Chapter 8
ACGME Requirements and Accreditation Issues

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Introduction

This chapter reviews the role of the Accreditation Council for Graduate Medical Education (ACGME) in residency education with a specific focus on the ambulatory experience for internal medicine residents. There will be specific descriptions of requirements that clinic directors need to be aware of in the realms of scheduling, assessment, and site obligations. Common program challenges and opportunities in residency clinics are highlighted.

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Background

The ACGME is a private nonprofit organization that accredits residency programs based on a set of standards. Accreditation is conferred through ongoing evaluation by the ACGME with the goal of ensuring that residency programs provide a high-quality educational environment [1]. The ACGME standards are delineated in the Common Program Requirements, which apply to all residency and fellowship programs [2]. The ACGME also sets specialty-specific requirements that are designed to encompass the core elements expected for training in the specified field. A portion of the Internal Medicine Program Requirements outlines requirements for continuity clinic experiences including expectations for faculty, required continuity clinics for each resident, and frequency of assessments [1]. It is important for academic clinic directors to understand these requirements in order to maintain certification for the residency program. Failure to meet these requirements can result in residency programs being placed under increased scrutiny from the ACGME and, in the worst-case scenario, the program being placed on probation or terminated. Clinic directors should work with residency program leadership to ensure that the resident clinic experience is meeting ACGME requirements while also balancing the needs and resources of the clinic.

In 1999, the ACGME established six overarching clinical competency domains to form a foundation for education and assessment of graduate trainees. Ten years later, the ACGME began to transform its accreditation system to focus on competency-based outcomes. The Next Accreditation System (NAS), born from this work, had three main goals: "to enhance the ability of the peer-review system to prepare physicians for practice in the twenty-first century, to accelerate the ACGME's movement toward accreditation on the basis of educational outcomes, and to reduce the burden associated with the current structure and process-based approach" [3]. The NAS introduced educational milestones, described as "developmentally based, specialty-specific achievements that residents are expected to demonstrate at established intervals as they progress through training" [3]. The six core competencies were further subdivided into these milestones to highlight educational outcomes expected for each resident to achieve during residency. A residency's Clinical Competency Committee (CCC) is responsible for reviewing all resident evaluations, makes recommendations to promote trainees to their next level of training, and identifies when they are ready for independent practice. The CCC is also responsible for providing summative assessments of each trainee's progression in each milestone, which are submitted to the ACGME twice per year. Further information regarding milestone-based feedback and assessment can be found in Chap. 10. In July 2021, the ACGME updated the internal medicine milestones, introducing Milestones 2.0. These updated milestones addressed several issues with the first iteration of milestones including integrating "growth mindset concepts" and removing negative phrases such as "critical deficiencies" [4].

Another component of the NAS was the introduction of the Clinical Leaning Environment Review (CLER), which was designed to provide assessments and

feedback to academic institutions in six areas: “patient safety, health care quality, care transitions, supervision, duty hours and fatigue management/mitigation, and professionalism” [5]. The CLER program includes periodic ACGME-sponsored site visits to institutions with graduate medical education programs. The CLER representatives meet with organizational leaders such as chief medical officers and graduate medical education leaders along with residents and faculty representatives from multiple residencies/fellowships. At the end of the visit, the CLER representatives meet with organizational leadership to review their assessment and feedback. Continuity clinics and clinic faculty may be included in the CLER visit, so it is important for clinic leadership to be aware of CLER-related discussions from hospital and residency leadership.

In July 2022, the ACGME Program Requirements for Internal Medicine underwent significant changes, and one of the goals is to encourage increased flexibility for both programs and residents to individualize training to better support resident career goals [6]. As part of those changes, the ACGME Internal Medicine Residency Review Committee (RRC) made substantial changes, including the elimination of many of the detailed requirements for the longitudinal clinic experience. This gives programs the opportunity to re-examine their structure and schedule but retains many of the core tenets for the continuity clinic experience.

