Review Committee for Family Medicine Update

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Chair, Review Committee for Family Medicine (RC-FM)
Mary Lieh-Lai, MD
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Eileen Anthony
Executive Director

PDW/RPS
Sunday, March 29, 2015
RC-FM Staff

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RC-FM Composition

- 4 appointing organizations - AAFP, ABFM, AMA and AOA (effective July 1, 2015)
- One public member (effective July 1, 2015)
- 14 voting members
- 6 year terms -- except resident (2 years)
- Program Directors, Chairs, Faculty, and Public
  - CA, GA, FL, ID, KS, NJ, MA, UT, VA, WA
- Ex-officio members (non-voting) from AAFP and ABFM
RC Members

- Suzanne Allen, MD
- John R. Bucholtz, DO
- Gary Buckholz, MD (HPM)
- Paul Callaway, MD - Vice Chair
- Peter J. Carek, MD, MS - Chair (SM)
- Sam Jones, MD
- Martha Lansing, MD
- Michael K. Magill, MD
- Stacy Potts, MD
- Nicholas Weida, MD - Resident

Effective July 1, 2015

- Robert Danoff, DO
- David Knowlton – Public member
- Harald Lausen, DO
- Joseph Mazzola, DO
Discussion of Topics

- NAS - First year review and reflections
- Single Accreditation System (SAS)
- RC-FM Updates and Issues
- Q & A
“Fool me once, shame on me, but fool me, like, nine times, shame on me! And fool me seven times after that and, well, I just wasn't paying attention! So fool me eleven times, and, well, that was an isolated incident. But fool me twenty times and I think I had wax in my ears that time. And fool me twenty-seven times and...well, I really can't explain that time, that one was on me, ha ha! Now fool me fifty times –”

Satchel Pooch
NAS is NOW
First year reviews and reflections

- All (core and fellowship) programs reviewed
  - Annual data submission
    - Programs receive accreditation decisions annually (either at winter or spring meeting)
    - Citations vs. Areas for Improvement
  - Self-Study and 10-year Site Visits
Background: Goals of NAS

• To prepare physicians for *practice* of medicine in 21st century (both current and future)
• To develop an accreditation model that focuses on educational outcomes
• To reduce *burden* associated with current (previous) accreditation model*

*This reduction may or may not be evident right away.*
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 ("If it isn’t listed, it didn’t happen.")
    – Faculty credentials (degree, certification, MOC)
    – Participating sites
    – Complete scholarly activity
    – Updated response to citation(s)
    – Complete block diagram
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

## PC1. History (Appropriate for age and impairment)

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
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</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>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>
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<td>Seeks and obtains data from secondary sources when needed</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>
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<td>Milestone</td>
<td>Models the gathering of subtle and difficult information from the patient</td>
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Information current as of December 2, 2013

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Review Process

Annual
- ADS data submission and review
- Additional information if requested
- Accreditation decision

Every 10 years
- Program self-study summary
- Self-study visit and report
- RC review
- Accreditation decision

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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
Full Site Visits

• 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

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)
Areas for Improvement
- Board Passage Rate
- Faculty Scholarly Activity
- Resident and Faculty Survey
- Inpatient Data
With Annual Data, RRC will…

Send a letter to every program every year

• Confirm accreditation status
• List citations (new, continued, unresolved)
• Indicate if additional information needed
  • Clarifying report
  • Progress report
  • Site Visit
Program Statuses

• Existing programs
  • Continued accreditation
  • Continued accreditation with warning
  • Probationary accreditation
  • Withdrawal of accreditation

• New programs
  • Accreditation withheld
  • Initial accreditation
  • Initial accreditation with warning
  • Continued accreditation without outcomes

“Proposed” no longer used.
Accreditation Status Options

Actions not open to appeal

- Continued Accreditation
- Continued Accreditation with Warning
- Initial Accreditation
- Initial Accreditation with Warning

- Voluntary Withdrawal of Accreditation
- Administrative Withdrawal of Accreditation
- Administrative Withdrawal due to withdrawal of sponsoring institution’s accreditation
Relationship of Core and Fellowships

Fellowships must have relationship with core residency program

• 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*)
Self Study: Switch in Mindset

• Ask not what you have to do (yet again) for the ACGME
• Ask what you can do for your program
The Conceptual Change
From…

The Previous Accreditation System

Rules

Corresponding Questions

“Correct or Incorrect” Answer

Citations and Accreditation Decision

“Decades of do this or else…..”
Program Self-Study

• Comprehensive review of 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

• To differentiate your program from others
• Self-study should evaluate program effectiveness in meeting the aims
• Move beyond compliance with minimum standards
• Assessment of relevant initiatives and their outcomes
Self-Study Scope

• Assesses program performance and ongoing improvement effort
• During the initial phase: Since the last accreditation review, at minimum, since entry into NAS
  • Ultimately, a 10-year interval
• Based on Annual Program Evaluations, ACGME Resident and Faculty Survey data, other relevant information and stakeholder input
Strengths and Areas for Improvement

• Strengths
  • Acknowledge and celebrate
  • What should be continued

• Areas for Improvement:
  • Citations, AFIs from the RC
  • The Annual Program Review
  • Other sources

• Expected: longitudinal tracking
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

Review of program aims, context and improvements made in follow-up to the self-study allows RC to assess effectiveness of self-study, with data on improvements achieved being one measure of effectiveness.
Single Accreditation System (SAS)

- 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)

- 227 Osteopathic FM programs (97 *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
Osteopathic Neuromusculoskeletal Medicine 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
- Other necessary supporting personnel
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. 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.

Contact Us
E-mail questions to info@acgme.org

Single Accreditation System for AOA-Approved Programs Main Page

Education
Opportunities for Education about the Transition to the Single Accreditation System

Application Process
The following guidelines apply to currently-AOA-approved core residency and subspecialty programs that apply for ACGME accreditation.
RC-FM Updates

- Recent revisions (effective July 2014)
- Review of “Core” vs. “Detail”
- Faculty
- Counting Continuity Patients
New PRs and New FAQs

Principles for new PRs

- 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
II.A.3. Qualifications of the program director must include:

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee; (Core)

II.A.3.b) current certification in the specialty by the American Board of Family Medicine, or specialty qualifications that are acceptable to the Review Committee; (Core)

II.A.3.b).(1) The Review Committee accepts no other qualifications. (Core)
Family Medicine Practice (FMP)

**FMG (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
Requirement Taxonomy

- Core Requirements
  - Statements that define structure, resource, or process elements essential to every graduate medical educational program.

- Detail Requirements
  - Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

- Outcome Requirements
  - Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

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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
"The RC-FM would just need to know that the program had 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."
Resident Increases

Expectation of RC-FM is that programs with citations (from most recent LON) in following areas will 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.
Entrustable Professional Activity

- EPAs can be used on individual program basis as part of their evaluation tools which are ultimately used in the Milestones assessment
- RC has not required their formal use
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

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Questions?