Review Committee for Family Medicine Update

Peter J. Carek, MD, MS
   Chair, Review Committee for Family Medicine (RC-FM)
Mary Lieh-Lai, MD
   Senior Vice President, Medical Accreditation
Eileen Anthony
   Executive Director, RC-FM

PDW/RPS
Sunday, April 3rd, 2016
Disclosure

• No conflict of interests to report.
RC-FM Staff

- Eileen Anthony, Executive Director
  - Ph: 312.755.5047
  - eanthony@acgme.org
- Sandra Benitez, Senior Accreditation Administrator
  - Ph: 312.755.5035
  - sbenitez@acgme.org
- Luz Barrera, Accreditation Assistant
  - Ph: 312.755.5077
  - lbarrera@acgme.org
RC-FM Composition

- 4 appointing organizations - AAFP, ABFM, AMA and AOA
- One public member
- 14 voting members
- 6 year terms -- except resident (2 years)
- Program Directors, Chairs, Faculty, and Public
  - CA (2), FL, GA, IL, KS, MA, NJ, NC, PA, VA, WA (2)
- Ex-officio members (non-voting) from AAFP and ABFM
RC-FM Members

- Suzanne Allen, MD
- John R. Bucholtz, DO
- Gary Buckholz, MD (HPM)
- Paul Callaway, MD - Vice Chair
- Peter J. Carek, MD, MS - Chair (SM)
- Robert Danoff, DO
- Sam Jones, MD
- Martha Lansing, MD
- Harald Lausen, DO
- Joseph Mazzola, DO
- Timothy Munzing, MD
- Stacy Potts, MD
- Nicholas Weida, MD (Resident)
- Alison Smith, MPH
- RC-Family Medicine meets **three times** a year
- Meeting dates and agenda closing deadlines on webpage
## Discussion of Topics

<table>
<thead>
<tr>
<th>Program Requirements Revisions</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Next Accreditation System (NAS)</td>
<td>Single Accreditation System (SAS)</td>
</tr>
</tbody>
</table>
Discussion of Topics

- Megatrends at ACGME
- Work of RC-FM
- NAS - First year review and reflections
- Single Accreditation System (SAS)
- RC-FM Updates and Issues
- Q & A
Evolution of the ACGME

15 years

Single Accreditation
CLER
NAS
ACGME-I
Milestones
Outcomes
Project
ACGME
independent


First residency

First RRC

ACGME established

1980 1990 2000

2003 Duty Hours

2011 Duty Hours

2015 Duty Hours studies in Medicine and Surgery

Courtesy of John Potts MD

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Megatrends at the ACGME

1. Expectations of the Profession to Public expectations
2. Expert-based to Evidence-based
3. Process to Outcomes based
4. Rules based to QI based
5. ACGME control to Local control
6. Focus on Accreditation to GME Improvement
7. Periodic review to Annual review
8. Paper (PIF) to Electronic (ADS)
9. ACGME focus to Collaborative focus

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Trends at the ACGME

Expectations of the Profession to Public expectations

- Patient safety and competency concerns: CLER
- Duty hours and IOM reports
- Public members
- Congress and GME funding
- ACGME Resource accountability
Trends at the ACGME

Expert-based to Evidence-based

• JGME
• Milestones 1.1 (Summit: 12/4/2015)
• Duty Hours: FIRST and iCOMPARE
• Future program requirement changes
Trends at the ACGME

**Duty Hours Studies**

**FIRST**: Flexibility in Duty Hour Requirements for Surgical Trainees
- Data from 138,691 patients, >13,000 residents
- Standard policy vs flexible policy
- Outcome: 30-d rate or post-op death or serious complications and resident perceptions and satisfaction: well being, education

**Outcome**: non-inferior patient outcomes and no significant difference in satisfaction
Trends at the ACGME

Process based to Outcomes based

• Outcomes project
• Core Competencies
• Milestones
• The Next (New) Accreditation System
• Focus from individual citations to overall accreditation status
Trends at the ACGME

Rule-based model to QI model: Minimum compliance (just getting by) to encouraging excellence (to be the best)

- Program Evaluation Committee
- Annual Program Review
- 10 Year Self-studies/Program Aims
- CLER Pathways to Excellence

