Family Medicine
Review Committee Update

PDW
June 12, 2011

James Martin, MD, Chair, RC-FM

Lynne Meyer, PhD, MPH, Executive Director, RC-FM

Objectives

1. Review 2009-2010 RC-FM work
2. Update New Duty Hours and Maternity Care
3. Discuss Resident Survey
4. Discuss proposed revisions to Family Medicine Program Requirements

ACGME and RC-FM Structure and Information

ACGME Organizational Chart

ACGME Committees			
•Executive Committee	•Committee on Finance	•Monitoring Committee	•Governance Committee
•Council of Review Committees	•Council of Review Committee Residents	•Committee on Requirements	•Journal Oversight Committee
•Bylaws and Policies Committee	•Committee on Innovation	•Awards Committee	

RRC Composition

- 3 appointing organizations - AAFP, ABFM, AMA
- 10 voting members
- 6 year terms -- except resident (2 years)
- Program Directors, Chairs, Faculty
- Geographic Distribution
  - CO, DE, IL, MA, NJ, NY, PA, SC, TX, UT
- Ex-officio members from each appointing organization (non-voting)

RRC-FM Composition – AY 2010-2011

AMERICAN BOARD OF FAMILY MEDICINE

James Martin, MD (TX) Chair
Colleen Conry, MD (CO) Co-Vice Chair
Michael Magill, MD (UT)
James Puffer, MD (KY), Ex-officio

COUNCIL ON MEDICAL EDUCATION (AMA)

Richard Neill, MD (PA)
Thomas Rosenthal, MD (NY)
Suzanne Allen, MD (ID)

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Peter Carek, MD (SC) Co-Vice Chair
Robin Winter, MD (NJ)
Penelope Tippy, MD (IL)
Perry Pugno, MD, (KS) Ex-officio

RESIDENT MEMBER

Adam Roise, MD (IA)

RRC Review of Programs

- Peer Review – 2 reviewers for core
- Reviewers use the following information to determine compliance with the requirements:

- The questions in the PIF correspond to program requirements
- Reviewers present program to Committee
- Committee determines degree of compliance and assigns accreditation status along with review cycle, range of 1-5 years

Review Cycle of Cores and Subs

- Historically: Review cycle of sub was aligned with core.
  - If core has a three year cycle, the sub (s) will have a three cycle.
  - The cycle of the sub did not exceed that of the core
- Now: RRC has un-coupled subs cycle from that of core.
  - Subs are still considered dependent, but the cycle of the sub can exceed that of the core.

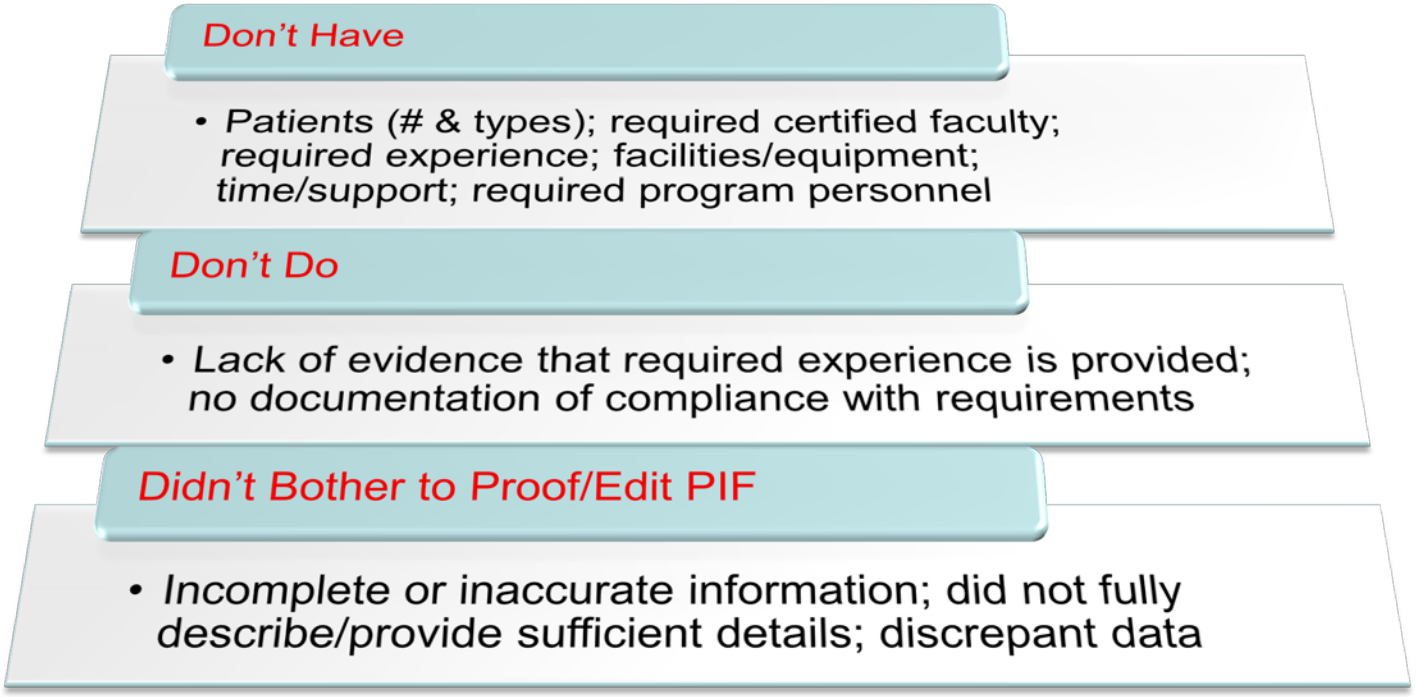
New Core Applications	New Subspecialty Applications
•Rare events •Site Visit required •12 month process •Maximum of a 3 yr cycle	•More regular occurrence •No site visit required •Need 2 months prior to meeting (agenda closing date) •Maximum of 3 yr cycle

- ACGME document: Applying in seven easy steps:

  http://www.acgme.org/acWebsite/home/accreditation_application_process.asp

Citation

- Citation = the program has not provided evidence of compliance with the requirements, or, an area identified by the site visitor is non-compliant



For Core Family Medicine Programs in AY 09/10, there were….

