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ROBIN O. WINTER, MD, MMM

### RRC STAFF

JERRY VASILIAS, PhD  
EXECUTIVE DIRECTOR  
312.755.7477  
JVASILIAS@ACGME.ORG

DENISE BRAUN-HART  
SENIOR ACCREDITATION ADMINISTRATOR  
312.755.7478  
DBRAUN@ACGME.ORG

SARA THOMAS  
SENIOR ACCREDITATION ADMINISTRATOR  
312.755.5044  
STHOMAS@ACGME.ORG

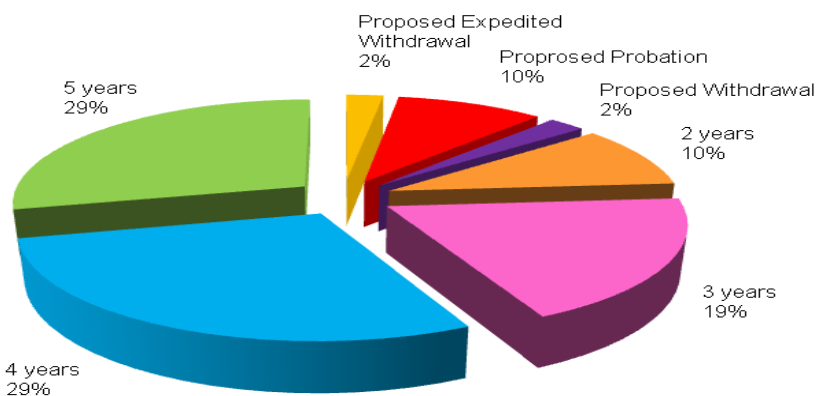
HOLLIS INBODEN  
ACCREDITATION ASSISTANT  
312.755.5037  
HINBODEN@ACGME.ORG

ACGME  
515 NORTH STATE STREET  
SUITE 2000  
CHICAGO, ILLINOIS 60654  
WWW.ACGME.ORG

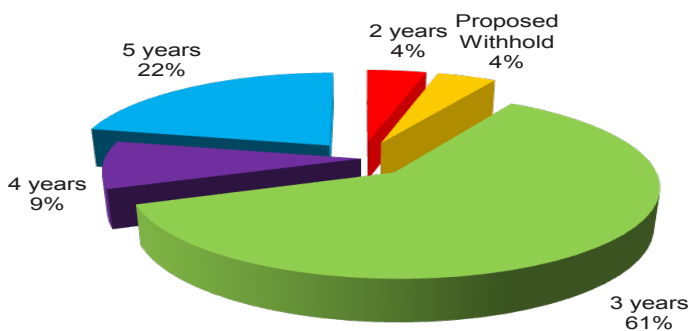
RRC NEWS PROVIDES REVIEW COMMITTEE AND ACGME UPDATES. PLEASE CONTACT THE EDITOR WITH QUESTIONS OR COMMENTS ABOUT THIS NEWSLETTER:  
MSCHWAB@ACGME.ORG.ORG.

### Summary of Actions Taken at September 2009 Meeting

The Residency Review Committee (RRC) for Family Medicine reviewed 42 core, and 23 subspecialty programs at its September 2009 meeting. The charts below provide a summary of the actions taken at the meeting. Also provided is a distribution of the review cycles of the programs reviewed.



Core Review Cycles- Fall 2009



Subspecialty Review Cycles- Fall 2009

### MEETING AND AGENDA CLOSING DATES

MEETING: MAY 24-26, 2010  
AGENDA CLOSING: MARCH 19, 2010

MEETING: SEPTEMBER 15-17, 2010  
AGENDA CLOSING: JULY 9, 2010

## RRC Welcomes New Chair: Jim Martin

James C. Martin, MD, will succeed Janice Nevin, MD, as the Review Committee's next chair, beginning his term July 1, 2010. He is a distinguished graduate of the University of Texas Health Science Center at San Antonio. After 20 years in private practice, Dr. Martin established the CHRISTUS Santa Rosa program, serving as its Program Director from 1995-2008. He currently serves as the Chief Medical Officer for CHRISTUS Santa Rosa. He has served the American Board of Family Medicine and the American Academy of Family Physicians, as President and Board Chair of both organizations. He also chaired the Future of Family Medicine Task Force and co-authored its 2004 national report on needed policy changes in primary care. Dr. Martin was the founding chair of TransforMED in 2005.