Residency Program Requirements

The ACGME requires residents to have supervised training over a broad range of experiences for a total of 36 months, with a minimum of 30 months of “clinical experience.” Over the 3 years, at least 10 months must be in the inpatient setting and at least 10 months in the outpatient setting (which includes time in longitudinal continuity clinic). Residency rotations must be structured to minimize conflicts between inpatient and outpatient responsibilities. In addition, there must be “a longitudinal, team-based continuity experience for the duration of the program.” The program requirements provide further specifics, stating that the longitudinal experience would preferentially be in a general internal medicine continuity clinic but that an internal medicine sub-specialty clinic could qualify if all learning environment criteria are met.

Primary Care Clinic Site Requirements

The primary longitudinal clinic site for each individual resident should ideally remain constant over the 3 years of training to assure the development of long-term therapeutic relationships with a panel of patients. This clinic experience will often be in a site at the sponsoring institution but can be located in a variety of other settings, including a physician group practice or federally qualified health center. For

any clinic site that is not directly under the sponsoring institution, a program letter of agreement (PLA) is required, which must be renewed every 10 years and be approved by the Designated Institutional Official (the individual in the organization who oversees all graduate medical education). For all clinics, there needs to be a clearly defined site director who is accountable for resident education. In addition, it is recommended that teaching faculty be identified and that there are specific policies and procedures that govern resident education, including specifics around teaching, supervision, and evaluation. The patient population should be representative of a broad spectrum of clinical disorders and conditions typically managed by internists. For patients in whom there is limited or no physical contact, opportunities for telemedicine services should be made available. As residents need to have opportunities to perform procedures relevant to career planning, longitudinal sites may be asked to provide such opportunities for common outpatient procedures (arthrocentesis, skin biopsy, etc.) for those residents interested in outpatient or procedural careers.

Faculty Requirements

As noted above, it is important for residency longitudinal clinics to identify the teaching faculty. Supervising faculty do not have to have an academic appointment, but they must be board certified either by the American Board of Medicine or the American Osteopathic Board of Internal Medicine. It is acceptable for a non-internist with appropriate qualifications to teach and supervise residents, such as a family medicine physician who has been approved by the site director and program director. Faculty must demonstrate a commitment to the education of residents and pursue faculty development to enhance their skills annually. Examples of faculty development include efforts to improve skills related to teaching quality improvement and/or patient safety. Additional faculty development can include engagement in training to improve personal or resident well-being and efforts to improve patient care. These faculty development experiences should be reported to residency program leadership annually.

Resident Requirements

One of the primary motivations behind the requirement for a longitudinal outpatient experience is the recognition of the importance of long-term relationships with patients. Therefore, it is critical that residents serve as the primary physician for their panel of patients, with responsibility for preventive health, acute health issues, and chronic disease management. In addition, residents must be involved in care coordination across health care settings and between clinic visits. Residents must demonstrate competence in respect and responsiveness to diverse patient

populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation. Additionally, they must develop skills in counseling, diagnosis, and treatment of adult diseases and conditions. Residents must also have the opportunity to develop longitudinal relations with supervising faculty members.

Scheduling Requirements

In the past, the ACGME Program requirements have provided specific guidelines for the required number of clinic sessions and the maximum time allowed away from their continuity clinic. As of the 2022 update, there is no longer this degree of specificity. Instead, the language of the requirements simply requires a longitudinal experience over the entire 3 years of residency. It will be crucial for outpatient faculty and leaders to continue to advocate for the critical importance of the continuity experience. If there are major changes implemented by programs to decrease or weaken the experience, it will potentially be to the detriment of their development as an independent physician and may impact faculty by decreasing their opportunities for teaching.