- 452 accredited programs
- Specialty Length = 3 years

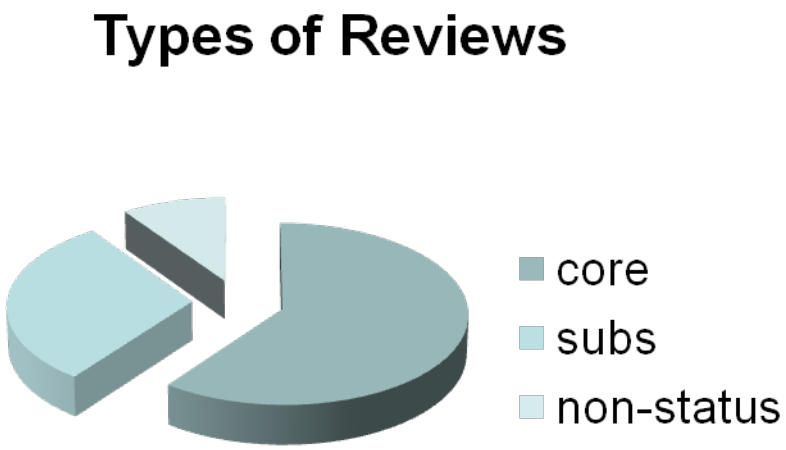
- 9,996/10,449 filled resident positions
- Average Program Cycle Length = 4.16

- 441 programs with continuing accreditation
- 9 programs with initial accreditation
- 2 programs with probation

Summary of RRC Activities in AY 2009/2010

- The RRC meets three times a year – January, May, September
- During AY 2009/2010, the Committee reviewed 186 programs
  - Average per meeting:
    - 42 core programs
    - 18 fellowship programs
    - 8 non-status

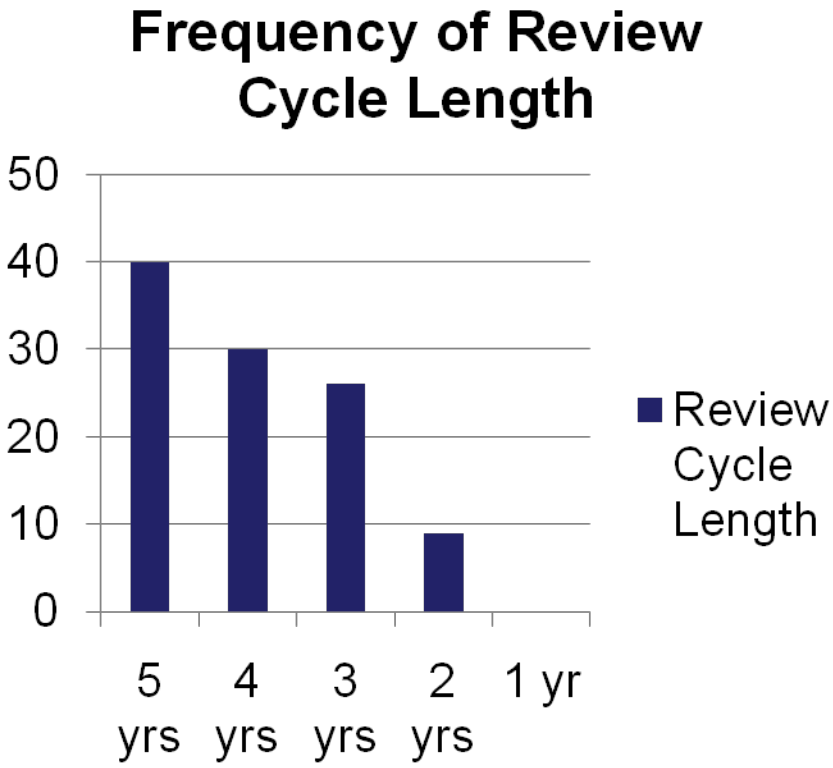
    (progress & duty hours reports)



Accreditation Decisions in AY 2009/2010

Core Family Medicine

Summary of Status Decisions	
Initial Accreditation	3
Continued Accreditation	102
Proposed Adverse Actions	4
Confirmed Adverse Actions	3
Voluntary Withdrawal	0
Total	***112***



