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

Question	Answer
Oversight	
Are there exceptions to the limit of one hour of travel time between the primary clinical site and participating sites? *[Program Requirement: I.B.5.]*	Exceptions may be considered depending upon the circumstances. Specifically, the Review Committee expects to see written verification from programs that they provide housing at the distant site, and/or that such experiences do not require excessive travel regularly (i.e., educational experience that requires greater than one hour of travel, but infrequent and with shift lengths that allow appropriate rests with the travel time considered).
What should the makeup of the Family Medicine Practice (FMP) advisory committee be, and if a program has more than one FMP and those FMPs are in proximity, can the advisory committee be shared? *[Program Requirement: I.D.1.h)]*	The FMP advisory committee must have community members and clinical leaders whose role is to assess and address the needs of the community cared for by the FMP. The intent of the requirement is to encourage a mixture of individuals using FMP services (patients, caregivers, family members), residents, faculty members, and care delivery leaders. Each FMP should have a unique advisory committee. For example, programs with three FMPs should have three separate advisory committees. Similarly, Federally Qualified Health Center (FQHC) boards with 51 percent community membership meet this requirement if the functions of assessing and addressing the needs of the FMP community are part of the work of the board, and only one FMP is supported by that board.
Personnel	
What is the difference between administrative time for the program director and devoted time for core faculty members? [*Program Requirement: II.A.]*	Starting July 1, 2024, administrative time for program directors is defined differently than it is for core faculty members. For program directors, this is time spent *only* doing administrative tasks and does not include precepting, resident supervision, scholarly activity, or their own direct patient care. For core faculty members, devoted time includes all time spent doing work for the residency outside of their own direct patient care. Therefore, devoted time for core faculty members includes administration, scholarly activity, and resident supervision, including precepting.
Can faculty members who are not family physicians or who are not physicians be considered in calculating the core faculty requirement?	Faculty members who are not family physicians may be core faculty members, but only core faculty members who are family physicians meet this requirement. Non-family physician faculty members may be core faculty, but they do not count toward the required number in program requirement II.B.4.b).

<table>
<tr><th>Question</th><th>Answer</th></tr>
<tr><td>[Program Requirements: II.B.4.c)-e)]</td><td></td></tr>
<tr><td>How should programs with a resident complement not equally divisible by four (or six for programs with less than 13 residents) meet the core family medicine physician faculty requirement?

[Program Requirement: II.B.4.b)]</td><td>The number of core family medicine physician faculty members is determined by program size and outlined in the table below. This detail requirement specifies the number of family medicine physicians who satisfy program requirement II.B.4., including corresponding Background and Intent, for core physician faculty.
<table>
<tr><th>Number of Residents</th><th>Required Core Faculty Members</th></tr>
<tr><td>0-8</td><td>1</td></tr>
<tr><td>9-12</td><td>2</td></tr>
<tr><td>13-15</td><td>3</td></tr>
<tr><td>16-19</td><td>4</td></tr>
<tr><td>20-23</td><td>5</td></tr>
<tr><td>24-27</td><td>6</td></tr>
<tr><td>28-31</td><td>7</td></tr>
<tr><td>32-35</td><td>8</td></tr>
<tr><td>36-39</td><td>9</td></tr>
<tr><td>40-43</td><td>10</td></tr>
<tr><td>44-47</td><td>11</td></tr>
<tr><td>48-51</td><td>12</td></tr>
</table></td></tr>
<tr><td>Can faculty members who are not family physicians or who are not physicians be core faculty?

[Program Requirements: II.B.4.c-e)]</td><td>Non-family physicians and non-physicians can be core faculty members if they meet the hours requirements as specified in requirements II.B.4., II.B.4.c) or d), and II.B.4.e).

