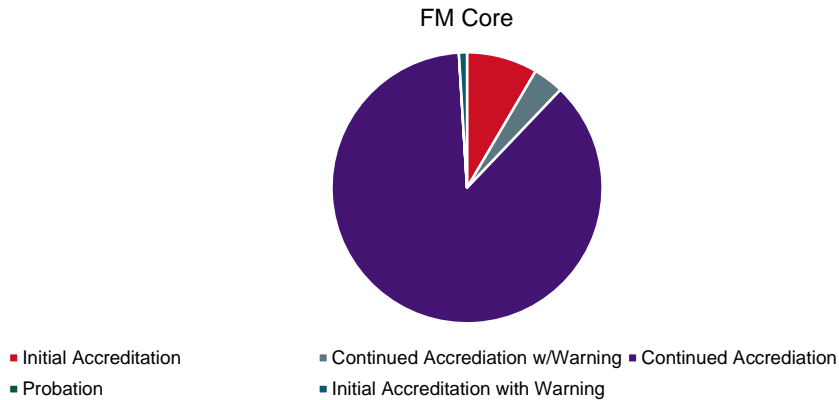# Status of Family Medicine Programs (as of January 2017)

Status	FM Core (#)	HPM (#)	Sports Med (#)	Geriatric Med (#)
Initial Accreditation	44	23	12	3
Initial Accreditation w/Warning	5	1	0	0
Continued Accreditation	452	101	118	40
Continued Accreditation w/Warning	19	1	0	0
Probation	0	0	0	0

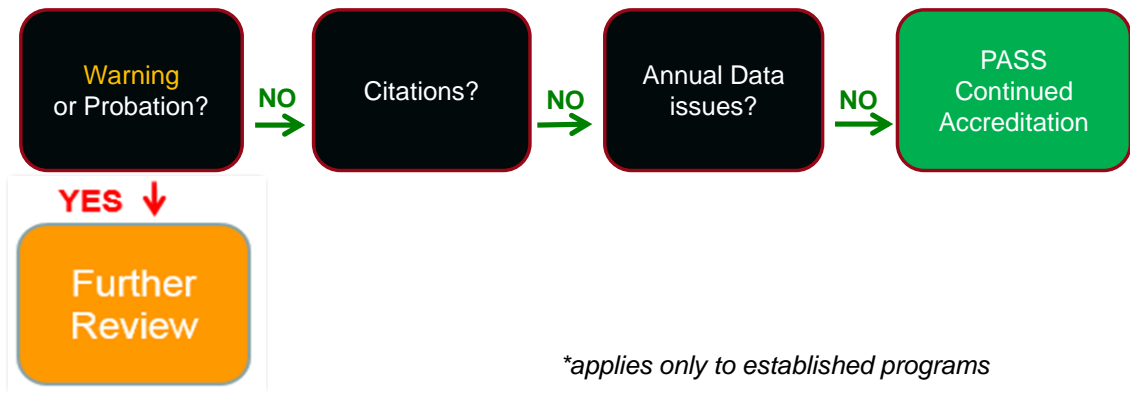# Status of Family Medicine Programs - CORE (as of January 2017)

FM Core

- Initial Accreditation
- Continued Accrediation w/Warning
- Continued Accrediation
- Probation
- Initial Accrediation with Warning

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Status of Family Medicine Program - Subs (GM, SM, HPM Combined) - as of January 2017

