

Frequently Asked Questions: Family Medicine
Review Committee for Family Medicine
ACGME

Question	Answer
ADS Update	
What is the intent of the specialty specific step in ADS?	The RRC is asking programs to provide information on an annual basis on the most frequent procedures and diagnoses in the FMC, the most frequent diagnoses on inpatient rotations, and patient visit and maternity data. Using quantitative data will allow the Committee to gain a better understanding of the specialty and allow programs to track progress on these key indicators across academic years and to compare their data to national numbers.
Family Medicine Applications	
What is the timetable for submission of an application for a new Family Medicine Program?	<p>The process for an application takes approximately 12 months from the time the application is received in the RRC office until the RRC evaluates the application. Take this into consideration when planning the start date. Consult the MATCH and ERAS for their deadlines, as well. A site visit will be scheduled. When the report of the site visitor is received, the file will be prepared for review by the RRC. Residents should not be appointed prior to accreditation of the program.</p> <p>Additional details can be found on our website: http://www.acgme.org/acWebsite/home/accreditation_application_process.asp</p>
What is the timetable for submission of an application for a new Geriatric Medicine or Sports Medicine Program?	<p>The RRC will review a fellowship application without a site visit. If upon review of the application at one of its regular meetings the RRC judges that it cannot conclude its evaluation without a site visit, one will be scheduled. Contact the RRC Administrator for the deadline related to a specific RRC meeting. NOTE: A Family Medicine Geriatric Medicine or Sports Medicine program must function in conjunction with and be an integral part of a fully accredited program in Family Medicine.</p> <p>Additional details can be found on our website: http://www.acgme.org/acWebsite/home/accreditation_application_process.asp</p>
Sponsorship Changes and Mergers	
How do we move an accredited program to another hospital?	The Executive Director of the RRC should be informed of the plans and will advise regarding the steps that are needed. A program is accredited as it was constituted at the time of its last review. It may not be "moved" without approval from the RRC.

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	<p>If a sponsoring entity wants to relocate a residency program from one hospital to another, it may be required to submit a full PIF and probably undergo a site visit.</p> <p>If the existing primary hospital wants to retain the program, it is suggested that the issue be resolved locally between the hospital and its sponsoring institution. The welfare of the residents who are currently in training must be considered.</p>
How do we change the sponsoring institution?	<p>In order to change the sponsor of a core program, a letter that is signed by the DIO's of both the relinquishing sponsor and the accepting sponsoring entity should be submitted. (Two separate letters may be submitted.) The existing sponsor should agree explicitly to the change in sponsorship. The proposed sponsor should agree to assume the responsibilities of a sponsoring institution that are outlined in the ACGME Institutional Requirements. The letter should contain a statement on the impact the change will have upon the structure and curriculum of the residency. If the change is approved, the program name and listing will be changed as appropriate.</p> <p>Questions may be addressed to the Executive Director of the Review Committee as well as the Director of the Department of Field Activities.</p>
What is the process for a merger of two programs to form a new program?	<p>Contact the Executive Director to discuss the type of merger and how to describe it for the RRC.</p> <p>Two programs will be combined to form a new entity. The full PIF, describing the proposed combined program, will be required. The executive director will advise whether a site visit will be required prior to RRC review of the proposal. A request for voluntary withdrawal of accreditation, and the date of closure, must be submitted using ADS by each of the currently accredited programs. The newly constituted program will be issued a new ACGME program number.</p>
What is the process for a merger of two programs keeping one program intact?	<p>Contact the Executive Director to discuss the type of merger and how to describe it for the RRC.</p> <p>One program (#1) will absorb the other program (#2) and will usually include rotations to the latter. Program #1 will submit the proposal, explaining the extent of the change in curriculum and resident complement, and documenting that all residents in the program will participate in a minimum of 20 months in common. The executive director of the RRC will review with you the degree to which the PIF should be completed. Program #2</p>