Trends at the ACGME

• Quality Improvement
  • Joint effort with the American Board of Pediatrics to offer MOC-4 credit for program improvement work from the annual program evaluation and self-study
    • Tracking form on ACGME website to be used for MOC credit
  • Will work with other specialty boards
ACGME Control to Local Institution Control

- GMECs: SI2025
- Annual Program Evaluations and PECs
- Linking core programs and fellowships
- Areas for Improvement (AFIs)
- Recognition of programs and institutions
  - Best practices
Focus from Accreditation to Improving GME

- Feedback at the site visit
- Increase in Educational Efforts:
  - Annual Education Conference
  - Faculty Development workshops (assessment)
  - Coordinator and chief resident training
  - Distance learning
- Wellness and Learning Environment
Periodic “biopsies” to Annual Review

- Program data
- Response to citations
- Resident and Faculty surveys
- Case logs
- Shift from citations to areas for improvement
Trends at the ACGME

Paper (PIF) based to Electronic (ADS) based
• Overall GME Summary reports
• Analysis (and research) is possible
• Trends are measurable
• More uniformity between specialties
• Expect initial bugs and transition woes
Trends at the ACGME

ACGME focus to Collaborative focus

• Comment period before requirement changes
• Milestones process
• Wellness efforts
• Duty Hours Reassessment
• Research efforts
Trends at the ACGME

• Wellness conference: 11/17-18/2015
  • [http://www.acgme.org/acgmeweb/tabid/487/MeetingsandConferences/SymposiumPWB.aspx](http://www.acgme.org/acgmeweb/tabid/487/MeetingsandConferences/SymposiumPWB.aspx)

• Common Program Requirements Phase I Task Force
  • 1/23-24/2016 – first of several meetings
  • Reviewing standards related to Resident Learning and Working Environment
  • Reviewing evidence available since implementation of 2011 DH standards
  • Will develop recommendations

• Duty Hours Task Force Congress: 3/16-17/2016
Trends at the ACGME

- February 2016: ACGME Board of Directors voted to expand the Self-Study Pilot to all Phase II programs with a first NAS site visit date between April 2016 - July 2017
- Pursuing excellence in CLE: 4-year initiative – transformative improvement
  - Funding: $75,000 per year over 4 years for up to eight sponsoring institutions
Megatrends at the ACGME

1. Professional expectations to Public expectations
2. Expert-based to Evidence-based
3. Process to Outcomes based
4. Rules based to QI based
5. ACGME control to Local control
6. Focus on Accreditation to GME Improvement
7. Periodic review to Annual review
8. Paper (PIF) to Computer (ADS)
9. ACGME focus to Collaborative focus
Work of RC-FM

• **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 specialty
• **Recommends** changes in policy, procedures and requirements to ACGME Council of Review Committee Chairs (CRCC)
Annual Data Reviewed

- Annual ADS Update
  - Program Demographics – Structure and resources
  - Program Changes/Attrition (PD, core faculty, residents)
  - Scholarly Activity – Faculty and residents
- Board Pass Rate
- Clinical Experience
- Resident Survey
- Faculty Survey
- Semi-Annual Resident Evaluation and Feedback (including Milestones)
- Ten year self-study consultation and accreditation visits
ADS Annual Update

• Program Director responsible
  • Information entered needs to be timely, accurate, complete, available, reproducible . . .

• Common omissions
  • Faculty credentials (degree, certification, MOC, etc)
  • Participating sites
  • Complete scholarly activity
  • Updated response to citation(s)
  • Complete block diagram

• Common Mistakes
  • Accurate scholarly activity
  • Ensuring that all residents log cases (Do not need to cease once minimums met)
  • Identification of core faculty
Role of RC-FM in Accreditation Process

• **Determine** accreditation status based on data review
  • Reviewing program’s responses to PREVIOUS citations to determine if issues corrected
  • Reviewing program data to determine substantial compliance with requirements

• **Request** additional information from program
  • Clarifying information
  • Full or Focused Site Visit

• **Change/Continue** accreditation status based upon data review
## Review Process

<table>
<thead>
<tr>
<th>Annual</th>
<th>Every 10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ADS data submission and review</td>
<td>• Program self-study summary</td>
</tr>
<tr>
<td>• Additional information if requested</td>
<td>• Self-study visit and report</td>
</tr>
<tr>
<td>• Accreditation decision</td>
<td>• RC review</td>
</tr>
<tr>
<td></td>
<td>• Accreditation decision</td>
</tr>
</tbody>
</table>
Annual Review Process

Data Submission

Review by RC-FM

Administrative/Committee Review

Request for clarifying or additional information; progress reports

Focused site visit

Full site visit

Accreditation Decision

Continued accreditation
- Citations
- Areas for improvement

Continued accreditation w/ warning
- Citations
- Areas for improvement

Probationary accreditation

Withdrawal of accreditation

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Focused Site Visit?