20, 6%
38, 12%
259, 82%

259, 82%
0, 0%

- Initial Accreditation
- Continued Accrediation w/Warning
- Continued Accreditation
- Probation
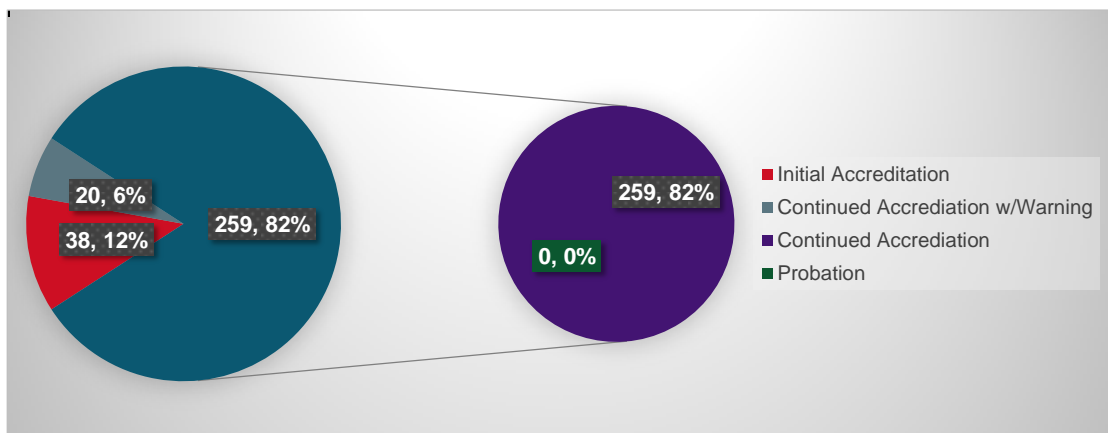
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Annual Program* Review

| Warning or Probation? | →NO→ | Citations? | →NO→ | Annual Data issues? | →NO→ | PASS Continued Accreditation |

YES ↓

Further Review

*applies only to established programs

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Site Visits

Application	Initial to Continued	Data Prompted	10-year Visits
• Full or focused SV • Typically requires no document preparation • 30-day notification	• Full SV after initial accreditation period of 2 years • Requires document preparation • 60-day notification	• Applies only to core programs applying for accreditation • No minimum notice required	• Full SV • 90-day notification

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Data Prompted Site Visit
Focused Site Visit

- Assesses *selected* aspects of the program and may be used:
  - to address *potential* problems identified during review of annually submitted data
  - to diagnose factors underlying deterioration in program's performance
  - to evaluate complaint against program

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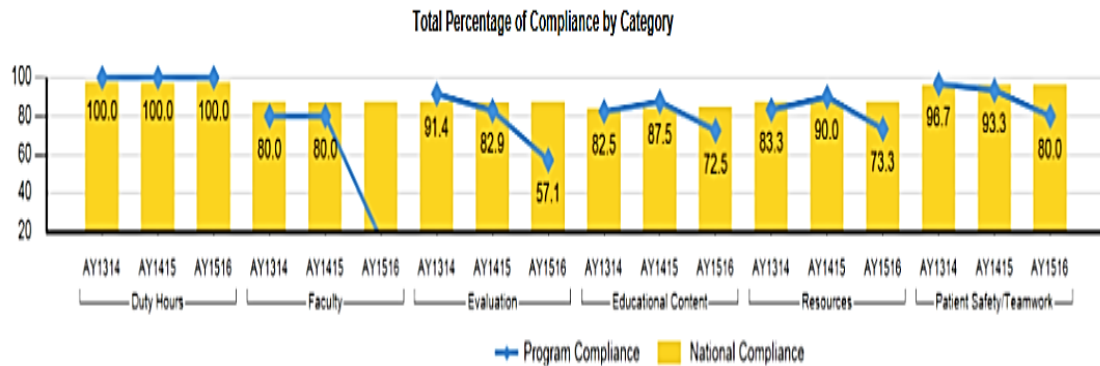
- Specific program area(s) assessed as instructed by the RC
- Minimal notification given
- Minimal document preparation expected
- Team of site visitors

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30

Example of Data Prompted Site Visit
Resident Survey Results

Total Percentage of Compliance by Category

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Data Prompted Site Visit
FULL Site Visit

- Application for new core program
- At end of initial accreditation period
- RC identifies broad issues/concerns
- Other serious conditions or situations identified by the RC
- 30-day notification given
- Minimal document preparation
- Team of site visitors