Among notable recognitions, he was recognized as Alumnus of the Year by the University of Texas Health Science Center at San Antonio, as a San Antonio Health Hero, in America's Best Physicians and Who's Who in U.S. Healthcare. In 2006, Dr. Martin received the John G. Walsh Award from the American Academy of Family Physicians, the Academy's highest award given in recognition for outstanding lifetime achievement.

Dr. Martin is well known both for his commitment to excellence in medical education and for his passion for health care reform in America. He has made presentations to many organizations in over 40 states and seven countries. Dr. Martin continues to have an active medical practice in San Antonio.

## Resident Survey

The national report summarizing all family medicine residents' responses on the resident survey is available in ADS. This report will allow each program director to view and compare his/her program's responses to those of all family medicine programs. To view this information, (1) Login into ADS (using your username and password); (2) On the left-hand side of the screen, you will see a list of report options. Select 'Resident/Fellow Survey'; (3) Select 'National Data by Core Specialty'; (4) Select an academic year using the drop-down menu.

In addition, the ACGME has posted a blank copy of the survey on its website:

[http://www.acgme.org/acWebsite/Resident\\_Survey/resident\\_survey\\_general\\_questions\\_20072008.pdf](http://www.acgme.org/acWebsite/Resident_Survey/resident_survey_general_questions_20072008.pdf)

as well as FAQs for the survey:

[http://www.acgme.org/acWebsite/Resident\\_Survey/res\\_FAQ.asp](http://www.acgme.org/acWebsite/Resident_Survey/res_FAQ.asp)

Many program directors download the survey and FAQs and use them in conversations with residents about the survey's contents (questions as well as requirements). This exposes residents to the survey items, reduces the possibility of confusion with items, and better informs program directors of residents' perceptions.

## Points of Clarification

Listed below are several questions the RRC has been asked to address in the past year.

*Question: The requirements state that residents need to provide continuity of care for two nursing home patients for 24 months, but can two or more residents "share" the same nursing home patient?*

Answer: The outcome of compliance with this requirement is competence in providing care to geriatric patients in a nursing home facility. The Review Committee judged that it would be acceptable for two residents to "share" a single patient if the aforementioned outcome can be achieved. This is a broader interpretation of the requirement, but is very consistent with the Review Committee's stance on the importance of team coverage. Each resident will still need to see and care for two patients over a 24-month period.

*Question: Can patient visits done at a non-FMC site be used/count towards meeting the requirement for 1,650 total visits? How many of these visits are allowed?*

Answer: The current requirements allow program directors some flexibility with regards to this issue: if program directors can document that residents have continuity experiences in non-FMC settings (e.g., in longitudinal clinics, nursing home visits, etc.) which are supervised by family medicine faculty, visits at the non-FMC site may be counted towards a residents' 1,650 total visits. However, it is not the intent of the Review Committee that programs use a non-FMC for the majority or entirety of patient visits. The non-FMC site can be used to supplement or augment patient visits, but cannot replace the FMC. So, the Committee would be supportive of having residents do a portion of their patient visits in a non-FMC setting (e.g., a private physician's office) as long as the visits are truly continuity in nature, and are supervised by family medicine faculty.

*Question: What percentage of FMC visits should be with pediatric and older patients?*

Answer: The Review Committee expects that approximately 10% of patient visits are with patients who are 19 years of age or younger, and 10% with patients 60 years of age or older. Based on information submitted by program directors into ADS for the annual program update, the national average for these age breakdowns is much higher than 10%. This has been consistently the case for the past three years the data have been collected. In order to review the national numbers, log into ADS, select the 'Family Medicine Specialty Data' menu and click on the 'Family Medicine National Report' link.

