



STATE OF WISCONSIN

Department of Safety and Professional Services
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MEDICAL EXAMINING BOARD MEETING
Room 121A, 1400 E. Washington Avenue, Madison
DSPS Contact: Tom Ryan (608) 261-2378
JULY 18, 2012

The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting items may be removed from the agenda. Please consult the meeting minutes for a summary of the actions and deliberations of the Board.

8:00 A.M.

OPEN SESSION

- 1. Call to Order – Roll Call**
- 2. Declaration of Quorum**
- 3. Introduction of New Board Member(s)**
- 4. Recognition of Board Member(s)**
 - a. Recognition of Dr. Raymond Mager (**insert**) (5-6)
 - b. Recognition of Dr. Sujatha Kailas (**insert**) (7-8)
- 5. Adoption of the Agenda (insert) (1-4)**
- 6. Approval of Minutes of June 20, 2012 (insert) (9-16)**
- 7. Case Presentations**

Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s) in the Matter of:

- a. Javier A. Rincon, MD - 12 MED 004 (131-138)
 - o Attorney Arthur Thexton
 - o Case Advisor – LaMarr Franklin
- b. James D. Hanna, MD – 12 MED 136 (139-150)
 - o Attorney Arthur Thexton
 - o Case Advisor – Raymond Mager
- c. Marta C. Muller, MD – 11 MED 131 (151-156)
 - o Attorney Arthur Thexton
 - o Case Advisor – Raymond Mager
- d. Bradley A. Bourkland, MD – 12 MED 069 (157-170)
 - o Attorney Kim Kluck
 - o Case Advisor – Carolyn Bronston

- e. John A. Kidd, MD – 10 MED 399 (171-176)
 - Attorney Kim Kluck
 - Case Advisor –
- f. Michael E. Brouette, PA-C – 10 MED 381 (177-188)
 - Attorney Pamela Stach
 - Case Advisor – Sujatha Kailas

8. Executive Director Matters

- a. Review Board Assignments for Screening and Exams (insert) (17-18)
- b. Other

9. Items Received After Mailing of Agenda

- a. Presentation of Proposed Stipulations and Final Decisions and Orders
- b. Presentation of Proposed Decisions
- c. Presentation of Interim Orders
- d. Petitions for Re-hearing
- e. Petitions for Summary Suspension
- f. Petitions for Extension of Time
- g. Petitions for Assessments
- h. Petitions to Vacate Orders
- i. Requests for Disciplinary Proceeding Presentations
- j. Motions
- k. Appearances from Requests Received or Renewed
- l. Speaking Engagement, Travel and Public Relation Requests
- m. Application Issues
- n. Examination Issues
- o. Continuing Education Issues
- p. Practice Questions

10. Items for Board Discussion

- a. Board Consideration of Council Appointments (insert) (19-40)
- b. FSMB Matters
- c. Maintenance of Licensure
 - 1. Maintenance of Licensure and Continuing Education – **TELEPHONE APPEARANCES 9:00 A.M. – LANCE TALMADGE, MD, FSMB Board Chair; HUMAYAN CHAUDHRY, DO, FSMB Chief Executive Officer; FRANCES CAIN, FSMB Director – Post Licensure Assessment System (PLAS)** (insert) (41-58)
- d. Chapter MED 8 Update
- e. Chapter MED 10 Discussion
- f. Legislative Report
- g. ACGME-International (insert) (59-126)
- h. Medical Board Newsletter
- i. Board Outreach

11. Screening Panel Report

12. Informational Item(s)

- a. Appointment Notice – Timothy Westlake, MD (insert) (127-128)
- b. Appointment Notice – Mary Jo Capodice, DO (insert) (129-130)

13. Public Comment(s)

14. New/Other Business

CLOSED SESSION

CONVENE TO CLOSED SESSION to deliberate on cases following hearing (Wis. Stat. § 19.85 (1) (a)); consider closing disciplinary investigation(s) with administrative warning(s) (Wis. Stat. § 19.85 (1) (b), and Wis. Stat. § 440.205); consider individual histories or disciplinary data (Wis. Stat. § 19.85 (1) (f)); and to confer with legal counsel (Wis. Stat. § 19.85 (1) (g)).

CS-1 Deliberation of Stipulation(s), Final Decision(s) and Order(s) in the Matter of:

- a. Javier A. Rincon, MD - 12 MED 004 (insert) (131-138)
 - o Attorney Arthur Thexton
- b. James D. Hanna, MD – 12 MED 136 (insert) (139-150)
 - o Attorney Arthur Thexton
- c. Marta C. Muller, MD – 11 MED 131 (insert) (151-156)
 - o Attorney Arthur Thexton
- d. Bradley A. Bourkland, MD – 12 MED 069 (insert) (157-170)
 - o Attorney Kim Kluck
- e. John A. Kidd, MD – 10 MED 399 (insert) (171-176)
 - o Attorney Kim Kluck
- f. Michael E. Brouette, PA-C – 10 MED 381 (insert) (177-188)
 - o Attorney Pamela Stach

CS-2 Deliberation of Proposed Administrative Warning(s)

- a. 11 MED 121 (R.P.R., MD) (insert) (189-190)
 - o Attorney Kim Kluck
 - o Case Advisor – Raymond Mager
- b. 11 MED 196 (F.S., MD) (insert) (191-192)
 - o Attorney Kim Kluck
 - o Case Advisor – Raymond Mager

CS-3 Review and Reconsideration of Application for PAP – APPEARANCES 10:45 A.M. – M.A.G., MD, AND ATTORNEY MAUREEN MOLONY (insert) (193-216)

CS-4 Monitoring (insert) (217-218)

- a. Rudy V. Byron, Jr., MD – Request for full licensure (insert) (219-228)
- b. Alfred L. Neuhoff, MD – Request for full licensure – APPEARANCES 11:00 A.M. – ALFRED L. NEUHOFF, MD, AND ATTORNEY MARY LEE RATZEL (insert) (229-272)

CS-5 Case Closings (insert) (273-274)

CS-6 Consulting with Legal Counsel

Deliberation of Items Received in the Bureau after Preparation of Agenda

- a. Proposed Stipulations
- b. Proposed Decisions and Orders
- c. Proposed Interim Orders
- d. Objections and Responses to Objections
- e. Complaints
- f. Petitions for Summary Suspension
- g. Remedial Education Cases
- h. Petitions for Extension of Time
- i. Petitions for Assessments
- j. Petitions to Vacate Orders
- k. Motions
- l. Administrative Warnings
- m. Matters Relating to Costs
- n. Appearances from Requests Received or Renewed
- o. Examination Issues
- p. Continuing Education Issues
- q. Application Issues
- r. Monitoring Cases
- s. Professional Assistance Procedure Cases

Division of Enforcement – Meeting with Individual Board Members

Division of Enforcement – Case Status Reports and Case Closings

Ratifying Licenses and Certificates

RECONVENE INTO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

Voting on Items Considered or Deliberated on in Closed Session if Voting is Appropriate

New/Other Business

ADJOURNMENT

1:15 PM

CLOSED SESSION

Examination of 6 Candidates for Licensure – Drs. Osborn, Swan and Vasudevan

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: July 18, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Recognition of Ray Mager's Service on the Medical Examining Board	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Dr. Mager's appointment has been rescinded, concluding his tenure on the Board. The Board may wish to record its appreciation of Dr. Mager for his service.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

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**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted: 7/9/2012	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: July 18, 2012	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? Recognition of Sujatha Kailas' Service on the Medical Examining Board	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: A replacement has been named to fill Dr. Kailas' position on the Board. Recognition of Dr. Kailas' service to the Board.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

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**MEDICAL EXAMINING BOARD
MINUTES
JUNE 20, 2012**

PRESENT: Carolyn Bronston; LaMarr Franklin; Jude Genereaux; Sujatha Kailas, MD; Raymond Mager, DO; Gene Musser, MD; Sandra Osborn (joined at 8:37 a.m. by telephone), MD; Kenneth Simons, MD; Timothy Swan, MD; Sridhar Vasudevan, MD; Sheldon Wasserman, MD

EXCUSED: Rodney Erickson, MD

STAFF: Tom Ryan, Executive Director; Colleen Baird, Legal Counsel; Karen Rude-Evans, Bureau Assistant; other DSPS staff

GUESTS: Mark Grapentine, Wisconsin Medical Society; Anne Hletko, Council on Physician Assistants; Judy Warmuth, WHA; Scott Becher, Becher Group; Julie Doyle WAPA; Eric Jensen, WAPA, WI Society of Anesthesiologists

CALL TO ORDER

Dr. Sheldon Wasserman, Chair, called the meeting to order at 8:00 a.m. A quorum of eleven (11) members was confirmed.

ADOPTION OF AGENDA

Amendments:

- Under PRESENTATION OF PROPOSED STIPULATIONS (open session), add:
 - h. Bradley A. Bourkland, MD – 12 MED 069
 - Attorney Kim Kluck
 - Case Advisor – Carolyn Bronston
- Item CS-2 (closed session), DELIBERATION OF PROPOSED STIPULATIONS, Insert after page 132:
 - h. Bradley A. Bourkland, MD – 12 MED 069
 - Attorney Kim Kluck
- Item 9m (open session) – Discussion of ACGME-International, is removed from the agenda
- Item 10h (open session) – FAQ – Physician Delegation of Tasks Constituting the Practice of Radiography, is removed from the agenda
- Item CS-5 (closed session) – DELIBERATION OF RESPONDENTS’ OBJECTIONS TO ALJ ORDERS DENYING MOTIONS TO DISMISS IN THE DISCIPLINARY PROCEEDING S AGAINST IFTEKHAR H. BADER, MD, AND PAUL L. BERCE, MD, is removed from the agenda
- Case Status Report – insert at the end of the agenda in closed session

MOTION: Sujatha Kailas moved, seconded by Suresh Misra, to adopt the agenda as amended. Motion carried unanimously.

APPROVAL OF MINUTES OF MAY 16, 2012

MOTION: Suresh Misra moved, seconded by Kenneth Simons, to approve the minutes of May 16, 2012 as written. Motion carried unanimously.

PRESENTATION OF PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS

DOE Attorneys presented Proposed Stipulations, Final Decisions and Orders in the following disciplinary proceedings:

George Pfaltzgraff, MD	11 MED 125
Jerome E. Hutchens MD	11 MED 133
Naiyer Imam, MD	11 MED 323
Christina D. Jackson, RCP	12 MED 064
Leon Cass Terry, MD	10 MED 169
Robert C. Turner, MD	10 MED 324
Marta C. Muller, MD	11 MED 131
Bradley A. Bourkland, MD	12 MED 069

These items will be deliberated in closed session.

EXECUTIVE DIRECTOR MATTERS

Tom Ryan addressed the Open Meetings Law requirement to notice all agenda items a minimum of 24 hours prior to the start of the meeting.

Several Board appointments expire on July 1, 2012. Mr. Ryan will confer with these individuals.

ITEMS FOR BOARD DISCUSSION

DOE Policy Regarding Screening

Jeanette Lytle, DOE Attorney Supervisor and Intake and Monitoring Supervisor, addressed the Board regarding the DOE screening policy. The original policy was effective July 1, 2009 and allowed intake staff to close specific categories of cases prior to the screening panel. The policy has been revised to allow legal oversight and added a reporting component to the boards with the cases that were closed. The policy has been put on hold pending input from the boards. The Board asked for a copy of the policy and the report on the closed cases. Ms. Lytle stated the policy is always open for comments.

FSMB Matters/Maintenance of Licensure

Tom Ryan reported the FSMB will give a telephone presentation at the July 18 Board meeting regarding maintenance of licensure and continuing education.

Wis. Admin. Code MED 8 Update

Gene Musser reviewed Chapter MED 8 updates with the Board. Dr. Musser drafted rules regarding administrative supervision and clinical supervision and submitted them to Legal Counsel Sandy Nowack. This is still a work in progress.

Wis Admin. Code Chapter MED 10 Update

Sheldon Wasserman reported the Wisconsin Medical Society is working with DSPS staff on MED 10. This will be reviewed further at the July 18 Board meeting.

Legislative Report

The Pharmacy Examining Board is moving forward with the rules writing for the PDMP.

Council Appointments

Tom Ryan stated the Board needs to make appointments to several councils affiliated with the MEB. Mr. Ryan will email information to the Board members on the council vacancies. Board members were encouraged to contact individuals who may be interested in council appointments and to have them submit resumes. All resumes received by the agenda deadline will be included for review at the July 18 Board meeting.

Drug Overdoses

The Board reviewed the information from Randy Brown, MD, Assistant Professor, Department of Family Medicine, UWSMPH, regarding drug overdoses.

Medical Examining Board Newsletter

Tom Ryan and Jude Genereaux will review articles for the Newsletter and should have a draft available for the July Board meeting. Dr. Wasserman asked Dr. Vasudevan to develop a one page policy statement on opioid prescribing and drug overdoses. Legal Counsel Colleen Baird reminded the Board that the Governor's Office has a review process for all published items.

Board Outreach

Sandra Osborn has been asked to talk to the faculty at the Department of Pediatrics and the UW Medical School regarding maintenance of licensure. Sujatha Kailas provided Dr. Osborn with a PowerPoint presentation. Dr. Osborn will contact the Department of Pediatrics after the MOL presentation at the July 18 Board meeting.

Gene Musser will give a presentation regarding the MEB to the Rural Hospital Association meeting next week.

SCREENING PANEL REPORT

LaMarr Franklin reported fifty (50) cases were screened. Eighteen (18) cases were opened and thirty two (32) cases were closed.

INFORMATIONAL ITEMS

None.

PUBLIC COMMENTS

None.

OTHER BUSINESS

None.

NEW BUSINESS

None.

RECESS TO CLOSED SESSION

MOTION: Timothy Swan moved, seconded by Sridhar Vasudevan, to convene to closed session to deliberate on cases following hearing (Wis. Stat. § 19.85 (1) (a)); consider closing disciplinary investigation(s) with administrative warning(s) (Wis. Stat. § 19.85 (1) (b), and Wis. Stat. § 440.205); consider individual histories or disciplinary data (Wis. Stat. § 19.85 (1) (f)); and to confer with legal counsel (Wis. Stat. § 19.85 (1) (g)). Roll call: Carolyn Bronston-yes; LaMarr Franklin-yes; Jude Genereaux-yes; Sujatha Kailas-yes; Raymond Mager-yes; Gene Musser-yes; Sandra Osborn-yes; Kenneth Simons-yes; Timothy Swan-yes; Sridhar Vasudevan-yes; Sheldon Wasserman-yes. Motion carried unanimously.

Open session recessed at 9:26 a.m.

RECONVENE IN OPEN SESSION

MOTION: Suresh Misra moved, seconded by LaMarr Franklin, to reconvene in open session. Motion carried unanimously.

Open session reconvened at 12:39 p.m.

ITEMS VOTED ON DURING CLOSED SESSION

FULL BOARD ORAL EXAMINATION(S)

MOTION: Suresh Misra moved, seconded by Kenneth Simons, to grant a license to **Jennifer M. Sabatier, MD**, when all the requirements for licensure are met. Motion carried. Sridhar Vasudevan abstained.

PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS

MOTION: Raymond Mager moved, seconded by Kenneth Simons, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **George Pfaltzgraff, MD (11 MED 125)**. Motion carried unanimously.

MOTION: Carolyn Bronston moved, seconded by Gene Musser, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Jerome E. Hutchens, MD (11 MED 133)**. Motion carried unanimously.

MOTION: Suresh Misra moved, seconded by Raymond Mager, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Naiyer Imam, MD (11 MED 323)**. Motion carried. Timothy Swan abstained.

MOTION: Sujatha Kailas moved, seconded by LaMarr Franklin, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Christina D. Jackson, RCP (12 MED 064)**. Motion carried unanimously.

MOTION: Sridhar Vasudevan moved, seconded by Sujatha Kailas, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Leon Cass Terry (10 MED 169)**. Motion carried unanimously.

MOTION: Jude Genereaux moved, seconded by Raymond Mager, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Robert C. Turner, MD (10 MED 324)**. Motion carried unanimously.

Marta C. Muller, MD (11 MED 131) – No Board action was taken.

MOTION: Raymond Mager moved, seconded by Sridhar Vasudevan, to reject the Final Decision and Order in the disciplinary proceedings against **Bradley A. Bourkland, MD (12 MED 069)**. Motion carried unanimously.

PROPOSED ADMINISTRATIVE WARNING(S)

MOTION: Sujatha Kailas moved, seconded by LaMarr Franklin, to issue the Administrative Warning in case **11 MED 162 against respondent M.R., MD**. Motion carried unanimously.

MOTION: Sujatha Kailas moved, seconded by LaMarr Franklin, to issue the Administrative Warning in case **11 MED 162 against respondent A.R.R., MD**. Motion carried unanimously.