Assessment and Feedback

Residents in longitudinal experiences, such as continuity clinic, must be assessed at least every 3 months usually with a standardized evaluation form. This evaluation must be submitted to the residency program and should be available for the resident to review. Clinic faculty should work with program leadership to assure that these evaluations are not too onerous to complete and provide constructive feedback to the residents. In addition, program leadership will be responsible for linking these evaluations to the ongoing milestone-based competency assessments. Longitudinal clinic often provides an opportunity for highly effective feedback, given the consistency of supervisor relationships, and therefore the clinic evaluations are critical. While assessment is a description of a trainee's performance over a period of time, feedback is timely and specific descriptions of a behavior coupled with actionable suggestions for improvement. This is particularly notable for the milestones focusing on outpatient management and commitment to personal growth, which is assessed by a resident seeking and incorporating performance data. Residents should regularly provide rotational evaluations on the longitudinal clinic experience and the faculty they work with. In addition to residents receiving regular feedback, faculty must receive assessment on their teaching performance at least annually.

Working and Learning Environment

At each site, there must be regular monitoring of the clinical learning and working environment to assure excellent resident experience and education. This includes assurances that resident education is not being adversely affected by the presence of other providers or learners. However, longitudinal clinic can often provide an opportunity to participate in inter-professional teams, a priority noted in the program requirements. During clinic sessions, an individual faculty member in clinic must not be responsible for more than four residents or other learners. Additionally, if supervising >2 residents/learners, they must not have any other patient care responsibilities. In general, residents must be able to attend medical, dental, and/or mental health visits during working hours, so it is important for clinic directors to familiarize themselves with their local program approaches to meeting that requirement. Clinic sites should be expected to provide accommodations for resident disabilities, working closely with human resources and program leadership. Given the high frequency of burnout during residency and beyond, clinic faculty and leadership should notify program leadership for any recognized concerns around resident well-being.

Common Opportunities and Challenges

The ACGME Program Requirements define standards and obligations for residency programs and academic institutions to maintain certification. Meeting the standards set by the ACGME can be challenging requiring cooperation between multiple stakeholders, investment of resources, and advanced planning. However, the ACGME guidelines can also be considered as an opportunity to reinvent and reinvigorate clinic efforts. Clinic directors can use the requirements as a basis for advocating for support for residency-related efforts. Within the context of the 2022 ACGME Program Requirements, we will highlight a handful of specific areas in the program requirements that present unique opportunities and challenges.

Population Health

The ACGME 2022 Program Requirements specify that residents "demonstrate the ability to manage the care of patients using population-based data" [6]. The ACGME also emphasizes that residents "need experience using, understanding, and analyzing population health data" to improve the health outcomes of their patients [6]. The ACGME purposely leaves the details of population health integration vague to allow for academic institutions and clinics develop programs that match their current resources and data availability.

The most cited barrier to integration of population health into clinical care is the lack of access to population data. While electronic medical systems can collect numerous data points, most were originally designed as electronic medical records and ordering systems as opposed to being designed as tools for population health. Clinicians and population health managers often struggle to obtain actionable population health data [7–9]. Residency programs and clinics can advocate for designs of electronic medical system-integrated dashboards to support and enhance population health endeavors [10]. Clinic leadership should work with their local health informatics staff to understand the barriers and potential options for population health data access. Initially, it may be important to focus on 1–2 common disease processes, such as diabetes mellitus or hypertension, and identify a handful of quality or population health-related goals to focus on.

While it is essential to develop and design population health data access for clinicians and clinic staff, it is also equally important to consider curricula or tools to guide both trainees and faculty in the use of population health data. A clinic- or residency-level quality improvement project can help focus efforts while also providing skills and experiences with population health [11, 12]. For further information, please refer to Chap. 25 on population health and quality.