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31

Citations vs. Areas for Improvement

- *Citation*
  - Must be tied directly to a Program Requirement
  - Program director must provide a written response as to how the citation has been corrected annually (ADS update)
  - Citation will be removed only after review of PD response to determine compliance (either winter or spring meeting)

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Citations vs. Areas for Improvement

- *Area for Improvement (AFI)*
  - Does not need to be tied directly to a Program Requirement
  - Will appear in the Letter of Notification (LON)
  - May include areas of concern by the Committee that may devolve into a citation if not addressed (e.g., case log data, Board Scores)
  - May rise to the level of a citation if persistent

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Practical Tips…

- <u>Do not omit</u> physician faculty other than the Family Medicine Physicians on the ADS faculty roster

Physician Faculty Instructions

List all physician faculty who have a significant role (teaching or mentoring) in the education of residents and who have documented qualifications to instruct and supervise. List the FM physician faculty in your program who devote more than 200 hours per year to resident education (refer to the Program Requirements) in the following order: (1) full-time, (2) part-time, and (3) volunteer faculty.

Other Faculty: After listing the FM faculty, identify the primary physician faculty members responsible for teaching FM residents in the following areas (listed in this order): Human Behavior/Mental Health; Adult Medicine; Cardiology; Critical Care; Obstetric Care; Gynecologic Care; Surgery; Orthopaedics; Sports Medicine; Emergency Medicine; Neonates, Infants, Children and Adolescents; Older Patient; Skin.

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Practical Tips…

- The ACGME defines "Core" physician faculty as those with 15 hours/week to the program for the **Faculty Survey** administration (*PD does not complete FS*)

A portion of the faculty must be indicated as core physician faculty. All physicians who devote at least 15 hours per week to resident education and administration are designated as core faculty. All core faculty should:
- Evaluate the competency domains;
- Work closely with and support the program director;
- Assist in developing and implementing evaluation systems; and
- Teach and advise residents

Program directors will not be designated as core faculty

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Practical Tips…

- In addition to other physician faculty, the RC-FM requires programs to have "**Core FM**" physician faculty.

II.B.6.a)	Core physician faculty members must:
II.B.6.a).(1)	dedicate at least 60 percent time (at least 24 hours per week, or 1200 hours per year), to the program, exclusive of patient care without residents; and, (Detail)
II.B.6.a).(2)	devote the majority of their professional effort to teaching, administration, scholarly activity, and patient care within the program. (Detail)

Practical Tips…

- This is a resident rotation schedule. It is NOT the block diagram showing curricular requirements

	UM DERM NOT AVAILABLE	UM DERM NOT AVAILABLE	UM DERM NOT AVAILABLE	UM DERM NOT AVAILABLE	INTERVIEWS	INTERVIEWS	INTERVIEWS	
PGY3	Block 1	Block 2	Block 3	Block 4	Block 5	Block 6	Block 7	Block 8
AY17	Fri July 1 - Sun July 31	Mon 8/1 - Sun. 8/28	Mon 8/29 - Sun 9/25	Mon 9/26 - Sun 10/23	Mon 10/24 - Sun 11/20	Mon 11/21 - Sun 12/18	Mon 12/19 - Sun 1/15/16	Mon 1/16 - Sun 2/12
BFHC		ALSO 8/4 & 8/5	Sept 21-23 in Orlando CHIEFS		ITE Oct 24, 25, 26, 27 and 28			ALL RETREAT 1/24/2017
NAME	DERM VIDERS V4	LOA 4 weeks	LOA 4 weeks	NB Elec (V1 vac) HC &Call 10/10 wk2	URGENT PEDIATRICS	PROFESSOR CHIEF 11/26 HC Call?	ELEC V2 don't move this HOL WK OFF	HEALTH CNTR CHIEF
NAME	ELEC Off 7/15-18 In Wedd (7/28-30 AAFP) Call 7/4	ORTHO Off 8/22 Bday Cov FMIS 8/4 & 8/5	HCC + CC 9/21-9/24 FLA	Elec/VOB Fellowship	URGENT PED CONF 11/18 & 19	HEALTH CNTR CHIEF	DERM UMASS (Don't Move) V(HOL Wk)off	FMIS (B.2)
NAME	MCH(2)	HEALTH CNTR CHIEF	ORTHOV2 9/5-9/9(Cov for NL CC 9/21-9/23)& NW 9/24	FAMILY MED IN PT (ADULT MED SELECTIVE)	HEALTH CNTR CHIEF	Elec	ELEC BOARD REV 1/7-1/15	URGENT PEDIATRICS
NAME	HEALTH CNTR CHIEF off JULY 16/17	PROFESSOR CHIEF Cov FMIS 8/4 & 8/5	MATERNAL CHILD HEALTH SELECTIVE	HEALTH CNTR CHIEF	Elec Off Wedd 10/28-11/4	ORTHO w/No Vac, Off 11/25	HEALTH CNTR CHIEF	ElecV3