MOTION: Sujatha Kailas moved, seconded by LaMarr Franklin, to issue the Administrative Warning in case **11 MED 387 against respondent V.M.K., MD**. Motion carried unanimously.

CONSIDERATION OF COMPLAINT(S)

MOTION: Carolyn Bronston moved, seconded by Sujatha Kailas, to find probable cause to issue a complaint in the matter of **09 MED 197, 09 MED 305, 09 MED 335 and 09 MED 399**. Motion carried unanimously.

MONITORING

Frank J. Salvi, MD, and Attorney Lester Pines appeared before the Board. Attorney Jeanette Lytle appeared on behalf of the Department.

MOTION: Kenneth Simons moved, seconded by Timothy Swan, to deny the respondent's Motion for Reconsideration in the Matter of Disciplinary Proceedings against **Frank J. Salvi, MD, LS 0707201 MED**, on the basis that the requirements for the granting of a rehearing under 227.49(3) or to vacate or modify any legal or factual findings or conclusions or terms and conditions in the Order have not been satisfied:

- The motion is untimely;
- Respondent has not established a material error in fact or law;
- Respondent has not submitted newly discovered evidence sufficient to warrant reversal or modification of the Order which could not have been previously discovered.

Motion carried. Sandra Osborn and Sridhar Vasudevan were recused during presentations and deliberations and abstained from voting.

CASE CLOSINGS

MOTION: LaMarr Franklin moved, seconded by Kenneth Simons, to close case **12 MED 086 for no violation**. Motion carried unanimously.

MOTION: Sujatha Kailas moved, seconded by LaMarr Franklin, to close case **11 MED 311 for no violation**. Motion carried unanimously.

MOTION: Carolyn Bronston, moved, seconded Suresh Misra, to close case **11 MED 330 for no violation**. Motion carried unanimously.

MOTION: Kenneth Simons, moved, seconded Sujatha Kaila, to close case **11 MED 401 for insufficient evidence**. Motion carried. Timothy Swan abstained.

MOTION: Timothy Swan, moved, seconded Kenneth Simons, to close case **12 MED 037 for no violation**. Motion carried. Sridhar Vasudevan opposed.

MOTION: LaMarr Franklin, moved, seconded Carolyn Bronston, to close case **12 MED 045 for insufficient evidence**. Motion carried unanimously.

RATIFY ALL LICENSES AND CERTIFICATES

MOTION: Sujatha Kailas moved, seconded by Gene Musser, to ratify all licenses and certificates as issued. Motion carried unanimously.

OTHER BUSINESS

None.

ADJOURNMENT

MOTION: Sujatha Kailas moved, seconded by Jude Genereaux to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 12:41 p.m.

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**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted: July 1, 2012	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 7/18/2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Executive Director Matters - Review of Screening and Exams Assignments	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Review assignments and add members where necessary.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

MEB ASSIGNMENTS

SCREENING

July	Bronston, Swan, Vasudevan
August	Franklin, Osborn, Simons
September	Bronston, Misra, Vasudevan
October	Genereaux, Kailas, Simons
November	Bronston, Wasserman, *
December	Genereaux, Kailas, Simons

***Need another screener to replace Dr. Mager.**

EXAMS

July	Osborn, Swan, Vasudevan, *
August	Osborn, Simons, Swan, *
September	Kailas, Osborn, Vasudevan, *
October	Kailas, Osborn, Simons, Swan
November	Misra, Osborn, Wasserman, *
December	Osborn, Simons, Wasserman, *

***Need another examiner to replace Dr. Mager.**

**State of Wisconsin
Department of Safety & Professional Services**

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3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: July 18, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Consider Council Appointments	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Attached are letters and resumes for three candidates for the Council on Physician Assistants. Two positions need to be filled; one must be a PA educator, the other a PA. Also attached is the resume of a perfusionist, to fill a position on the Perfusionist Examining Council. The Board should review the materials and make a decision as to the appointments.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

Ryan, Thomas - DSPS

From: Doyle, Julie A. [jadoyle@phci.org]
Sent: Monday, June 25, 2012 9:25 PM
To: Ryan, Thomas - DSPS
Subject: Julie A1
Attachments: Julie A1.xml

Dear Tom:

It was a pleasure to meet you at the MEB meeting on Wednesday. As I mentioned, I am interested in a position on the PA Council. I have been a PA in Wisconsin for 17 years. My primary job has been in family practice but I have experience in emergency medicine as well. I've also been a preceptor to many students from both UW-Madison and Marquette. I've been active in WAPA and am currently a member of the LGA committee. I have a broad range of interests and experience that I would like to bring to the PA Council. My resume is attached. Thank you for your consideration.

Sincerely,

Julie A. Doyle, PA-C
262-395-3089 cell
262-363-1900 work
jadoyle126@att.net

This information is confidential and intended solely for the use of the individual or entity to whom it is addressed. If you have received this email in error please notify the sender or our Customer Support Center at (262) 928-2777. We have scanned this e-mail and its attachments for malicious content. However, the recipient should check this email and any attachments for the presence of viruses. ProHealth Care accepts no liability for any damage caused by any virus transmitted by this email.

Julie A. Doyle, PA-C
20935 Coventry Dr.
Brookfield, WI 53045
262-821-3810
jadoyle126@att.net

Education:

UW-Madison Physician Assistant Program. Graduated 1994 with degree in Physician Assistant Studies. Magna Cum Laude.

UW-Eau Claire. Graduated 1988 with Bachelor's degree in Social Work. Magna Cum Laude.

Primary Work Experience:

ProHealth Care Medical Associates, family practice physician assistant, 1994-present. Responsibilities include history and physical examination, diagnosis and treatment of acute and chronic disease.. Patient load and productivity is comparable to physician colleagues. Preceptor to PA students from UW-Madison and Marquette University.

Secondary and Supplemental Work Experience:

Emergency Medical Associates of Waukesha, emergency department physician assistant, 1995-2001. Responsibilities included history and physical examinations, diagnosis and treatment of patients with acute and emergent medical conditions.

ECI, Wheaton Franciscan Urgent Care, 2004-2006. Responsibilities included history and physical examinations, diagnosis and treatment of patients with acute and emergent medical conditions.

Prior Work Experience:

St. Mary's Hospital, laboratory, 1990-1992. Phlebotomy and specimen preparation.

State of Wisconsin Department of Health and Social Services, public health educator, 1988-1990. Epidemiology and counseling patients with communicable diseases.

Certification:

BLS with AED current through 4/2012.
Family Medicine Certification through NCCPA.
Licensed in Wisconsin to practice family medicine.
DEA registration.

Professional Affiliations:

Wisconsin Academy of Physician Assistants
American Academy of Physician Assistants

Ryan, Thomas - DSPS

From: Lytle, Jeanette - DSPS
Sent: Tuesday, June 12, 2012 9:31 AM
To: Ryan, Thomas - DSPS
Subject: FW: PA Council Position
Attachments: J. Barrett's Resume.docx; Cover Letter June 2012.docx

Hi Tom,

There have been no complaints. PA license was granted November 6, 2001 and is current. Let me know if you need anything else.

Thanks,

Jeanette

-----Original Message-----

From: Horn, Patara - DSPS
Sent: Tuesday, June 12, 2012 8:58 AM
To: Lytle, Jeanette - DSPS
Subject: FW: PA Council Position

Hi Jeanette,

Can you help Tom? Normally, I just check ICE to see if there's any complaint against his license.

Thank you.
Patara

From: Ryan, Thomas - DSPS
Sent: Friday, June 08, 2012 1:29 PM
To: Horn, Patara - DSPS
Subject: FW: PA Council Position

Hi Patara, any discipline or pending complaints on this PA? Thanks. Tom

From: Barrett, Jeremiah [<mailto:jeremiah.barrett@marquette.edu>]
Sent: Friday, June 08, 2012 1:28 PM
To: Ryan, Thomas - DSPS
Subject: PA Council Position

Dear Director Ryan,

Please accept my resume as application to the PA Council.

Sincerely,

Jeremiah Barrett, PA-C, MPAS
Clinical Assistant Professor
Physician Assistant Program
Marquette University
1700 Building office #004

Ryan, Thomas - DSPS

From: Barrett, Jeremiah [jeremiah.barrett@marquette.edu]
Sent: Friday, June 08, 2012 1:28 PM
To: Ryan, Thomas - DSPS
Subject: PA Council Position
Attachments: J. Barrett's Resume.docx; Cover Letter June 2012.docx

Dear Director Ryan,

Please accept my resume as application to the PA Council.

Sincerely,

Jeremiah Barrett, PA-C, MPAS

Clinical Assistant Professor
Physician Assistant Program
Marquette University
1700 Building office #004
P.O. Box 1881
Milwaukee, WI 53210-1881
Office: 414-288-8482 / Fax: 414-288-7951
Jeremiah.Barrett@Marquette.edu

June 2012

Physician Assistant Studies
1700 Building
Marquette University
P.O. Box 1881
Milwaukee, WI 53201-1881

Dear Director Ryan,

Please accept my enclosed resume as application to the Physician Assistant Council position.

A quick review of my resume will show that I'm currently employed full time at Marquette University in the Physician Assistant Program as a Clinical Assistant Professor and I have been involved in the Wisconsin Academy of Physician Assistants. I served as an alternate representative to the American Academy of Physician Assistants House of Delegates in 2010 and I was a student member in 2000. I'm also involved with community organizations and I'm currently a board member and regional director of the Milwaukee Kickers Soccer Club.

In my faculty position at Marquette University, I serve as faculty co-director of community based research. I'm currently involved with America Scores and we are studying a project that involves conflict resolution, nutrition and team building in our urban communities. I currently serve as liaison to Milwaukee Health Department for our public health curriculum.

I would appreciate an opportunity to interview for this position and can be easily reached at (414) 412-1275.

Sincerely,

Jeremiah L. Barrett, PA-C, MPAS

Jeremiah L. Barrett, PA-C, MPAS

3762 S. Iowa Ave.
St. Francis, WI 53235
Phone: (414) 412-1275
Jeremiah.Barrett@mu.edu

EDUCATION

1998-2001 Masters Physician Assistant Studies, Marquette University, Cum Laude

1993-1998 Bachelor of Science Biology, Indiana University

TEACHING/LECTURES

-2010 – Current *Adjunct Faculty*, Marquette University Aurora Health Care Post Graduate Physician Assistant Emergency Medicine Program Lecturer

-2010 – Current *Clinical Assistant Professor*, Department of Physician Assistant Studies, Marquette University

-Course Director and Instructor – Introduction to Clinical Medicine, Clinical Medicine II, Clinical Decision-Making I. Develop syllabi, objectives, lecture content, assessment, and student advising

-Instructor – Introduction to Medical History and Physical Examination, Emergency Medicine and Clinical Decision-Making II

-2002 – 2010 *Adjunct Clinical Professor*, Department of Physician Assistant Studies, Marquette University

-Lecturer, Endocrine and Surgery Section of Clinical Medicine courses (2004-2010)

-Preceptor for Physician Assistant students interested in Endocrinology (2002-2010)

-2002 – 2010 *Clinical Preceptor*, Department of Physician Assistant Studies, University of Wisconsin

-Preceptor for Physician Assistant students interested in Endocrinology (2002-2010)

-2005 Lecturer, Continuing Medical Education Resources

-Teach Review Course for Physician Assistant National Certifying / Recertifying Examination

-Lecture topic Endocrinology

CLINICAL EXPERIENCE

-2008 – Current *Physician Assistant*, Department of Endocrinology, Medical College of Wisconsin, Milwaukee, Wisconsin.

Inpatient and outpatient endocrinology consultation service

-2002 – 2008 *Physician Assistant*, Midwest Endocrinology, St. Luke's Medical Center, Milwaukee, Wisconsin.

Inpatient and outpatient endocrinology consultation service

-2001 – 2002 *Physician Assistant*, Cardiology, Beloit Clinic, Beloit, Wisconsin.

Inpatient and outpatient cardiology consultation service

PROFESSIONAL AFFILIATIONS

American Academy of Physician Assistants. Fellow member since 2001.

Alternate Wisconsin member to the House of Delegates in 2010 and student member of the House of Delegates in 2000.

Wisconsin Academy of Physician Assistants. Member since 1998.

Christian Medical and Dental Association. Member since 2000.

PROFESSIONAL LICENSURE AND CERTIFICATIONS

Wisconsin Physician Assistant License. 10/2001 to present.

Certified by the National Commission on Certification of Physician Assistants, 10/2001. Recertified in 2007.

Basic Life Support for Healthcare Providers certification-2011.

COMMITTEES / SERVICE

-Member, Didactic Curriculum Committee

-Member, Progress and Promotion Committee

-Member, Admissions Committee

-Liaison to the Milwaukee Public Health Department

REFERENCES

Available upon request

Ryan, Thomas - DSPS

From: Conard, Michael G [Michael.Conard@cuw.edu]
Sent: Tuesday, May 22, 2012 1:57 PM
To: Ryan, Thomas - DSPS
Cc: Heinan, Michelle L; anne.hletko.pa@gmail.com
Subject: PA Council (faculty member) application
Attachments: Curriculum Vitae.doc

Dear Mr. Ryan:

I would like the Medical Examining Board to consider me as an applicant for the PA educator seat on the Council on Physician Assistants. My CV is attached for their consideration. Thank you for your time and consideration of this request.

Sincerely,

Michael Conard

Michael Conard, MPAS, PA-C, DFAAPA
Assistant Professor of Physician Assistant Studies
Director of Clinical Education
Concordia University-WI Physician Assistant Program
(920) 217-1921 mobile
(920) 498-1077 fax
<mailto:michael.conard@cuw.edu>

Curriculum Vitae
Michael G. Conard, MPAS, PA-C, DFAAPA

CONTACT INFORMATION

1021 Juneau Street, Kewaunee, WI 54216
(920) 388-2728
(920) 255-0717
mconard@itol.com

PERSONAL INFORMATION

Date of Birth: 29 April 1957
Place of Birth: Green Bay, WI
Citizenship: USA

EMPLOYMENT HISTORY

May 2012- **Concordia University-WI**
Present Mequon, WI

Assistant Professor of Physician Assistant Studies
Director of Clinical Education

- Identify, establish, and develop clinical rotation sites for physician assistant students in their clinical year
- Train preceptors who are supervising PA students during their clinical rotations
- Teach Advanced Cardiac Life Support during the PA student's didactic training
- Develop and teach PA professional modules during the PA student's didactic training

Aug 2011- **Divine Savior Health System**
June 2012 Portage, WI

Physician Assistant, Emergency Medicine

- Provide full-spectrum urgent care and emergency medicine services in a hospital setting

Dec 2011- **Advanced Care Providers**
Present Minocqua, WI

- Locum tenens PA Care

April 2011 – **Bellin Health Medical Group, Bay Shipbuilding**
July 2011 Sturgeon Bay, WI

Physician Assistant, Family Medicine

- Provide full-spectrum family medicine services as a solo provider in a medical clinic established exclusively for employees and their families under the direction of Loren Fugelstad, MD.

Curriculum Vitae
Michael G. Conard, MPAS, PA-C, DFAAPA

- Chairman of the medical group's Peer Review committee

May 2000 – **Bellin Health Medical Group, Bonduel Clinic**
April 2011 Green Bay, WI

Physician Assistant, Family Medicine & Emergency Medicine

- Provide full-spectrum family medicine services as a solo provider in a rural medical clinic under the direction of Tomasz Miaskowski, MD.
- Staff the emergency department of the Bond Health/Bellin Health critical access hospital in Oconto, WI.
- Assist with retail medicine clinics
- Currently serve on the Bellin Medical Group's Pharmacy & Therapeutics committee
- Co-chairman of the medical group's Chronic Pain management committee.
- Chairman of the medical group's Peer Review committee

Sep 1993 – Apr 2000 **Emergency Physicians, Ltd. & BayCare Clinics**
Green Bay, WI

Physician Assistant, Emergency Medicine & Urgent Care

- Provided patient care in new urgent care center under supervision of off-site physician.
- Served as initial project director for development of that urgent care center involved in staffing plans, supplies, and operations.
- Provided hospital-based emergency medicine and urgent care services with that same emergency medicine group in two urban hospital emergency departments. Primary duties included focused history & physical exams, ordering & interpreting imaging and laboratory studies, making assessments, forming treatment plans, patient education, and arranging for follow-up care. I also performed written and dictated documentation for all patient encounters.

Curriculum Vitae
Michael G. Conard, MPAS, PA-C, DFAAPA

- Additional care included treatment of work-related injuries, assisting physicians with procedures as required, performing minor surgery, and providing complete advanced cardiac life support in the absence of the emergency department physician.
- Served as the physician assistant advisor to the department's patient care council in formulation of policies and procedures.