If the program director determines that a psychologist, pharmacist, non-family physician, or other health professional is a core faculty member, then that person should devote the percentage of time for teaching, administration, scholarly activity, and supervising resident patient care, as noted in II.B.4., II.B.4.c) or d), and II.B.4.e).</td></tr>
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Question	Answer
How much non-clinical dedicated time is required for core faculty members? *Program Requirements: II.B.4.c)-e)]*	The core faculty time requirements address the role and responsibilities of core faculty members, inclusive of both clinical and non-clinical activities, and the corresponding time to meet those responsibilities. The requirements do not address how this is accomplished, and do not mandate dedicated or protected time for these activities. Programs, in partnership with their Sponsoring Institutions, will determine how compliance with the requirements is achieved.
Who should serve as a role model for residents in inpatient adult care, maternity care, and other locations outside of the FMP? *[Program Requirements: II.B.1.c), II.B.1.d).(1)-(3)]*	All accredited family medicine programs must have a family medicine physician faculty member role modeling inpatient medicine. Programs providing maternity care competency training to the level of independent practice must have a family medicine physician role modeling this care. Core or non-core family medicine physician faculty members who satisfy program requirement II.B.4., including the corresponding Background and Intent, can serve in this role. There may be separate individuals for each subcomponent of this requirement. For example, there may be a non-core family medicine physician faculty member role modeling inpatient care of adults and another role modeling maternity care.
What qualifications are acceptable for faculty members dedicated to the integration of behavioral health? *[Program Requirement: II.B.2.h.)]*	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, and experience in behavioral health.
Educational Program	
Will the Review Committee expect incoming PGY-2 and PGY-3 residents to provide care for a minimum of 1650 patient encounters in the FMP site?	The 1650 continuity visit requirement will be applied to 2023 graduates. For graduates of 2024 and beyond, the Committee will be considering FMP visit volume, hours, and continuity in its assessment of the learning environment of the FMP and expects programs to do the same. The number of visits a resident has in the FMP is one of the components used by the committee to assess the learning environment for this competency. Programs can use the previous 1650 visit requirement as one measure of competence in this domain, even though it no longer will be cited by the committee.
What are the Committee's expectations regarding educational experiences and how should they be documented or verified? *[Program Requirements: IV.C.1.a)-c)]*	An educational experience is defined as a planned learning activity that is an integrated component of the overall curriculum; is developed around a set of competencies with tailored learning objectives and with significant input from program faculty members; includes an experiential aspect to learning (if the number of patient encounters is not otherwise specified); is supervised; has evaluation (including reflection) and feedback mechanisms; and is of sufficient length (if length is not otherwise specified) and content to ensure residents achieve the desired competencies. The documentation and verification of

Question	Answer
	experiences should be done utilizing the same tools used to assess the resident's learning experience.
Will a skilled nursing facility or skilled nursing unit satisfy the long-term care requirement? *[Program Requirement: IV.C.3.c).(5).(a)]*	The Review Committee recognizes that long-term care may include both temporary 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 the majority of, a resident's experience in long-term care.
How will the Review Committee utilize the FMP clinic data collected in the Accreditation Data System (ADS) now that there is no longer a requirement for 1650 visits? *[Program Requirement: IV.C.3.c).(5).(b)]*	The Review Committee adheres to the view that the "practice is the curriculum" and that programs must ensure a robust learner experience in the FMP. Volume of exposure is important; however, volume alone is inadequate for development or assessment of competence. The Committee believes that 1650 visits remains a reasonable goal for programs; however, programs will not be cited for not meeting 1650. Programs with a low resident clinic visit count will prompt the Committee to do a more holistic review of the FMP learning environment. Data collected in ADS about the resident experience in the FMP will help inform the Review Committee about the program's ability to facilitate competency development. The family medicine-specific questions in ADS related to the FMP will include the data needed to assess the program requirements related to FMP continuity, panel management, and hours.
What is the implication of using "and" versus "or" regarding hours/months of certain patient exposures/experiences? *[Program Requirements: IV.C.3.i), IV.C.3.j), IV.C.3.k), IV.C.3.l)]*	The nature of these requirements is to allow for flexibility in designing curricular experiences without time restrictions, while 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 can use either measurement.
Can time spent caring for children in the urgent care setting be used to meet the required 50 hospital or emergency setting visits? *[Program Requirements: IV.C.3.g) and IV.C.3.k)]*	The expectation is that residents have a minimum number of encounters with acutely ill children and adults to prepare them for independent practice. 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 an acutely ill pediatric and adult patient, as well as the specific urgent care setting (as these might vary considerably based on region, severity of patients seen, etc.).