These items will be added to the Committee's FAQ, which can be found on the Family Medicine web page on the ACGME site:

[http://www.acgme.org/acWebsite/RRC\\_120/62008FAQ\\_FM\\_AA\\_081908.pdf](http://www.acgme.org/acWebsite/RRC_120/62008FAQ_FM_AA_081908.pdf)

## **New Format for Citations**

"Citations" – areas of non-compliance that the RRC identified during its review of a program – have a new format. Citations will now include the following five components:

(1) Citation Heading – Summary of issue being cited

(2) Program Requirement

(3) Program Requirement Reference

(4) Citation

(5) PIF, Site Visitor Report, or Board Reference (if proposed adverse action)

### **Example of New Citation Format:**

Board Scores/Poor Performance on Exam

Program Requirement V.C.3.a-b

a. One measure of the quality of a residency program is the performance of its graduates on the certifying examination of the American Board of Family Medicine. In its evaluation of residency programs, the Review Committee will take into consideration the information provided by ABFM regarding resident performance on the certifying examinations over a period of several years.

b. The committee will use scores for a minimum of three and a maximum of five years and will take into consideration noticeable improvements or declines during the period considered. Poor performance will be cited if more than 10% of a program's candidates fail on the first examination over a period of consecutive years and/or the program's composite score is consistently at or below the 25th percentile in the nation.

Only 72% of first time test takers passed the certifying exam over the last five years.

During the last three years, only 68% of first time test takers passed the exam.

(Information provided to the Committee by the American Board of Family Medicine)

## **Program Requirements Revision Process**

The ACGME requires that each set of program requirements undergoes major revision at least once every five years. Approximately 18 months before the scheduled date of a specialty or subspecialty's next major revision, the ACGME's Requirement Development Committee (RDC) reviews the existing requirements and program information form (PIF) and provides feedback to the Review Committee regarding potential areas for improvement. The Committee considers the RDC's suggestions and also updates the requirements and PIF as needed based on input from the medical community. The revised requirements and PIF are submitted

to the RDC for further review. Upon approval from the RDC, the revised requirements are posted, along with an impact statement, on the ACGME website for a review and comment period of 45 days. Program directors and Designated Institutional Officials (DIOs) are notified via the ACGME's weekly e-Communication that the proposed requirements are available for review and comment. At the conclusion of the review and comment period, the Review Committee reviews comments submitted, considers whether additional changes to the requirements are needed in response to the comments, and prepares the final draft of the revised requirements for submission to the ACGME Board of Directors. A summary of the submitted comments and the Review Committee's response to these comments must accompany the requirements when they are submitted to the Board. Upon Board approval, the new requirements are posted on the ACGME website, along with their effective date. Program directors and DIOs are notified of this via the ACGME e-Communication.

### **Revisions to Sports Medicine Program Requirements**

The RRC for Family Medicine collaborated with the Review Committees for Emergency Medicine, Pediatrics, and Physical Medicine and Rehabilitation on the major revision to the sports medicine program requirements. The proposed draft requirements were posted for review and comment in early November.

### **Hospice and Palliative Medicine (HPM) Advisory Group**

In December, the Hospice and Palliative Medicine Advisory Group will officially sunset. The RRC would like to formally thank the following members for their hard work and devotion: Peter Angelos, MD, PhD, Chicago, IL; Susan Block, MD, Boston, MA; Gary Buckholz, MD, San Diego, CA; Perry Fine, MD, Salt Lake City, UT; James Hallenbeck, MD, Palo Alto, CA; Joanne Hilden, MD, Indianapolis, IN; Russell K. Portenoy, MD (Chair), New York, NY; Steven M. Radwany, MD (Co-Chair), Akron, OH; Geraldine Schechter, MD, Washington, DC; and Peter Selwyn, MD, MPH, Bronx, NY.

The work of the HPM Advisory Group educated the RRC on HPM matters and facilitated the review and accreditation of 62 HPM applications. The RRC's work would have been significantly different and more

difficult without the Advisory Group's involvement in the accreditation process.