Jun 1991 – Sep 1993 **St. Mary's Kewaunee Area Memorial Hospital**
Kewaunee, WI

- Provided independent coverage of the emergency department in a rural hospital with off-site physician supervision.
- Developed and operated an after-hours clinic as an adjunct service of that department.
- Provided neonatal resuscitation for low-risk deliveries performed at that hospital. I also conducted Advanced Cardiac Life Support training to the hospital nursing staff.
- Served as administrative director and assistant medical director for the independent rural ambulance service.

Academic Teaching

2000-2006

CME Chairman & Coordinator
Wisconsin Academy of Physician Assistants

1994 – present

Northeast Wisconsin Technical College
Advanced Cardiac Life Support Instructor
NREMT-Paramedic Examiner
EMS-Basic Instructor/Coordinator
EMS Administration Course director & instructor

1982-1985

5045th USAR School
Instructor- US Army Combat Medical Specialist course

1979 – 1987

High School Teacher, Vocational Agriculture
Oakfield High School, Oakfield WI
Appleton Public Schools, Appleton, WI
Algoma High School, Algoma, WI

Curriculum Vitae
Michael G. Conard, MPAS, PA-C, DFAAPA

EDUCATION

Master of Physician Assistant Studies (August 1999)
University of Nebraska Medical Center, PA Program
42nd & Emile Sts.
Omaha, NE 68192 (402) 559-4000

Bachelor of Science- Physician Assistant (May 1991)
University of Wisconsin PA Program
750 Highland Avenue, Room 1278
Madison, WI 53705 (608) 263-5620

Bachelor of Science-Secondary Education (May 1979)
University of Wisconsin
River Falls, WI

PROFESSIONAL QUALIFICATIONS

1. Certified by the National Commission for Certification of Physician Assistants
2. Licensed as Physician Assistant in State of Wisconsin
3. Advanced Cardiac Life Support (Instructor) – American Heart Association
4. Pediatric Advanced Life Support – American Heart Association
5. Basic Cardiac Life Support – American Heart Association
6. DEA License

AWARDS

Wisconsin Physician Assistant of the Year 2003
Bellin Health VIP Awards recipient 2001, 2004, 2007
Special Service Recognition Award from Wisconsin Academy of PAs 2006
Army Commendation Medal awarded for lifesaving 1985
National Defense Medal- United States Army

PROFESSIONAL MEMBERSHIPS

Distinguished Fellow – American Academy of Physician Assistants

- Named as a Distinguished Fellow 2007
- Sergeant-at-Arms, House of Delegates (2006 to present)
- Reference Committee Member (2003-2005)
- House of Delegates – Wisconsin delegation (1999-2005)
- Standing Rules committee (2004-present); Chairman 2006

Fellow - Wisconsin Academy of Physician Assistants (1991 – present)

- President (1999-2000)
- Director (1998-1999)
- CME Chairman (2001-2006)
- Standing Rules & Policies chairman (2000-present)

Curriculum Vitae
Michael G. Conard, MPAS, PA-C, DFAAPA

Founding Member – Society of Emergency Medicine Physician Assistants

Member – Veteran's Caucus

Trustee – Wisconsin Academy of Physician Assistants Foundation 1999-2006

- President 2002-2003

INTERESTS

- Home brewing, winemaking, cider making
- Historical re-enactment (18th century British & SCA)
- Computers

MILITARY EXPERIENCE

Wisconsin Army National Guard 1977-1998

- Physician Assistant
- Platoon Sergeant
- Evacuation Section Sergeant
- Aid Station Senior Sergeant
- Senior Medical Specialist/combat medical specialist

REFERENCES Available upon request

Ryan, Thomas - DSPS

From: Esser, Eric - GOV
Sent: Wednesday, November 23, 2011 5:02 PM
To: Gary Tsarovsky
Cc: Ryan, Thomas - DSPS
Subject: RE: Perfusionist Examining Council

Good Afternoon Mr. Tsarovsky,

Thank you for your interest in serving on the Perfusionists Examining Council. Governor Walker is only able to appoint the public member to the Council, however, the Medical Examining Board makes the professional appointments. I am copying Mr. Tom Ryan of the Dept. of Safety and Professional Services on this e-mail. Mr. Ryan can forward your materials directly to the Medical Examining Board for their consideration.

Thank you again for your time and interest.

Happy Thanksgiving!

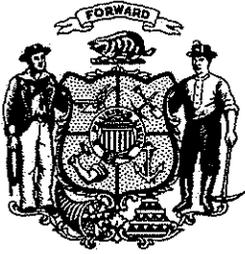
Eric Esser
Director of Gubernatorial Appointments
Office of Governor Walker
Post Office Box 7863
Madison, Wisconsin 53707-7863
608/266-1212

From: Gary Tsarovsky [<mailto:tsarovsky@yahoo.com>]
Sent: Thursday, November 17, 2011 11:17 AM
To: Esser, Eric - GOV
Subject: Perfusionist Examining Council

Hello Mr. Esser,

My name is Gary Tsarovsky and I am a practicing perfusionist. I am contacting you regarding an opportunity to serve on the Perfusionists Examining Council. I was made aware of this opportunity by Sarah Briganti, and would be honored to serve my profession and, perhaps even more importantly, my community and the residents of our state in this manner. Please find enclosed my application and curriculum vitae. If you have any questions, I can be reached at 608-770-7950 or at tsarovsky@yahoo.com. Thank you so much for the consideration of my application.

Gary Tsarovsky



SCOTT WALKER
OFFICE OF THE GOVERNOR
STATE OF WISCONSIN

P.O. Box 7863
MADISON, WI

APPLICATION FOR A GUBERNATORIAL APPOINTMENT

INSTRUCTIONS

Thank you for expressing an interest in serving Wisconsin. Generally, the Governor fills most senior level positions in the various departments, positions in the Governor's executive office, and any vacancies on the many Boards and Commissions that operate under state law through the Gubernatorial appointment process.

To be considered, please complete the application below.

PART I

Name (First, Middle Initial, Last): Gary Tsarovsky	
Home Address 1: 2729 Marledge Street, Fitchburg, Wisconsin 53711	
Address Line 2:	
Home Phone: 608-277-7562	Cell Phone: 608-770-7950
E-mail Address: tsarovsky@yahoo.com	Date of Birth: May 7, 1969
State Senator: Jon Erpenbach	State Representative: SONDY POPE-ROBERTS
Job Title, Company: President, Total Circulatory Solutions	
Work Address 1: 2729 Marledge Street, Fitchburg, Wisconsin 53711	
Address Line 2:	
Work Phone: 608-770-7950	Fax Number:
Preferred Mailing Address (please check one):	<input checked="" type="checkbox"/> Home <input type="checkbox"/> Work
What is your state of residence? Wisconsin	
Are you a state employee? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
If yes, list your Department and Division.	
Are you an elected official? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
If yes, what is your position?	

Are you a licensed/certified professional? If so, please specify.

Yes. I am licensed in Wisconsin and Illinois. I am certified by the American Board of Cardiovascular Perfusion

Do you belong to any professional groups? If so, please specify.

Yes. Wisconsin Perfusion Society, American Society of Extracorporeal Technology

***Demographic Information Is Optional**

Disability:	Veteran: N/A
Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity: White

Part II

Boards Sought (Please list in order of preference and specify member type, if known.):

1. Perfusionists Examining Council
2.
3.
4.

In the space provided below, please list the names of three people who are willing to serve as references. **Please also include phone numbers and their relationship to you.**

Name	Phone Number	Relationship to You
1. Peter Marks, MD	815-971-4285	Supervising Physician
2. David Malkow, LP, CCP	608-206-7591	Professional Colleague
3. Matthew Pycior, LP, CCP	815-742-4515	Professional Colleague

Did anyone refer you to this board? If so, who?

1. Sarah Briganti

RESUME

Please attach a copy of your resume to this application. Please include all relevant work experience, education, community involvement, government or military service, honors, awards and other talents.

ESSAY

Please attach a separate document of 500 words or less on the following essay question.

Please describe why you are interested in working for Governor Scott Walker and the State of Wisconsin.

- By submitting this application you are affirming that all the statements you have made in this document are true and that you understand that an extensive background check may be conducted if you are considered for appointment.
- Under Wisconsin Statutes 19.36 (7)(b), as an applicant for this position, you have the limited right to request that your identity be kept in confidence. If you wish to preserve this right, you must attach to your application a letter requesting confidentiality of your identity with respect to this application.
- This right prevents your identity from being released in response to a public records request unless; you are appointed to the position or you are a finalist for the position as defined by Wisconsin Statute 19.36(7)(a).

<p>Applications should be e-mailed to:</p> <p>GovAppointments@wisconsin.gov</p>	<p>Applications should be mailed to:</p> <p>Governor Scott Walker Appointments Department</p> <p>P. O. Box 7863 Madison, WI 53707 -- 7863 (608) 266 -- 1212</p>
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This document can be made available in alternate formats to individuals with disabilities upon request.

OBJECTIVE

To provide the highest quality of professional service as a locum tenens perfusionist while promoting further professional and personal growth

CAPABILITIES

- Operate extracorporeal devices, such as, cardiopulmonary bypass equipment, IABP, ECMO, autotransfusion equipment, cardiopulmonary support devices, and appropriate laboratory equipment
- Consult with medical staff regarding procedure requirements, outcomes and expectations
- Coordinate and maintain a stat laboratory for use by the surgical suite
- Arrange database management of cardiovascular perfusion department and generate informative reports for use by necessary departments within the hospital to assist in cost management and efficiency
- Manage inventory for a perfusion department within a hospital

EMPLOYMENT HISTORY

TOTAL CIRCULATORY SOLUTIONS, INCORPORATED Chicago, Illinois
President Madison, Wisconsin
December 2001 – PRESENT

Principal founder of a locum tenens company providing perfusion, autotransfusion, and autologous platelet gel services to clients on long- and short-term basis.

RUSH UNIVERSITY MEDICAL CENTER Chicago, Illinois
RUSH UNIVERSITY, COLLEGE OF HEALTH SCIENCES Chicago, Illinois
Assistant Director, Department of Extracorporeal Services, August 2002 - October 2003
Assistant Program Director, Department of Perfusion Technology
Staff Perfusionist, Instructor January 2001 - August 2002

Responsibilities included serving as program director of the Rush University Perfusion Technology Program; maintaining accreditation of the training program; maintaining all records necessary for accreditation; chairing admissions and curriculum committee; assignment of course directors; oversight of teaching responsibilities; upkeep of student records; and advising perfusion students.

Other duties included coordinating the daily activities of the staff perfusionists; providing adequate staffing of all procedures requiring a perfusionist; coordinating clinical supervision of Perfusion Technology students, and supervising the maintenance of supplies and equipment for daily activities.

Gary Tsarovsky, MS, CCP, LP

2729 Marledge Street
Fitchburg, WI 53711
(608) 277-7562 Home
(608) 770-7950 Cell

tsarovsky@yahoo.com E-Mail

LOYOLA UNIVERSITY MEDICAL CENTER

Staff Perfusionist

Maywood, Illinois

January 2000 – January 2001

- Perfusionist for a Level I Trauma Center which provides both adult and pediatric services
- Procedure experiences include: adult cardiovascular and thoracic cases; deep hypothermic circulatory arrest with retrograde cerebral perfusion; neonatal and adult ECMO; right, left and bi-ventricular assist devices; heart, lung, and liver transplantation
- Responsible for intra-aortic balloon pump insertion and monitoring;
- Responsible for autotransfusion during open heart, vascular, orthopedic, and neurosurgery procedures

MCW PERFUSION SERVICES

MEDICAL COLLEGE OF WISCONSIN

Staff Perfusionist

Milwaukee, Wisconsin

June 1998 – January 2000

- Perfusionist for a Level I Trauma Center which provides adult cardiac and thoracic services
- Perfusionist for four additional community hospitals which provide adult and thoracic services
- Procedure experiences include: adult cardiovascular and thoracic cases; various methods of myocardial preservation; deep hypothermic circulatory arrest with retrograde cerebral perfusion; adult ECMO; right, left and bi-ventricular assist devices; left-heart bypass; heart and lung transplantation
- Responsible for intra-aortic balloon pump insertion and monitoring

CERTIFICATION AND LICENSURE

State of Wisconsin Perfusion License

State of Illinois Licensed Perfusionist

American Board of Cardiovascular Perfusion Board

EDUCATION

- **Master of Science, Perfusion** **9/96 - 5/98**
MILWAUKEE SCHOOL OF ENGINEERING
Milwaukee, Wisconsin
- **Bachelor of Science, Natural Science** **9/88 - 6/94**
UNIVERSITY OF WISCONSIN
Madison, Wisconsin

PROFESSIONAL AFFILIATIONS

- **American Society of Extra-Corporeal Technology**
- **Wisconsin Perfusion Society**
- **Illinois State Perfusion Society**

PRESENTATIONS AND PUBLICATIONS

- **Retrospective Analysis of Systemic Inflammatory Response Syndrome in Patients Following Cardiopulmonary Bypass**
Wisconsin Perfusion Society Spring Conference, April 5-7, 2002, Madison, Wisconsin
- **Effect of Cardiopulmonary Bypass Duration on Platelet Function**
AmSECT Region VII Meeting, October 29-31, 1999, Denver, Colorado
- **Effect of CPB on Platelet Function and the Inhibitor System of Hemostasis**
Wisconsin Perfusion Society Spring Conference, April 3-5, 1998, Madison, Wisconsin
- **Intermittent Aortic Cross-Clamping: A Myocardial Preservation Technique**
AmSECT, Region VI Meeting, October 10-12, 1997, Iowa City, Iowa
- **Ostrowsky J, Foes J, Warchol M, Tsarovsky G, Blay J.** Plateletworks platelet function test compared to thromboelastograph for prediction of postoperative outcomes. JECT. 2004;36:149-152.

COMPUTER KNOWLEDGE AND FOREIGN LANGUAGE SKILLS

- Extensive Macintosh and PC experience
- Fluent in Russian (Native Speaker)

PERSONAL

- Married, four children
- Hobbies include camping and outdoor activities, tutoring at elementary and middle schools in Madison area, coaching youth soccer and basketball, participating in indoor and outdoor sports

REFERENCES

- **Peter Marks, MD**
Rockford Memorial Hospital
Heart & Vascular Center
Rockford, Illinois
(815) 971-2485
- **Matthew Pycior, CCP, LP**
Chief Perfusionist
Rockford Memorial Hospital
Rockford, Illinois
(815) 742-4515
- **David Malkow, CCP, LP**
Chief Perfusionist, Perfusion Solutions Inc
OSF St. Anthony's Hospital and Medical Center
Swedish American Hospital and Medical Center
Rockford, Illinois
(815) 601-8380
- **Cea Correnti, MS, CCP, LP**
Chief Perfusionist, Heart To Beat Inc
West Suburban Hospital and Medical Center
Oak Park, Illinois
(630) 841-2705

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**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: July 18, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Maintenance of Licensure and Continuing Education – Discussion 9:00 a.m. APPEARANCES (TELEPHONE) – Lance Talmadge, MD, FSMB Board Chair; Humayan; Humayan Chaudhry, DO, FSMB Chief Executive Officer; Frances Cain, FSMB, Director – Post Licensure Assessment Systems (PLAS)	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? YES by FSMB Representatives <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Representatives from the FSMB will appear by phone to discuss the FSMB (see materials enclosed).			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

OVERVIEW OF MAINTENANCE OF LICENSURE (MOL)

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OVERVIEW OF MAINTENANCE OF LICENSURE (MOL)

BACKGROUND

In 2004, the FSMB House of Delegates, comprising all 70 state medical boards in the U.S. and its territories, unanimously adopted a policy statement affirming that state medical boards have an obligation to the public to assure the continuing competence of physicians as a condition of re-licensure (license renewal). The FSMB spent the next several years considering ways in which the current licensure process could be updated to ensure this mandate is fulfilled. The resulting licensure framework, Maintenance of Licensure (MOL), was adopted by the FSMB House of Delegates in 2010. It recommends that licensing boards require physicians seeking license renewal to provide evidence of participation in a program of continuous professional development that reflects the three major components of what is known about effective lifelong learning: 1) reflective self-assessment, 2) assessment of knowledge and skills and 3) performance in practice. The framework for MOL does not mandate or spell out the details of continuous professional development; rather, it creates a system that enables physicians to demonstrate they are meaningfully engaged in these activities.

The following provides background information about events that precipitated discussions about the need and desire for physicians to demonstrate their ongoing knowledge, skills and fitness to practice as part of the license renewal process, as well as an overview of literature in support of the rationale for MOL.

RATIONALE FOR MAINTENANCE OF LICENSURE

Licensure Processes

In the United States, the practice of medicine is a privilege granted by the public through their elected representatives. Medical licensing authorities are charged through state Medical Practice Acts to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine. Every medical practice act is built upon this same premise, and likewise, each state medical board uses criteria to assess a physician's competence and fitness to practice prior to granting initial licensure.

