



ACGME



ACGME and Rural Graduate Medical Education

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ACGME

Council on Graduate Medical Education | July 17, 2020



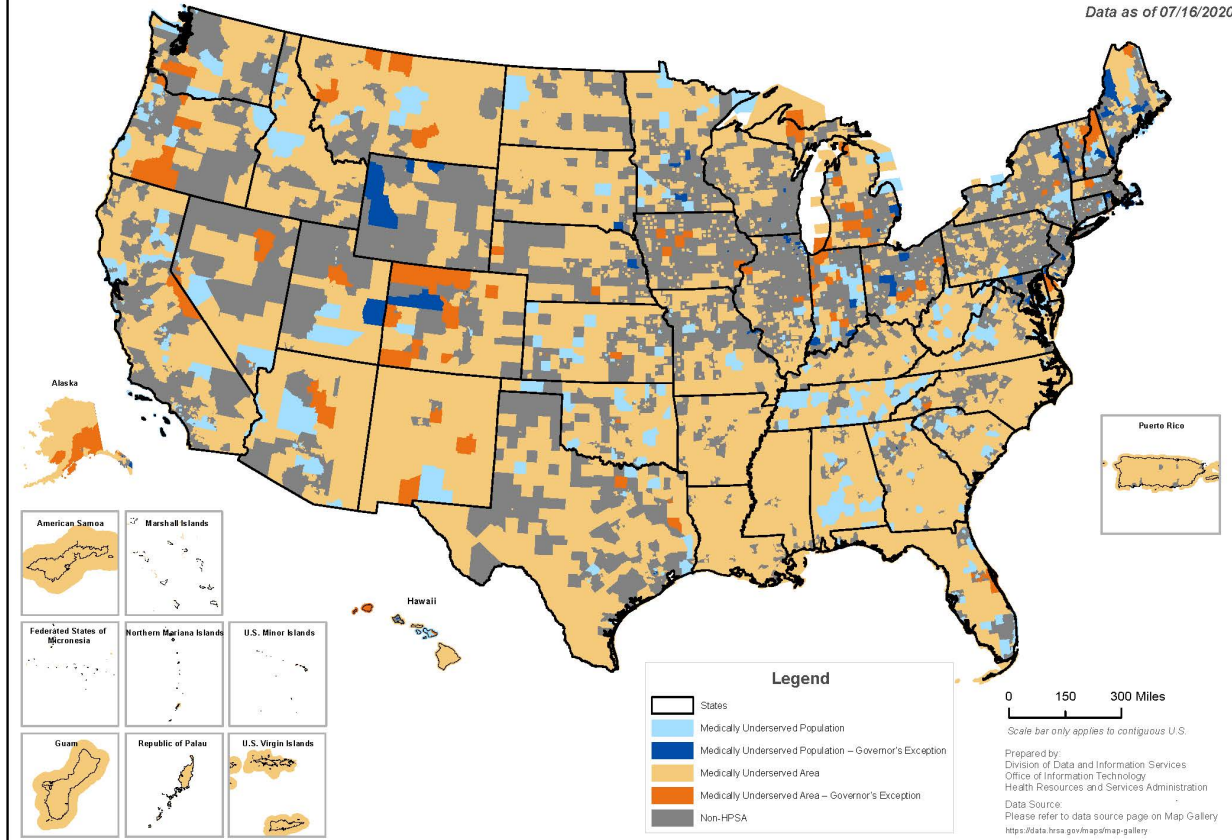
Mission

To improve health care and population health by assessing and advancing the quality of resident physicians' education through accreditation.



- 861 ACGME-accredited Sponsoring Institutions
- 12,043 ACGME-accredited programs
- 145,830 residents and fellows in ACGME-accredited programs

Data as of 07/16/2020





Accreditation Council for Graduate Medical Education

What We Do

Designated
Institutional Officials

Program Directors
and Coordinators

Residents and Fellows

Meetings and
Educational Activities

FEATURED

July 1, 2020

ACGME, AOA, and AACOM Usher in New Era of Single Accreditation for Graduate Medical Education

The ACGME, the American Osteopathic Association (AOA), and the American Association of Colleges of Osteopathic Medicine (AACOM) celebrate the successful transition to a single accreditation system for graduate medical education (GME) in the US.

[READ MORE »](#)

[Monitor Our Progress Toward a Single GME Accreditation System »](#)



Work Group: Accreditation Framework for Medically Underserved Areas and Populations (External Members)

Name	Title	Organization
Donald Brady, MD	Designated Institutional Official	Vanderbilt University Medical Center
Thomas Hansen, MD	Designated Institutional Official	Advocate Health Care
Robert Juhasz, DO	Medical Staff	Cleveland Clinic
Jeffrey Kirsch, MD	Associate Dean for Clinical and Veterans Affairs	Oregon Health and Science University
Sandeep Krishnan, MD	Fellow, Interventional Cardiology	University of Washington School of Medicine
Lorrie Langdale, MD	Professor & Chief of General Surgery	University of Washington School of Medicine
Karen Nichols, DO, MA	Dean	Midwestern Univ/Chicago Coll of Osteopathic Medicine
Jeffrey Pettit, PhD	Clinical Associate Professor (Public Member)	University of Iowa Hospitals & Clinics
Benjamin Preyss, MD	Medical Director of Population Health	Lawndale Christian Health Center
Claudia Ramirez Sanchez, MD	PGY-2, Internal Medicine (Resident Member)	Cook County Health and Hospital System
Gary Slick, DO	Designated Institutional Official	Oklahoma State University Center for Health Sciences