- Assesses *selected* aspects of program and may be used to:
  - *address potential problems* identified during review of annually submitted data
  - *diagnose factors underlying deterioration* in program’s performance
  - *evaluate complaint* against program
  - Minimal notification/preparation, team of visitors

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Full Site Visit is Different

- Factors leading to 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
- 30-day notification given, minimal document preparation, team of site visitors
Citations vs. Area for Improvement

Citation

- Identified areas of noncompliance
- Linked to specific requirement
- Response to citations required in ADS
- Responses reviewed annually by RC (*either winter or spring meeting*)
- Remain active until corrected
Citations vs. Area for Improvement (AFI)

- May not be specifically linked to a requirement
- Written response not required, but data will be reviewed
- Will appear in LON
- May include areas of concern by Committee that may devolve into or rise to level of citation if not addressed (e.g., patient visits, Board scores, resident survey)
Top Five’ish Citations/Categories
(AY 2014-2015)

1. Evaluation – Performance on Board Exams (34)
2. Responsibility of the Faculty: Role modeling inpatient experiences (24)
3. Qualifications of the Faculty: ABMS certification or equivalent (20)
3. The Educational Program – Patient Care Experiences- FMC patient population/visits (20)
3. Curricular Development (20)
4. Scholarly Activities – Residents (13)
Top Four Areas for Improvement
(AY 2014-2015)

• Board Passage Rate
• Faculty Scholarly Activity
• Resident and Faculty Survey
• Inpatient Data
RC-FM Citations Since 2009

<table>
<thead>
<tr>
<th>Academic Year</th>
<th>Citations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-2010</td>
<td>365</td>
</tr>
<tr>
<td>2010-2011</td>
<td>445</td>
</tr>
<tr>
<td>2011-2012</td>
<td>523</td>
</tr>
<tr>
<td>2012-2013</td>
<td>570</td>
</tr>
<tr>
<td>2013-2014</td>
<td>333</td>
</tr>
<tr>
<td>2014-2015</td>
<td>230</td>
</tr>
</tbody>
</table>
2015-16 FM Annual Data Review

• Total: 490 core programs reviewed
  • 386 programs granted Continued Accreditation
  • 93 programs “pulled” for full committee review (Jan 2016 meeting)
    • 66 – Continued Accreditation
    • 27 – Continued Accreditation with Warning
      – Continuity (1,650), Board Scores
  • 11 programs “pulled” for Full or Focused Site Visit
• Five (5) New Program Applications
  • Three (3) – AOA/Single Accreditation System applications
  • Two (2) – Allopathic program applications
Accreditation Statuses

• Existing programs
  • Continued accreditation
  • Continued accreditation with warning - Not appealable
  • Probationary accreditation - Appealable action
  • Withdrawal of accreditation - Appealable action

• New programs
  • Accreditation withheld - Appealable action
  • Initial accreditation
  • Initial accreditation with warning - Not appealable
  • Continued accreditation without outcomes
With Annual Data, RC will...

Send a letter to every program every year

- Confirm accreditation status
- List citations (new, continued, unresolved) and AFIs
- Indicate if additional information needed
  - Clarifying report
  - Progress report
  - Site Visit
Program Self-Study

• Comprehensive review of program
  
  Different mindset – “How can we (ACGME) help you (program)”
  • Review of how program creates effective learning and working environment and how this leads to desired educational outcomes (SWOT and QI)
  • Written summary (brief) of key dimensions uploaded to ADS
    • Aims, Opportunities, Threats, Process used
    • Areas noted in need of improvement not included

