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

Question	Answer
Institutions	
What is considered "excessive" travel time? *[Program Requirement: I.B.3.]*	The Committee considers an hour of driving time or a distance of more than 60 miles to be excessive.
Program Personnel and Resources	
What are considered acceptable qualifications in lieu of American Board of Family Medicine (ABFM) certification? *[Program Requirement: II.B.2.]*	If a program includes a non-ABFM-certified faculty member on the core family physician roster (e.g., a faculty member with AOA certification only), it must provide documentation that the individual participates in processes similar to the ABFM's Maintenance of Certification.
Is there a numeric expectation with respect to faculty members' scholarly activity? *[Program Requirement: II.B.5.b)]*	The goal of the requirement is to ensure that residents are training in an environment of inquiry with appropriate role-modeling by the members of the physician faculty. The Committee considers appropriate role-modeling of scholarship to include at least two entries of the examples listed in the Program Requirements over five years by some faculty members (i.e., not every member of the physician faculty must demonstrate that numeric goal).
Can two (or more) faculty members be counted on the same scholarly activity entry? *[Program Requirement: II.B.5.b)]*	As long as both faculty members have contributed to a piece of scholarly work, then both may count it towards their scholarly activity.
Are scholarly activity entries other than PubMed IDs counted and valued by the Review Committee? *[Program Requirement: II.B.5.b)]*	Yes. The Review Committee values all types of scholarly activity.

Question	Answer
May a program use two individuals to satisfy the time dedication required for at least one core family medicine physician? *[Program Requirement: II.B.6.]*	No. The expectation is that the core physician faculty member position is not a "shared" position.
Would time that a core family medicine physician faculty member spends caring for his or her own patients in clinic (with a resident present) count toward the 60 percent time requirement? *[Program Requirement: II.B.6.a).(1)]*	No. The expectation is that the core family medicine physician faculty members are dedicating 60 percent of their time to the hands-on education of the residents in the program. However, it is important to note that this time is not limited to supervision, but should include other duties, such as teaching, administration, scholarly activity, etc. Having a resident present while a faculty member attends to his or her own patients does not fulfill the spirit of the requirement.
Who should serve as a role model for inpatient adult, inpatient pediatric, and maternity care? *[Program Requirement: II.B.7.]*	The Committee considers core and non-core family medicine faculty members (may also be three separate—one for each area) as appropriate role models in these areas.
What qualifications are acceptable for faculty members dedicated to the integration of behavioral health? *[Program Requirement: II.B.10.]*	A qualified family physician, psychiatrist, or other behavioral health professional would meet the requirement for such faculty expertise. “Qualified” implies a specific interest, education/training, or experience in behavioral health.
When submitting a request for use of a new Family Medicine Practice (FMP) site, are there specifications regarding identification of the practice? *[Program Requirement: II.D.2.]*	The FMP site is a model unit that must be contained within walls, and be clearly identified as the FMP site on the door of entry. All the components listed as required, and nothing else, must be in the FMP site. No non-residency-related activities can take place within the walls of the FMP site. While this unit may be on the same floor as other specialty clinics or private practices, the FMP site must be a discrete unit that is physically separated from those activities by walls.
What is the minimum number of residents required to be assigned to an FMP site? *[Program Requirement: II.D.2.]*	No specific minimum is required, but it is expected that there be at least two residents assigned to an FMP site at a given time.

Question	Answer
Must a program seek prior approval from the Review Committee for any additional FMP sites? *[Program Requirement: II.D.2.b)]*	No. The requirement that programs must seek prior approval from the Review Committee for new FMP sites relates to any site where the residents will spend the majority (>51 percent) of their time. Additional sites the program uses to augment the continuity experience of the residents (and that do not serve as their main continuity site) do not need Review Committee approval. A program may utilize multiple sites that independently serve as the main FMP site for an individual resident [each satisfying Requirements II.D.2.c)-k)], yet the program may not assign an individual resident to more than one main site. Each of the FMPs serving as a main FMP site for residents requires individual approval by the Review Committee.
Resident Appointments	
Can a program accept a resident over the approved complement? *[Program Requirement: III.B.2.]*	To accept any residents over the approved complement, the program director must request a complement change electronically through the Accreditation Data System (ADS). When the Review Committee evaluates a program, it judges the adequacy of the resources in relation to the proposed resident complement. Of particular concern are the patient population, number of faculty members, and space in the FMP site.