Most Frequent Citations in AY 2009/2010

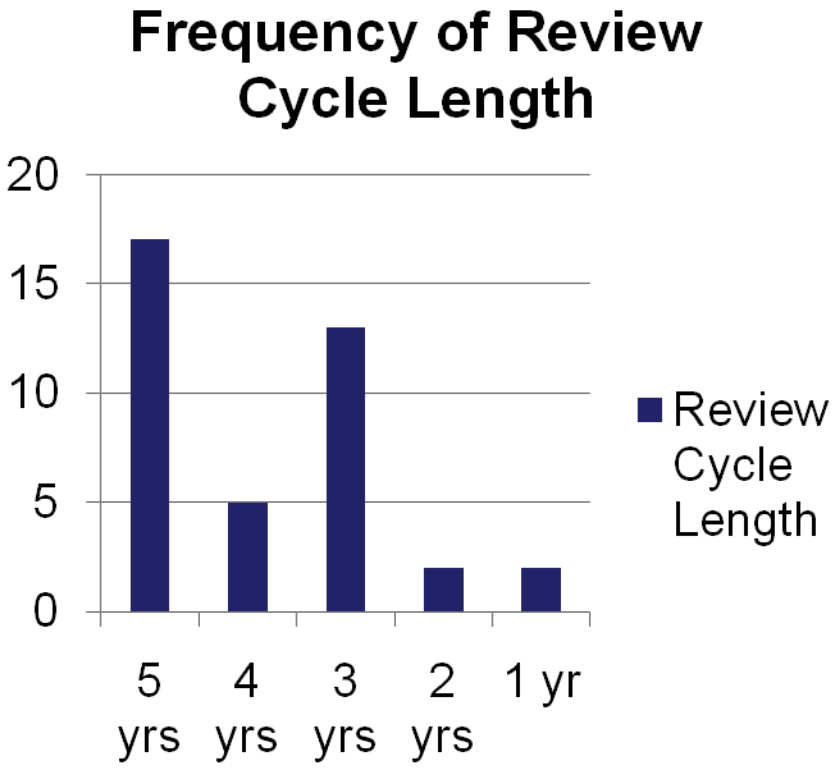
Core Family Medicine
1. **FMC Patient Visit/Demographics**
2. **Maternity care –** total and continuity deliveries
3. **Institutional Issues –** internal review; facilities issues; lack of support for GME
4. **Responsibilities of the PD –** PIF not accurate or complete
5. **Management of Health Systems Curriculum**
6. **Service to education imbalance**
7. **Resident Appointment –** attrition; verification of prior educational experiences
8. **The Education Program** – Goals & Objectives

Accreditation Decisions in AY 2009/2010

Subspecialties of Family Medicine

GM – 10 programs; SM – 29; HPM – 18

Summary of Status Decisions	
Initial Accreditation	26
Continued Accreditation	27
Proposed Withhold	4
Proposed Withdrawal	0
Voluntary Withdrawal	0
Voluntary Withdrawal of Application	0
Total	57



For Geriatric Medicine Programs in AY 2009/2010, there were….

- 45 accredited programs
- Specialty Length = 1 year

- 74/114 filled resident positions
- Average Program Cycle Length = 4.21

- 33 programs with continuing accreditation
- 12 programs with initial accreditation

Most Frequent Citations during AYs 08/09 – 09/10

Subspecialty of Geriatric Medicine
1. Evaluation of the Program – not done annually; residents and faculty don't provide written, confidential evaluation; no evidence of action plan to address deficiencies; low board pass rate, not clear how this outcome data is used to improve the program
2. Scholarly Activities -- little or no faculty involvement in scholarly activity; fellow participation in scholarly activity not supported
3. Curriculum – missing or inadequate curricular components
4. Sponsoring Institution -- timing of internal reviews

For Sports Medicine Programs in AY 2009/2010, there were….

- 109 accredited programs
- Specialty Length = 1 year

- 175/198 filled resident positions
- Average Program Cycle Length = 4.27

- 89 programs with continuing accreditation
- 20 programs with initial accreditation

Most Frequent Citations during AYs 08/09 – 09/10

ACGME

Subspecialty of Sports Medicine
1. **Evaluation of Residents** – documentation of ability to practice competently and independently; multiple evaluators
2. **Evaluation of Program --** not done annually; residents and faculty don't provide written, confidential evaluation; no evidence of action plan to address deficiencies; documentation of annual meeting, composition of program evaluation committee
3. **Institutional Support-Sponsoring Institution** – timing of internal review; internal review committee member composition; education on fatigue;
4. **Scholarly Activities** -- little or no faculty involvement in scholarly activity; fellow participation in scholarly activity not supported; structured conferences such as research conferences and journal club

For Core Hospice and Palliative Medicine Programs in AY 2009/2010, there were….

- 72 accredited programs
- Specialty Length = 1 year

- 153/206 filled resident positions
- Average Program Cycle Length = 2.98

- 1 program with continuing accreditation
- 71 programs with initial accreditation

Most Frequent Citations during AYs 08/09 – 09/10

Subspecialty of Hospice and Palliative Medicine
1. **Educational Program: Patient Care Experience: Care of infants, etc.** – inadequate pediatric experience due to volume – inpatient; outpatient
2. **Educational Program: Patient Care Experience: Other** – inadequate experiences in inpatient and long-term care; inadequate duration of experience; limited range of diagnoses; treatment to the bereaved
3. **Curricular Development:** Other – Long-term care; ambulatory care; interdisciplinary team/hospice
4. **Scholarly Activities** -- little or no faculty involvement in scholarly activity; limited fellow participation in scholarly activity

Duty Hour Information

Duty Hours Update

1. **Implementation Date: July 1, 2011**
2. **ACGME/RC-FM inconsistencies**
   - **The RC will use ACGME wording**
     - VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
     - Intermediate-level residents [PGY-2] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
3. **Program documentation: actual vs. attestation**
4. **Allowance of continuity experiences with sufficient educational value.**