• Annual Program Evaluations feed Self-Study
Aims of Self-Study

• Differentiate your program from others
• Evaluate program effectiveness in meeting the aims
• Move beyond compliance with minimum standards
• Assess relevant initiatives and their outcomes
After Self-Study. . .
Program Prepares Self-Study Summary

• Brief (4 to 5 pages, ~ 2300 word) summary of key dimensions of Self-Study
  • Aims
  • External environmental assessment
  • Opportunities and Threats
  • Process of Annual Program Evaluation and Self-Study
  • Learning that occurred during self-study (Optional!)
    • Information on areas for improvement identified in self-study not included in Summary (internal use only)

• Summary uploaded into ADS
10-Year Accreditation Site Visit

- Approximately 18 months after self-study to allow programs to implement improvements
- A “PIF-Less” Visit
  - Program updates their self-study summary and provide information ONLY on improvements that were realized from their self-study
  - No request for information on areas that have not been resolved
- Team provides verbal feedback
  - Key strengths and suggestions for improvement
  - Team prepares a written report for RC
10-Year Accreditation Site Visit
RC-FM Review

• Information available to RC
  • ADS Data
  • Program’s self-study summary
  • 10-yr site visit report

• RC provides a LON
  • Program’s aim and context
  • Citations and AFIs
  • Feedback concerning self-study program
    • Effectiveness of self-study reviewed and feedback provided
    • No accreditation impact for initial feedback on self-study
Self-Study/Accreditation Visit Timeline

ACGME notifies program to initiate Self-Study (Date set to begin Self-Study)

Program conducts and completes Self-Study
- Program uploads Self-Study Summary into ADS

10-year Site visit: Self-Study Summary + Accreditation Visit

Annual Program Evaluation feeds Self-Study

Plan -> Do

Annual Program Evaluation

Act -> Study

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Relationship of Core and Fellowships

- Self-study visits of core and associated fellowships will occur at same time
- Adverse action in core results in same status for their associated fellowships
  - Withdrawal of core means withdrawal of all associated fellowships
- New fellowships can only be granted IA status if core status is Continued Accreditation (not on Probation)
Milestones

- Specific benchmarks of skills, knowledge, and behaviors each resident expected to achieve at identified stages of residency
- Build upon existing evaluation tools and observations
  - Additional evaluation tools and techniques may be developed
  - Not rotation evaluation tool
- Progress of each resident assessed by Clinical Competency Committee (CCC)
# Milestones

## History (Appropriate for age and impairment)

<table>
<thead>
<tr>
<th>PC1.</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquires a general medical history</td>
<td>Acquires a basic psychiatric history including medical, functional, and psychosocial elements</td>
<td>Acquires a comprehensive psychiatric history integrating medical, functional, and psychosocial elements</td>
<td>Seeks and obtains data from secondary sources when needed</td>
<td>Efficiently acquires and presents a relevant history in a prioritized and hypothesis driven fashion across a wide spectrum of ages and impairments</td>
<td>Gathers and synthesizes information in a highly efficient manner</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Milestone</td>
<td>Elicits subtleties and information that may not be readily volunteered by the patient</td>
<td>Rapidly focuses on presenting problem, and elicits key information in a prioritized fashion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Models the gathering of subtle and difficult information from the patient</td>
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</tbody>
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Information current as of December 2, 2013

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New PRs and New FAQs

Principles for new PRs *(effective July 2014)*

- Knowledge base + experience required for competency
- Increased flexibility and support for program directors
- Provide flexibility to have longitudinal curriculum or alternative approaches for education besides rotations
- Focus on Patient-Centered Care using principles of current PCMH
- Allow FMP-site to provide greater spectrum of experiences
- Clear minimum standards
Family Medicine Practice (FMP)

**FMP (now FMP site)**
- Model ambulatory practice
- Focus on patients who present to facility
- In past, only these patients could be counted for required continuity visits

**FMP**
- Acknowledges care beyond walls of building
- Provides comprehensive and continuous care to individuals and populations
- Experience team- and systems-based care, including specialty care

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New PRs and FAQs

Core Faculty - Requirement
• Must 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
• Must devote the majority of their professional effort to teaching, administration, scholarly activity, and patient care within the program