Question	Answer
Educational Program	
How is substantial compliance determined for requirements that no longer include minimum numbers for resident deliveries (e.g., vaginal, spontaneous, continuity)? *[Program Requirement: IV.A.5.a).(1).(c).(iii)]*	The Committee expects that programs provide experiences that give residents the opportunity to acquire and demonstrate competence in prenatal, intra-partum, and postpartum care as described in the Program Requirements. The Committee allows flexibility to program directors and faculty members to develop a systematic process to determine that at the end of the 36-month program a resident is competent to practice family medicine independently. The Committee understands that while all programs are expected to be in substantial compliance with the Requirements, there may be programs that go beyond and offer areas of additional focus for those residents who desire added experience in various areas (such as maternity care). Programs will still report data relating to resident experiences in maternity care through ADS. The Committee will review data yearly to help determine whether minimum criteria are required in the future.
May a program provide rotational credit to a resident during an international rotation, and what documentation is required? *[Program Requirement: IV.A.6.]*	Although there is no specific language in the Program Requirements related to international rotations (broadly addressed under "Curriculum Organization and Resident Experience"), the Committee sees the following issue with regard to such rotations: (1) A decision for an *elective* international rotation is a decision between the program and the Sponsoring Institution (assurance of resident safety, etc.) and would not require prior review/approval by the Review Committee. A decision to allow international rotational experience (e.g., patient care experiences) by a resident *to satisfy minimum standards* requires prior review and approval by the Review Committee. The program must submit a request for credit for an international rotation experience, goals and objectives for the experience, names of physician faculty members responsible for on-site supervision, and an example of the evaluation for the experience.
Must family medicine faculty members accompany residents on home visits? *[Program Requirement: IV.A.6.a).(3)]*	No. Faculty members must be involved with residents regarding home visits, including reviewing charts, discussing the cases and any required follow-up, evaluating the residents, etc., but are not required to accompany residents on home visits with patients.

Question	Answer
What is the Committee's expectation regarding nursing home definitions and requirements, and are resident experiences at "skilled nursing facilities" or "skilled nursing units" acceptable toward meeting these requirements? *[Program Requirement: IV.A.6.a).(3)]*	The Review Committee recognizes that long-term care may include "temporary long-term care" and" ongoing long-term care." A skilled nursing facility or skilled nursing unit usually provides temporary long-term care, bridging inpatient care with dismissal to home management, or movement to a nursing home setting. A skilled nursing facility may provide some portion, but not a majority of a resident's experience in long-term care.
May residents count experiences with patients during rural rotations toward the required 1650 FMP patient encounters? *[Program Requirement: IV.A.6.a).(5)]*	The Committee may consider continuity experiences in rural settings, but not if they are only episodic experiences with no evidence of a continuous/meaningful physician-patient relationship.
Must the supervising physicians in the FMP site be family physicians in order for those patient encounters to be counted toward the required 1650 patient encounters? *[Program Requirement: IV.A.6.a).(5)]*	Residents treating patients seen in the FMP site must be supervised primarily by members of the family medicine program faculty. Many programs employ non-family medicine physicians to assist in supervising subsets of the patient demographic seen in the FMP site. The program is responsible for ensuring that the overall approach to patient care within the FMP site is in line with standards and principles of family medicine, rather than a subspecialty focus. The expectation, therefore, is that the majority of the 1,650 patient encounters be supervised by family medicine program faculty members.
May residents count experiences with continuity patients seen in the hospital toward the required 1650 patient encounters in the FMP site? *[Program Requirement: IV.A.6.a).(5)]*	No. The expectation is that the 1650 be patients exclusive to the FMP site. A hospital as a setting does not fit that criterion.
How does the Committee define a patient encounter? *[Program Requirement: IV.A.6.a).(5)]*	A patient encounter is a meaningful interaction between a physician and a patient that includes a history, assessment, critical thinking, and care plan. An encounter is documented in the patient record for later reference.