State medical boards have rigorous requirements in place to ensure individuals seeking to enter medical practice are competent. When an applicant for initial licensure provides evidence of successfully meeting such conditions, state medical boards – and by extension, the public – can be confident that the physician has the requisite knowledge and skills to practice medicine competently and safely.

In contrast, license renewal is largely an administrative function that assumes licensees are competent unless a reported event or other development indicates otherwise. In addition to completing a renewal form and payment of a fee, the majority of boards require physicians to obtain a specified number of CME credits. Few jurisdictions, however, require licensees to take CME that is directly related to his or her scope of practice. As currently mandated by state

medical boards, CME is not sufficient to verify or ensure practice needs are being identified and addressed.

MOL will enable state medical boards to demonstrate that their physician licensees are actively engaged in a lifelong program of professional assessment and improvement in their area of practice.

Environmental Assessment

The U.S. health care system is in a period of flux and change, facing significant questions about its future. Among developments in recent years is a growing interest in the enhancement of patient safety, the measurement of quality outcomes, and improvements to systems and processes. As health care consumers have become more empowered and informed they, too, have put a new emphasis on safety and quality.

At the same time, health care organizations throughout the system – from hospitals to medical specialty societies – have committed themselves to new systems of quality measurement and improvement. The growth of such concepts as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs) all have at their core a commitment to continuous improvement and evidence-based outcomes – with the ultimate goal of better serving the needs of patients.

The MOL concept has evolved as a result of these trends and developments. Its ultimate goal can be simply stated: Ensuring safe medical care by promoting continuous professional development and lifelong learning among physicians.

ENVIRONMENTAL EVIDENCE SUPPORTING MOL

Public Expectations Regarding Physician Competence

- The Institute of Medicine's (IOM) *To Err is Human* report challenges licensing boards to do their part in making the overall health care system safer for patients by periodically re-examining and re-licensing providers "based on both competence and knowledge of safety practices." Subsequent IOM reports also recommend that health regulatory boards take a more proactive and involved approach to practitioner competence.
- The Pew Health Professions Commission Taskforce on Health Care Workforce Regulation's initial report, *Reforming Health Care Workforce Regulation*, recommends that states "require each licensing board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals."
- In 2007, the AARP, in collaboration with the Citizen Advocacy Center, conducted a study of Virginians 50 years of age and older to assess their understanding and knowledge of Virginia's existing licensure requirements for health professionals to maintain competence. More than 95 percent of respondents said they believe that health care professionals should be required to show they have the up-to-date knowledge and skills needed to provide quality care as a condition of retaining their medical license.

- Efforts by organizations and websites such as Consumers Union, Healthgrades.com, and Angieslist.com to disseminate consumer-focused information about physicians (e.g., ratings of health care providers and hospitals, credentials/background information on individual physicians, information on how to choose a physician) highlight a growing interest on the part of the public and health care consumers for information about their physicians and the quality of care they provide.

Emphasis on Continuous Improvement in Medicine

- ABMS
 - The American Board of Medical Specialties and all of its member specialty boards have adopted the Maintenance of Certification (MOC) program, which requires physicians to provide evidence of meeting the following criteria on a continual basis in order to maintain specialty board certification:
 - Part I: Licensure and professional standing
 - Part II: Lifelong learning and self-assessment
 - Part III: Cognitive expertise
 - Part IV: Practice performance assessment
- Continuing Medical Education (CME)
 - Historically, concerns about the utility of CME centered on whether such activities truly impact physician performance, especially if the CME is not related to the physician's day-to-day practice or deficiencies. Empiric evidence from meta-analyses supports the use of CME as a tool for physician learning and change if it is part of a system of continuous professional development that includes self-assessment, remediation, and reassessment. The CME community has made great strides in addressing concerns about CME's impact on physician practice and in developing CME programs and criteria that address physician performance and lifelong learning.
 - In September 2006, the ACCME released new standards for the accreditation of CME providers that aim to improve physician practice and, thus, the quality of patient care by requiring CME providers to develop and implement programs that focus on improving physician competence, physician performance and/or patient outcomes.
- American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS)
 - In January 2013, the AOA BOS will implement Osteopathic Continuous Certification (OCC), which consists of the following 5 components:
 - Component 1: Unrestricted licensure
 - Component 2: Lifelong learning/CME
 - Component 3: Cognitive assessment
 - Component 4: Practice performance assessment and improvement
 - Component 5: Continuous AOA membership
- Graduate Medical Education
 - As part of its mission to ensure and improve the quality of graduate medical education, in 1999 ACGME began implementation of the Outcome Project. While the accreditation

process traditionally focused on the potential of a program to educate residents, the Outcome Project focuses on the actual accomplishments of a program through an assessment of its outcomes. In 2008, the Outcome Project was expanded into Milestone Development, where each specialty is responsible for identifying milestones of competency development.

- The Joint Commission
 - Implemented new credentialing and privileging standards in 2007 and 2008 which were intended to make the credentialing and privileging process more objective and evidence-based by facilitating continuous monitoring of physicians' performance and by providing a basis for intervening when quality of care concerns are identified.

- American Medical Association
 - Has expanded credit for the AMA Physician Recognition Award (PRA) Category 1 Credit to include performance improvement activities and internet learning and point of care.

- Other Health Care Practitioners
 - In 2001, the Citizen Advocacy Center (CAC) released a summary of proceedings from a conference it held to discuss initiatives by medicine and other health care professions to evaluate the continuing competence of their practitioners. As noted in the CAC report, as well as a 2002 article in the *Journal of Allied Health*, this issue has been discussed for a number of years by a variety of health care professions including dentistry, nursing, pharmacy and physical therapy.

- International Initiatives
 - Since 1998, the General Medical Council in the United Kingdom has been developing a "revalidation" program that will require all licensed physicians to undergo regular review of their practice in order to maintain their licenses. The program is set to be implemented in January 2013.
 - The College of Physicians and Surgeons of Ontario evaluates the continuing competence of its licensees through its Peer Assessment Program, which it initiated in 1981. As part of the program, physicians undergo an office-based evaluation of their facilities, medical records and quality of care once every 10 years.
 - Discussions around ongoing physician competence are also occurring in Ireland, Australia, and New Zealand.

Quality Improvement Movement

Another factor that is moving medicine toward a continuous professional development model is increasing focus on quality improvement and measurement of physician performance in practice. In 2008, the Council of Medical Specialties (CMSS) released a primer, *The Measurement of Health Care Performance*, which summarizes recent discussions and interest in quality improvement, outcome measures, practice measurement and the validity and integrity of physician performance. The primer also provides an introduction to quality improvement

initiatives; participation in such initiatives and/or use of such QI measures could be one way in which physicians demonstrate performance in practice for purposes of MOL.

Organizations such as the National Committee for Quality Assurance (www.ncqa.org) have dedicated themselves to measuring, evaluating and improving the quality of health care in the United States through tools such as the Healthcare Effectiveness Data and Information Set (HEDIS) and health plan “report cards.”

ARTICLES AND RESEARCH SUPPORTING MOL

A full bibliography of research, articles, reports and commentary related to MOL is included in a comprehensive list at the end of this document. Following is a summary of some of the key resources related to MOL. (Please note that many of the links in these resources provide access to copies of the articles in full; however, some are abstracts and are only available by purchase.)

No studies have been conducted on the efficacy of Maintenance of Licensure in the United States yet, for the simple reason that such a system has not yet been implemented. But, evidence supporting the need for such a system – that is, demonstrating that robust, continuous professional skills development is good for patients, as well as for physicians – is compelling.

There is growing evidence in the medical literature about variables in medical practice – including the volume of procedures completed by physicians, and how these variables impact outcomes – as well as about the value of enhanced CME and continued professional skills development over the course of a physician’s career. Both of these categories are addressed by the FSMB’s MOL framework.

The evidence clearly suggests better outcomes can be expected from physicians who keep their skills and knowledge sharp by maintaining them through a proactive, practice-specific, ongoing development process over time.

Maintaining Knowledge and Skills

The rate of expansion in medical knowledge and advancement in technology continues to increase, highlighting the critical need for physicians to engage in lifelong learning. Throughout medical school and residency training physicians are encouraged to embrace lifelong learning as an integral part of professionalism. Failure to keep pace with advances in knowledge and technology has the potential to negatively impact healthcare quality and patient safety.

Self-assessment

When guided by objective assessment data or compared with external standards, self-assessment can be a useful tool for physicians as part of the lifelong learning and continuous professional development process. Recommendations for improving the use of self-assessment as a tool for physicians include providing external feedback or validation, via the application of various assessment methods or standards, as part of the process tying self-assessment to the

physician's practice profile and broadening self-assessment beyond knowledge of practice-relevant content to other domains of physician proficiency, such skills, behaviors, processes of care and outcomes. Researchers also point to the need for incorporating self-assessment as an essential professional skill in as early a stage of physician education and training as possible.

Linking Competence to Quality of Care

A 2003 study by McGlynn and other researchers at the Rand Corporation found that patients are not receiving the full amount of recommended processes involved in care. Specifically, the results of the study showed that patients received approximately 55% of recommended care – in other words, there is a significant gap between what is known to work and what is actually done. The researchers concluded that the “deficits we have identified in adherence to recommended processes for basic care pose serious threats to the health of the American public.” The researchers go on to state that while there is no simple solution to this problem, a key component of any solution is the routine availability of information on performance at all levels.

Physician Competence and Performance

Most people make several basic assumptions about the relationship between clinical experience and the quality of health care provided, namely that although broad medical knowledge declines over time as practice narrows, tacit knowledge and skills (expertise), as well as humanistic and interpersonal qualities, increase with experience. In short, the conventional wisdom is that experience means expertise which means higher quality health care. Studies by Eva and by Choudhry et al, challenge this assumption and suggest, instead, an inverse relationship between age or years in practice and performance.

- Choudhry et al systematically reviewed 62 studies evaluating medical knowledge; adherence to standards of care for diagnosis, screening, or prevention; adherence to standards of care for therapy; or health outcomes. Results of the review suggest that physician performance, among multiple specialties, declines over time in both medical knowledge and skills. Specifically, the results showed that over half (32) of the studies showed a decline in physician performance over time for all outcomes measured; only one study showed improved performance.
- In 1994, Caulford et al evaluated physicians referred to the physician assessment center at Mc Master University. The physicians were evaluated in seven skill areas: knowledge, communication, interview skills, history taking, physical exam, problem solving, management and record keeping. The results of the study found that age, graduation year, solo versus group practice, reported CME hours and certification status had significant simple correlations with competence in these areas. A multivariate analysis found the only significant predictors of competence were age and certification status.
- A 2000 study by Norcini et al of the relationship between specialty certification and mortality of patients with acute myocardial infarction found a .5% increase in mortality for every year since graduation from medical school.

- Studies of psychiatrists by Epstein et al indicate that the tendency to diagnose major depression is significantly associated with fewer years in practice and that lower agreement with experts on diagnosis and treatment of anxiety and depression is associated with years in practice and percentage of time spent in solo practice. Epstein et al found that psychiatrists in practice for 11 to 20 years had mean accuracy scores 10.5% points lower than those in practice 0-5 years, and that psychiatrists in practice for more than 20 years had scores 12.5% points lower than those in practice 0-5 years.

Continuing Medical Education

Scientific literature shows strong evidence that targeted CME, aimed at specific skill development, is beneficial to patient outcomes. The Johns Hopkins Evidence-based Practice Center for Healthcare Research and Quality conducted a systematic review of the effectiveness of such education and reported in 2009 that multimedia, multiple instruction techniques and multiple exposures to content were associated with improvements in physician knowledge. Robertson and colleagues demonstrated in 2003 that CE can improve knowledge, skills, attitudes, behavior, and patient health outcomes. Other studies have shown similar results.

Specialty Certification

A systematic review of studies published between 1966 and 1999, by Sharp et al (2002), found that over half (16/29) showed positive and statistically significant associations between certification and superior outcomes. Since 1999, a number of studies (Chen et al, 2006; Silber et al, 2002; Prystowsky et al, 2002; Norcini et al, 2002) have concluded that board certification is associated with higher quality care. Recent studies have also found that a lack of certification is associated with increased risk of disciplinary action. The association between certified status and higher quality of care is consistent across a range of clinical specialties.

The ABMS and its member boards are actively conducting research to evaluate the impact of specialty board certification and maintenance of certification on patient care. Emerging research indicates that certification and MOC has a positive impact on the quality of care provided by physicians. A full list of research regarding the impact of specialty certification on patient care and outcomes is available at <http://www.certificationmatters.org/research-supports-benefits-of-board-certification.aspx>

IMPACT ON PHYSICIANS

One of the key undergirding principles of the FSMB's framework for MOL is the creation of a system that minimizes burdens on physicians and eliminates overlap or redundancy with other quality improvement systems in which they are participating.

For example, physicians may be able to substantially comply with MOL requirements through participation in the Maintenance of Certification (MOC) program of the American Board of Medical Specialties or the Osteopathic Continuous Certification (OCC) program of the American Osteopathic Association Bureau of Osteopathic Specialists. MOL, MOC and OCC are similar in that they each demonstrate a commitment on behalf of a physician to lifelong learning and self-

assessment through a variety of approaches. MOL does not distinguish between specialty and sub-specialty board certification; if MOC or OCC is available for a specialty or sub-specialty and the physician is in good standing with the ABMS MOC or AOA-BOS OCC program, this should fulfill any state's MOL requirements.

But many other pathways to compliance have been identified, beyond MOC and OCC. To fulfill MOL requirements, physicians will be able to repurpose tools and data from many other quality improvement programs that they are already engaged in.

Simply put, the system does NOT envision the need for a complicated or time-consuming new process. For many physicians, an MOL system would operate as more of an aggregator/verification method of lifelong learning – a dossier of professional development activities.

Physicians who are not already engaged in targeted continuous professional development would need to provide more evidence of participation in such activities – which is the ultimate point of an MOL system. The system should make it easy for physicians already involved in continuous professional development to formally demonstrate their commitment, while providing well defined pathways to help physicians not involved in continuous professional development get on track.

To give an example of the extant sources that can be drawn upon by practicing physicians for fulfillment of an envisioned MOL system, two hypothetical pathways are provided here for the fulfillment of MOL's three components – Reflective Self Assessment, Assessment of Knowledge and Skills, and Performance in Practice:

Physician A: Board-certified Surgeon

Currently, Physician A must renew his license biennially with the Wisconsin board. As part of this process, the physician is required to complete 30 hours of Category 1 CME. Physician A is also required to participate in Maintenance of Certification (MOC) through the American Board of Surgery (ABS) in order to maintain hospital privileges. The ABS MOC requirements run in three-year cycles. At the end of each cycle, Physician A is required to "check in" by completing a brief online form about his MOC activities. A secure examination is also required at 10-year intervals.

As part of the license renewal process, Physician A is provided with a list of "approved" activities, including MOC, that will meet the Wisconsin board's requirements for the three MOL components. The list indicates that demonstration of continuous participation in MOC will enable the physician to comply with all three components of MOL. Physician A opts to comply with MOL through participation in the ABS MOC program since he is already participating in this program as part of his professional development and to meet his employer's requirements.

Since the Wisconsin board's license renewal cycle is biennial, while the MOC program is a 10-year program with check-in every 3 years, the Wisconsin board asks Physician A to demonstrate his continued, successful participation in MOC as part of every other license renewal cycle (that is, every 4 years). To verify participation in MOC as part of the license renewal audit process, the board asks Physician A to provide evidence or documentation from the ABS (or from the ABMS) that he is participating in MOC.

As part of each license renewal cycle (that is, every 2 years), the Wisconsin board asks Physician A to document completion of 30 hours of Category 1 CME, as required under Wisconsin Administrative Code. Since the ABS MOC program requires completion of 90 hours of Category 1 CME over a three-year MOC cycle, Physician A can also meet the board's CME requirements through participation in MOC.

Physician B: Non Board-certified Family Medicine Physician

Currently, Physician B must renew her license biennially with the Wisconsin board. As part of this process, the physician is required to complete 30 hours of Category 1 CME. As a non-board certified family medicine physician, Physician B is not participating in any Maintenance of Certification (MOC) programs. However, Physician B engages in CME activities geared toward family practice every year, typically completing more than the 30 hours required biennially by the Wisconsin board. Physician B also engages in regular literature reviews and has subscriptions to several medical journals to make sure she is staying abreast of the latest information and changes in medicine. She is also a member of the American Academy of Family Physicians.

Physician B is part of a small group practice that uses electronic health records to record patient data and to track patient visits, concerns, compliance with treatment and outcomes. The practice also participates in the Improving Performance in Practice (IPIP) program, which provides her and her fellow colleagues in the practice with tools and support to assess their performance and engage systematically in improving activities using their own practice data and comparisons to others in their cohort groups as benchmarks.