Question	Answer
How should programs demonstrate compliance with the requirement for 50 emergency department encounters with children? *[Program Requirement: IV.C.3.g)]*	The Committee does not prescribe the method to track the experiences, allowing programs flexibility.
What types of care should be counted toward the 1,000-hour continuity requirement? *[Program Requirement: IV.C.3.c).(5).(b).(i)]*	The Review Committee expects this requirement will be met by the scheduled hours residents spend providing in-person (direct) or telemedicine (virtual) care to patients in the resident's continuity clinic (FMP). It does not include time outside the FMP doing indirect patient care activities such as charting, inbox management (managing labs/referrals/patient messages, etc.), shadowing, population health panel management, or patient encounters performed outside of the FMP. The Committee expects programs to track and report individual resident hours in the FMP.
How should patient-sided continuity be calculated? *[Program Requirement: IV.C.3.c).(5).(b).(ii)]*	Patient-sided continuity is the percentage of FMP visits that resident-paneled patients have with their resident primary care physician. The 30 percent and 40 percent continuity requirement will be calculated from the visits that occurred during the PGY-2 and PGY-3 levels, respectively. Patient primary care physician assignment at the time of the visit should be used to determine continuity. Individual resident (not team) continuity will be assessed. For example: PGY-3 Resident A has a panel of 300 patients who have a total of 1,000 visits to the FMP during the PGY-3, and 600 of these visits are with Resident A. Resident A's PGY-3 patient-sided continuity is 600/1,000 x 100 = 60 percent. The Committee will ask programs to provide individual resident visit and panel data in ADS and will aggregate data to assess the learning environment in this domain.
How should resident-sided continuity be calculated? *[Program Requirement: IV.C.3.c).(5).(b).(iii)]*	Resident-sided continuity is the percentage of visits a resident has with patients on their panel. The 30 percent and 40 percent continuity requirements will be calculated from the visits that occurred during the PGY-2 and -3 respectively. Patient Primary Care Physician assignment at the time of a visit should be used to determine continuity. Individual resident (not team) continuity will be assessed. Example: R3 B had 1,000 visits in the FMP during the R3 year and 500 of those were with patients on the resident's panel. This resident's R3 resident-sided continuity is 500/1,000 X 100 = 50 percent. The Review Committee will ask the program to provide individual resident visit and panel data in ADS and will aggregate the data to assess the learning environment in this domain.

Question	Answer
What is considered an “active patient” on a resident’s panel? *[Program Requirement: IV.C.3.c).(5).(b).(iii)]*	The Committee has not specified parameters of empanelment, such as “active patient.” Active patients are traditionally defined as those patients who have been seen in the FMP within a specific time. Only patients with FMP visits within this time are included in the clinician’s panel. The conventional look-back period ranges from 18-36 months (24 months is common). The program will determine the appropriate time by balancing the comprehensiveness and accuracy of population management with resident education and training and patient care.
What empanelment and continuity data should programs measure and report in ADS? *[Program Requirements: IV.C.3.c).(5).(b).(ii)-(iii)]*	Programs report individual resident visit and panel data for active patients in ADS. This data includes individual resident PGY-1, -2, and -3 yearly panel size (total, under 18 years, over 65 years), total panel visits, panel visits with resident primary care physician, total resident visits, and residents’ visits with patients on their panel. The Committee will review individual resident and aggregate data to assess the learning environment in this domain. The ACGME will indicate when panel data should be reported in ADS for each program.
What are the suggested targets for resident panel size? *[Program Requirement: IV.C.3.c).(5).(b).(vi)]*	The Committee has not specified resident panel size. The appropriate panel size may be determined by utilizing measures of resident clinic access, the amount of time the resident is in clinic, the interplay between patient- and resident-sided continuity, and the exposure necessary for resident competence in the FMP. The correct panel size will be the number that best fits these measures and is expected to vary across programs. Minimum and maximum panel sizes may be defined in future requirements.
Do visits or hours in the FMP count toward program requirements other than those related to FMP continuity? *[Program Requirement: IV.C.3.c).(5)]*	A program may not double count hours or visits in the FMP to meet more than one requirement. Curriculum experiences (hours or visits) in the FMP can fulfill non-continuity requirements only if they are additional experiences separate from their continuity clinics. For example, programs may not count hours or visits caring for older adults in the FMP (IV.C.3.l)) if they are also part of the 1,000-hour FMP continuity experience (IV.C.3.c).(5).(b).(i)). This applies to other similar requirements such as ambulatory pediatrics (IV.C.3.f)) and gynecology (IV.C.3.h)).
Must family medicine faculty members accompany residents on home visits? *[Program Requirement: IV.C.3.c).(5)]*	Indirect supervision is permitted for home visits in the appropriate context, with faculty members reviewing charts, discussing cases and any required follow-up, evaluating residents, etc., but are not required to accompany residents on home visits with patients. They must, however, be available for consultation and/or assistance during the visit.