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	will submit a request for voluntary withdrawal of accreditation with the date by which current residents will complete their training in that program. This must be co-signed by the DIO of that program's sponsoring entity. The executive director of the RRC will tell you whether the changes necessitate a site visit prior to RRC review of the proposal. Unless the changes are so extensive that the RRC considers the finished product to be virtually a new program, program (#1) will retain its current ACGME program number and accreditation status.
Program Changes	
How do I report a change in program leadership?	A change in program director must be reported electronically through the ACGME Accreditation Data System (ADS), using the login ID and password for the program. Be sure to provide all of the information requested.
What type of change in the program is considered major and requires RRC approval?	<p>Use of a new FMC requires prior approval of the RRC.</p> <p>Check with the Executive Director of the RRC regarding other changes. Generally, use of a participating hospital that is not currently approved as part of the program for required rotations one month or longer must be reported in ADS. This change should be initiated by your DIO.</p> <p>Revising the curriculum or shifting experiences among the three years of training do NOT require RRC notification.</p>
PIF Preparation	
Where and how should the non-FM faculty members be listed in PIF?	After you have entered all the FM faculty in your program, make sure to identify the individuals responsible for teaching FM residents in the following areas: (listed in this order): Human Behavior/Mental Health; Adult Medicine; Cardiology; Critical Care; Obstetric Care; Gynecologic Care; Surgery; Orthopaedics; Sports Medicine; Emergency Medicine; Neonates, Infants, Children and Adolescents; Older Patient; Skin. Provide the ABMS certification information for all faculty. Provide a one page CV for anyone who is not ABMS- certified.
How should a FM faculty member who also teaches in Geriatric Medicine or another area of training be listed in the PIF?	The PIF should contain the individual's primary specialty information (ABFM certification date) along with information on the most recent date of subspecialty certification.
May we add additional information such as program brochures which	All information should be provided in the designated section of the PIF. No additional material is to be attached to the PIF unless expressly stated in the PIF

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contain information requested in the PIF?	(e.g., Appendices from ADS).
How do I edit Part I of the PIF?	Edits to the pre-populated information in Part I of the PIF must be made in the annual update screen in ADS. Once this data has been updated, you may return to the PIF Part I screen to print the form.
Should letters of agreement be appended to the PIF?	No, programs that are having a site visit no longer need to append letters of agreement to the PIF they are preparing. However, the letters of agreement will need to be made available to the site visitor on the day of the site visit.
What if we don't have the same fonts as specified on the forms?	Comparable fonts and point sizes may be used as long as they are easy to read
Single Residency Institutions	
Must a single residency institution conduct an internal review as specified in the institutional requirements? <i>(Institutional Requirements IV.A)</i>	A single residency institution is expected to be in compliance with the Institutional Requirements but may have a modified version of a GMEC. The Committee must conduct an internal review mid-way through the interval between site visits and should include representatives from other specialty areas and from administration. It should not include the program director and faculty of the program being reviewed, but they should be interviewed during the process. Since there are no other residencies in a single- residency institution, resident membership on this committee is not required. Formal minutes should be kept of the meeting at which the GMEC reviews the information and makes its conclusions. These must be discussed with the program director. If it is found that the program is not in compliance with the program requirements, it is the responsibility of the sponsoring institution to ensure that the program has the required resources to achieve compliance.
FMC	
How do I get approval for use of a new FMC?	Use of a new FMC requires prior RRC approval. The packet used to submit a proposal may be obtained from the Website http://www.acgme.org/acWebsite/RRC_120/120_fpcProposal.asp . An FMC should be approved by the RRC before residents are assigned there for training.
What size floor plan is considered acceptable for submission?	The FMC proposal states that floor plan drawings should not exceed 11" X 17" in size. Reduced copies of blueprints are not acceptable.
What are the expectations regarding FM physicians having offices in the residency	The requirements state that non-residency activities may not take place in the Family Medicine Center.