As part of the license renewal process, Physician B is provided with the list of "approved" activities that meet the Wisconsin board's requirements for the three MOL components:

- **Component 1: Reflective Self Assessment**
 - Home study courses or web-based materials
 - Medical professional society/organization or institution-based simulation
 - CME in the physician's current practice area that enhances patient care, performance in practice and or patient outcomes.
- **Component 2: Assessment of Knowledge and Skills**
 - Performance improvement (PI) CME
 - Patient and peer surveys
 - Hospital privileging processes and activities

- Practice relevant multiple choice exams
- Computer-based clinical case simulations
- Mentored or proctored observation of procedures
- Formalized assessment/Performance Improvement programs overseen by health systems or robust medical groups (e.g. likely larger organizations)
- Participation in other performance improvement projects such as the Surgical Care Improvement Project (SCIP), American Medical Institute (AMI), Institute for Healthcare Improvement (IHI), Improving Performance in Practice (IPIP), Healthcare Effectiveness Data and Information Set (HEDIS)
- **Component 3: Performance in Practice**
 - 360-degree/multi-source evaluations (self evaluation, peer assessment and patient surveys)
 - Patient reviews, such as satisfaction surveys
 - Performance Improvement CME
 - Collection and analysis of practice data such as medical records, claims review, chart review and audit, case review and submission of a case log
 - Participation in Registries
 - Participation in American Osteopathic Association(AOA) Clinical Assessment Program
 - Participation in medical professional society/organization clinical assessment/practice improvement programs
 - Peer review
 - Use of Centers for Medicare and Medicaid Services (CMS) and other similar institutional based measures
 - Participation in other performance improvement projects such as the Surgical Care Improvement Project (SCIP), American Medical Institute (AMI), Institute for Healthcare Improvement (IHI), Improving Performance in Practice (IPIP), Healthcare Effectiveness Data and Information Set (HEDIS)

Noticing that IPIP is on the list of approved activities, Physician B opts to use her engagement in IPIP to comply with MOL. To verify participation in appropriate activities as part of the license renewal audit process, the board asks Physician B to provide evidence or documentation of participation in IPIP. The board also asks Physician B to document completion of 30 hours of Category 1 CME, as required under Wisconsin Administrative Code.

IMPACT ON STATE MEDICAL BOARDS

One of the key questions that arises as the concept of MOL continues to evolve is: What will be its impact on state boards in terms of costs and work required for implementation?

When the FSMB House of Delegates approved a framework for MOL, one of the key principles adopted was that “maintenance of licensure systems should be administratively feasible” and that they “should not compromise patient care or create barriers to physician practice.” In addition, the House specified that the “infrastructure to support physician compliance with

maintenance of licensure requirements must be flexible and offer a choice of options for meeting requirements.”

The FSMB recognizes that the decision as to whether and how to implement MOL requirements remains the purview of each state medical board. The FSMB also believes that the most viable way to accomplish what will be a sea change in physician regulation is for states to use a consistent model in implementing MOL. Therefore, the FSMB is currently developing a number and variety of pilot projects to advance understanding of the process, structure and resource requirements necessary to develop an effective and comprehensive MOL system. This will include looking at the processes, tools and reporting methodologies available to state boards to administer and verify licensees’ participation in MOL. For example, pilot studies range from assessing the readiness of a state medical board to adopt MOL through integration of MOL with the existing license renewal system; and demonstrating the means by which MOL activities such as MOC will be reported at the time of license renewal.

It is anticipated that most resources will be needed for start-up, including amending legislation (if necessary), revising policies, and educating staff and licensees about the new MOL requirements. Beyond that, however, implementation of MOL should require minimal or no process changes on the part of state medical boards. Similar to current CME systems, licensees would attest to the completion of required activities and a sample of licensees would be audited annually. For example, it is recommended that, for privacy reasons and to simplify medical board record-keeping, practice performance data collected and used by physicians to comply with maintenance of licensure requirements should not be reported to state medical boards. Instead, third-party attestation of collection and use of such data (as part of a continuous professional development program) should satisfy reporting requirements. Again, these aspects and assumptions of the MOL system will be evaluated by the FSMB through the MOL pilot projects.

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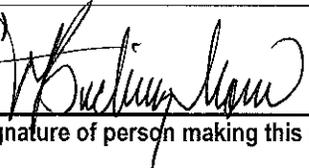
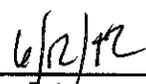
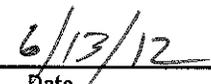
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**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Tamie Buckingham License/Permit Program Associate		2) Date When Request Submitted: 6/12/12	
<p align="center">Items will be considered late if submitted after 4:30 p.m. and less than:</p> <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 			
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 6/20/12	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? ACGME-International (ACGME-I)	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: The Board is being asked to evaluate ACGME-International (ACGME-I) to determine if it is equivalent to the 12 months of ACGME approved post-graduate training that is completed in the United States. See email chain and email dated 5/29/12 from r s [rsc300@hotmail.com]			
11) Authorization:			
 Signature of person making this request		 Date	
 Supervisor (if required)		 Date	
Bureau Director signature (indicates approval to add item to agenda post agenda deadline)			
<p>Directions for including supporting documents:</p> <ol style="list-style-type: none"> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting. 			

Buckingham, Tamie - DSPS

From: Ryan, Thomas - DSPS
Sent: Monday, June 11, 2012 4:06 PM
To: Buckingham, Tamie - DSPS
Cc: Rude-Evans, Karen - DSPS
Subject: FW: International ACGME

Tamie, can you submit this as an application review? If there is time sensitivity, we can add it as a red folder item this month.

From: Nowack, Sandra L - DSPS
Sent: Monday, June 11, 2012 3:41 PM
To: Ryan, Thomas - DSPS
Cc: Buckingham, Tamie - DSPS; Leatherwood, Shancethea N - DSPS
Subject: International ACGME

Tom, based on Dr. Simon's information my advice is to put it on the agenda for Board discussion. That way if they make a policy determination, we can give better legal guidance both to Tamie and potentially on the web.

Sandy

From: Simons, Kenneth [<mailto:ksimons@mcw.edu>]
Sent: Monday, June 11, 2012 3:38 PM
To: Nowack, Sandra L - DSPS
Subject: RE: Inquiry on

Sandy

This discussion just came up at the Board and at present it is the Board's position that ACGME-I **IS NOT** equivalent to ACGME accreditation!

How's that for a timely response?

Ken

From: Nowack, Sandra L - DSPS [<mailto:Sandra.Nowack@wisconsin.gov>]
Sent: Monday, June 11, 2012 3:36 PM
To: Simons, Kenneth
Subject: Inquiry on

Hi Dr. Simons:

Happy Monday. This is an applicant who completed the ACGME International qualification of 12 months and is inquiring whether that satisfies Wisconsin's requirement for the ACGME program. Before we determine whether this is something the Board should just make a policy about, I wanted to check with you on the inside view from ACGME. Is the "ACGME International" essentially the equivalent of ACGME?

Thanks for whatever help you can offer.

Sandy

From: Buckingham, Tamie - DSPS
Sent: Tuesday, May 29, 2012 11:26 AM
To: Ryan, Thomas - DSPS
Subject: RE: general inquiry

Hi Tom,

I spoke to this doctor this morning & I had told him that I am aware if the Board has ever addressed ACGME approved International program & if they would consider it the same as an ACGME approved program in the United States. He was sending this to you to possibly have put on the agenda for the Board to address.

Let me know if I can be of any further help.

Thanks,
Tamie

From: r s [<mailto:rsc300@hotmail.com>]
Sent: Tuesday, May 29, 2012 11:10 AM
To: Ryan, Thomas - DSPS
Subject: general inquiry

Hi I am a US citizen with an MD from asia, and wanted to ask that if I complete the ACGME International qualification of 12 months(<http://www.acgme-i.org/web/index.html>) can I get state license from Wisconsin state?

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Welcome to ACGME-International

A web site for ACGME's International Division

The Accreditation Council for Graduate Medical Education International LLC (ACGME-I) is a non-governmental organization responsible for the accreditation of international Graduate Medical Education (GME) programs.

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

Accreditation of residency programs and sponsoring institutions by the ACGME-I is a voluntary Peer Review process of evaluation and review performed by a non-governmental agency. The goals of the process are to evaluate, improve, and publicly recognize programs or sponsoring institutions in GME that are in substantial compliance with standards of educational quality established by the ACGME-I. Accreditation was developed to benefit the public, protect the interests of residents, and improve the quality of teaching, learning, research, and professional practice.

ACGME-I has established standards for institutional, foundational, and advanced specialty accreditation. Physicians who complete an ACGME-I Accredited Program have been trained in an educational setting where these standards have been met.

International Updates

[Advanced Specialty Program
Information Forms \(PIFs -
updated 02.16.12\)](#)

[International Foundational
Requirements \(updated
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Advanced Specialty Program Information Forms (PIFs)

Below are New Application for Advanced Specialty Accreditation to apply for a new ACGME-I accredited program. The appropriate application should be completed and uploaded into the Accreditation Data System (ADS) along with the New Application for Foundational Accreditation which must be completed in ADS. The final documents should be electronically sign-off by the Sponsoring Institution's Designated Institutional Official. Initial login information can be obtained from Jim Cichon at jcichon@acgme-i.org.

[Anesthesiology 2010](#) (updated 06.06.11)

[Emergency Medicine 2010](#) (updated 01.13.10)

[Family Medicine 2010](#) (updated 02.16.12)

[General Surgery 2010](#) (updated 09.14.10)

[Internal Medicine 2010](#) (updated 01.13.10)

[Anatomical Pathology 2010](#) (updated 03.19.10)

[Obstetrics & Gynecology 2010](#) (updated 01.27.11)

[Ophthalmology 2010](#) (updated 01.27.11)

[Orthopaedic Surgery 2010](#) (updated 01.27.11)

[Otolaryngology 2010](#) (updated 04.06.11)

[Pediatrics 2010](#) (updated 06.07.10)

[Preventive Medicine 2010](#) (updated 01.13.10)

[Psychiatry 2010](#) (updated 01.13.10)

[Diagnostic Radiology 2010](#) (updated 01.27.11)

[Transitional Year 2010](#) (updated 10.10.11)

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[Glossary of Terms \(updated 07.21.11\)](#)

[Family Medicine Program Application Document \(updated 07.21.11\)](#)

[Frequently Asked Questions](#)

ACGME International Foundational Program Requirements for Graduate Medical Education

I. Institutions

A. Sponsoring Institution

1. One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites.
2. The sponsoring institution and the program must ensure the program director has sufficient protected time and financial support for his/her educational and administrative responsibilities to the program.
3. The sponsoring institution must ensure there is a single program director with qualifications and appropriate authority.

B. Participating Sites

1. 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 five years.
The PLA should:
 - a) identify the faculty who will assume both educational and supervisory responsibilities for residents;
 - b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;
 - c) specify the duration and content of the educational experience; and,
 - d) state the policies and procedures that will govern resident education during the assignment.
2. The program director must submit any additions or deletions of participating sites routinely providing required or elective educational experiences for the majority of residents through the ACGME-I Accreditation Data System (ADS).
3. Resident assignments away from the sponsoring institution should not prevent residents' regular participation in required didactics.

II. Program Personnel and Resources

A. Program Director

1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME-I via the ADS.
2. The program director should continue in his/her position for a length of time adequate to maintain continuity of leadership and program stability.
3. Qualifications of the program director should include:
 - a) A minimum of three years documented experience as a clinician, administrator, and educator in the program specialty;
 - b) current American Board of Medical Specialties (ABMS) certification in the program specialty or specialty qualifications that are deemed equivalent or acceptable to the ACGME-I Review

Committee; and,

- c) current medical licensure to practice in the sponsoring institution's host country and appropriate medical staff appointment.
4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME-I competency areas. The program director must:
- a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;
 - b) must dedicate no less than 50% (a minimum of 20 hours per week) of his/her professional effort to the administrative and educational activities of the educational program;
 - c) approve a local director at each participating site who is accountable for resident education;
 - d) approve the selection of program faculty as appropriate;
 - e) evaluate program faculty and approve the continued participation of program faculty based on evaluation;
 - f) monitor resident supervision at all participating sites;
 - g) prepare and submit all information required and requested by the ACGME-I, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure the information submitted is accurate and complete;
 - h) provide each resident with documented semi-annual evaluation of performance with feedback;
 - i) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;
 - j) provide verification of residency education for all residents, including those who leave the program prior to completion;
 - k) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment and must:
 - (1) distribute these policies and procedures to the residents and faculty;
 - (2) monitor resident duty hours, according to institutional and program policies, with a frequency sufficient to ensure compliance with ACGME-I requirements;
 - (3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
 - (4) monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue, if applicable.
 - l) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
 - m) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements for selection, evaluation and promotion of residents, disciplinary action, and resident supervision;
 - n) obtain review and approval from the sponsoring institution's GMEC/DIO before submitting to the ACGME-I information or

requests for the following:

- (1) all applications for ACGME-I accreditation of new programs;
 - (2) changes in resident complement;
 - (3) major changes in program structure or length of training;
 - (4) progress reports requested by the ACGME-I Review Committee;
 - (5) responses to all proposed adverse actions;
 - (6) voluntary withdrawals of ACGME-I accredited programs;
 - (7) requests for appeal of an adverse action;
 - (8) appeal presentations to ACGME-I Review Committee
- o) obtain DIO review and co-sign off on all program information forms as well as any correspondence or document submitted to the ACGME-I that addresses:
- (1) program citations, and/or
 - (2) request for changes in the program that would have significant impact, including financial, on the program or institution.

B. The Faculty

1. There must be a sufficient number of (physician and non-physician) faculty with documented qualifications to instruct and supervise all residents for the program.
2. A portion of the faculty must be core physician faculty who:
 - a) are expert evaluators of the competency domains
 - b) work closely with and support the program director
 - c) assist in developing and implementing evaluation systems,
 - d) teach and advise residents
 - e) devote a minimum of 15 hours per week to resident education and administration
3. All faculty must:
 - a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in resident education;
 - b) administer and maintain an educational environment conducive to educating residents in each of the ACGME-I competency areas;
 - c) participate in faculty development programs designed to enhance the effectiveness of their teaching and to promote scholarly activity;
 - d) establish and maintain an environment of inquiry and scholarship with an active research component.
 - (1) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.
 - (2) Core faculty must demonstrate at least 1 piece of scholarly activity per year, averaged over 5 years by one or more of the following:
 - (a) peer-reviewed funding;
 - (b) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;
 - (c) publication or presentation of case reports or peer-reviewed educational seminars, or clinical series at

- (d) local, regional, national, or international professional and scientific society meetings; or, participation in national or international committees or educational organizations.

(3) Faculty should encourage and support residents in pursuing scholarly activities.

4. All physician faculty must:
 - a) have current ABMS certification in the program specialty or possess qualifications acceptable to the ACGME-I Review Committee; and
 - b) possess current medical licensure and appropriate medical staff appointment.
5. Physician Faculty to Resident Ratio
 - a) In addition to the program director, the core physician faculty to resident ratio must be no less than 1:6.
 - b) The ratio of all physician faculty to residents, which includes all core faculty and the program director, should be 1:1.
6. The non-physician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.

C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

D. Resources

1. The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.
2. There must be sufficient patient population of different ages and gender, with a variety of ethnic, racial, sociocultural and economical backgrounds, having a range of clinical problems to meet the program's educational goals. Insufficient patient experience does not meet educational needs, and excessive patient load suggests an inappropriate reliance on residents for service obligations, which may jeopardize their educational experience.
3. Residents must have software resources to produce presentations, manuscripts, etc.

E. Medical Information Access

1. Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Resident Appointments

A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the ACGME-I Institutional Requirements.

B. Number of Residents

The program director may not appoint more residents than approved by the ACGME-I Review Committee unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program. There should be at least three residents in each year of the program unless otherwise specified by the specialty.

C. Resident Transfers

1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences including their summative competency-based performance evaluation.
2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

IV. Educational Program

A. The curriculum must contain the following educational components:

1. Overall educational goals for the program must be distributed to residents and faculty annually in either written or electronic form;
2. Competency-based goals and objectives for each assignment at each educational level that must be distributed to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;
3. The core curriculum must include a didactic program based upon the core knowledge content and areas defined as resident outcomes in the specialty. Regularly scheduled didactic sessions, including but not limited to:
 - a) multidisciplinary conferences;
 - b) morbidity and mortality conferences;
 - c) journal or evidence-based reviews;
 - d) case-based planned didactic experiences;
 - e) seminars and workshops to meet specific competencies;
 - f) computer-aided instruction; and
 - g) grand rounds.
4. Delineation of educational experiences ensuring the program continues to provide each resident with increased responsibility in patient care and management, leadership, supervision, teaching, and administration.