Core Faculty - ADS input
• ACGME’s “common” ADS instruction for all core specialty programs applies 15 hours for core,
• Differs from RC-FM requirement
• Each RC has their own requirement for core faculty if stricter
• Non-physicians and peer-review process
"The RC-FM needs to know that the program has a system to collect and enter the data (as you said, be able to show the work if asked). The mechanics of the system are left to the program."
## Continuity of Care Patients

<table>
<thead>
<tr>
<th>PGY</th>
<th>Sessions (per wk)</th>
<th>Patients (per session)</th>
<th>Weeks</th>
<th>Patient visit</th>
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<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>4</td>
<td>40</td>
<td>160</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>5</td>
<td>40</td>
<td>600</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>6</td>
<td>40</td>
<td>960</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TOTAL 1,720</td>
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</table>
"A patient encounter is a meaningful interaction between a physician and a patient that includes a history, assessment, critical thinking, and care plan. An encounter is documented in the patient record for later reference. Therefore, a resident may have more than one encounter with a patient per day on the inpatient service."

“Also, more than one resident may have an encounter with an inpatient on any given day, though any more than the primary and supervising resident involved in an encounter would require additional educational rationale and justification."
Resident Increases

Expectation of RC-FM is that programs with citations \textit{(from most recent LON)} in following areas will \textbf{not} be considered for permanent increases in complement until deficiency in area resolved:

- Board Pass Rate
- Patient Visit (outpatient) Data (1,650)
Resident Increases

Requests for TEMPORARY increases are typically due to extraneous circumstances, such as resident remediation, medical leave, or resignations, and are therefore PGY-specific and not applied across all educational levels for a program.

PLEASE NOTE: The RC will request additional information (see above) should they determine that a temporary increase request is for a three-year period (PGY-1 through PGY-3). Contact the RC-FM office directly with questions.
Other Items

• Graduate Survey
  • “Program graduates should be surveyed at least every five years, and the results should be used in the annual program evaluation. (Detail)”

• Video-precepting
ACGME, AOA, and AACOM form single GME accreditation system for residency/fellowship programs in US

• To apply, programs must be associated with ACGME-accredited sponsoring institution or institution with “Pre-Accreditation Status” (April 2015 – Application for Institutions)
• To achieve Initial Accreditation, programs must demonstrate “substantial compliance” with requirements
Single Accreditation System (SAS)

275 Osteopathic FM programs (99 dually-accredited)

- Important Dates
  - April 2015 – Application for Institutions
  - July 2015 – Application for Programs
  - June 2020 – Window for application closes; AOA ceases accreditation
- 5-year window for “Pre-accreditation” Status
- All core program applications will require site visit prior to RC-FM review
Single Accreditation System (SAS)

Osteopathic Neuromusculoskeletal RC

• Delegated accreditation authority for accreditation of Neuromusculoskeletal and Osteopathic Manipulative Medicine residency programs

• Eight members
  • Five nominated by AOA and appointed by BOD
  • One appointed by ACGME
  • Resident member
  • Public member

• Chair will sit on CRCC
Osteopathic Principles Committee

• Responsible for review and evaluation of the osteopathic principles dimension of programs that seek ongoing Osteopathic Recognition

• 17 Members
  • 13 nominated by AOA and appointed by BOD
  • 2 appointed by ACGME
  • Resident member
  • Public member

• Chair will sit on CRCC
New ACGME Staff

- Lorenzo Pence, DO, Senior Vice President, Osteopathic Accreditation
- Tiffany Moss, Executive Director
- Julia Weigle, Accreditation Administrator and Executive Assistant to SVP
Single Accreditation System for AOA-Approved Programs

On February 26, 2014, the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM) announced their agreement to a Memorandum of Understanding (MOU) that outlines a single graduate medical education accreditation system for residency and fellowship programs in the United States.

Click here for the executive summary of the MOU

The single accreditation system allows graduates of allopathic and osteopathic medical schools to complete their residency and/or fellowship education in ACGME-accredited programs and demonstrate achievement of common Milestones and competencies.

Over the next five years, beginning July 1, 2015, AOA-approved programs and sponsoring institutions will have the opportunity to apply for ACGME accreditation. The ACGME and AOA have created and will continue to create elements of operations and infrastructure to ensure a smooth transition to the single system.

Click here for the timeline
Other Updates

• RC-FM/ACGME updates we didn’t have at the time the slides were due. . .
  1.
  2.
  3.
  4.
  5.
Questions?