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<p>program's FMC?</p> <p><i>(Program Requirements II.D.2)</i></p>	<p>Family physicians may have their offices in the FMC only if they are identified as teaching faculty who contribute at least 400 hours per year to the residency.</p>
<p>What are the expectations regarding other non-FM physicians having offices in the FMC?</p> <p><i>(Program Requirements II.D.2)</i></p>	<p>Physicians from other specialties may have offices in the FMC, in which they see private patients, if they contribute at least 1400 hours per year to the family medicine residency and no more than 600 hours is devoted to seeing their own private practices in the FMC without FM residents.</p> <p>Other clinics, such as occupational medicine, may take place in the FMC if these activities are directed by the family medicine faculty and exist for the purpose of teaching the family medicine residents.</p> <p>Accredited programs in Family Medicine Sports Medicine and in Family Medicine-Geriatric Medicine may take place in the FMC.</p> <p>If a private practice is used as the FMC for the rural component of a 1-2 program, all of the physicians in the practice must be actively involved in the education of the Family Medicine residents. Their involvement in the teaching program must be documented by the Program Director at the time of each review. Because of the small number of residents at the rural site, the faculty need not contribute the hours listed above to the program.</p>
<p>What are the expectations related to the FMC?</p> <p><i>(Program Requirements II.D.2)</i></p>	<p>This is the model unit that must be contained within walls and is clearly identified as the Family Medicine Center on the door of entry to this unit. When one enters the door of the FMC, one finds all of the components that are listed as required, and nothing else. That is, there are no non-residency related activities taking place within the walls of the FMC.</p> <p>While this unit may be on the same floor as other specialty clinics or private practices, it must be a discrete unit that is separated from those activities by walls.</p>
<p>Although the requirements no longer require a minimum number of half-days in the FMC for residents, can programs still use this to schedule residents' time in the FMC?</p>	<p>Although no longer required to do so, if PDs wish to adhere to the half-day assignments they may continue to do so. The requirements now stipulate that assignments to the FMC need to be 40 weeks during each year of training.</p>

Question	Answer
<i>(Program Requirements IV.A.5.a).(2).(c).(iv).(c))</i>	
FMC Faculty	
<p>What is the interpretation of "posses qualifications judged to be acceptable to the RRC?"</p> <p><i>(Program Requirements II.B.2)</i></p>	<p>The phrase is in the requirements for every ACGME specialty to allow those who might have achieved certification in a comparable system from another country, e.g., the Royal College, to be considered qualified. The determination of whether qualifications are equivalent to certification by an ABMS Board is a judgment call on the part of the Committee. In some instances, a significant record of publication in peer reviewed journals is considered evidence of adequate specialty qualifications. Years of practice are not an equivalent of specialty board certification and neither ABMS nor the RRC accepts the phrase "board eligible." The onus of documenting alternate qualifications is on the program director.</p>
<p>Which faculty may be counted in the required faculty/resident ratio of 1/6?</p> <p><i>(Program Requirements II.B.7)</i></p>	<p>This is stated unambiguously in the requirements, i.e., family physicians who are currently ABFM certified or who demonstrate appropriate educational qualifications, as so judged by the RRC. Physicians from other specialties may not be counted in this ratio, regardless of the time they devote to the program.</p>
Resident Complement	
<p>May I take an extra resident over the approved number?</p> <p><i>(Program Requirements III.B.4)</i></p>	<p>You must request a change electronically through the ACGME Accreditation Data System (ADS). Refer to the requirements regarding uneven numbers in the three levels of the program. When the RC-FM evaluates a program it judges the adequacy of the resources in relation to the proposed resident complement. Of particular concern is the patient population, number of faculty, space in the FMC. Please go to the following website for more information:</p> <p>http://www.acgme.org/acWebsite/RRC_120/120_family_medicine_Resident_Complement_Request_02_2011.pdf</p>
<p>What is the minimum number required in a rural program?</p> <p><i>(Program Requirements III.B.3.a)</i></p>	<p>At the rural site of a 1-2 program there must be at least two residents, one at each of the two levels of training, i.e., one PGY-2 and one PGY-3.</p>
<p>What is the minimum number of residents assigned to an FMC?</p>	<p>No minimum has been specified in the requirements but it is expected that there be at least two.</p>
Block vs. Longitudinal	
<p>Is a block month in a particular experience</p>	<p>Yes, a number of required experiences can be done in either block or longitudinal</p>

