Chapter 5
ACGME Requirements/Accreditation Issues

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Introduction

The Accreditation Council for Graduate Medical Education (ACGME) is a private nonprofit organization that accredits institutions, residency, and fellowship programs. Accreditation occurs via a voluntary process of evaluation and review based on published standards. By maintaining accreditation, an institution and residency program can provide assurance that it is meeting specified quality standards. In 2013, the accreditation system was revamped to the Next Accreditation System (NAS) [1]. The NAS was designed to reduce the barriers and complexities inherent in the previous accreditation system. In the previous system, programs would be evaluated by episodic reviews every 4–5 years. With NAS, programs submit data on an annual basis which is then evaluated by an ACGME Review Committee. The episodic on-site review intervals have now been increased to every 10 years in most cases unless there is a significant violation that requires a more timely evaluation. Another aspect of the NAS was the development of the Clinical Learning Environment Review (CLER), an episodic site visit that evaluates the learning environment for all residency and fellowship programs at a particular institution [2].

The requirements act as a guide for basic requirements and can also be used to support increased resource allocation from the institution. Failure to follow the requirements can result in probation, or even worse, closure of a program. Clinic

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L.B. Lu et al. (eds.), *Leading an Academic Medical Practice*,
https://doi.org/10.1007/978-3-319-68267-9_5

directors can use the ACGME clinic requirements as leverage to help ask for more resources such as more preceptors or access to an EMR [3].

There are no defined requirements for resident clinic leadership. However, we would suggest that program directors work with clinic directors to identify and appropriately fund the resident clinic director position. There are numerous ACGME requirements along with other foreseeable and unplanned issues that arise in resident clinic. Identifying a faculty member who can oversee the resident clinic experience can help improve patient care, improve integration of the resident clinic into the institutional clinic, promote communication with preceptors, and improve the resident experience. The resident clinic director may also have non-ACGME specified duties such as evaluating and giving feedback to preceptors. Depending on the number of residents in a clinic, the FTE allocated to this position may vary from a small percentage effort to a considerable percentage effort.

Learning Objectives

1. Understand ACGME requirement for continuity clinics, including scheduling issues, preceptor-to-resident ratios, and faculty expectations.
2. Recognize importance of incorporating practice evaluation and population health into resident continuity clinics.
3. Understand the duties expected of residents in continuity clinic.
4. Identify the challenges clinics face in meeting requirements.

Outline

- Continuity Clinic Requirements
  - Continuity Clinic Schedule requirements
  - Resident-to-Preceptor Ratio
  - Faculty Requirements
- Resident Practice Evaluation
- Patient Care Duties for residents
- Challenges

Continuity Clinic Requirements

In 2009, the ACGME published a new set of requirements for internal medicine. As part of these requirements, there was an increased emphasis on more flexible ambulatory experiences for residents. These changes in requirements have helped fuel

innovations within resident education including new scheduling models such as the X + Y model or the ambulatory long block while maintaining a commitment to longitudinal care [4].

Continuity Clinic Schedule Requirements

The ACGME requires that at least 1/3 of residency time must occur in the ambulatory setting including continuity clinics and other ambulatory experiences (emergency department rotations can count for no more than 2 weeks). In addition, there is a requirement of at least 130 distinct half-day outpatient sessions per resident over the course of at least 30 months. The maximum duration of time between clinic sessions should be no greater than 1 month excluding vacation time. This time limit helps prevent possible continuity issues that would occur if a program held multiple sessions in a short period of time or if there was a scheduling conflict that prevented a resident from having a clinic. It should be noted that ACGME does not specify how many patients must be seen per session. The ACGME also requires that residency programs develop models and schedules for ambulatory training that minimize conflicting inpatient and outpatient responsibilities.