Question	Answer
Why is there a requirement to count 20 vaginal deliveries rather than attesting to competence in delivery care? *[Program Requirement: IV.C.3.i).(1).(b)]*	The Review Committee understands that competency development and assessment of learner competence cannot be based solely on volume of experiences. The cognitive, psychomotor, and communication skills and knowledge expected of all family physicians for management of labor and delivery requires an adequate exposure to the variety of situations and complications that may occur. Using expert opinion and looking at the scope of delivery numbers across the country, the Committee determined that 20 was the minimum number required to have at least an adequate exposure volume.
How can a program meet the requirement for time and encounters with older adults? *[Program Requirement: IV.C.3.l)]*	This program requirement specifies time (100 hours or one month) and patient encounters (125) with older adults (older than 65). Both the time and encounter requirements must be met with experiences that are unique to this requirement and not double counted with other aspects of the curriculum. Examples of experiences that would satisfy this requirement include learning in long-term care facilities, home visits, inpatient facilities, care provided in the FMP, and geriatric assessments. These experiences should be part of a curricular experience as defined in the FAQ for IV.B.1.b).(1).(a).(ii).
Given the move to competency-based medical education, why does the Review Committee require counting visit numbers for curricular areas such as geriatrics?" *[Program Requirements: IV.A.1-5., IV.B.1.a).(1).(f), IV.B.1.b).(1).(a).(ii), IV.B.1.b).(1).(a).(iii), IV.B.1.b).(1).(a).(iv), IV.B.1.b).(1).(a).(xv), IV.B.1.e).(2), IV.B.1.f).(2), IV.C.1., IV.C.3.c).(5), IV.C.3.c).(5).(a), IV.C.3.c).(5).(b).(v), IV.C.3.l)]*	Resident competence is determined by the residency program and is not the purview of the Review Committee. The Committee assesses whether the program provides residents with the clinical and educational experiences needed for attainment of the required competencies. Programs are expected to demonstrate that the learning environment includes the educational components, curriculum organization, resident experiences, scholarship, and assessment in the volume and comprehensiveness required for graduates to attain competence as outlined in the Program Requirements, reported in ADS, and assessed during site visits. Numbers of visits and hours of education and training are only one way used to assess a program's learning environment. Regarding the example of competence in geriatrics, the Program Requirements specify the educational components, curriculum organization, and experiences that the program must provide. The Review Committee will evaluate the program's geriatric learning environment by assessing these specific program requirements. The program director will assess and attest (as applicable) to resident competence in this domain, per the curriculum and the program's system of assessment, to report geriatric competence to the applicable licensing bodies, specialty boards, and organizational privileging committees.