Practical Tips…

- This is a <u>Block Diagram</u> - it shows compliance with curricular requirements

Block Diagram Sample

Block Rotations – 1st Year												
Experience of Rotations	4 weeks Fam Med Ofc FHC	4 weeks Fam Med Inpt Svc	4 weeks Fam Med Inpt Svc	4 weeks Int Med #1	4 weeks Int Med #1	4 weeks Peds Inpt #1	4 weeks Peds Outpt #1	4 weeks OB #1	4 weeks OB #1	4 weeks Peripartum #1	4 weeks ER Dept	4 wks Critical Care #1	4 wks Dermatology #1
FMC Sessions (per week)	8	2	2	2	2	2	4	2	2	2	2	2	4
Location	FHC	MCCG	MCCG	MCCG	MCCG	MCCG	MCCG/PED SCHC/PRI Office	MCCG OB	MCCG OB	MCCG NBN	MCCG/ EC	MCCG ICM	Private Derm Office FHC Wound care
Duty Hours	45/10/3x	65/10/3x	65/10/3x	65/12/2x	65/12/2x	65/10/3x	45/9/8x	70/12/5x	70/12/5x	45/10/8x	36/12/3x	60/11/2x	45/9/8x

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Continuity of Care Patients

- Graduates are required to have 1,650 outpatient visits…not a high bar! The average per graduate (*3342 graduates total*) in AY 2015-16 was…
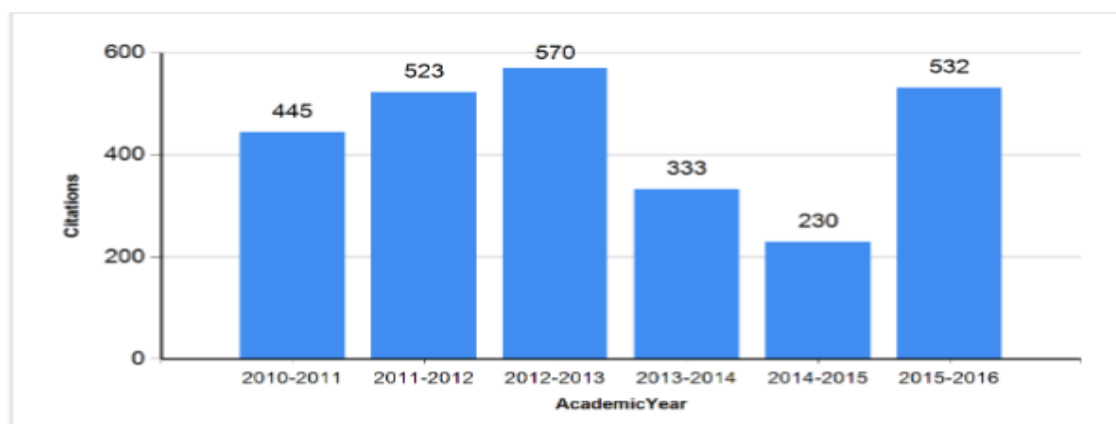
1,814