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<p>equivalent to 100 hours if it is done longitudinally?</p> <p><i>(Program Requirements II.A.4)</i></p>	<p>format. If done longitudinally, the program will need to document 100 hours of the required experience.</p>
EM Experience	
<p>What is the required time in EM?</p> <p><i>(Program Requirements IV.A.5.b.7.b)</i></p>	<p>The requirements state that residents must receive a structured educational experience in EM that includes didactic teaching, skills training, and clinical experience caring for patients of all ages and with acute illnesses and injuries in an EM care setting. The clinical experience alone must be 200 hours in duration.</p>
<p>Can the required EM experience be done within a single block month?</p>	<p>This would be acceptable as long as the program can document that residents receive 200 clinical hours of EM education in the one block month and there is compliance to the duty hour standards.</p>
<p>Can the time residents spend in the Pediatric ED be counted towards fulfilling the 200 hours of clinical time in EM?</p>	<p>Time in the Pediatric ED can be counted towards fulfilling the EM requirement. Time spent in urgi-care departments should not be counted unless it can be demonstrated that residents are caring for patients' acute and emergency medicine care needs (e.g., lacerations, resuscitations, etc). If training in the Pediatric ED is used to fulfill the pediatric requirement it must not be used to also fulfill the EM requirement. Double-dipping is to be avoided.</p>
Continuity of Care Experience	
<p>Home Visits: What is the expectation with the 2 home visits that residents are required to do?</p> <p><i>(Program Requirements IV.A.5.a.2.a.iii)</i></p>	<p>The expectation is that the 2 home visits will be with 2 different patients. At least one of the home visits must be done with an older adult continuity patient.</p>
<p>Nursing Home: Are residents required to provide continuity of care for the same 2 patients over a 24 month period?</p>	<p>Although this would be the preferred way to meet this requirement, the Committee realizes that this is not always possible. If a nursing home patient for whom a resident is providing continuity of care transfers to another facility or expires, a new patient needs to be provided for the resident.</p>
<p>Nursing Home: Can an intermediate care facility be used to provide the nursing home experience?</p>	<p>A facility that is purely an intermediate care facility will have difficulty meeting the continuity expectation of two patients over a two year period, as noted in the requirements. Patients admitted to intermediate care are subacute patients who are transition from hospital to home and are probably in the facility typically no more than two months. A facility that combines skilled nursing home facility and intermediate care would be fine if residents could achieve the continuity requirement, as is a pure</p>