### **Parker J. Palmer Courage to Teach Award Recipient in Family Medicine**

In late September, the ACGME announced its Courage to Teach award recipients. The award is named after Parker J. Palmer, PhD, a noted teacher and sociologist who wrote *The Courage to Teach* and other books on teaching and vocation, and given annually to 10 program directors who have developed innovative teaching practices and demonstrated a commitment to teaching. The RRC would like to formally congratulate Michael Rhodes, MD, of Provo, UT, for being one of the recipients of the Parker J. Palmer Courage to Teach Award. Awardees receive \$1,000 and a plaque, and will be invited to a retreat in May, 2010. In addition, Dr. Rhodes will be invited to an awards luncheon held during the 2010 ACGME Annual Educational Conference, which will take place March 4-7 in Nashville, Tennessee.

### **Accreditation and Innovation**

Program directors interested in having an experimental or innovative proposal reviewed by the RRC are encouraged to complete the ACGME's form for such proposals, and submit it to the Executive Director for review by the Committee. The form can be found on the ACGME's website at:

[http://www.acgme.org/acWebsite/navpages/nav\\_program\\_experimentation.asp](http://www.acgme.org/acWebsite/navpages/nav_program_experimentation.asp)

### **Progress Reports to the RRC**

In an effort to reduce burden, the RRC would like to remind program directors that progress reports should only be submitted for review upon specific request (within the language of the notification letter). Unsolicited progress reports will not be scheduled for review by the committee, but will be administratively acknowledged with no further action. It is also important to note that the RRC does not rescind (remove) citations from a program's history upon review of a (requested) progress report. A progress report should update the Committee on how the program is addressing those areas identified for comment in the RRC's request for the report. Citations may only be identified as corrected at the time of a full program review when they are each thoroughly evaluated through the site visit and review of accreditation materials.

## Useful ACGME Online Resources

- Virtual PD handbook:  
<http://www.acgme.org/acWebsite/home/PDVirtualHandbook.asp>
- ACGME Data book:  
[https://www.acgme.org/acWebsite/dataBook/dat\\_index.asp](https://www.acgme.org/acWebsite/dataBook/dat_index.asp)
- Frequency of Accreditation Statuses by Specialty and Average Cycle Length by Accreditation Status and by specialty:  
<http://www.acgme.org/adspublic/>  
click 'Search Programs and Sponsors'
- Resident Survey National Data Report - available in ADS for Program Directors:
  1. log into ADS
  2. click 'Resident/Fellow Survey'
  3. click 'National Data'
  4. DIOs select 'Reporting Tools'
  5. click 'Resident Survey National Data Overall'
- Resident Survey Institutional Data Report for each sponsoring institution's programs - available in ADS for DIOs:
  1. log into ADS
  2. select 'Reporting Tools'
  3. click 'Institution Level Resident Survey Results'
- Faculty development resources for competency-based education - a series of four PowerPoint presentations with facilitator's manuals (introduction to competency-based resident education, practical implementation of the competencies, developing an assessment system, developing a competency-based curriculum):  
[http://www.acgme.org/outcome/e-learn/e\\_powerpoint.asp](http://www.acgme.org/outcome/e-learn/e_powerpoint.asp)

## Notable Practices

A notable practice is a process or practice that an RRC or other ACGME committee deems worthy of notice. Notable practices are shared through the ACGME website or other ACGME publications to provide programs and institutions with additional resources for resident education. A notable practice is not a requirement, which is a minimum standard, and its use on the ACGME website does not imply or refer to a practice necessary to comply with a requirement.

Many committees have begun to identify notable practices and are making these available to programs in the specialty on their RRC webpages. Potential notable practices may be identified in several ways: a comment in a site visitor report; identified during

review of submitted program materials; solicitation by the executive director or an RRC member based on knowledge of the program; an unsolicited submission sent to the executive director or an RRC member. Potential notable practices are reviewed and discussed by the RRC and, if approved, will be posted on both the RRC webpage and the 'All Review Committees Notable Practices' webpage.

Programs in other specialties may find some of these practices useful, and could adapt them for their specialty-specific program needs as relevant. The 'All Review Committees Notable Practices' webpage can also be accessed through the RRC webpage (<http://www.acgme.org/acWebsite/notablepractices/default.asp?SpecID=14>) and is a collection of all notable practices from all RC webpages, organized by topic.

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Annual Educational  
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*Transitions in GME*

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