Question	Answer
May a program consider meaningful patient encounters by residents outside of the FMP site (specifically, those patients seen during rural experiences, long-term care, etc.) toward meeting the minimum requirement of 1650 continuity patients? *[Program Requirement: IV.A.6.a).(5)]*	The term “Family Medicine Practice” was consciously chosen, not to replace the Family Medicine Center (FMC), but to acknowledge that family physicians care for patients, populations, and communities beyond the walls of the FMC. The FMP site should provide the experience a resident needs in comprehensive and continuous care, as well as in population health. Additionally, residents may gain experience in areas of specialty care through subpopulations of patients seen as part of the FMP site. For patients to count as continuity patients, they must be seen by the same resident over a significant period of time (i.e., six months). Long-term care patients would meet this requirement, but a patient seen more than twice in a one-month rural rotation would not.
May residents count ambulatory pediatric patient encounters towards the required 165 FMP pediatric patient encounters? *[Program Requirement: IV.A.6.a).(5).(b)]*	The Committee expects resident experiences that count towards the ambulatory pediatric patient requirements to be above and beyond the total required 165 FMP patient encounters.
May residents count pediatric gynecologic patient encounters towards both the 125 (gynecology) and the 165 (pediatric FMP numbers)? *[Program Requirements: IV.A.6.a).(5).(b) and IV.A.6.j)]*	No. Residents may not double-count pediatric gynecologic patient encounters.
May a program count the required 15 critical care patients toward the required 750 hospitalized adult patients? *[Program Requirements: IV.A.6.b).(1)-(2)]*	No. The 15 required critical care patients are distinct, and not to be included (no "double-counting") with the required 750 hospitalized adult patients for whom a resident must provide care.
What is the implication of the use of "and" versus "or" in relation to hours/months of certain patient exposure/experiences? *[Program Requirements: IV.A.6.b)-j)]*	The nature of these requirements is not to confine, but to allow for flexibility. Measurement of specific patient encounters is required or allowed to meet several requirements, providing programs the flexibility to design curricular experiences without time restrictions, yet ensuring adequate experience for each resident. If a requirement uses “and,” the program must document *both* hours *and* patient numbers; if a requirement uses “or,” the program may use either measurement.

Question	Answer
Are the resident encounters required for care of older patients and pediatric patients distinct and separate from the minimum required 1650 continuity patient encounters, and may didactic hours be included? *[Program Requirements: IV.A.6.d) and f)]*	Yes. The 125 are distinct and not to be included (no "double-counting") with the 1650 continuity patient total requirements. Didactic hours may be counted toward specific patient population (e.g., adult and pediatric) requirements. Meaningful resident encounters *beyond* the minimum for that specific population may be counted toward meeting the required 1650 continuity patient encounters. When reporting resident experience for care of the older or pediatric patient, either time (hours or months) or encounters must be used. Reporting a combination of time and encounters was not the intent and will not satisfy the minimum standard.
Can the time residents spend in the Pediatric Emergency Department be counted towards fulfilling the 200 hours of required clinical time in emergency medicine? *[Program Requirement: IV.A.6.e)]*	Yes. Time in the Pediatric Emergency Department can be counted towards fulfilling the emergency medicine requirement. However, if this experience is used to fulfill the pediatric requirement, it must not be used to also fulfill the emergency medicine 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.).
Can time spent caring for children in the urgent care setting be utilized to meet the required 75 hospital or "emergency setting" visits. *[Program Requirement: IV.A.6.e).(1)]*	The expectation is that residents have a minimum number of encounters with very ill children in order to prepare them for private practice following completion of the program. The Committee does not consider an urgent care setting in and of itself as satisfying the spirit of the requirement. However, the program does have some flexibility to determine what constitutes a very sick pediatric patient, as well as the specific urgent care setting (as these might vary considerably based on region, severity of patients seen, etc.). Therefore, the Committee does not recommend that the urgent care setting be the *only* option for meeting this requirement. If, however, the program director can make the argument based upon the patients seen and the type of setting, etc., it might serve to satisfy some of the required experiences.
What does the Committee consider compliant with respect to age, and in particular, to the age of pediatric patients? *[Program Requirements: IV.A.6.e) and IV.A.6.e).(1)]*	The Committee allows flexibility with respect to actual age classification for the pediatric patient that is consistent with local standards.