B. Residents' Scholarly Activities

1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

2. Residents should participate in scholarly activity.
3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

V. Evaluation

A. The program director must appoint the Clinical Competency Committee and the Program Evaluation Committee.

1. The Clinical Competency Committee should:
 - a) be composed of members of the residency faculty;
 - b) have a written description of its responsibilities including its responsibility to the sponsoring institutions and to the program director; and
 - c) participate actively in:
 - (1) reviewing all resident evaluations by all evaluators; and
 - (2) making recommendations to the program director for resident progress, including promotion, remediation, and dismissal.
2. The Program Evaluation Committee should:
 - a) be composed of members of the residency faculty and include representation from the residents;
 - b) have a written description of its responsibilities including its responsibility to the sponsoring institution and to the program director; and
 - c) participate actively in:
 - (1) planning, developing, implementing, and evaluating all significant activities of the residency program,
 - (2) developing competency-based curriculum goals and objectives;
 - (3) reviewing annually the program as noted in Section V.D below; reviewing the GMEC internal review of the residency program with recommended action plans.; and,
 - (4) assuring that areas of non-compliance with ACGME-I standards are corrected.

B. Resident Evaluation

1. Formative Evaluation
 - a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation at completion of the assignment.
 - b) The program must:
 - (1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
 - (2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
 - (3) document progressive resident performance improvement appropriate to educational level; and,

- (4) provide each resident with a documented semi-annual evaluation of performance with feedback.
 - c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.
 - d) Assessment must include a review of case volume, and breadth and complexity of patient cases.
 - e) Assessment should specifically monitor resident knowledge by use of formal in-service cognitive exams.
 - 2. Summative Evaluation
 - a) The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy.
 - b) The evaluation must:
 - (1) document the resident's performance during the final period of education, and
 - (2) verify the resident has demonstrated sufficient competence to enter practice without direct supervision.
- C. Faculty Evaluation
- 1. The program must evaluate faculty performance as it relates to the educational program at least once per year.
 - 2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.
 - 3. The evaluation must include the confidential evaluations written by the residents each year.
- D. Program Evaluation and Improvement
- 1. The program must document formal, systematic evaluation of the curriculum at least once per year. The program must monitor and track each of the following areas:
 - a) resident performance;
 - b) faculty development;
 - c) graduate performance, including performance of program graduates taking the certification examination; and,
 - d) program quality. Specifically:
 - (1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at a minimum of once per year, and
 - (2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.
 - 2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the above listed areas. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.
- VI. Resident Duty Hours in the Learning and Working Environment

- A. Principles
1. The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.
 2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.
 3. Didactic and clinical education must have priority in the allotment of residents' time and energy.
 4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.
- B. Supervision of Residents
- The program must ensure that qualified faculty provides appropriate supervision of residents in patient care activities. All residents must have supervision commensurate to their level of training. Although senior residents require less direction than junior residents, even the most senior residents must be supervised by teaching faculty.
- C. Fatigue
- Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.
- D. Duty Hours (the terms in this section are defined in the ACGME-I Glossary and apply to all programs).
- Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.
1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
 2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of in-house call.
 3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.
- E. On-call Activities
1. In-house call must occur no more frequently than every third night, averaged over a four-week period.
 2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.
 3. No new patients may be accepted after 24 hours of continuous duty.
 4. At-home call (or pager call)
 - a) The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so

- frequent as to preclude rest and reasonable personal time for each resident.
- b) Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
 - c) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

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Updated: 110211

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Advanced Specialty Program Requirements

Below are the International Specialty Specific Program Requirements that are currently available. Please click on the link to download and view each Program Requirements document.

[Anesthesiology 2010](#)  (updated 09.22.10)[Emergency Medicine 2010](#)  (updated 11.29.10)[Family Medicine 2010](#)  (updated 01.10.11)[General Surgery 2010](#)  (updated 09.13.10)[Internal Medicine 2010](#)  (updated 04.28.10)[Obstetrics & Gynecology 2010](#)  (updated 09.22.10)[Ophthalmology 2010](#)  (updated 09.22.10)[Orthopaedic Surgery 2010](#)  (updated 09.22.10)[Otolaryngology 2010](#)  (updated 03.31.11)[Anatomical Pathology 2010](#)  (updated 11.09.10)[Pediatrics 2010](#)  (updated 01.12.10)[Preventive Medicine 2010](#)  (updated 02.04.10)[Psychiatry 2010](#)  (updated 08.04.10)[Diagnostic Radiology 2010](#)  (updated 04.25.11)[Transitional Year 2010](#)  (updated 10.10.11)

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Program Documents for Continued Accreditation

Advanced Specialty Accreditation Documents

Below are Advanced Specialty Continued Accreditation Program Information Forms for ACGME-I programs that currently are accredited. The appropriate document should be completed and uploaded into the programs Accreditation Data System (ADS) account. Both the Foundational Continued Accreditation and Advanced Specialty materials must be completed in ADS and electronically signed off by the Sponsoring Institution's Designated Institutional Official.

[Emergency Medicine](#)  (updated 10.10.11)[Internal Medicine](#)  (updated 10.10.11)[Pathology](#)  (updated 10.10.11)[Pediatrics](#)  (updated 10.10.11)[Preventive Medicine](#)  (updated 10.10.11)[Psychiatry](#)  (updated 10.10.11)[Surgery](#)  (updated 10.10.11)[Transitional Year](#)  (updated 10.10.11)

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ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION INTERNATIONAL

GLOSSARY OF TERMS

July 2011

ACGME-I GLOSSARY OF TERMS

Academic Appointment: An appointment to a faculty category (e.g. professor, Associate Professor, Adjunct Clinical Instructor, etc.) of a degree-granting (e.g. BS, BA, MA, MD, DO, PhD, etc.) school, college, or university.

Accreditation: A voluntary process of evaluation and review based on published, standards and following a prescribed process, performed by a non-governmental agency of peers.

Advanced Specialty Program: A structured educational experience in a field of medical practice following completion of medical school and, in some cases, prerequisite basic clinical education designed to conform to the Advanced Specialty Requirements of a particular specialty; also known as 'core' programs.

Applicant: A physician invited to interview with a GME program.

Assessment: An ongoing process of gathering and interpreting information about a learner's knowledge, skills, and/or behavior.

At-Home Call (Pager Call): A call taken from outside the assigned site. Time in the hospital, exclusive of travel time, counts against the 80 hour per week limit but does not restart the clock for time off between scheduled in-house duty periods. At-Home Call may not be scheduled on the resident's one free day per week (averaged over four weeks).

Certification: A process to provide assurance to the public that a certified medical specialist has successfully completed an approved educational program and an evaluation, including an examination process designed to assess the knowledge, experience and skills requisite to the provision of high quality care in a particular specialty.

Chief Resident: Typically, a position in the final year of the residency (e.g., surgery) or in the year after the residency is completed (e.g., internal medicine and pediatrics).

Citation: A finding of the Review Committee that a program or an institution is failing to comply substantially with a particular accreditation standard or ACGME-I policy or procedure.

Clinical: Refers to the practice of medicine in which physicians assess patients (in person or virtually) or populations in order to diagnose, treat, and prevent disease using their expert judgment. It also refers to physicians who contribute to the care of patients by providing clinical decision support and information systems, laboratory, imaging, or related studies.

Clinical Responsibility/Workload Limits: Reasonable maximum levels of assigned work for residents/fellows consistent with ensuring both patient safety and a quality educational experience. Such workloads, and their levels of intensity, are specialty-specific and must be thoroughly examined by the RCs before inclusion in their respective program requirements.

Clinical Supervision: A required faculty activity involving the oversight and direction of patient care activities that are provided by residents/fellows.

Competencies: Specific knowledge, skills, behaviors and attitudes and the appropriate educational experiences required of residents to complete GME programs.

Complement: The maximum number of residents or fellows approved by the ACGME-I per year and/or per program based upon availability of adequate resources.

Compliance: A program's or institution's adherence to a set of prescribed requirements.

Confidential: Information intended to be disclosed only to an authorized person; that an evaluation is deemed confidential does not imply that the source of the evaluation is anonymous.

Consortium: An association of two or more organizations, hospitals, or institutions that have come together to pursue common objectives (e.g., GME).

Continuous time on duty: The period that a resident or fellow is in the hospital (or other clinical care setting) continuously, counting the resident's (or fellow's) regular scheduled day, time on call, and the hours a resident (or fellow) remains on duty after the end of the on-call period to transfer the care of patients and for didactic activities.

Core Program: See "Advanced Specialty Program"

Cycle Length: The interval between a final accreditation action and the target date identified for the next site visit.

Dependent Subspecialty Program: A program that is required to function in conjunction with an accredited subspecialty/core program, usually reviewed conjointly with the specialty or subspecialty program, usually sponsored by the same sponsoring institution, and geographically proximate. The continued accreditation of the subspecialty program is dependent on the specialty or subspecialty program maintaining its accreditation.

Designated Institutional Official (DIO): The individual in a sponsoring institution who has the authority and responsibility for all of the ACGME-I-accredited GME programs.

Didactic: A kind of systematic instruction by means of planned learning experiences, such as conferences or grand rounds.

Disaster: An event or set of events causing significant alteration to the residency/fellowship experience at one or more residency/fellowship programs.

Duty-Hours: Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site. (See Foundational Program Requirements)

Dreyfus Model: A developmental construct of skill acquisition using six stages, novice to master, with each step building on the previous. A novice is rule based but context free. An advanced beginner takes into account situational aspects. Competent is to be able to devise a plan and decide what is important. Proficient is when intuitive behavior replaces reasoned process. Expert is to routinely make subtle discriminations and immediate intuitive responses. A master loves surprises.

Elective: An educational experience approved for inclusion in the program curriculum and selected by the resident in consultation with the program director.

Essential: (See "Must")

Extreme Emergent Situation: A local event (such as a hospital-declared disaster for an epidemic) that affect resident education or the work environment but does not rise to the level of an ACGME-I-declared disaster.

Faculty: Any individuals who have received a formal assignment to teach resident/fellow physicians. At some sites appointment to the medical staff of the hospital constitutes appointment to the faculty.

Fatigue management: Recognition by either a resident or supervisor of a level of resident fatigue that may adversely affect patient safety and enactment of a solution to mitigate the fatigue.

Fellow: A physician in a program of graduate medical education accredited by the ACGME-I who has completed the requirements for eligibility for first certification in the core specialty. The term "subspecialty residents" is also applied to such physicians. Other uses of the term "fellow" require modifiers for precision and clarity, e.g., research fellow.

Fellowship: see "subspecialty program"

Fitness for duty: Mentally and physically able to effectively perform required duties and promote patient safety.

Focused Institutional Site Visit: An on-site review requested by the ACGME-I. The focused institutional site visit concentrates on institutional oversight of compliance with duty hour standards, potential egregious violations related to resident safety and security, or serious disruption to the resident educational and work environment at a sponsoring institution following a disaster.

Formative Evaluation: Assessment of a resident/fellow with the primary purpose of providing feedback for improvement as well as to reinforce skills and behaviors that meet established criteria and standards without passing a judgment in the form of a permanently recorded grade or score.

Foundational Program Requirements: The set of ACGME-I requirements that apply to all advanced specialties and subspecialties.

Graduate Medical Education: The period of didactic and clinical education in a medical specialty which follows the completion of a recognized undergraduate medical education and which prepares physicians for the independent practice of medicine in that specialty, also referred to as residency education. The term "graduate medical education" also applies to the period of didactic and clinical education in a medical subspecialty which follows the completion of education in a recognized medical specialty and which prepares physicians for the independent practice of medicine in that subspecialty.

Graduate-Year Level: Refers to a resident's current year of accredited GME. This designation may or may not correspond to the resident's particular year in a program. For example, a

resident in pediatric cardiology could be in the first program year of the pediatric cardiology program but in his/her fifth graduate year of GME (including the 4 prior years of pediatrics.) Also referred to as 'post graduate year' or 'PGY".

In-House Call: Duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

Institutional Agreement: (See "Program Letter of Agreement")

Institutional Review: The process undertaken by the ACGME-I to determine whether a sponsoring institution offering GME programs is in substantial compliance with the Institutional Requirements.

Intern: Historically, a designation for individuals in the first year of GME. This term is no longer used by the ACGME-I.

Internal Review: A self-evaluation process undertaken by sponsoring institutions ACGME-I-accredited programs to judge whether each is in substantial compliance with accreditation requirements.

In-Training Examination: Formative examinations developed to evaluate resident/fellow progress in meeting the educational objectives of a residency/fellowship program. These examinations may be offered by certification boards, specialty societies, or specialty training committee.

JC-I: Joint Commission International, formally known as the Joint Commission on Accreditation of Healthcare Organizations International or JCAHO-I, which evaluates and accredits health care organizations outside the United States.

Letter of Notification: The official communication from the ACGME-I that states the action taken by the Review Committee.

Medical School Affiliation: A formal relationship between a medical school and a sponsoring institution.

Must: A term used to identify a requirement which is mandatory or done without fail. This term indicates an absolute requirement.

New Patient: Any patient for whom the resident/fellow has not previously provided care. An individual Review Committee may further define new patient (See Foundational and Advanced Specialty Program Requirements).

Night Float: Rotation or educational experience designed to either eliminate in-house call or to assist other residents during the night. Residents assigned to night float are assigned on-site duty during evening/night shifts and are responsible for admitting or cross-covering patients until morning and do not have daytime assignments. Rotation must have an educational focus.

One Day Off: One (1) continuous 24-hour period free from all administrative, clinical and educational activities.

Ownership of Institution: Refers to the governance, control, or type of ownership of the institution.

Pager Call: (See At-Home Call) A call taken from outside the assigned site.

Participating Site: An organization providing educational experiences or educational assignments/rotations for residents/fellows. Examples of sites include: a university, a medical school, a teaching hospital which includes its ambulatory clinics and related facilities, a private medical practice or group practice, a nursing home, a school of public health, a health department, a federally qualified health center, a public health agency, an organized health care delivery system, a consortium or an educational foundation.

PDSA (Plan-Do-Study-Act):

A four part method for discovering and correcting assignable causes to improve the quality of processes; the method may be applied to individual learning, courses, programs, institutions, and systems, in repeated cycles.

Posting: (See Rotation)

Primary Clinical Site: If the sponsoring institution is a hospital, it is by definition the principal or primary teaching hospital for the residency/fellowship program. If the sponsoring institution is a medical school, university, or consortium of hospitals, the hospital that is used most commonly in the residency/fellowship program is recognized as the primary clinical site.

Program: A structured educational experience in graduate medical education designed to conform to the Foundational and Advanced Specialty Requirements of a particular specialty/subspecialty, the satisfactory completion of which may result in eligibility for certification.

Program Director: The one physician designated with authority and accountability for the operation of the residency/fellowship program.

Program Evaluation: Systematic collection and analysis of information related to the design, implementation, and outcomes of a resident education program, for the purpose of monitoring and improving the quality and effectiveness of the program.

Program Information Form (PIF): The PIF is the document completed by the program director in preparation for a site-visit. The document is a compilation of requested information that reflects the current status of the educational program. The PIF is organized in two parts: Foundational PIF, which addresses the program's compliance with the Foundational Program Requirements, and the advanced specialty or subspecialty PIF, which addresses compliance with the Advanced Specialty or subspecialty program requirements. The Foundational PIF is electronically generated through the Accreditation Data System.

Program Letter of Agreement (PLA): A written document that addresses GME responsibilities between an individual accredited program and a site other than the sponsoring institution at which residents receive a required part of their education. (See Foundational Program Requirements)

Program Merger: Two or more programs that combine to create a single program. One program may maintain continued accreditation while accreditation is voluntarily withdrawn from

the other program or programs. Alternatively, both programs may be withdrawn and a new program may be established.

Program Year: Refers to the current year of education within a specific program; this designation may or may not correspond to the resident's graduate year level.

Required: Educational experiences within a residency/fellowship program designated for completion by all residents/fellows.

Resident: A physician in an accredited graduate medical education specialty program.

Residency: A program accredited to provide a structured educational experience designed to conform to the Foundational and Advanced Specialty Requirements of a particular specialty.

Rotation: An educational experience of planned activities in selected settings, over a specific time period, developed to meet goals and objectives of the program.

Scheduled duty periods: Assigned duty within the institution encompassing hours which may be within the normal work day, beyond the normal work day, or a combination of both.

Scholarly Activity: An opportunity for residents/fellows and faculty to participate in research, as well as organized clinical discussions, rounds, journal clubs, and conferences. In addition, some members of the faculty should also demonstrate scholarship through one or more of the following: peer-reviewed funding; publication of original research or review articles in peer-reviewed journals or chapters in textbooks; publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or participation in national committees or educational organizations. (See Foundational Program Requirements)

Shall: (See Must)

Short call: Responsibility for admitting patients to the teaching service during the early part of the day. Residents begin call in the morning, admit patients until some designated time in the afternoon or late morning and do not stay in the hospital over night.