Continuity of Care Patients

PGY	Sessions (per wk)	Patients (per session)	Weeks	Patient visit
1	1	4	40	160
2	3	5	40	600
3	4	6	40	960
			TOTAL	1,720

RC-Family Medicine Citations Since 2009

Most Common Citations

- Board pass rate

- Pediatric patient population (<10 years)

- Faculty role-modeling inpatient care (maternity, pediatric, adults)

Most Common AFIs

- Faculty scholarship

- Resident and Faculty Survey

- Board pass rate

Program Statuses

- *Existing programs*
  - Continued Accreditation
  - Continued Accreditation w/Warning - Not appealable
  - Probationary Accreditation - Appealable action
  - Withdrawal of Accreditation - Appealable action

- *New programs*
  - Accreditation Withheld - Appealable action
  - Initial Accreditation
  - Initial Accreditation w/Warning - Not appealable
  - Continued Accreditation Without Outcomes
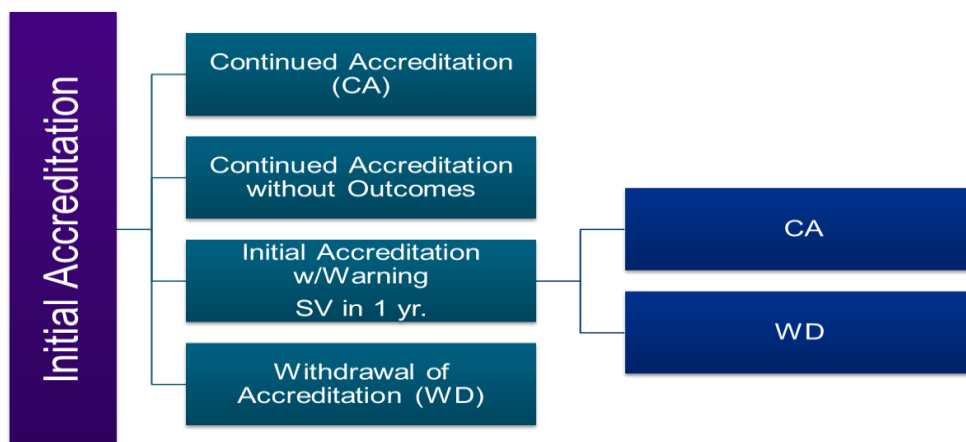
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Accreditation Status Options
for New Applications
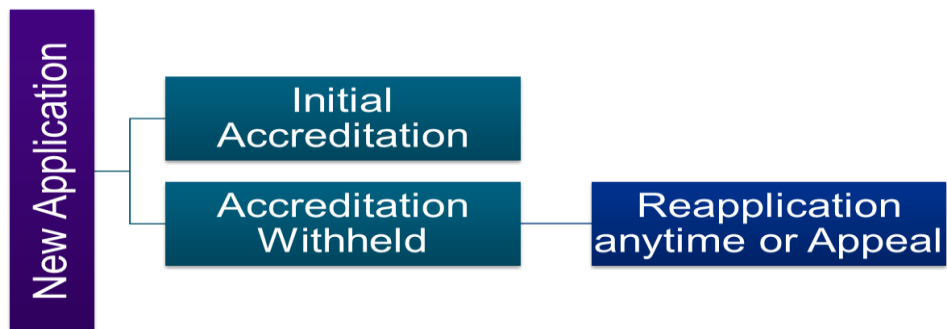
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Accreditation Status Options
Following the Initial Site Visit

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Relationship of Core and Fellowships

- Fellowships must have a relationship with a core residency program

  - Self-study visits of core and associated fellowships will occur at the same time