Question	Answer
Does the Committee have a preferred method of tracking in order to provide evidence of compliance with the requirement for 75 Pediatric Emergency Department visits? *[Program Requirement: IV.A.6.e).(2)]*	The Committee understands the burden of tracking various patient encounters, yet also holds the program director responsible for compliance with the requirement. However, the Committee does not prescribe the method to track the experiences, allowing programs flexibility with their methods.
What are the expectations for resident experiences while in the operating room? *[Program Requirement: IV.A.6.h).(1)]*	A resident in the operating room should be actively participating in the procedure being conducted, such that he or she gains knowledge of the involved anatomy, acquires proper surgical techniques, and understands the pathophysiology, as well as the potential complications associated with it.
What are the Committee's criteria for a structured sports medicine experience? *[Program Requirement: IV.A.6.i).(1)]*	A structured experience in sports medicine should include specific patient care experience in a clinical setting, conduction of pre-participation physical examinations, team and event coverage, and didactic activities that augment the patient care activities.
What supervision is required during deliveries? *[Program Requirement: IV.A.6.k)]*	There must be on-site supervision in the delivery suite/labor deck by a family physician, an obstetrician, a senior resident in an ACGME-accredited obstetrics and gynecology program, a certified nurse midwife, or a third-year family medicine resident with documented delivery experience. When a resident provides direct supervision, there must be on-site physician faculty member supervision immediately available at the hospital.
What constitutes acceptable on-site supervision for a PGY-1 resident caring for a low-risk pregnant woman in labor? *[Program Requirement: IV.A.6.k)]*	Acceptable supervision for a resident who is providing care for such a patient includes: (a) a physician with privileges for providing obstetric labor and 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.
Does the omission of specific procedural competency suggest that the Committee does not consider procedural competence as a critical component to the practice of family medicine? *[Program Requirements: IV.A.6.r).(1).(a)-(b)]*	No. As the list of procedures performed by the practicing family physicians varies based upon the needs of the community, the program directors and members of the faculty should develop a list of required procedures based upon the needs of their FMP site and recommendations of organizations, such as the American Academy of Family Physicians (AAFP), the Society of Teachers of Family Medicine (STFM), and the Association of Family Medicine Residency Directors (AFMRD).

Question	Answer
The Learning and Working Environment	
What are some examples of indirect supervision and oversight? *[Program Requirements: VI.A.2.c).(2)-VI.A.2.c).(3)]*	**Indirect supervision with direct supervision immediately available:** The resident is seeing patients in the FMP site 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. **Indirect supervision with direct supervision available:** 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 physician faculty member determines additional assistance is needed, he or she is available and able to go to the hospital and see the patient together with the resident. **Oversight:** A resident is seeing a patient in either a 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, as well as evaluate the resident.
May patient encounters during internal moonlighting count toward the required 1650 encounters? *[Program Requirement: VI.F.5.]*	No. Resident experiences while moonlighting (internal or external) may not be used to meet minimum accreditation requirements.
Under which circumstances can a first-year resident be supervised indirectly with supervision immediately available? *[Program Requirement: VI.A.2.e).(1).(a)]*	Programs must assess the independence of each first-year resident based upon the six Core Competencies in order for a given resident to progress to indirect supervision with direct supervision immediately available. Various required experiences may necessitate different sets of skills. For example, if a resident is deemed to have progressed to indirect supervision with direct 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.