Continuity

The ACGME requires that residents have a "a longitudinal team-based continuity experience for the duration of the program through which they develop a long-term therapeutic relationship with a panel of patients" [6]. The ACGME does not specifically define what continuity means aside from identifying that there must be a long-term relationship between the resident and their panel of patients. The American Academy of Family Physicians defines continuity of care as "the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high-quality, cost-effective medical care" [13]. The ACGME emphasizes that the care of patients in the primary care setting should be team based but should allow "patients to understand that the resident is "their" primary care doctor, and residents to see the continuity clinic patients as "their" patients" [6]. Above all else, the primary care clinic experience should foster the development of long-lasting relationships between patients and residents. These efforts should be done in conjunction with the development of a robust team-based care model that will provide high-quality care for patients even when residents are working in nonambulatory settings. If possible, clinics may consider setting continuity goals for example X number of visits per session that a resident has with patients on their panel [14, 15]. Based on this data, clinics may consider interventions to increase continuity such as resident clinic-specific training for front-desk staff to ensure that residents' patients are scheduling with their primary care provider.

Outside of the patient-primary care relationship, primary care clinics may want to consider approaches to encourage continuity between residents and attending preceptors. Depending on the scheduling model utilized for resident clinics, preceptors may be a vital safety net for resident patients between clinic sessions. Preceptor schedules can be modified to enhance patient and resident-preceptor continuity. For example, in an X + Y model, preceptors could potentially precept on a specific afternoon every week, and thereby end up working with a different group of residents every week. Alternatively, preceptors may be scheduled to match the resident schedule such that a preceptor only precepts during the +Y week. This approach will mean that preceptors will have intense weeks where they work closely with a smaller group of residents. If the preceptor works with the same grouping of residents over a period, they can become acquainted with patients and can act as a form of continuity when graduating residents transfer their patients to incoming interns.

Conclusion

One of the many roles for the residency clinic site director is to offer a rewarding experience for residents and faculty, all while ensuring compliance with ACGME requirements summarized in the table. This includes collaborating closely with the residency program leadership to be certain that all relevant requirements are addressed and to identify priorities for the outpatient setting. In addition, the longitudinal clinic provides an excellent opportunity for constructive resident feedback and evaluation as they work toward achievement of developmental milestones. The requirement that residents care for their patients over the 3-year span leads to excellent opportunities for work on population health and quality improvement, which are the key elements of program requirements. Numerous complexities arise in developing a well-balanced clinical experience for residents, given the challenges in balancing between the inpatient and outpatient needs. To provide the best ambulatory training, resident longitudinal clinics must instill efficient, patient-centered care while giving appropriate attention to the resident experience and the learning environment.

ACGME Ambulatory Specific Requirements as of July 1st, 2022	
Required ambulatory experience	At least 10 months in the outpatient setting
Calculation of time devoted to longitudinal experience as portion of outpatient setting	One month = 4 weeks, 20 days, or 40 half-days of clinic
Specific primary care clinic requirements	No specific number of clinics required
Max interval between primary care clinics	No requirements

ACGME Ambulatory Specific Requirements as of July 1st, 2022	
Primary care/continuity clinic requirement	Must have a longitudinal team-based continuity experience for the duration of residency
Clinic settings that can be considered outpatient experiences	Primary care clinic, internal medicine sub-specialty clinics, non-medicine clinics, walk-in clinics, and home care visits
Definition of continuity clinic experience	A longitudinal, team-based, continuity experience through which they develop a long-term therapeutic relationship with a panel of patients
Resident continuity clinic experience in same clinic throughout residency	ACGME **suggests** that residents will remain in the same clinic throughout the 36 months to maintain continuity of care for their patient panel. ***staying in the same clinic throughout residency is not required by the ACGME***
Days off	Residents must be scheduled for a minimum of 1 day in seven free of clinical work and required education (when averaged over 4 weeks)
Primary care physician definition for residents	Residents must serve serving as the primary physician for a panel of patients, with responsibility for chronic disease management, management of acute health problems, and preventive health care for their patients
Faculty-to-trainee ratio	Faculty cannot supervise >4 trainees (residents and other learners)
Faculty responsibilities when supervising residents	If >2 trainees (residents and other learners), faculty cannot have other patient care responsibilities
Electronic medical system (EMS) access	Must have access to an electronic health record, but not required at every clinical site

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