  - Adverse action in core results in the same status for their associated fellowships

    - Withdrawal of core means administrative withdrawal of all associated fellowships

  - New fellowships can only be granted Initial Accreditation status if core status is on Continued Accreditation (*not on Probation*)

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39

Program Requirement Focused Revisions

- **Board Take/Pass Rates**

- *Requirement(s) #: V.C.4.*

- At least 95 percent of a program's eligible graduates from the preceding five years must have taken the American Board of Family Medicine (ABFM) <u>or American Osteopathic Board of Family Practice (AOBFP)</u> certifying examination for family medicine. (Outcome)

- *Requirement(s) #: V.C.5.*

- At least 90 percent of a program's graduates from the preceding five years who take the ABFM <u>or AOBFP</u> certifying examination for family medicine for the first time must pass. (Outcome)

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New FAQ: Faculty Scholarship

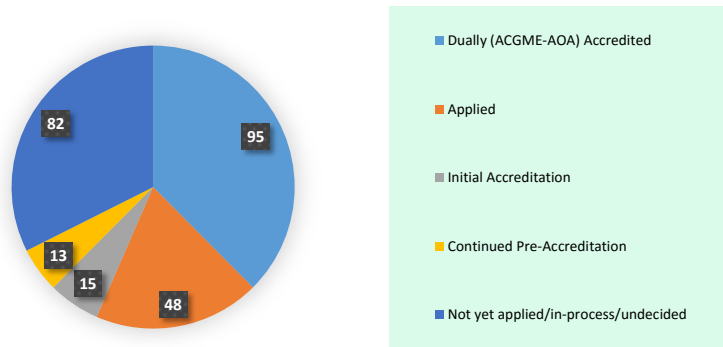|	
Is there a numeric expectation with respect to peer-review funding, publications, presentations, participation in national committees, etc.? *[Program Requirement: II.B.5.b)]*	The goal of the requirement is to ensure that residents are training in an environment of inquiry with appropriate role-modeling by the members of the core family medicine physician faculty(whom, per the PR II.B.6.a).(1), dedicate at least 60 percent time -- at least 24 hours per week, or 1200 hours per year to the program). The Committee considers appropriate role-modeling of scholarship to include at least two entries of the examples listed in the Program Requirements (see below) over five years by the core family medicine physician faculty members (i.e., the requirement indicates "some" that would be interpreted as all core FM faculty completing at least two scholarly activities in five years). Other non-core faculty should be encouraged to participate in scholarly activity. The committee however does not have a minimal numeric expectation for non-core faculty. Examples of appropriate scholarship include: • peer-reviewed funding; • publication of original research or review articles in peer reviewed journals, or chapters in textbooks; • publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; • participation in national committees or educational organizations.

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40

Single GME Accreditation System

AOA FM Programs - 253 Total

- Dually (ACGME-AOA) Accredited
- Applied
- Initial Accreditation
- Continued Pre-Accreditation
- Not yet applied/in-process/undecided

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Single GME – Osteopathic Recognition

- The RC-FM does not have oversight (e.g., review applications, annual decisions, etc.) for Osteopathic Recognition
  - Oversight is provided by the Osteopathic Recognition Committee
  - The status of the Osteopathic Recognition of a program (e.g., Withdrawn, etc.) has no impact on the accreditation status of the related core FM program.

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Single GME – Osteopathic Recognition

Home > What We Do > Recognition > **Osteopathic Recognition**

Osteopathic Recognition

Recent News and Updates

The documents and resources housed within this section are provided by the Osteopathic Principles Committee and its staff at the ACGME.

Requirements Currently in Effect

7/1/2015   📄 Osteopathic Recognition

         📄 Osteopathic Recognition FAQs

Milestones

     📄 Osteopathic Recognition
     📄 Milestones FAQ

Application for Recognition

     📄 Osteopathic Recognition

✉ ☎
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