Work Group: Accreditation Framework for Medically Underserved Areas and Populations (Internal Members)

Name	Title
Paige Amidon, MBA, MPH	Senior Vice President, Department of Communications
John Combes, MD	Visiting Scholar, Department of Education
Kate Hatlak, MEd	Executive Director, Hospital-Based Accreditation
Paul Johnson, MFA	Executive Director, Institutional Accreditation
Mary Lieh-Lai, MD	Senior Vice President, Medical Accreditation
Lorenzo Pence, DO	Senior Vice President, Osteopathic Accreditation
Paul Rockey, MD	Scholar-in-Residence
Kevin Weiss, MD	Senior Vice President, Institutional Accreditation



Presenters at Work Group Meetings

Presenter	Presenter Title, Organization	Presentation Title
Lori Mihalich-Levin	Partner, Dentons	Regulatory Mechanisms for GME Financing in Medically Underserved Areas
John Sealey, DO	DIO, Detroit Wayne County Health Authority GME Consortium	GME and Accreditation in Urban Medically Underserved Areas
Roxanne Fahrenwald, MD, MS	DIO, Montana Family Medicine Residency	GME and Accreditation in Rural Medically Underserved Areas
Candice Chen, MD	Director, Division of Medicine and Dentistry, HRSA	HRSA's Support of GME in Medically Underserved Areas
Tom Gearan, MD	Program Director, Internal Medicine, Maine Medical Center	Maine Medical Center, Rural Internal Medicine
Kathleen Klink, MD Edward Bope, MD	Chief, Health Professions Education (Klink), GME Affiliations Officer (Bope), Department of Veterans Affairs	Presentation from Department of Veterans Affairs
Randall Longenecker, MD	Assistant Dean, Rural & Underserved Programs, Ohio University Heritage College of Osteopathic Medicine	Presentation from RTT Collaborative



Regional Visits: Washington, DC

- America's Essential Hospitals
- Indian Health Service
- National Association of Community Health Centers
- National Rural Health Association



Regional Visits: Washington, DC



Unity Health – Anacostia Health Center



Regional Visits: Jackson, MS



- State Legislators
- William Carey University College of Osteopathic Medicine
- Magnolia Regional Medical Center
- University of Mississippi Medical Center
- Merit Health Wesley
- Mississippi State Medical Association
- EC Health Net
- Forrest General Hospital
- Baptist Memorial Health Systems
- Community Health Center Association of Mississippi
- Central Mississippi Health Services
- Family Health Care Clinic, Inc.
- Jackson-Hinds Comprehensive Health Center
- Coastal Family Medicine Clinic



Regional Visits: New York, NY

- Institute for Family Health
- Greater New York Hospital Association
- New York City Health and Hospitals Corporation
- Rochester Regional Health
- Memorial Sloan Kettering Cancer Center
- Montefiore Health System
- Iroquois Healthcare Association
- Center for Health Workforce Studies
- Associated Medical Schools of New York



Regional Visits: Tulsa, OK

- Oklahoma State University College of Osteopathic Medicine
- Cherokee Nation
- Oklahoma State Legislature & Office of the Governor
- Northeastern Health System
- Pawnee Indian Hospital (IHS)
- Physician Manpower Training Commission
- Great Salt Plains Health Center
- Comanche County Memorial Hospital
- Tobacco Settlement Endowment Trust
- OMECO
- Choctaw Nation Health Services Authority
- AllianceHealth Durant



Regional Visits: Portland, OR

- Legacy Health
- Oregon Health & Science University
- Yakima Valley Farm Workers Clinic
- Good Shepherd Hospital
- Providence St. Peter Hospital
- Providence Milwaukie Hospital
- Providence St. Vincent Medical Center
- University of Washington School of Medicine
- Roseburg Family Medicine
- Virginia Garcia Memorial Health Center
- Oregon GME Consortium
- Elson S. Floyd College of Medicine
- Oregon Health Authority
- Western University of Health Sciences
- Puyallup Tribal Health Authority
- Kaiser Permanente
- VA Portland Health Care System
- Washington State University
- Good Shepherd Hospital
- Wipfli LLP





Accreditation Framework for MUA/P

- I. Enhanced ACGME Support
- II. Proposed Modifications to Accreditation Process
- III. Potential Variance in ACGME Requirements
- IV. Evolving Sponsoring Institutions to Succeed in Educating Physicians for MUA/Ps



I. Enhanced ACGME Support

- New programmatic unit and advisory committee
- Enhancement of ACGME systems and data collection
- Additional learning activities



II. Proposed Modifications to Accreditation Process

- ACGME committees' engagement with MUA/P framework
- ACGME processes aligned with funding mechanisms (e.g., rural tracks)
- Oversight of progress in establishing new GME in MUA/Ps