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Active Involvement with Hospitalized Patients: should residents be “involved” in caring for their patients who become hospitalized?	Residents must remain actively engaged in the care of their continuity patients when they are hospitalized. At a minimum, this includes two way communication between the primary resident and the inpatient team at admission, at discharge and at key moments during the hospitalization. It is acceptable for the direct care to be provided through a Family Medicine team.
Nursing Home: Are residents required to provide continuity of care for the same 2 patients over a 24 month period? <i>(Program Requirements IV.A.5.b.3.c)</i>	Although this would be the preferred way to meet this requirement, the Committee realizes that this is not always possible. If a nursing home patient for whom a resident is providing continuity of care transfers to another facility or expires, a new patient needs to be provided for the resident.
Maternity Care/Continuity Deliveries	
What constitutes a “continuity” delivery? <i>(Program Requirements IV.A.5.b.3.c)</i>	At a minimum, the residents must provide antenatal, natal, and postnatal care for a delivery to be counted as a continuity delivery.
Neonates, Infants, Children and Adolescents	
What is the required amount of time for the inpatient Pediatrics experience? <i>(Program Requirements IV.A.5.b.2.a)</i>	There is no specific duration expected for inpatient pediatrics. The requirements state that residents need experience with neonates, infant care (both well baby and ill), ambulatory pediatrics, emergency care of children and adolescent medicine. They do not stipulate the amount of time during the 4 months of this experience that should be devoted to each aspect of care.
EMR	
What happens if a program does not have an EMR? <i>(Program Requirements II.D.2.g.4)</i>	Programs will need to provide evidence that they are in compliance with the requirement or document that they are moving towards implementing an EMR in the near future. The RC intentionally did not specify a timeframe for conversion, in order to provide programs flexibility with regards to meeting this requirement. Programs without an EMR should be able to provide evidence of institutional support for it and should have an expected date of implementation. Meeting minutes or a letter from administration would be evidence of support for the EMR.
Interruptions to Continuity Experience	
If a resident returns to his/her continuity sessions after being away for two weeks, must he/she wait for four weeks before taking a second break?	No, for a two week interruption to continuity, residents do not need to wait a month before taking another break. For interruption to continuity of 4 weeks or more, residents must resume their continuity sessions for at least 4 weeks prior to taking a second break. Interruptions to continuity must not exceed 8 weeks at any given

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	time or in any one year.
Critical Care	
<p>What is the definition of a “critically ill patient”?</p> <p><i>(Program Requirements IV.A.5.b.1.b.iii)</i></p>	<p>A critically ill patient is someone who is unstable and needs more than routine floor care. Patients on any of the ICU, CCU, Neuro ICU, PCU and any subspecialty unit could be counted as critically ill patients.</p>
<p>Is it necessary that the 15 patients for whom residents are required to care for during the critical care experience are adult patients?</p> <p><i>(Program Requirements IV.A.5.b.1.b.iii)</i></p>	<p>The program must document that at the end of three years of training, each resident has managed a substantial portion of the care of 15 critically ill adult patients</p>
Patient Visits	
<p>Can visits to patients in assisted living facilities count towards the nursing home experience?</p>	<p>No, visits to patients in assisted living facilities cannot be used fulfill the nursing home requirement. The patients seen and the competencies achieved during the nursing home experience are not equivalent to the patients seen and the competencies achieved during the assisted living experience. Visits to patients in assisted living facilities can be counted towards fulfilling the home visits requirement.</p>
<p>Is the Committee interested in whether residents achieve a specific number of patient visits per PGY level?</p> <p><i>(Program Requirements IV.A.5.a.2.c.iii.c)</i></p>	<p>The program needs to ensure that PGY1 level residents achieve at least 150 patient encounters and graduating residents achieve at least 1,650. It is expected that patient visits will increase as residents progress through the program.</p>
Documentation of Cases	
<p>What type of documentation should programs have as evidence that residents are meeting requirements?</p>	<p>The RC is not prescribing how programs should document that residents care for at least 5 patients during the adult medicine inpatient experience, and 15 critically ill patients during the critical care experience, only that there must be documentation and it must be available to the site visitor on the day of the site visit. The use of census data as documentation is acceptable.</p>
Supervision	
<p>What supervision is required during deliveries?</p>	<p>There must be on-site supervision in the delivery suite/labor deck by a family physician, an obstetrician or a senior resident in an ACGME-accredited OB/GYN program, a certified nurse midwife or a 3rd year FM resident who has sufficient</p>