Each clinic site is required to have a program letter of agreement (PLA) with the residency program if they are not directly part of the health care system affiliated with the residency. The PLA is renewed every 5 years. As part of the PLA, the clinic must identify faculty who will assume both educational and supervisory responsibilities for residents. All faculty who teach or supervise residents must have current certification in internal medicine by the American Board of Internal Medicine and possess qualifications judged acceptable to the ACGME Review Committee. Thus, faculty from other specialties such as family medicine or other providers such as nurse practitioners cannot supervise residents in clinic unless there is a special exception made by the ACGME. The clinic is responsible for identifying and recruiting faculty that fulfills these roles.

The ratio of learners to preceptors, including medical students and residents, must not exceed 4:1. There are no studies on optimal learner-to-resident ratios, but in our experience at Boston University and the University of Vermont, a 3:1 ratio allows for an optimal balance of integrating teaching opportunities with appropriate and efficient use of preceptor time. When a faculty member is precepting residents, they cannot have other patient care duties when supervising more than two residents or other learners such as medical students. If they only supervise 1–2 residents and/or learners, they can also see their own patients at the same time. However, in sites that use the Medicare Primary Care Exception, preceptors that see their own patients are required to see all resident patients [5]. In general, we would discourage preceptors seeing their own patients as the complexities of seeing patients and precepting at the same time may detract from the teaching experience and can decrease direct observation of the learners.

Resident Practice Evaluation

Over the last decade, there has been an increased emphasis on performance data and quality metrics by our health systems, insurance companies, and accreditation boards. In anticipation of this increased focus on quality measures, the ACGME has modified its requirements to help prepare residents for the future healthcare environment. As part of the continuity clinic experience, the ACGME requires that each resident has an evaluation of their performance data for their continuity panel. The performance data relates to both their chronic disease management and preventive healthcare. It should be noted that there are no specifics in terms of which diseases, which preventive measures, or how many data points should be evaluated for each resident. Associated with this evaluation is a requirement that each resident develop and implement a plan based on this data to improve their performance, with faculty supervision. This plan should be evaluated at least twice year. While it is not specifically mentioned in the ACGME requirements, practice improvement modules (PIMs) are a common tool used to assess performance [6–8]. These modules often offer structured data collection and provide direction on assessing for improvement. Clinics can develop these tools to coincide with the local clinic quality improvement projects. Clinic directors may work with the residency program especially if the residency has multiple clinic locations. A residency program may utilize a generic PIM that can be applied with slight modification to each clinic location.

Patient Care Duties for Residents and Clinic Resources

The continuity clinic experience must be longitudinal with residents developing a continuous long-term relationship with a panel of general internal medicine patients. The resident must serve as the primary physician for a panel of patients and be responsible for preventive healthcare, chronic disease management, and care of acute health problems.

Between outpatient visits, residents are required to be accessible so that they can be involved in the longitudinal management of their patient panel. If the resident is not available, there must be a process or system in place to provide coverage for urgent issues.

The ACGME is aware that resident clinics can sometimes be under-resourced, and residents may be asked to perform nonphysician duties that do not add benefit to their training experience. The ACGME requests that the clinic be responsible for creating systems to prevent residents from performing routine clerical functions, such as scheduling tests and appointments, and retrieving records and letters. The residency program is also required to provide access to an electronic health record (EHR) or demonstrate that the institution is in the process of implementing an EHR.

Challenges Meeting ACGME Requirements

Not surprisingly, there are a number of challenges to create a successful longitudinal clinic. Meeting all of the requirements requires a significant amount of effort and coordination, but it is also critical to create a positive clinical experience for the residents and patients. One of the initial issues to address is assuring minimization of conflict between the inpatient and outpatient settings. The block system has been one popular and effective way to separate these experiences – but programs continue to be creative in addressing this issue, including programs going to full clinic days during inpatient rotations. Another challenge is providing continuity of care during times that residents are not physically present in clinic [9–12]. Electronic health records have helped immensely but also add to the workload of residents while delivering outpatient care. Documentation and completion of EMR-related patient care tasks add the workload of resident physicians and may in fact lead to duty hour violations [13]. Faculty and covering residents can be part of the solution in trying to achieve more seamless and patient-centered care. In the authors' experience, some of the most difficult barriers to adherence to requirements have been the population health and practice evaluation requirements. It is critical to engage and develop faculty, as residents frequently require structure, support, and assistance in trying to achieve successful practice improvement interventions.