III. Potential Future Variance in ACGME Requirements

Important considerations for GME in MUA/Ps:

- Program directors, faculty members, program coordinators
- Supervision
- Continuity of educational experiences
- Primary sites and participating sites
- Curriculum
- Retention
- Small programs



IV. Sponsoring Institutions

- Three SI models:
 - MUA/P-based SI
 - Non-MUA/P-based SI extension
 - Non-MUA/P-based SI transition to MUA/P-based SI
- Streamline SI/program application
- Learning and working environment
- Oversight



Work through Spring 2020

Work Group listening sessions

Work Group development of framework

ACGME Board of Directors approval of framework

Launch of new programmatic unit and director hired



New Programmatic Unit for Medically Underserved Areas/Populations and GME



Laney McDougal, MS
Director, MUA/P and GME
Department of Sponsoring Institutions and CLE
Department of Accredited, Recog, and Field Activities



Paul Foster Johnson, MFA
Executive Director
Institutional Accreditation



New Programmatic Unit: Some Initial Steps

- Developing ACGME web presence
- Introducing framework to ACGME staff, Review Committees, GME community
- Planning action related to rural tracks



Addressing Rural and Rural Track Programs

“Rural Track” Project [42 CFR 413.79(k)]

- Terms and definitions
- Accreditation data management
- ACGME Review Committee processes
- Guidance for DIOs and program directors

Electronic Code of Federal Regulations

[Title 42](#) → [Chapter IV](#) → [Subchapter B](#) → [Part 413](#) → [Subpart F](#) → 5413.79

(k) **Residents training in rural track programs.** Subject to the provisions of §413.81, an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks, in addition to the residents subject to its FTE cap specified under paragraph (c) of this section. An urban hospital with a rural track residency program may count residents in those rural tracks up to a rural track FTE limitation if the hospital complies with the conditions specified in paragraphs (k)(2) through (k)(7) of this section.

(1) If an urban hospital rotates residents to a separately accredited rural track program at a rural hospital(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital. The urban hospital may include in its FTE count those residents in the rural track training at the urban hospital, not to exceed its rural track FTE limitation, determined as follows:

(i) For rural track programs started prior to October 1, 2012, for the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average at paragraph (d)(7) of this section, training in the rural track at the urban hospital. For rural track programs started on or after October 1, 2012, prior to the start of the urban hospital's cost reporting period that coincides with or follows the start of the sixth program year of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average at paragraph (d)(7) of this section, training in the rural track at the urban hospital.

(ii) For rural track programs started prior to October 1, 2012, beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of the highest number of residents, in any program year, who during the third year of the rural track's existence are training in the rural track at the urban hospital and are designated at the beginning of their training to be rotated



Accreditation Council for Graduate Medical Education

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Sponsoring Institution Emergency Categorization

As the COVID-19 pandemic continues in the US, the response and needs of the graduate medical education (GME) community also continue to evolve. The ACGME continues to monitor the situation in order to ensure that its accreditation processes are responsive to the circumstances.

In all cases, Sponsoring Institutions and programs must ensure that residents and fellows can successfully complete their programs and become eligible for board certification. In recognition of this imperative, and of the ongoing adaptation of GME operations in the pandemic, the ACGME's new framework for Emergency and Non-Emergency categorization of Sponsoring Institutions provides a process for managing accreditation concerns resulting from pandemic-related educational disruption.



Telesupervision – Common Program Requirement Changes (effective 3/18/20)

VI.A.2.c).(1) Direct Supervision:

VI.A.2.c).(1).(a) the supervising physician is physically present with the resident during the key portions of the patient interaction; or, ^(Core)

[The Review Committee may further specify]

VI.A.2.c).(1).(a).(i) PGY-1 residents must initially be supervised directly, only as described in VI.A.2.c).(1).(a). ^(Core)

[The Review Committee may describe the conditions under which PGY-1 residents progress to be supervised indirectly]

VI.A.2.c).(1).(b) the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology. ^(Core)

[The Review Committee must further specify if VI.A.2.c).(1).(b) is permitted]