Duty Hours – Duty Free Time

- MUST have 8 hours free of duty between scheduled duty periods
- SHOULD have 10 hours free of duty between scheduled duty periods
  - "Should" require a rationale if not done
- Non-violations for special continuity experiences

Complement Change Request Information

Complement Increases

- Temporary complement increases: more than 3 months; one position per year.
  - Note: Temporary complement requests are intended for circumstances such as leaves of absence, remediation, off-cycle residents, etc. Temporary increases should be limited to one position per year unless unique circumstances such as accommodating residents from closed programs occur.
- RC-FM Approval: All temporary requests more than 1 per year and all permanent complement increase requests (including new federally funded programs or positions)

Complement Increases cont'd

- When reviewing requests, the RC-FM will pay particular attention to:
  - Board Scores and related previous citations
  - Patient Population Volume and Space and related previous citations
  - Resident Survey Results
  - Educational Rationale: This must include why the change is a benefit to the residents and to the program

Resident Survey Information

Resident Surveys

- **Now Annual**
- **RC Review Areas**
  - **Duty Hours**
  - **Educational Content**
  - **Evaluation**
  - **Faculty**
  - **Resources**

Report Name: Resident Survey Data, 2009 - 2010, National Normative Data

Programs Surveyed: 5,703
‡Residents: 97,771 / 106,239 92%

Content Area	Question		Yes	No	Not Applicable
Faculty	Q01	Do the faculty spend sufficient time TEACHING residents/fellows in your program?	92.5%	7.5%	
	Q02	Do the faculty spend sufficient time SUPERVISING the residents/fellows in your program?	96.6%	3.4%	
	Q03	Do your faculty members regularly participate in organized clinical discussions?	94.8%	4.2%	1.0%
	Q04	Do your faculty members regularly participate in rounds?	88.2%	2.8%	9.0%
	Q05	Do your faculty members regularly participate in journal clubs?	89.9%	7.3%	2.7%
	Q06	Do your faculty members regularly participate in conferences?	96.1%	3.3%	0.6%
Evaluation	Q07	Do you have the opportunity to confidentially evaluate your FACULTY, in writing or electronically, at least once a year?	97.9%	2.1%	
	Q08	Do you have the opportunity to confidentially evaluate your overall PROGRAM, in writing or electronically, at least once a year?	96.9%	3.1%	
Educational Content	Q09	Has your program provided you access to, either by hard copy or electronically, written goals and objectives for the program overall?	98.8%	1.2%	
	Q10	Has your program provided you access to, either by hard copy or electronically, written goals and objectives for each rotation and major assignment?	96.7%	3.3%	
Evaluation	Q11	Do you receive written or electronic feedback on your performance for each rotation and major assignment?	95.8%	4.2%	
	Q12	Are you able to review your current and previous performance evaluations upon request?	99.0%	1.0%	
Educational Content	Q13	Have you had sufficient education (from your program, your hospital(s), your institution, or your faculty) to recognize and counteract the signs of fatigue and sleep deprivation?	94.0%	6.0%	
	Q14	Does your program offer you the opportunity to participate in research or scholarly activities?	98.2%	1.8%	
Evaluation	Q15	Have residents / fellows had the opportunity to assess the program for the purposes of program improvement?	97.1%	2.9%	
Resources	Q16	Has your ability to learn been compromised by the presence of trainees who are not part of your program, such as residents from other specialties, subspecialty fellows, PhD students, or nurse practitioners?	17.5%	82.5%	
	Q17a	Does your program provide an environment where residents/fellows can raise problems or concerns without fear of intimidation or fear of retaliation?	93.1%	6.9%	

			Exremely Satisfied	Very Satisfied	Somewhat Satisfied	Slightly Satisfied	Not at all Satisfied
Resources	Q17b	How satisfied are you with your program's process to deal confidentially with problems or concerns you might have?	41.0%	38.4%	14.5%	3.8%	2.3%

			At All Times	Some of the Time	None of the Time
Resources	Q18	How often are you able to access, either in print or electronic format, the specialty specific and other reference materials that you need?	90.0%	9.9%	0.1%

			Extremely often	Very often	Some-times	Rarely	Never
Educational Content	Q19a	How often do your rotations and other major assignments provide an appropriate balance between clinical education and other demands, such as service obligations?	33.8%	49.4%	14.4%	2.1%	0.3%

			Never	Rarely	Some-times	Very often	Extremely often
Educational Content	Q19b	How often has your clinical education been compromised by excessive service obligations?	28.7%	42.2%	23.7%	4.4%	1.0%

			Extremely often	Very often	Some-times	Rarely	Never	Not Applicable
Resident Duty Hours	Q20a	Duty hours must be limited to 80* hours per week, averaged over a four-week period, inclusive of all in-house call activities.	83.3%	14.1%	1.5%	0.4%	0.4%	0.3%
	Q20b	Residents / fellows must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call.	88.5%	9.7%	0.9%	0.2%	0.3%	0.4%
	Q20c	There should be a 10-hour time period provided between all daily duty periods and after in-house call.	77.6%	16.5%	2.5%	0.4%	0.3%	2.8%
	Q20d	In-house call must occur no more frequently than every third night, averaged over a four-week period.	83.1%	5.5%	0.5%	0.1%	0.4%	10.4%
	Q20e	Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents and fellows may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care.	77.9%	13.3%	2.3%	0.5%	0.5%	5.6%
	Q20f	No new patients may be accepted after 24 hours of continuous duty.	75.6%	10.2%	2.1%	0.6%	0.6%	11.0%
	Q20g	At-home call must not be so frequent as to preclude rest and reasonable personal time for each resident / fellow.	57.1%	7.1%	1.5%	0.4%	0.5%	33.4%
	Q20h	Residents / fellows taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.	60.6%	4.9%	0.6%	0.2%	0.3%	33.4%
	Q20i	When residents and fellows are called into the hospital from home, the hours they spend in-house are counted toward the 80*-hour limit.	63.0%	5.2%	0.8%	0.3%	0.5%	30.2%