Should: A term used to designate requirements so important that their absence must be justified. A program or institution may be cited for failing to comply with a requirement that includes the term 'should'.

Site: An organization providing educational experiences or educational assignments/rotations for residents/fellows.

Sponsoring Institution: The organization (or entity) that assumes the ultimate financial and academic responsibility for a program of GME. The sponsoring institution has the primary purpose of providing educational programs and/or health care services (e.g., a university, a medical school, a hospital, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, a consortium, an educational foundation).

Clarification: When the sponsoring institution is a non-rotation site the major associated hospital is the participating rotation site. Additionally, for multiple ambulatory medical sites under separate ownership from the sponsoring institution one central or corporate site

(and address) must represent the satellite clinics (that are located within 10 miles of the main site).

Strategic napping: Short sleep periods, taken as a component of fatigue management, which can mitigate the adverse effects of sleep loss.

Subspecialty Program: A structured educational experience following completion of a prerequisite specialty program in GME designed to conform to the Specialty Specific Requirements of a particular subspecialty.

Summative Evaluation: Assessment with the primary purpose of establishing whether or not performance measured at a single defined point in time meets established performance standards, permanently recorded in the form of a grade or score.

Supervising Physician: A physician, either faculty member or more senior resident, designated by the program director as the supervisor of a junior resident. Such designation must be based on the demonstrated medical and supervisory capabilities of the physician.

Supervision: The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care.

Supervision Levels: To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

Direct Supervision:

The supervising physician is physically present with the resident and patient.

Indirect Supervision:

- (1) With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
- (2) With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Oversight:

The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Transfer resident: Residents are considered as transfer residents under several conditions including: moving from one program to another within the same or different sponsoring institution; when entering a PGY 2 program requiring a preliminary year even if the resident was simultaneously accepted into the preliminary PGY1 program and the PGY2 program as part of the match (e.g., accepted to both programs right out of medical school). Before accepting a transfer resident, the program director of the 'receiving program' must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation from the current program director. The term 'transfer resident' and the

responsibilities of the two program directors noted above do not apply to a resident who has successfully completed a residency and then is accepted into a subsequent residency or fellowship program.

Transitional-Year Program: A one-year educational experience in GME, which is structured to provide a program of multiple clinical disciplines; its design to facilitate the choice of and/or preparation for a specialty. The transitional year is not a complete graduate education program in preparation for the practice of medicine.

Transitions of care: The relaying of complete and accurate patient information between individuals or teams in transferring responsibility for patient care in the healthcare setting.

WER 12/01/10

COMMON ACRONYMS/ABBREVIATIONS USED IN GRADUATE MEDICAL EDUCATION

AAMC	Association of American Medical Colleges
ABMS	American Board of Medical Specialties
ABMS-I	American Board of Medical Specialties International
ACGME	Accreditation Council for Graduate Medical Education
ACGME-I	Accreditation Council for Graduate Medical Education International LLC
ADS	Accreditation Data System
AIIA	Application for International Institutional Accreditation
AIPA	Application for International Program Accreditation
APD	Associate Program Director
AS-PIF	Advanced Specialty – Program Information Form
CCC	Clinical Competency Committee
CBE	Competency-Based Education
DIO	Designated Institutional Official
FRCS	Fellow of the Royal College of Surgeons
FS	Annual ACGME-I Faculty Survey
GME	Graduate Medical Education
GMEC	Graduate Medical Education Committee
IRD	Institutional Review Document
JC	Joint Commission on Accreditation of Healthcare Organizations
JC-I	Joint Commission on Accreditation of Healthcare Organizations International
LON	Letter of Notification
MBBS	Bachelor of Medicine, Bachelor of Surgery
MB ChB	Bachelor of Medicine, Bachelor of Surgery
MB BCh	Bachelor of Medicine, Bachelor of Surgery
MRCPC	Member of the Royal College of Pediatrics and Child Health
MRCS	Member of the Royal College of Surgeons
PD	Program Director
PEC	Program Evaluation Committee
PGY	Post Graduate Year
PIF	Program Information Form
PLA	Program Letter of Agreement (for residency and fellowship program)
RC	Review Committee
RS	ACGME-I Annual Resident Survey
SV	Site Visitor
SVR	Site Visitor Report
TY	Transitional Year

New Application for the Advanced Specialty: FAMILY MEDICINE
515 N State, Suite 24510, Chicago, IL 60654 • (312) 755-7031 • www.acgme-i.org

ACGME-International

APPLICATIONS FOR A NEW PROGRAM: This Advanced Specialty Application is for programs applying for **INITIAL ACCREDITATION ONLY** (for Continued Accreditation or re-accreditation, use the **CONTINUED ACCREDITATION DOCUMENT** in conjunction with the Web Accreditation Data System).

All sections of the form applicable to the program must be completed in order to be accepted for review. The information provided should describe the proposed program. For items that do not apply indicate N/A in the space provided. Where patient numbers are requested, estimate what you expect will occur. If any requested information is not available, an explanation should be given and it should be so indicated in the appropriate place on the form. Once the forms are complete, number the pages sequentially in the bottom center.

The program director is responsible for the accuracy of the information supplied in this form and must sign it. It must also be signed by the designated institutional official of the sponsoring institution, who will submit the application electronically.

Review the International Foundational Program Requirements for Graduate Medical Education and Advanced Specialty Program Requirements for Graduate Medical Education in Family Medicine. The International Foundational, Advanced Specialty, and Institutional Requirements may be downloaded from the ACGME-I website (www.acgme-i.org):

For questions regarding:

- the completion of the form (content), contact James Cichon at jcichon@acgme-i.org.
- the Accreditation Data System, email WebADS@acgme.org and write "Singapore" in comment line.

Note that the process **can takes up to one year** from the time the application is received until it is evaluated by the Review Committee. A site visit will be scheduled during that year.

APPLICATION FOR ADVANCED SPECIALTY: FAMILY MEDICINE

515 N State Street, Suite 24510, Chicago, IL 60654 • (312) 755-7031 • www.acgme-i.org

Program Name:

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Advanced Specialty Document

I. CLINICAL EXPERIENCES (AS-PR II.H)

A. Types

1. Home Visits (II.H.15.a)

- a) Do residents perform at least 2 continuity home visits? YES () NO ()
- b) Is at least one home visit with an older adult continuity patient? YES () NO ()
- c) If a "NO" response was provided to either question, explain below.

d) Describe how residents are supervised during this experience.

2. Nursing Home Visits (II.H.15)

- a) Do residents provide at least two nursing home patients continuity of care for a minimum of 24 consecutive months?
..... YES () NO ()
- b) Is this experience separate from that which residents may have as part of a block rotation?
..... YES () NO ()

c) If a "NO" response was provided to either question, explain below.

d) Describe how residents are supervised during this experience.

3. Family Oriented Care (AS-PR II.J)

For the following required curricular elements, indicate with an 'X' the setting(s) in which each is taught.

Curricular Elements	Clinical					
	Didactic	FMC	Inpt	Home	Long-term Care Facility	Other (Specify)
INDIVIDUAL						
Health assessment						
Health maintenance						
Preventive care						
Acute/Chronic illness or injury						
Rehabilitation						
Behavioral counseling						
Health education						
Human sexuality						
FAMILY						
Family structure and dynamics						
Genetic counseling						
Family planning						
Child rearing/child education						
Aging						
End of life issues						
Role of the family in illness care						
Family counseling						

4. Patient Care Skills: Documentation

1. Faculty in most clinical settings may observe and assess, to some degree, the residents' ability to counsel patients and families. List the setting(s)/activities in which this skill is specifically emphasized and evaluated, e.g., in FMC, giving discharge instructions, getting informed consent, etc.

II. STRUCTURED EDUCATION (AS-PRS II.G, II.H, AND II.I)

A. Block Diagram (Upload as Attachment 9)

COMPLETE THE FOLLOWING CHARTS FOR EACH OF THE THREE YEARS OF Family Medicine Education.

Block Rotations:

- Top row: Identify the curricular experience and location. Identify each hospital (or other location) in which the particular assignment occurs. Hospitals should be identified by the number used in the Foundational Application (i.e., #1, #2, etc.). Assignments to private offices should be designated as Ofc.
- Middle Row: Include the FMC time (enter the number of sessions/week in the FMC).
- Last Row: Report (1) the usual number of hours/week worked, (2) the longest consecutive hours, and (3) the frequency of the longest consecutive hours for any one resident during that month. For rotations to another specialty service, the duty hour requirements of the host service apply. If residents rotate on a service whose specialty has received approval for an exception to the 80 hour work hour requirement, a copy of the official letter of approval from that RRC should be made available to the site visitor.

General Information:

- Do not indicate the time in percentages.
- Programs with multiple 'tracks' will need to highlight the 20 months of curriculum that all residents experience.
- Programs in the 1-2 format should highlight the experiences in year 1 that will be identical for residents in the core program and the 1-2 program.
- Since residents may experience the rotations in different sequence, list all similar rotations sequentially: OB OB PED PED
- Residents' Experiences: 1 month = 1 block = 100 hours

Sample:

Experience of Rotations	Orientation in FMC	1 mon OB #1	1 mon OB #2	(35 hrs) Uro Ofc (35 hrs) Derm Ofc														
FMC	FMC1 (Number of Sessions/Week in FMC)	FMC1	FMC1	FMC1														
Duty Hours	70/20/2X	76/30/2X	74/28/2X	80/24/2X														

B. Adult Medicine (AS-PR II.H.2 and II.I.4)

Indicate on this chart what the program requires in structured experiences in the care of adults. For location, use site numbers (#) as included in the Foundational Application. Do not fill in the shaded cell in the table.

Curricular Area	Inpatient Time	Location	Outpatient Time	Location	Yr(s). of Training in Which Experience Occurs
Adult Medicine					
Critical Care					

For the following curricular areas, indicate with an 'X' the setting(s) in which each is taught. If a separate block rotation is used identify the PG year and duration of experience.

Curricular Area	Didactic	Interaction with Consultants	Integrated in Adult Med Rotations	Separate Block Rotations			
				Year	Duration	Inpt	Outpt
Cardiovascular Disease							
Endocrinology							
Pulmonology							
Hematology-Oncology							
Gastroenterology							
Infectious Disease							
Rheumatology							
Allergy and Immunology							
Neurology							
Women's Health							

1. Inpatient (AS-PR II.I.18)

- a) Complete the table below that describes the required adult medicine inpatient experience. Identify each hospital in which the particular assignment occurs. Hospitals should be identified by the site number used in the Foundational Application (i.e., #1, #2, etc.)

Hospital	Average daily census on the service	Total # of residents on service providing care	FM or IM service	Supervisor (Name and specialty)	Do residents take call?	
					Yes	No

- b) If FM residents rotate with other residents on services, briefly describe the relationship between the two groups below.

- c) List the procedures that all residents are required to learn by the end of the required experience in adult medicine. List no more than 10 procedures.

- d) Indicate the top 10 diagnoses at the hospital where your residents will train by inserting numbers 1-10 in the following table. Let 1 indicate the most common diagnosis.

Diagnosis	Rank
Abdominal Pain, NOS	
Acute myocardial infarction	
Alcohol abuse	
Alzheimer's Disease	
Asthma acute exacerbation	
Atrial fibrillation	
Backache, vertebrogenic (pain) syndrome	
Cellulitis and abscess of leg	
Cerebral infarction	
Cholecystitis	
Congestive heart failure	
Convulsive disorder, NOS	
COPD	
Coronary artery disease	
Depression	
Depressive type psychosis	
Dystrophy due to malnutrition; malnutrition (calorie), NOS	
Hemorrhage of gastrointestinal tract	
Human immunodeficiency virus (hiv), aids	
Hypertension	
Hypokalemia	
Hyposmolality and/or hyponatremia	
Influenza with other respiratory manifestations	
Iron deficiency anemia	
Malignant neoplasm of bronchus and lung	
Other chest pain, r/o mi	
Pancreatitis	
Pneumonia, organism, NOS	
Renal Failure	
Septicemia due to gram-neg organism	
Septicemia, NOS	
Syncope & collapse blackout;fainting;(near/pre) syncope;vasovagal attack	
Type two diabetes mellitus	
Ulcer of lower limb, NOS	

Diagnosis	Rank
Urinary tract infection, pyuria	
Volume depletion disorder, dehydration; hypovolemia	

- e) Provide the average number of patients that each resident will personally manage on a day-to-day basis by resident level.

Rotation	FM YR1	FM YR2	FM YR3
Adult Medicine			

- f) Describe (1) how residents learn supervisory skills; (2) what opportunities are available for supervision; and (3) the mechanisms used to assess residents' supervisory skills.

Limit your response to 400 words

(1)
(2)
(3)

2. Critical Care (AS-PR II.H.12 and II.I.6)

Describe how the program ensures that each resident manages the care of at least 15 critically ill patients. Describe the tracking mechanism used.

--

3. The Older Patient (II.I.7)

For the following required curricular elements, indicate with an 'X' the setting(s) in which each is taught.

Curricular Elements	Didactic	Clinical					
		FMC	Outpt	Inpt	Home	Long-term Care Facility	Other (Specify)
Preventive aspects of health care							
Physiological and psychological changes of senescence							
Social-cultural parameters							
Geriatric syndromes							
Functional assessment of elderly patients							

- a) For the training that all family medicine residents are required to receive in geriatrics, provide a brief description of how a structured multi-disciplinary approach involving clinical experience in the FMC, hospital, long-term care facility, and the home is implemented.

--

C. Care of Neonates, Infants, Children, and Adolescents (AS-PR II.H.3 and II.I.8)

	Duration of Experience	Yr(s). of Training Experience Occurs	Location(s)
Inpatient (exclude newborns)			
Newborn nursery			
Outpatient (exclude FMC)			
Other			

For the following curricular elements, indicate with an 'X' the setting(s) in which each is taught. Do not fill in the cells in the table that are shaded grey.

Curricular Elements	Didactic	Clinical			
		FMC	Outpt	Inpt	Other (Specify)
Experience with neonates					
Infant care (both well-baby and ill)					
Hospitalized children					
Ambulatory pediatrics					
Emergency care of children					
Adolescent medicine					

1. Describe the training in pediatrics, demonstrating how the required components are addressed.

2. Do FM faculty teach and role model continuity of responsibility for hospitalized children?
 YES () NO ()

3. List the procedures that all residents are required to learn by the end of the required experience in pediatrics. List no more than 10 procedures.

D. Pediatric Diagnoses

a. Indicate the top 10 pediatric diagnoses at the hospital where your residents will train by inserting numbers 1-10 in the following table. Let 1 indicate the most common diagnosis.

Diagnosis	Rank
Abdominal pain, NOS	
Acute respiratory failure	
Allergic Reactions	
Appendicitis/Appendectomy	
Asthma	
Bronchiolitis	
Burns	
Cancer, various	
Cellulitis, skins infections	
Child Abuse	

Diagnosis	Rank
Congenital Heart Disease	
Croup	
Cystic Fibrosis	
Dehydration/Hypovolemia	
Depression	
Diabetes	
Diarrhea	
Esophageal reflux	
Failure to thrive	
Fracture	
FUO r/o sepsis	
Gastroenteritis	
Head Trauma	
Headache	
Hyperbilirubinemia	
Jaundice	
Leukemia	
Meningitis	
Mental status change	
Metabolic Disorder	
Osteomyelitis	
Otitis Media	
Pneumonia	
Poisoning	
Renal	
Respiratory Distress (RSV)	
Seizure	
Sepsis	
Sickle Cell Crisis	
Trauma/abuse	
UTI/Pyelonephritis	
Viral Illness, unknown etiology	
Viral Meningitis	

- b. Provide the average number of patients that each resident will personally manage on a day-to-day basis by resident level.

Rotation	FM YR1	FM YR2	FM YR3
Pediatric Inpatient - Newborn			
Pediatric Inpatient - Excluding Newborn			

E. Maternity Care (AS-PR II.H.5 and II.I.9)

1. Indicate the amount of time required of all residents and the location for the structured experience in obstetrics. **Do not count time spent in the FMC when residents care for their panels of patients.** Report required time in months or hours. For location use hospital #, priv. ofc. clinics, etc.

Specialty	Inpt Time	Location	Outpatient Time	Location	Yr(s). Of Training in Which Experience Occurs
Maternity care					

2. Care of the Pregnant Patient

a. Describe the residents' experiences in Maternity Care, specifically the program's structured curriculum in pre-natal, intrapartum and post-partum care.

b. Will all residents have successfully completed an ALSO course (or similar curricular experience) to demonstrate measurable basic competency in obstetrical emergencies?

.....Yes ()... No ()

If not ALSO course explain.

c. Describe how all residents will have a maternity care experience sufficient to recognize abnormal from normal pregnancy, care for common medical problems arising from pregnancy or coexisting with pregnancy and assisting a woman experiencing a spontaneous precipitous birth.

d. Describe how all residents will have "participatory experience" in a minimum of 20 deliveries.