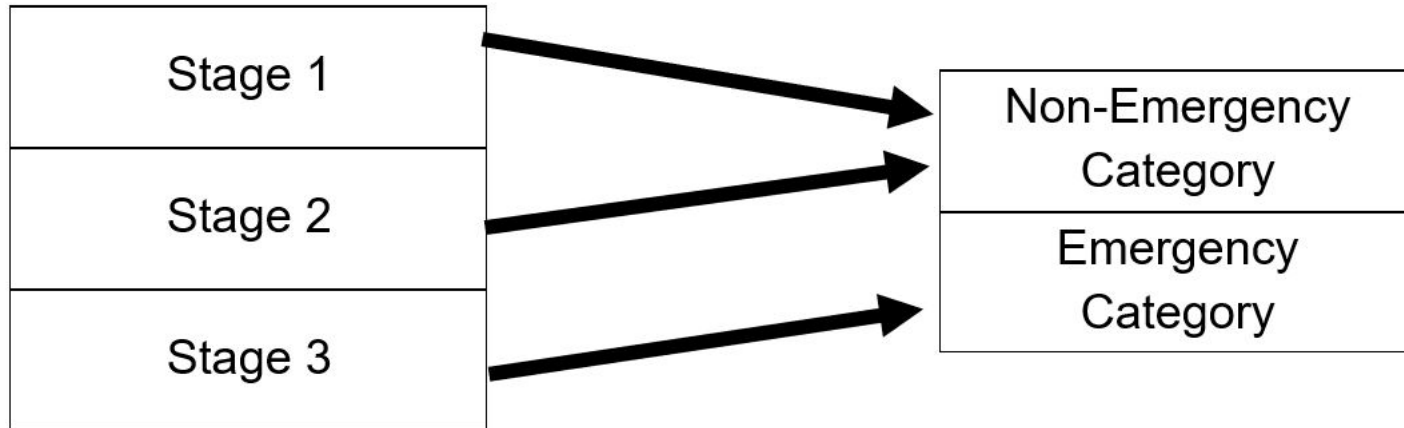
[The Review Committee will choose to require either VI.A.2.c).(1).(a), or both VI.A.2.c).(1).(a) and VI.A.2.c).(1).(b)]

VI.A.2.c).(2) Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision. ^(Core)

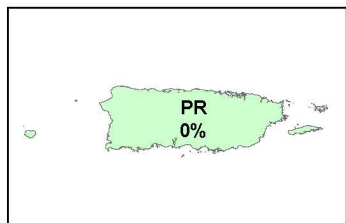
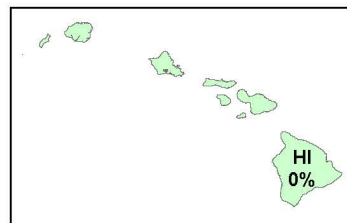
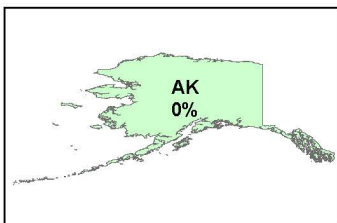
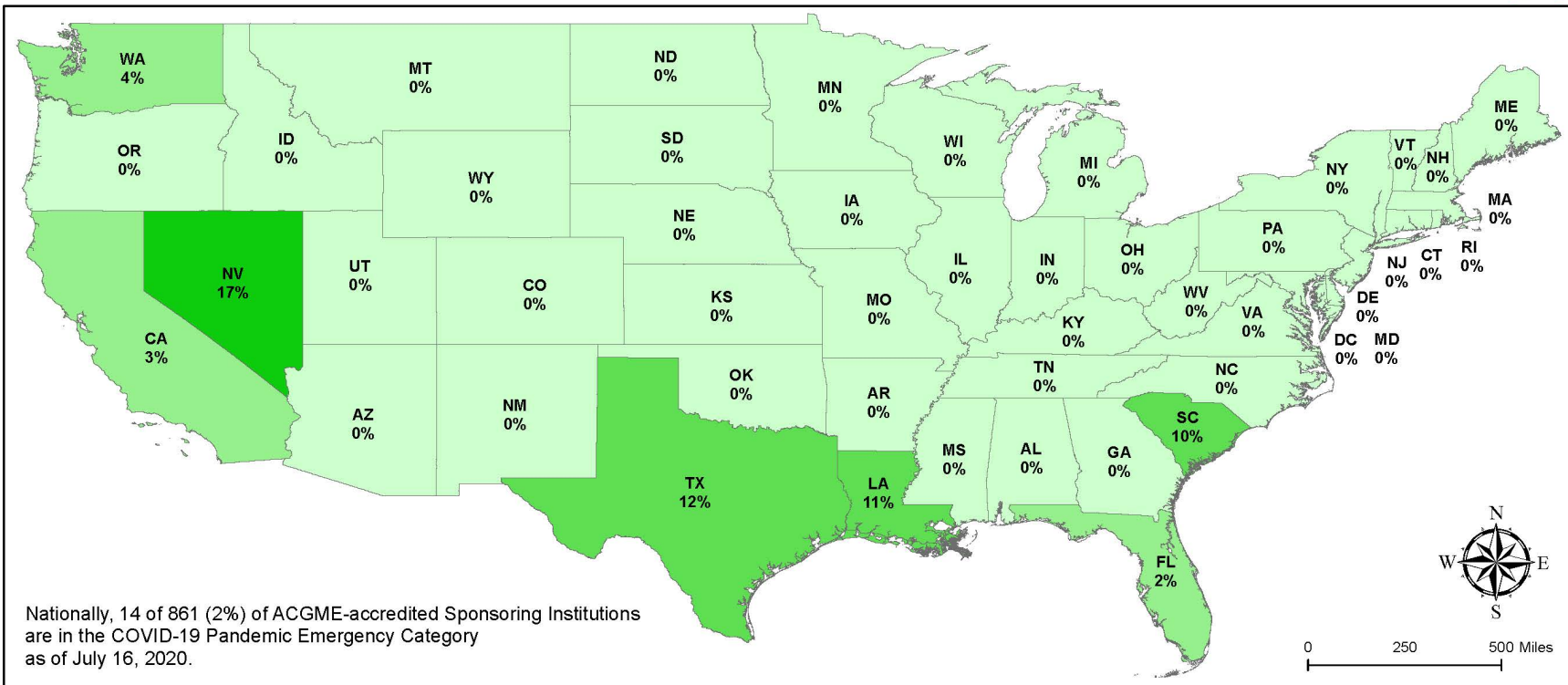
VI.A.2.c).(3) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. ^(Core)