Question	Answer
How should programs design and implement elective experiences? *[Program Requirement: IV.C.3.u)]*	Elective experiences should be driven by individualized learning plans, address future practice goals, and require resident-specific pre-planning of each elective. The assessment tools can include resident self-assessment and reflection on needs met with the planned elective rotation. Standard assessment tools can also be used such as those found in the Milestones page of the ACGME website. Overview (acgme.org) Programs may create a list of electives that meet the learning goals and competencies of the curriculum. The Committee has not set criteria for the number of experiences created by programs or the residents. Programs may utilize elective time to address learning gaps for residents not meeting competency goals, areas of concentration, or tracks. For programs that do not utilize traditional block scheduling, 600 hours is considered the equivalent of six months. Programs are encouraged to use their Program Evaluation Committee to build, evaluate, and improve the elective experience.
The Learning and Working Environment	
What are the expectations of the Committee with respect to faculty members precepting the resident via teleconference? *[Program Requirement: VI.A.2.]*	It is the responsibility of the program and institution to ensure that in situations in which a faculty member is precepting via telemedicine (resident has the face-to-face encounter with patient), there is either direct or indirect supervision available to the resident as needed, as compliance with the supervision requirements still applies.
What are some examples of indirect supervision? *[Program Requirement: VI.A.2.b).(2)]*	**Indirect supervision with direct supervision immediately available:** The resident is seeing patients in the FMP 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, the faculty member is available and able to go to the hospital and see the patient together with the resident

Question	Answer
Who should be included on the interprofessional teams? *[Program Requirement: VI.E.2.]*	Examples of professional personnel who may be part of the interprofessional teams include nurses, physician assistants, advanced practice providers, pharmacists, social workers, psychologists, dentists, occupational and physical therapists, and care coordinators.
Can patient encounters during internal moonlighting count toward the required 1,650 encounters? *[Program Requirements: IV.C.4.e) and VI.F.5.-VI.F.5.c)]*	No. Resident experiences while moonlighting (internal or external) may not be used to meet minimum accreditation requirements.
Other	
What is the timetable for review of an application for a new program?	The review process for a new program application takes approximately 12 months from the time the application is received by the ACGME until the Review Committee evaluates the application. Programs should consult the National Resident Matching Program (NRMP) and Electronic Residency Application Service (ERAS) for their deadlines. Upon receipt of the application by the ACGME, an accreditation application site visit will be scheduled. Once the Site Visit Report is submitted, the file will be prepared for consideration by the Review Committee at its next available meeting. Residents should not be appointed prior to accreditation of the program.
Can an accredited program move from one hospital to another?	The Review Committee executive director 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 Institution wants to relocate a residency program from one hospital to another, a site visit may be required. If the primary clinical site wants to retain the program, the issue should 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 a program's Sponsoring Institution 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 Sponsoring Institution and the accepting Sponsoring Institution 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 in ADS as appropriate. Questions should be addressed to the Review Committee executive director and the executive director of the Institutional Review Committee. Contact information can be found on the ACGME website.
What is the process for merging two programs?	Contact the Review Committee executive director to discuss the type of merger and how to describe it for the Review Committee's consideration. When two programs combine to form a new entity, documentation describing the proposed combined program is 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 using ADS by each of the currently accredited programs. The newly constituted program will be issued a new ACGME 10-digit program number.
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; orthopaedic surgery; sports medicine; emergency medicine; neonates, infants, children, and adolescents; older patients; and skin. Provide the American Board of Medical Specialties (ABMS)/American Osteopathic Association (AOA) 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 (American Board of Family Medicine (ABFM) or American Osteopathic Board of Family Physicians (AOBFP) certification date) along with information on the most recent date of subspecialty certification.
How should programs determine changes to residents' curriculum or extension of their education and training when applying family leave policies (e.g., ABFM, institutional, health system)?	The decision of whether a resident does or does not extend education and training and which, if any, curricular adjustments are needed will be made by the program director with Clinical Competency Committee advice based on resident competence for advancement, autonomous practice at graduation, and individual resident learning needs. Refer to the ACGME Institutional Requirements, as well as the ABFM website

Question	Answer
[Program Requirement: VI.C.2.]	for details regarding leave and board eligibility.
Does patient simulation training count toward patient visit requirements?	Patient simulation training does not count toward patient visit requirements such as in program requirements IV.C.3.g).(1), IV.C.3.g).(2), IV.C.3.i).(1).(b), IV.C.3.i).(2), IV.C.3.j), IV.C.3.k), and IV.C.3.l).