			Other services	Within my specialty	Both	Not Applicable
Resident Duty Hours	Q21	If you noted any duty hours issues in the section above, would you say that those issues occurred mostly on rotations to other services outside your specialty?	5.9%	11.1%	2.3%	80.7%

Percentages may not add to 100% due to rounding.
*Programs with a duty hour exception have an 88 hour per week limit.

-> shaded areas contain at least 0.1% non-compliant response

‡Number of residents responding / Number surveyed, Response rate

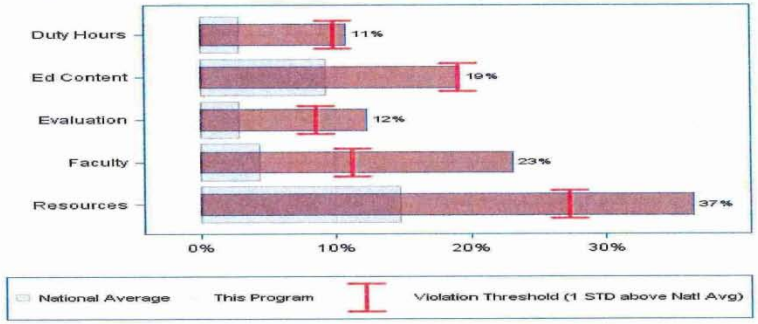
Sample Resident Survey Threshold Report Program Profile

ACGME

Report Name: Resident Survey Threshold Report - Program Profile
Description: Data are shown for programs exceeding established thresholds for the resident survey.

Specialty Code And Name: 120 Family medicine
Year Survey Administered: 2010
Threshold Total: 5
Program Code:
Program Name:

Areas At Or Above Threshold	Acc. Status	Cyc. Length	Acc. Effective	Next Site Visit	Responses / Onduty	Resident Survey - Current Year Link (Adm)
5 Areas: Faculty, Evaluation, EdContent, Resources, DutyHours	Continued Accreditation	5	05/18/09	05/01/14	13/ 17 = 76%	2010



1. Programs' values are highlighted if they are above the established thresholds, i.e., one standard deviation over the national average.
2. Actual values are adjusted so that no program is identified as non-compliant on the basis of a single resident's report.

Reference: Holt KD and Miller RS. (2009). The ACGME Resident Survey Aggregate Reports: An Analysis and Assessment of Overall Program Compliance. *Journal of Graduate Medical Education, Journal of Graduate Medical Education, Dec 1(2)*, 327-333.

ACGME Response

Proposal is for action required for programs more than 1 standard deviation from norm in 3 or more domains.

- **1St year-Letter to PD to develop improvement plan**
- **2nd year-Letter requesting implementation and outcomes data**
- **3rd year-Possible change in cycle length**

Family Medicine 2010 Programs Threshold Violations

5-categories	3 programs
4-categories	16 programs
3-categories	17 programs
2-categories	32 programs
1-category	80 programs

Maternity Care Information

Care of the Pregnant Patient

Care of the pregnant patient: Residents must have an experience in maternity care that includes a structured curriculum in prenatal, intra-partum and post-partum care. Residents must have a maternity care experience sufficient to:

-Recognize abnormal from normal pregnancy;

-Care for common medical problems arising from pregnancy or coexisting with pregnancy and assisting a patient experiencing a spontaneous precipitous birth;

-Demonstrate basic skills in managing obstetrical emergencies;

-Complete a minimum of 20 deliveries; and,

-Document 200 hours of labor and delivery experience, or two blocks/months dedicated to participating in deliveries, prenatal care and post-partum care.

Care of the Pregnant Patient cont'd

Residents may elect an advanced level of education in maternity care. Each resident wanting to achieve an advanced level must:

-Perform prenatal care,

-Independently manage labor and delivery patients, including:

»Intra-partum care that includes conduction of a spontaneous vaginal delivery and management of common intra-partum complications and emergencies;

»assisted deliveries (vacuum and forceps);

»first assist at Caesarean section or vaginal operative deliveries; and,

»obstetrical emergencies

-Perform post-partum care, including management of post-partum complications.

-Perform a program total of 80 documented vaginal deliveries in a designated labor and delivery area, including a total of 10 continuity deliveries; and

-Document a program total of 400 hours of labor and delivery experience or four blocks/months dedicated to resident performance of maternity care

Maternity Care

All programs training residents in an advanced level of education in maternity care should have at least one family physician delivering and teaching maternity care

Maternity Care Requirement Revision Process Tentative Timeline

- Review by RC-OB -- May 2011
- 45 Day Posting for Public Comment (includes impact statement and FAQs) – Summer 2011
- Submission to Committee on Requirements – Fall 2011
- Approval by Committee on Requirements – Early 2012 (programs may begin implementation of new maternity guidelines once approved)

Core Program Requirement Information

Revisions Preparation

- Prior Requirements (back to 1969 originals)
- Educational papers regarding curricular needs, educational strategies, and competency-based training and assessment
- Recommendations from AFMRD, RPS, ABFM, AAFP
- Interviews with FM thought leaders, health policy writers, other stakeholders.