ACGME Emergency Categorization for Sponsoring Institutions during the COVID-19 Pandemic

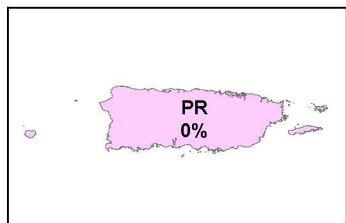
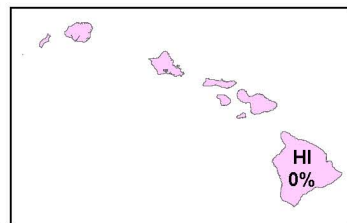
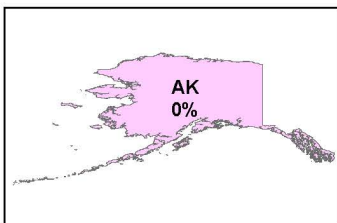
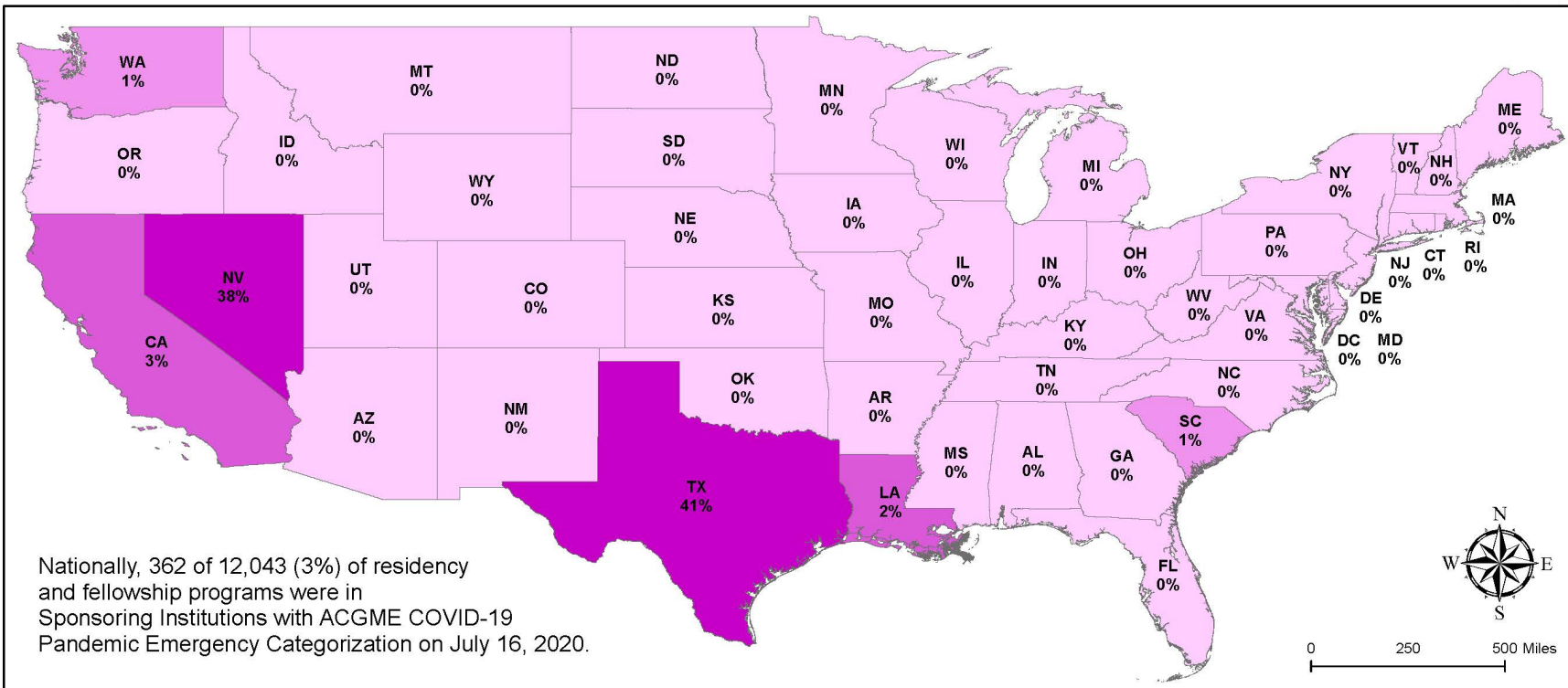