Conclusion

Overall, involvement and leadership in a resident continuity clinic can be incredibly satisfying experience. Clearly, there are challenges, but awareness of the requirements is an extremely important component to making it successful for leadership, preceptors, residents, and patients. Frequently, knowledge of the requirements can help advocate for necessary changes and resources. In addition, working closely with program administration is critical.

ACGME requirements as of July 2016 (4)

Topic	Requirement
Required ambulatory time	At least 1/3 of residency time must occur in ambulatory setting
Continuity clinic	Each resident should have a minimum of 130 distinct half-day outpatient sessions, extending at least over a 30-month period
Max clinic intervals	Time between clinics should be <1 month, not including vacation time
EMR	Programs are required to provide access to an electronic health record or demonstrate institutional commitment to implementation of an EMR
Teaching faculty requirements	The physician faculty must have current certification in the specialty by the American Board of Internal Medicine

Topic	Requirement
Faculty duties while precepting	Faculty must not have other patient care duties while supervising more than two residents or other learners
Resident/preceptor ratio	Ratio of resident or other learners to faculty preceptors not to exceed 4:1
Resident practice evaluation	Each academic year, there has to be an evaluation of performance data for each resident's continuity panel of patients relating to both chronic disease management and preventive healthcare

Specific ACGME wording for each requirement

Ambulatory time	**At least 1/3 of the residency training time must occur in the ambulatory setting**. Emergency medicine may count for no more than 2 weeks toward the required 1/3 ambulatory time
Continuity clinic	Residents must have a longitudinal continuity experience in which residents develop a continuous, long-term therapeutic relationship with a panel of general internal medicine patients. Programs must develop models and internal medicine schedules for ambulatory training that minimize conflicting inpatient and outpatient responsibilities
	Each resident's longitudinal continuity experience must include the resident serving as the primary physician for a panel of patients, with responsibility for chronic disease management, management of acute health problems, and preventive healthcare for their patients
Clinic # required	**Each resident should have a minimum of 130 distinct half-day outpatient sessions, extending at least over a 30-month period**, devoted to longitudinal care of the residents' panel of patients
Clinic intervals	**Time between clinics should not be interrupted by more than a month**, not inclusive of vacation
Clinic sites-	There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every 5 years. The PLA should identify the faculty who will assume both educational and supervisory responsibilities for residents
EMR access-	Programs are required to provide access to an electronic health record. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development and progress toward its implementation
Clinic resources-	Outpatient systems to prevent residents from performing routine clerical functions, such as scheduling tests and appointments, and retrieving records and letters
Teaching faculty-	**The physician faculty must have current certification in the specialty by the American Board of Internal Medicine** or possess qualifications judged acceptable to the Review Committee
	At each participating site, there must be a sufficient number of internal medicine faculty with documented qualifications to instruct and supervise all residents at that location
	Faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and to administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas
Faculty duties	**Faculty must not have other patient care duties while supervising more than two residents or other learners**. Other faculty responsibilities must not detract from the supervision and teaching of residents

Ratio res/ preceptor	Must maintain **a ratio of residents or other learners to faculty preceptors not to exceed 4:1**
Practice evaluation	Each academic year, there has to be an evaluation of performance data for each resident's continuity panel of patients relating to both chronic disease management and preventive healthcare. Residents must receive faculty guidance for developing a data-based action plan and evaluate this plan at least twice a year
Patient care	Residents should be accessible to participate in the management of their continuity panel of patients between outpatient visits. There must be systems of care to provide coverage of urgent problems when a resident is not readily available

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