Revision Preparation Findings

- Family Medicine not well recognized by stakeholders
- Family Medicine not well respected academically by some other disciplines
- Concern over board failure rates
- Policy maker expectations
  - Quality
  - Continuity
  - Expertise in PCMH

Family Medicine Program Requirements Revisions Strategy

ACGME

1. Reemphasis on basic tenets (continuity, comprehensive care, etc.) for plurapotential graduate
2. Emphasis on FM role in healthcare reform
3. Emphasis on continuity and personal relationships

Family Medicine Program Requirements Revisions Strategy

4. Emphasis on medical home competency
5. Increase flexibility
6. Commitment to excellence, not minimal standards

Areas of Revision: Institutional Issues

- **PD salary support** (*Provide at least 70% salary support (at least 27 hours per week) for the program director as protected time to the program for administrative and non-teaching duties related to the program)*
- **Electronic Health Records** (must)
- **Emphasis on quality and patient safety**
- **Emphasis on professionalism**

Program Director

- **ABFM certification** (if approved by ACGME Board of Directors in 2013, then must have by effective date of new program requirements)
- **Faculty experience** (5 years, or 4 years + NIPDD)
- **Residency dedication in non-direct patient care**

Faculty

- Core faculty commitment
  - Full time (24 hrs/wk commitment to non-direct patient care)
  - Specific hours commitment
  - Protected administrative time
- MOC or parallel structure

Curriculum

- Continuity panel
- 1650 face to face encounters (plus telephone, e-visit, group visits, etc.)
- Documentation toward competency in medical home skills
- New emphasis on community and mental health integration
- Continued emphasis on hospital experiences
- Continued emphasis on care of children
- New procedures requirement

Required Clinical Experiences

- *Family Medicine is a primary care specialty which demonstrates high quality care within the context of a personal doctor-patient relationship and with an appreciation for the individual, family and community connection.*
- *Continuity of comprehensive care for the diverse patient population family physicians serve is foundational to our specialty.*
- *Access, accountability, effectiveness and efficiency are essential elements of our discipline.*
- *Furthermore, the coordination of patient care within the current complicated health care arena is another vital role for the family physician.*
- *In order to fully prepare family physicians for the future, residency training programs should not only meet but exceed the following criteria.*

Required Experiences cont'd

- 1 block/month = 100 hours (125 patient encounters)
- 1 patient encounter = the continuous care of a unique patient during a one day time period over hospitalization
- The following listed requirements include patient numbers that are in addition to the minimum of 1650 Family Medicine Practice (FMP) patient encounters unless otherwise specified
- If a FMP has adequate volume above the required minimum of 1650 continuity patients, these numbers may be met in an FMP.

Required Experiences cont'd

Required Experiences	Requirement
Electives	3 blocks/300 hours
Care of surgical patient	1 block/100 hours
Care of patient with musculoskeletal problems (with a documented Sports Medicine experience)	2 blocks/200 hours or 250 patient encounters
Care of the acutely ill or injured adult patient	2 blocks/200 hours or 250 patient encounters
Hospitalized adults	6 blocks/600 hours AND 750 patient encounters including 15 ICU patients
Female reproductive health	1 block/100 hours or 125 patient encounters
Management of Health Systems	1 block/100 hours

Required Experiences cont'd

Required Experiences	Requirement
Ill children/adolescents	2 blocks/200 hours AND 250 patient encounters including a minimum of 75 inpatient encounters and a minimum of 75 emergency department patient encounters
Newborns	40 patient encounters
Ambulatory children/adolescents	2 blocks/200 hours or 250 patient encounters

Required Experiences cont'd

Required Experiences	Requirement
Pregnant patient	2 blocks/200 hours AND 20 deliveries
Advanced level of maternity care elective (Programs are not required to offer this elective. Residents should be informed as applicants whether this elective will be available.)	4 blocks/400 hours AND 80 deliveries including 10 continuity patient deliveries. This is includes the 2 blocks/200 hours and 20 deliveries during the required maternity care experience.
FMP Demographics	1650 patient encounters. 10% of FMP patient visits must be between the ages of 0-9 years, and an additional 10% of FMP patients must be 60 years of age or older.

Required Experiences cont'd

Required Experiences	Requirement
Older patient	1 block/100 hours or 125 patient encounters. This experience can occur in various settings such as long term care, assisted living, home care, or day care. It must include at least one home visit and a continuity experience of caring for at least two patients for 24 months in one of the settings listed above. If a skilled nursing facility is not used, the PD must describe how residents learn about the care of patients in a skilled nursing facility. Adult inpatient encounters cannot be counted for this requirement.