Percentage of Sponsoring Institutions with Emergency Categorization



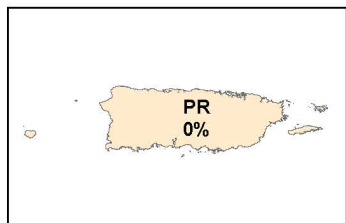
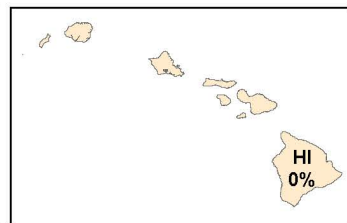
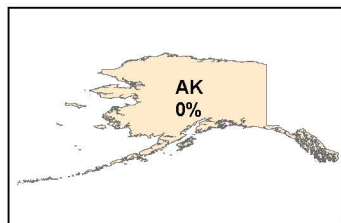
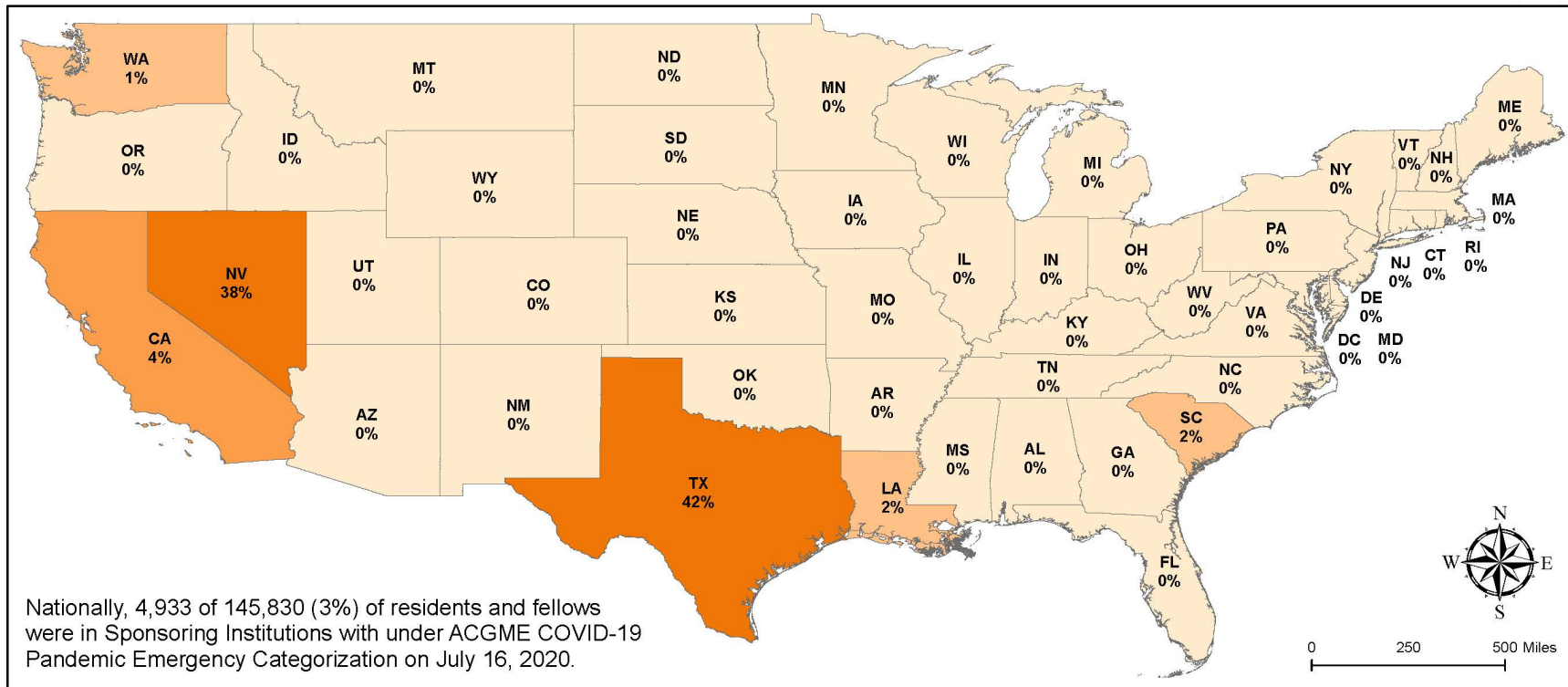
ACGME-accredited Sponsoring Institutions in the COVID-19 Pandemic Emergency Category, as a percentage of all Sponsoring Institutions in each state, the District of Columbia, and Puerto Rico, on July 16, 2020. Alaska, Hawaii, and Puerto Rico are not shown to scale.