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<i>(Program Requirements IV.A.5.b.3.e)</i>	delivery experience. When a resident provides the direct supervision, there must be on-site physician faculty supervision immediately available at the hospital.
Must FM faculty accompany residents on home visits? <i>(Program Requirements IV.A.5.a.2.a.iii)</i>	No, but they must be involved with the residents regarding their home visits. This includes reviewing the chart, discussing the case and any required follow-up, evaluating the resident, etc.
What constitutes acceptable on site supervision for a PGY-1 resident caring for a low risk pregnant woman in labor? <i>(Program Requirements IV.A.5.b.3.e)</i>	Acceptable supervision for a resident who is providing care for such a patient include: (a) a physician with privileges for providing OB labor & delivery services in the hospital associated with the program, (b) a resident who fulfills written program criteria for the supervision of low risk labor, or (c) a licensed midwife with privileges to provide labor and delivery services in the hospital.
Can two residents take credit for the same delivery? <i>(Program Requirements IV.A.5.b.3.c)</i>	Two residents may take credit for the same delivery if one resident is supervising the other resident. However, only one resident may take credit for the continuity delivery. The program will need to document the criteria it uses to ensure that the resident who is supervising has sufficient maternity care experience to function competently as a supervisor.
Geriatric Medicine and Sports Medicine Programs	
The requirements in Geriatric Medicine and Sports Medicine state that the program director and faculty "must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities." How does the RRC interpret "sufficient time?" <i>(General Subspecialty Program Requirements III.A.1)</i>	The Committee expects the program director to devote at least 10 hours a week to the program. Additionally, since both sets of requirements state that "at least one other faculty member with similar qualifications who devotes a substantial portion of professional time to the program," the Committee also expects that this individual devote at least 10 hours a week to the program.
Duty Hours	
Are there situations when residents may be supervised by licensed independent practitioners?	Physician assistants, nurse practitioners, clinical psychologists, licensed clinical social workers, and certified nurse midwives may, on occasion, supervise residents in unique educational settings within the scope of their licensure. Oversight by a faculty physician member during these situations is required.

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[Program Requirement: PR. VI.D.1]	
Under which circumstances can a first-year resident be supervised indirectly with supervision immediately available?	Programs must assess the independence of each first-year resident based upon the six core competencies in order to progress to indirect supervision with supervision immediately available.
[Program Requirement: PR. VI.D.5.a).(1)]	Various required experiences may necessitate different sets of skills. For example, if a resident is deemed to have progressed to indirect supervision with supervision immediately available while on the family medicine service, this may not be the case in a subsequent required experience if it is the resident's first experience for another rotation such as inpatient pediatrics or surgery.
What are some examples of indirect supervision?	Examples are as follows:
[Program Requirement: PR. VI.D.5.a).(1)]	<p><u>Indirect Supervision with direct supervision immediately available:</u> The resident is seeing patients in the family medical center and the supervising physician faculty member in the precepting room is immediately available to see the patient together with the resident as needed. The faculty member is in another area of the hospital, but is immediately available to see the patient together with the resident in the labor and delivery department as needed.</p> <p><u>Indirect Supervision with direct supervision available:</u> A resident is on call for the family medicine service and needs advice from the physician faculty member in order to manage a patient's care. This can be done either by telephone or electronically. After communication with the resident, if the attending determines additional assistance is needed, the attending physician is available and able to go to the hospital and see the patient together with the resident.</p> <p><u>Indirect Supervision oversight:</u> A resident is seeing a patient in either the nursing home or at home, and the supervising faculty member can then review the patient chart, discuss the case and any required follow-up with the resident, and evaluate the resident.</p>
What is an optimal clinical workload?	The program director must ensure resident patient loads are appropriate. The optimal case load will allow each resident to see as many cases as possible, without being overwhelmed by patient care responsibilities, or without compromising a resident's educational experience.
[Program Requirement: PR. VI.E.]	
Who should be included in interprofessional	Nurses, physician assistants, advanced practice providers, pharmacists, social workers,

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teams? <i>[Program Requirement: PR.VI.E.]</i>	child-life specialists, physical and occupational therapists, respiratory therapists, psychologists, and nutritionists are examples of professional personnel who may be part of interprofessional teams with which residents must work as members.

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