Required Procedures

- Anoscopy
- Chest x-ray interpretation
- Cryosurgery
- EKG Interpretation
- Endometrial biopsy
- Eye fluorescein exam
- Incision and drainage of abscess
- Immobilization and stabilization of severe sprains
- Immobilization and stabilization of non-displaced fractures

Required Procedures cont'd

- Injection and aspiration of joints
- Injection and aspiration of tendons, ligaments and muscles
- Pap smear
- Simple laceration repair with sutures
- Skin biopsies: punch, excisional, incisional
- Splints
- Wart, fingernail, toenail, and foreign body removal
- Wet Mount

Medical Home

1. Personal relationships and communication ability
2. Teams training
3. EHR competency
4. Leadership in care coordination and chronic disease management
5. Ongoing quality and performance improvement
6. Community needs assessment and practice modification

Scholarly Activities

- Scholarly Activity:
  - Shared by peers and contributes to knowledge
  - Evaluation component

- Faculty: regional or national level
- Residents: local, regional or national level

- Local – at institution
- Regional – outside the institution

Scholarly Activities (Based on Boyer's Scholarship Model)

Type of Scholarship	Purpose	Performance Measures (FAQs will provide examples for core and subspecialty, and for faculty and residents
Discovery	Build new knowledge through traditional research	**Residents:** e.g. poster presentations, publish original research paper or abstract, original research presentation at a grand rounds **Fellows/Faculty:** e.g. refereed poster presentation, authorship of papers in peer-reviewed journals, investigator on grants, development of patents for discoveries, original research presentations at regional or national meetings

Scholarly Activities (Based on Boyer's Scholarship Model)

Type of Scholarship	Purpose	Performance Measures (FAQs will provide examples for core and subspecialty, and for faculty and residents
Integration	Synthesize current knowledge to make it useful to others	**Residents:** e.g. case study and literature review presentation at local Grand Rounds, lead local patient education conference series, publish an op-ed in local newspaper regarding current public health concern, letter to editor of national medical journal analyzing results of a paper published by others **Fellows/Faculty:** e.g. publish a POEM, publish a clinical review paper in peer-reviewed national journal, testify in state legislature regarding public health problem strategy, serve as editor for a state or national medical journal

Scholarly Activities (Based on Boyer's Scholarship Model)

Type of Scholarship	Purpose	Performance Measures (FAQs will provide examples for core and subspecialty, and for faculty and residents
Application (FM Focus)	Use knowledge to improve health care, medical practice, health systems operations, public health or policy	**Residents:** e.g. present the design and results of a clinical quality improvement project; local publication of design, implementation and effects of a patient education program, risk behavior, or chronic disease management in a residency newsletter **Fellows/Faculty:** e.g. present results of clinical QI program implemented in a group of practices at a regional professional meeting, present results of a practice-based research network at a national professional meeting; serving on a state or national committee developing and implementing programs to improve medical practice or education; obtainment of grant funding for practice improvement or redesign

Scholarly Activities (Based on Boyer's Scholarship Model)

Type of Scholarship	Purpose	Performance Measures (FAQs will provide examples for core and subspecialty, and for faculty and residents
Teaching	Development, implementation and evaluation of educational curriculum, courses, program, materials, and so forth for educational purposes.	**Residents:** e.g., preparation of an enduring curriculum for use in a residency program (needs assessment, goals and objectives development, activities, evaluation process, implementation and summarization of pilot results **Fellows/Faculty:** e.g., obtain Title VII grant funding to implement new curriculum; develop, implement and report to sponsoring professional organization a new curriculum for a national professional educational course or module; publish evaluation of a new curriculum in a peer-reviewed journal

Program Requirement Revision Process Algorithm

Abbreviations used:

- AST = Accreditation Standards Team
- CoR = ACGME Committee on Requirements
- EDAS = Executive Director, Accreditation Standards
- EDRC = Executive Director, Review Committee
- PIF = Program Information
- RC = Review Committee
- RDC = Requirement Development Committee

Program Requirement Revision Process Algorithm

1. ☒The RDC staff prepares a worksheet identifying each requirement.
2. ☒The RDC conducts an initial review of the existing requirements and PIF.
3. ☒The RC requests preliminary review and comment on the existing requirements and PIF from the community either via the ACGME eCommunication or an alternative method(s).
4. ☒The EDAS and the RDC Chair meet with the EDRC to discuss the RDC's comments.

Program Requirement Revision Process Algorithm

5. ☒The RC or a subcommittee reviews the input received from the community and the RDC, proposes revisions to the requirements and addresses the RDC's concerns/comments. A member of the RDC provides assistance as requested.
   - Additional information pertaining to the requirements, such as definitions, that will be provided in an FAQ should be developed at the same time the requirements are revised.
   - The RC should also consider the impact that any substantive changes to the requirements may have on education, patient care, resources and other services/programs. These will need to be addressed in the Impact Statement.
   - The RC should also review the respective Board requirements to ensure that there is no conflict with the program requirements that would result in a graduate not being Board eligible.

Program Requirement Revision Process Algorithm

6. ☒The RC staff returns the worksheet with the RC's responses to the RDC's comments along with a copy of the annotated, revised requirements and a clean copy of the revised requirements.
7. ☒The full RDC reviews the worksheet and revised requirements to ensure that all concerns have been satisfactorily addressed. If concerns remain, the RDC Chair communicates those to the EDRC.
8. ☐Work on an impact statement begins. Work on a revised PIF begins. Work on FAQs continues.
9. ☐The EDRC submits the RDC-approved draft of the revised requirements and the impact statement to the AST.
10. ☐The AST editor reviews the requirements document. If any changes are made, the document is sent to the EDRC for approval.

Program Requirement Revision Process Algorithm

11. ☐The proposed requirements and the impact statement are posted for review and comment.
12. ☐The RC reviews the comments received, provides a response to each substantive comment, and revises the requirements accordingly. FAQs should be revised and/or new FAQs should be developed as needed.
13. ☐RC staff returns revised requirements, revised PIF (and other data compliance sources when appropriate), and FAQ to RDC Chair.
14. ☐Full RDC reviews all documents to ensure all concerns have been met. If concerns remain, the RDC Chair communicates those to the EDRC.