Percentage of Residency and Fellowship Programs in Sponsoring Institutions with Emergency Categorization



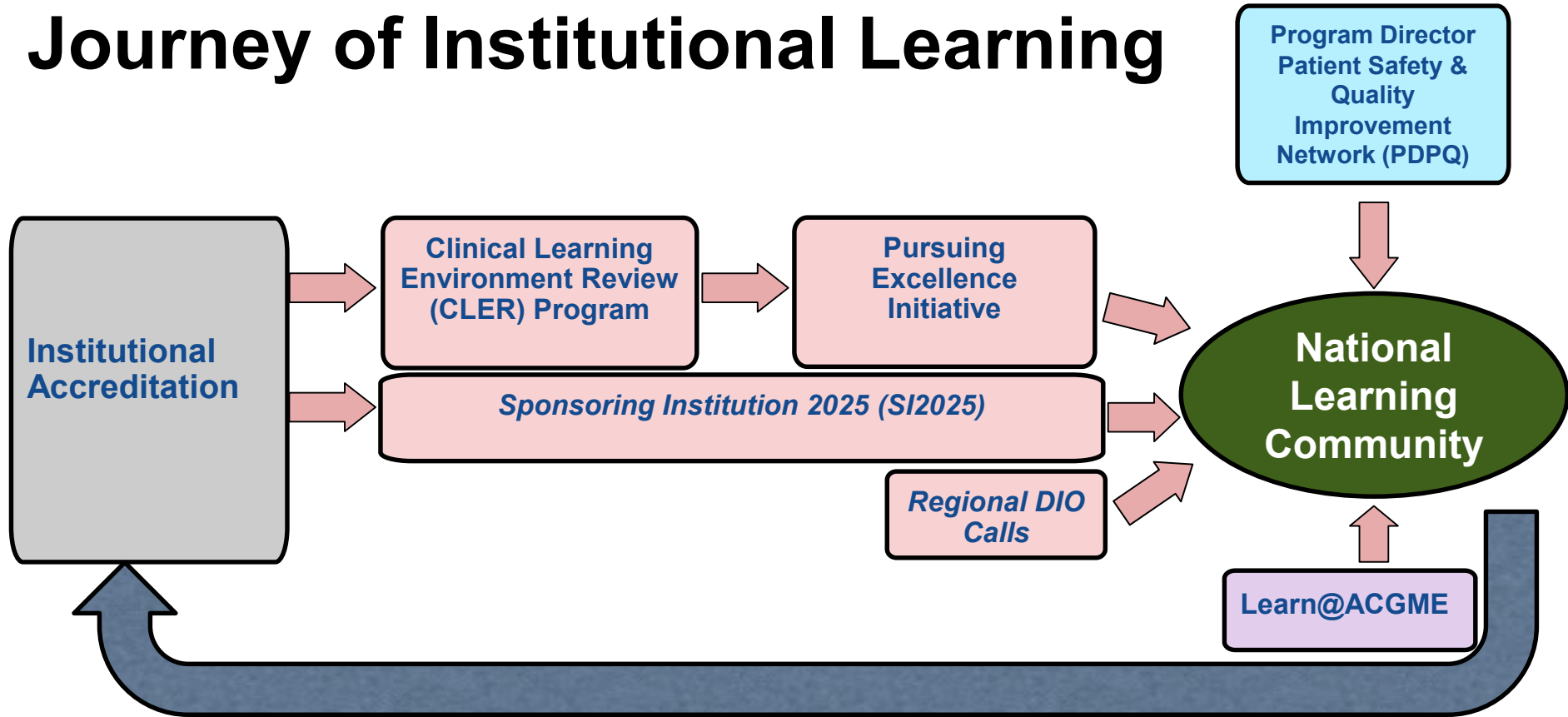
Residency and fellowship programs in Sponsoring Institutions with ACGME COVID-19 Pandemic Emergency Categorization, as a percentage of all residency and fellowship positions in each state, the District of Columbia, and Puerto Rico, on July 16, 2020. Alaska, Hawaii, and Puerto Rico are not shown to scale.

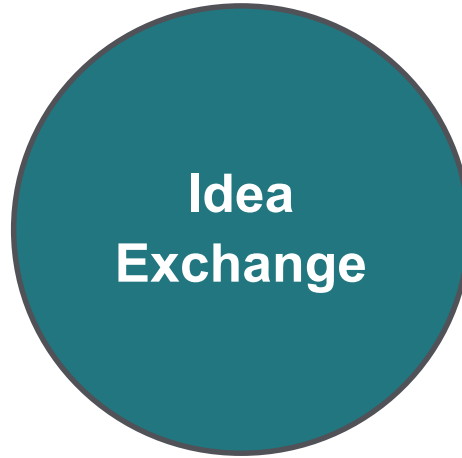
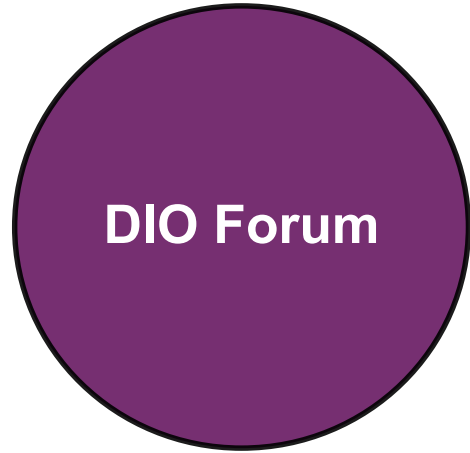
Percentage of Residents and Fellows in Sponsoring Institutions with Emergency Categorization

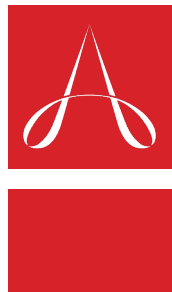


Residents and fellows in Sponsoring Institutions with ACGME COVID-19 Pandemic Emergency Categorization, as a percentage of all residents and fellows (filled positions) in each state, the District of Columbia, and Puerto Rico, on July 16, 2020. Alaska, Hawaii, and Puerto Rico are not shown to scale.