Question	Answer
Who should be included in interprofessional teams? *[Program Requirement: VI.E.2.]*	Nurses, physician assistants, advanced practice providers, pharmacists, social workers, 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.
Other	
What is the timetable for submission of an application for a new program?	The process for a new program application takes approximately 12 months from the time the application is received by the Review Committee staff until the Review Committee evaluates the application. Programs are advised to consult the Match and ERAS for their deadlines. A site visit will be scheduled. When the site visit report is submitted by the field representative, the file will be prepared for consideration by the Review Committee. Residents should not be appointed prior to achievement of Initial Accreditation by the program.
Can an accredited program move from one hospital to another?	The Executive Director of the Review Committee should be informed of such plans, and will advise the program regarding the steps that must be followed. A program is accredited as it was constituted at the time of its last review. It may not be "moved" without Review Committee approval. If a sponsoring entity wants to relocate a residency program from one hospital to another, it may be required to undergo a site visit. If the existing primary clinical site 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 currently in the program must be considered.

Question	Answer
How can the Sponsoring Institution for a program be changed?	In order to change the sponsor of a core program, a letter signed by the designated institutional officials (DIOs) 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. Questions should be addressed to the Executive Director of the Review Committee, as well as to the Senior Vice President of the Department of Field Activities, both at the ACGME. Contact information can be found on the ACGME website.
What is the process for a merger of two programs to form a new program?	Contact the Executive Director of the Review Committee to discuss the type of merger and how to describe it for the Review Committee's consideration. Two programs will be combined to form a new entity. Documentation describing the proposed combined program will be required. The Executive Director will advise whether a site visit will be required prior to Committee review of the proposal. A request for voluntary withdrawal of accreditation, and the date of closure, must be submitted through ADS by each of the currently-accredited programs. The newly constituted program will be issued a new ACGME program number.

Question	Answer
What is the process for a merger of two programs keeping one program intact?	Contact the Executive Director of the Review Committee to discuss the type of merger and how to describe it for the Review Committee's consideration. 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. Program #2 will submit a request for voluntary withdrawal of accreditation with the date by which current residents will complete their education in that program. This must be co-signed by the DIO of that program's sponsoring entity. The Executive Director will advise whether the changes necessitate a site visit prior to Committee review of the proposal. Unless the changes are so extensive that the Committee considers the finished product to be a new program, Program #1 will retain its current ACGME program number and accreditation status.
Where and how should non-family medicine faculty members be listed in the ADS Annual Update?	After all of the family medicine faculty members in a program have been entered, identify the individuals responsible for teaching family medicine 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 American Board of Medical Specialties certification information for all faculty members.
How should a family medicine faculty member who also teaches geriatric medicine or another subspecialty be listed in the ADS Annual Update?	The ADS Annual Update should contain the individual's primary specialty information (ABFM certification date) along with information on the most recent date of subspecialty certification.

Question	Answer
Will previously AOA-approved fellowships that have achieved ACGME accreditation be permitted to continue to appoint fellows whose prerequisite residency program was AOA-approved, and not ACGME-accredited?	During the transition to the single accreditation system, AOA-approved fellowships will be working through the ACGME accreditation process while continuing to recruit fellows for upcoming academic years. These programs may wish to consider applicants from AOA-approved residency programs, as they have traditionally done. Applicants may be in programs with a status of pre-accreditation or continued pre-accreditation or may be in programs that have not yet applied for ACGME accreditation. The Common Program Requirements require that prerequisite clinical training be completed in an ACGME-accredited program. During the transition, the Review Committee for X will permit AOA-approved programs that have achieved ACGME accreditation to appoint fellows whose prerequisite training was completed in an AOA-approved program that is not ACGME-accredited. Eligibility for and completion of ACGME-accredited programs does not guarantee eligibility for board certification. Board certification eligibility is determined by the individual certifying boards. Questions regarding eligibility for ABMS member board certification should be directed to the appropriate ABMS member board; questions about AOA certification should be directed to the appropriate AOA specialty certifying board.