Program Requirement Revision Process Algorithm

15. ☐The final draft of the requirements, impact statement, RC's response to comments received, copies of correspondence and copies of any FAQs related to the requirements are submitted to the EDAS for CoR review and approval.
16. ☐A CoR member reviews the material submitted and provides comment.
17. ☐The RC Chair and EDRC respond to the comments.
18. ☐Approximately 2 weeks prior to the CoR meeting, the CoR meets in a closed executive session via conference call to review the requirements, comments and responses. Any additional concerns are communicated to the EDRC.

Program Requirement Revision Process Algorithm

19. ☐The RC Chair and EDRC attend the CoR meeting and present their responses to the CoRs concerns.
20. ☐Once approved by the ACGME Board of Directors, the requirements and FAQ, as well as the new PIF, are finalized by the AST staff. The EDRC reviews and approves the final documents prior to posting.

Core Program Requirement Revision Process Tentative Timeline

- May 2011 – Revised PRs submitted for 1st Full RDC Review in May 2011 (Steps 6 and 7)
- 45 Day Posting for Public Comment – Late 2011 (Step 11)
- 2nd Full RDC Review – Mid 2012 (Steps 13 and 14)
- Submission to Committee on Requirements – Fall 2012 (Step 15)
- Approval by Committee on Requirements – Early 2013 (Steps 19 and 20) (Programs will be given time to implement new approved program requirements)

RC-FM Issues

Committee Issues

- Commitment to a higher bar of expectations
- Assure the safety and quality of care rendered to patients in our teaching hospitals today
- Assure the safety and quality of care rendered to patients of our current residents in their future independent clinical practice
- Assure the provision of a safe and humanistic educational environment for our residents to learn and demonstrate professionalism and subordination of self interest

Committee Issues cont'd

- Philosophical shift in educational emphasis
  - Critical thinking skills
  - Process improvement
- Balance of time/numbers vs. competency assessment
- Efforts to increase transparency to program directors

Quality of Programs and Graduates

- Issue raised by other stakeholders
- Future healthcare system requirements
- Deteriorating graduate performance on ABFM exam
- Chronic poorly performing programs

Raising the Bar for Accreditation

ACGME

- Short cycle programs
- Board score thresholds
- Recruiting deficiencies
- Institutional support and resources
- Weighting citations

RC-FM Philosophy 2011

- **Flexibility but clear concept of anticipated responses and results**
- **Transparency**
- **Committee Member involvement in ACGME communications**
- **Focus on process improvement**
- **Commitment to excellence**

Future Projects

- Integration of Milestones Project
- 1-2 programs and rural programs
- 3 years vs. 4 years of training

Recognized Concerns

- Program Resources to capture resident activity
- Numbers requirement with limited EBM
- Incorporating Milestones competencies when developed

Resources

ACGME Data Collection

- All core programs and all subspecialty programs (with 4 or more fellows) will be required to participate in the resident survey *ANNUALLY*
- More information is being/will be collected through ADS
  - Common PIF = Questions all programs need to complete
    - Information on faculty/teaching staff
    - Residents/fellows - # completed; # transfer, withdraw; dismissed
  - Responses to previous citation
  - Evaluation (resident, faculty and program)
  - Duty hours
  - Complement increases, PD/Institution changes
  - Voluntary withdrawal

RRC Communications

Newsletter

- Communication tool implemented in 2007
  - Enhances communication between the RRC and the Family Medicine community
  - Provides updates on RRC and ACGME initiatives
- Sent to all core and subspecialty program directors, coordinators, and designated institutional officials
- Sent 1 – 2 times per year
- Newsletter postings announced in the weekly e-communications email

ACGME Communications

- Weekly e-communication
  - Contains GME information: New requirements, newsletters; updates on ACGME issues/initiatives
- E-mail status of programs on RRC agenda
  - 5 business days after meeting will receive email w/status and review cycle.
- E-mail notification when letter is available on Accreditation Data System (ADS)
  - Hard copies of letters not provided
  - Letter is posted within 60 days following the meeting
- E-mail notification of site visit date
  - For questions related to site visits contact:
    - Ingrid Philibert: (312) 755-5003, iphilibert@acgme.org
    - Jane Shapiro: (312) 755-5015, jshapiro@acgme.org
    - Penny Lawrence (312) 755-5014, pil@acgme.org

Program Resources

Program Director Guide

- Common competency questions inserted in all specialty PIFs (common but not hard-wired into ADS as in Part I of the PIF).

- PD Guide to the Common Requirements: http://www.acgme.org/acWebsite/navPages/nav_commonpr.asp

- Provides PDs:
  - Explanations of the intent of most of the common requirements (particularly competency-based)
  - Suggestions for implementing requirements and types of documentation expected.

www.acgme.org

- ACGME Policies & Procedures
- Competencies/Outcomes Project
- List of accredited programs
- Accreditation Data System (ADS)
- Duty hours Information/FAQ
- Affiliation Agreements FAQ
- General information on site visit process and your site visitor
- Notable Practices
- Family Medicine Webpage
  - Resident complement increase policy
  - Program Requirements and PIFs
  - Archive of RRC Updates/Newsletters
  - FAQs

Handouts

- During this presentation, you have been emailed these handouts.
- Please help us to save trees by viewing these attachments electronically during PDW.

- Thank you!