Journey of Institutional Learning

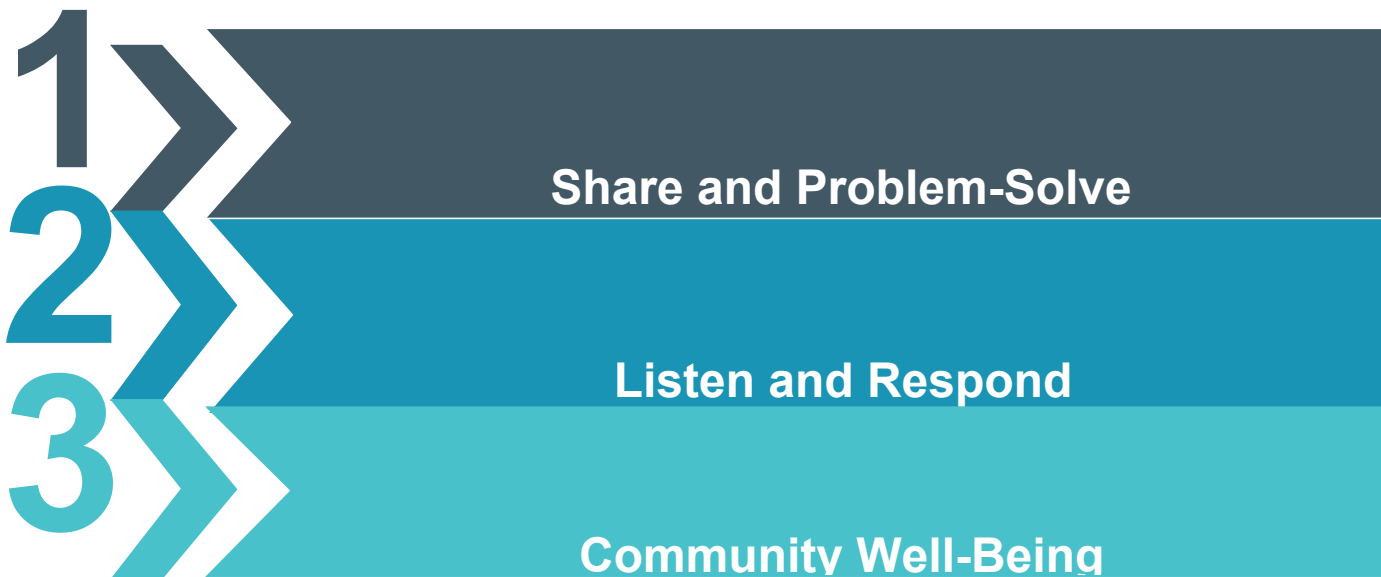






DIO Forum

Conversation on COVID-19





WELL-BEING IN THE TIME OF COVID-19

THE DIO COMMUNITY FORUM ON COVID-19



SI Idea Exchange:

- Emergency Staging Maps
- Supervision
- Emergency Preparedness
- Education
- Infection Protection
- National Well-Being Call Summaries

DIO Forum:

- National Call Recordings & Chats
- Special Topic Call Recordings & Chats
- Special Topic Resources
- ABMS Grid
- Racial Equity Resources





Diversity, Equity, and Inclusion



William A. McDade, MD, PhD
Chief Diversity and Inclusion Officer

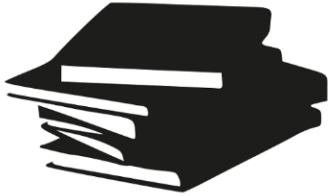


Bonnie Simpson Mason, MD
Vice President, Diversity and Inclusion

[WELL-BEING IN THE TIME OF COVID-19](#)[THE DIO COMMUNITY FORUM ON COVID-19](#)

Well-Being Task Force

Led by:
Maureen Leffler
John Duval



Resource Library

National Calls

Well-being experts who occupy many different roles across our institutions



Idea Exchange



Participant's Forum

New Resource Available

The *Guidebook for Promoting Well-Being during the COVID-19 Pandemic* offers evidence-informed recommendations that can be applied across contexts and changing situations, including for areas yet to experience a surge, in the midst of a surge, or recovering from a surge. It also includes resources addressing how the pandemic can affect residents, fellows, and other clinicians, both professionally and personally.

[LEARN MORE >](#)

Promoting Well-Being

DURING THE COVID-19 PANDEMIC





Clinical Learning Environment Review (CLER) Changes – *Coming Soon*

- Specially-designed CLER visits via teleconferences and surveys to understand the impact of COVID-19 on the clinical learning environment
 - Inform GME leaders and community as they examine and adapt systems to optimize learning and patient care
 - Timely identification of new needs of SIs and their CLEs



Thank you!