3. Labor and Delivery Competency (OPTIONAL)

To train in labor and delivery competency, describe how, where, and when the resident will:

a. Perform a minimum of 80 vaginal deliveries

b. How will a resident demonstrate competence:

i. To conduct a spontaneous vaginal delivery

ii. In the management of common intrapartum and post-partum complications

iii. In assisted deliveries

iv. As a first assistant in Caesarean section delivery

4. If the supervisor for labor and delivery is someone other than a faculty physician, describe his/her qualifications to supervise residents. If the supervising physician is a family medicine resident, in what year of training and how many deliveries would s/he have had?

--

5. If family medicine residents rotate with obstetrics residents, describe the relationship between the two groups.

--

6. List the procedures that all residents are required to learn by the end of the required experience in obstetrics. List no more than 10 procedures.

--

Number and types of deliveries per resident by completion of education.

Minimum number of deliveries per resident	
Minimum number of continuity deliveries per resident	
Minimum number of vaginal deliveries per resident	

F. Gynecology (AS-PR II.H.6 and II.I.10)

1. For the following curricular areas, indicate with an 'X' the setting(s) in which each is taught.

Curricular Elements	Didactic	Clinical			
		FMC	Outpt	Inpt	Other (Specify)
Normal gyn exam					
Gyn cancer screen					
Preventative health care in females					
Common STD & infections					
Reproductive & hormonal physiology including fertility					
Family planning, contraception, option counseling for unintended pregnancy					
Pelvic floor dysfunction					
Disorders of menstruation					
Disorders of perimenopausal, menopause & osteoporosis					
Sexual health					
Breast disorders					
Management of cervical disease					

2. Document how the required 100 hours (or one block month) of structured experience is provided, excluding the routine care of continuity patients in the FMC and call duties. Provide information on the number of hours for each activity per clinic or session. Specify what percentage of the 100 hours is non-clinical.

--

3. List the procedures that all residents are required to learn by the end of the required experience in gynecology. List no more than 10 procedures.

G. Care of the Surgical Patient (AS-PR II.H.7 and II.I.12)

Indicate on this chart the amount of required time and the location for the structured general and subspecialty surgical experiences. Do not count time spent in the FMC when residents care for their panels of patients. Specialty structured surgical clinics within the FMC should be listed. Report general surgery time in months and subspecialty time in actual hours of experience with number of hours per day or session (excluding lunch or off time). For location use hospital #, priv. ofc., FMC, etc. Identify whether the experience allowed for hands-on experience.

Specialty	Inpatient Time	Location	Outpatient Time	Location	Hands-On Experience (Yes/No)
General Surgery					
Otolaryngology					
Ophthalmology					
Urology					

1. General Surgery

- a) Briefly describe the two-months of general surgical rotations, including the supervision provided, and the degree of resident responsibility for and involvement with patients. If non-generalist surgeons are used, explain how this experience exposes residents to common surgical procedures.

- b) Describe how the diagnosis and management of surgical emergencies are taught.

- c) Describe how pre- and post-operative care are taught and the degree to which residents are actively involved.

- d) Does the resident have the opportunity to be first assistant in the O.R.? YES () NO ()
If not, how does the resident learn the surgical principles of asepsis, tissue handling, and technical skills?

- e) List the procedures that all residents are required to learn by the end of the required experience in surgery. List no more than 10 outpatient and inpatient procedures.

H. Musculoskeletal and Sports Medicine (AS-PR II.H.8 and II.I.13)

1. Demonstrate how the structured experience in orthopaedics is ensured, excluding the routine care of continuity patients in the FMC and call duties. Provide information on the number of hours for each

activity per clinic or session. List the procedures that all residents are required to learn by the end of the required experience. List no more than 10 procedures.

2. Demonstrate how the structured experience in sports medicine is ensured, excluding the routine care of continuity patients in the FMC and call duties. Provide information on the number of hours for each activity per clinic or session. List the procedures that all residents are required to learn by the end of the required experience. List no more than 10 procedures.

3. In the two tables below, indicate with an "X" how residents are taught about the following curricular components.

Orthopaedic Curricular Components	Didactic	Clinical			
		FMC	Outpt	Inpt	Other (Specify)
Degenerative arthritic conditions					
Evaluation and management of acute musculoskeletal injury					
Rehabilitation and restorative function					
Acute pain syndromes					
X-ray interpretation					
Splinting and casting					
Aspiration/injection of joints					

Sports Medicine Curricular Components	Didactic	Clinical			
		FMC	Outpt	Inpt	Other (Specify)
Education and experience in performing pre-participation physicals					
Education and experience in caring for athletic and recreational injuries					
Non-articular rheumatic disorders					

I. Emergency Care (AS-PRs II.H.9 and II.I.14)

Provide responses in the boxes below. If two or more hospitals are used for emergency room training, duplicate this section and answer for each.

Location of Experience: _____

1. Is there an accredited emergency medicine residency program? YES () NO ()

If **YES**, describe the relationship between the emergency medicine and the family medicine residents.

2. Describe how the program meets the requirement for a structured clinical experience of at least 200 hours including hours, days, shifts, days per week and total hours.

3. Educational content:

a) Describe the training residents receive in standard current life support skills and procedures for medical emergencies in patients of all ages. If they do not receive this training, explain.

b) Describe the training residents receive in standard current life support skills and procedures for trauma emergencies in patients of all ages. If they do not receive this training, explain.

c) Is a faculty physician on site 24 hours a day, 7 days a week for on-site supervision? If not, is any attending physician on-site at all times and responsible for the ER and the resident? Provide details.

d) Describe the didactic component of the emergency medicine experience.

e) List the procedures that all residents are required to learn by the end of the required experience in emergency medicine. List no more than 10 procedures

J. Human Behavior and Mental Health (AS-PR II.I.15)

For the following curricular areas, indicate with an 'X' the setting(s) in which each is taught.

Curricular Elements	Didactic	Clinical Teaching			
		FMC	Inpt	Priv. Office	Other (Specify)
Diagnosis and management of psychiatric disorders in children and adults					
Emotional aspects of non-psychiatric disorders					
Psychopharmacology					
Alcoholism and other substance abuse					
The physician/patient relationship					

Curricular Elements	Didactic	Clinical Teaching			
		FMC	Inpt	Priv. Office	Other (Specify)
Patient interviewing skills					
Counseling skills					
Normal psycho-social growth and development in individuals and families					
Stages of stress in a family life cycle					
Sensitivity to gender, race, age, and cultural differences in patients					
Family violence, including child, partner, and elder abuse (physical and sexual), as well as neglect, and its effect on both victims and perpetrators					
Medical ethics, including patient autonomy, confidentiality, and issues concerning quality of life					
Factors influencing patient compliance					

1. For the training that all family medicine residents are required to receive in behavioral science, provide a brief description of how a structured approach involving clinical experience in the FMC, hospital, long-term care facility, and the home is implemented. Describe the faculty involved in teaching this curriculum to residents.

K. Community Medicine (AS-PR II.I.16)

For the following curricular areas, indicate with an 'X' the setting(s) in which each is taught.

Curricular Elements	Didactic	Hands-On Experience	Other (Specify)
Assessment of risks for abuse, neglect, and family and community violence			
Reportable communicable disease			
Population epidemiology / interpretation of public health statistical information			
Environmental illness and injury			
School health			
Disease prevention			
Disaster responsiveness			
Community-based disease screening, prevention, health promotion			
Factors associated with differential health status among sub-populations			

Indicate whether the program provides residents training in the curricular areas noted below.

Clinical Experiences in Community Medicine	Yes / No
Experience in using community resources appropriately for individual patients who have unmet medical or social support needs	

2. In addition to structured didactic conferences what other methods of learning does your program use to foster continuous professional development of residents? Check all that apply and identify the content of these learning activities.

Learning Venue	Place an "X" in this column if used	Content Addressed
Self-directed learning modules		
Small group discussions		
Journal club		
Workshops		
Other learning activities (identify):		

P. Management of Health Systems (AS-PR II.G.4)

1. Do all residents receive at least quarterly reports on:
 - a) individual/practice productivity YES () NO ()
 - b) financial performance YES () NO ()
2. Do residents receive training to analyze these quarterly reports? YES () NO ()
3. Do residents attend at least annually FMC business meetings with staff and faculty? YES () NO ()
4. Do residents participate in projects to improve quality and service to FMC patients? YES () NO ()
5. Do residents receive training in how to provide leadership for:
 - a) a clinical practice YES () NO ()
 - b) a hospital medical staff YES () NO ()
 - c) professional organizations, and YES () NO ()
 - d) community leadership skills to advocate for the public health YES () NO ()
6. For each of the following educational elements, indicate with an "X" where such training is taught/provided.

	Didactic	Practice/Office Environment
Current billing practices		
Designing and managing a budget		
Assessing practice staffing needs		
Impact of new technologies on practice		
Determining value in the marketplace		
Assessing customer satisfaction		

Measurement of clinical quality		
Tort liability and risk management		
Office scheduling systems		
Computers in practice		
Alternative practice models		
Employment law and procedures		
Principles of public relations		
Media training		
Personnel management		

7. Explain how the program provides 100 hours of practice management.

III. Competencies (AS-PR III)

A. Patient Care (AS-PR III.A)

Briefly describe how the program will judge that a resident, after completing the 3rd year of Family Medicine accredited education, will demonstrate competence in:

- the following essential skills/competencies of both productivity and efficiency necessary to meet the expectations of independent clinical practice, such as: (a) ability to collect a complete initial data base and examination; (b) ability to define and expand the differential diagnoses list; (c) identification of the most likely diagnoses and the establishing of a plan for diagnostic and treatment modalities; (d) ability to educate the patient and family about the diagnoses, evaluation and treatment of the disease, to obtain informed consent, and perform appropriate procedures; ability to practice in a team and with a systems-based approach; (e) ability to present data to other members of the team and consultants; (f) cost-conscious ordering of diagnostic tests and therapeutics; (g) construction of a medical record summary with accuracy and in compliance with expected format and in compliance with the hospital's medical records policies; (h) formulate short and long term goals; and, (i) the providing of guidance to patients regarding advanced directives, end-of-life issues and unexpected diagnoses/outcomes.

- preventive healthcare, promotion of independent living, and maximizing function and quality of life in the elder patient.

- cultural competence in caring for patients from varied ethnic and cultural backgrounds.

4. provision of longitudinal health care to families, including assisting them in coping with serious illness and loss, and in promoting family mechanisms to maintain wellness of its members.

5. assessing and meeting the healthcare needs of declining elders, episodic, illness related care, delivery of healthcare in the home, FMC, hospital, and long-term facility, and end-of-life care.

6. managing a normal pregnancy and delivery.

7. the common problems of prenatal and postnatal care;

8. the performance of appropriate gynecological procedures.

9. giving proper advice, explanation, and emotional support during the care of surgical patients and their families and recognizing surgical conditions that are preferably managed on an elective basis.

10. the diagnosis and management of a wide variety of common general surgical problems typically cared for by family physicians.

11. diagnosing and managing common inpatient problems of adults and children as seen by the family physician.

12. knowledge, attitudes, and skills to care independently for hospitalized male and female patients having various levels of severity of illness without supervision, and to utilize appropriate consultation by other specialists;

13. providing supervision to others in a learning environment.

B. Medical Knowledge (AS-PR III.B)

Briefly describe how the program will judge that a resident, after completing the 3rd year of accredited Family Medicine education, will demonstrate knowledge of:

1. health assessment, health maintenance, preventive care, acute and chronic illness and injury, rehabilitation, behavioral counseling, health education, and human sexuality.

2. family structure and dynamics, genetic counseling, family development, family planning, child rearing and education, aging, end of life issues, epidemiology of illness in families, the role of family in illness care, family counseling and education, nutrition, and safety.

3. the biological and psychosocial impacts on a woman and her family of pregnancy, delivery, and care of the newborn.

4. the varieties of surgical treatments and the potential risks associated with them.

Describe the planned program learning activities which will provide experience in the general competencies for residents. Examples of learning activities include: didactic lecture, assigned reading, seminar, self-directed learning module, conference, small group discussion, workshop, online module, journal club, project, case discussion, one-on-one mentoring.

C. PRACTICE-BASED LEARNING AND IMPROVEMENT (AS-PR III.C)

1. Describe one learning activity in which residents will engage to identify strengths, deficiencies, and limits in their knowledge and expertise (self-reflection and self-assessment); set learning and improvement goals; identify and perform appropriate learning activities to achieve self-identified goals (life-long learning).

Limit your response to 400 words.

2. Describe one learning activity in which residents will engage to develop the skills needed to use information technology to locate, appraise, and assimilate evidence from scientific studies and apply it to their patients' health problems. The description should include:
 - a) locating information
 - b) using information technology
 - c) appraising information
 - d) assimilating evidence information (from scientific studies)
 - e) applying information to patient care

Limit your response to 400 words.

[Empty text box]

3. Describe one planned quality improvement activity or project in which at least one resident will participate that will require the resident to demonstrate an ability to analyze, improve and change practice or patient care. Describe planning, implementation, evaluation and provisions of faculty support and supervision that will guide this process.

Limit your response to 400 words.

[Empty text box]

4. Describe how residents will:
 - a) develop teaching skills necessary to educate patients, families, students, and other residents;
 - b) teach patients, families, and others; and,
 - c) receive and incorporate formative evaluation feedback into daily practice. (If a specific tool is used to evaluate these skills, please include it as **Attachment 7**).

Limit your response to 400 words.

[Empty text box]

D. INTERPERSONAL AND COMMUNICATION SKILLS (AS-PR III.D)

1. Describe one learning activity in which residents will develop competence in communicating effectively with patients and families across a broad range of socioeconomic and cultural backgrounds, and with physicians, other health professionals, and health related agencies.

Limit your response to 400 words.

[Empty text box]

2. Describe one learning activity in which residents will develop their skills and habits to work effectively as a member or leader of a health care team or other professional group. In the example, identify the members of the team, responsibilities of the team members, and how team members communicate to accomplish responsibilities.

Limit your response to 400 words.

[Empty text box]

3. Explain (a) how the completion of comprehensive, timely and legible medical records will be monitored and evaluated, and (b) the mechanism that will be used for providing residents feedback on their ability to competently maintain medical records.

Limit your response to 400 words.

[Empty text box]

E. PROFESSIONALISM (AS-PR III.E)

1. Describe at least one learning activity, other than lecture, by which residents will develop a commitment to carrying out professional responsibilities and an adherence to ethical principles.

Limit your response to 400 words.

[Empty text box]

- How will the program promote professional behavior by the residents and faculty?

Limit your response to 400 words.

- How will lapses in these behaviors be addressed?

Limit your response to 400 words.

F. SYSTEMS-BASED PRACTICE (AS-PR III.F)

- Describe the learning activity(-ies) through which residents will achieve competence in the elements of systems-based practice: work effectively in various health care delivery settings and systems, coordinate patient care within the health care system; incorporate considerations of cost-containment and risk-benefit analysis in patient care; advocate for quality patient care and optimal patient care systems; and work in interprofessional teams to enhance patient safety and care quality.

Limit your response to 400 words.

- Describe an activity that will fulfill the requirement for experiential learning in identifying system errors.

Limit your response to 400 words.

- Do residents have the opportunity to work in interdisciplinary teams? YES () NO ()

If the answer to the above question is yes, complete the table below (add rows as necessary) by listing the setting and putting a "Y" or an "N" to indicate a "yes" or a "no" in each of the columns.

Setting	Team Members						
	Nurses	Mid-Level Provider	Respiratory Therapist	Pharmacist	Case Manager	Social Worker	Other (Specify)

IV. FACULTY RESPONSIBILITIES (AS-PR II.C)

- Did the faculty help identify and monitor the most common medical problems cared for by family physicians during the residency inpatient rotations? () Yes () No
- Have the faculty helped the program director to develop a list of required procedural competencies? () Yes () No
- Is there at least one faculty member scheduled and present at all required core conferences?

Yes No

4. Does a faculty member always provide on-site supervision when services or procedures needed exceed the competency of the most senior supervising resident who is on site? Yes No

Please explain any "No" responses indicated above. Limit your response to 150 words.

V. FAMILY MEDICINE CENTER (AS-PR II.E.1)

1. LIST THE FMC'S USED IN THIS PROGRAM AND PROVIDE THE FOLLOWING INFORMATION.

Place an "X" in the cell below if this is new facility since last review	Name of FMC	Name of FMC Director	Miles from primary hospital/travel time	Scheduled operating hours	Square feet of floor space available	FM preceptor:resident ratio	# of exam rooms	Maximum # of resident & faculty in FMC simultaneously	# of other learners in FMC	Number of FMC Personnel			
										Nursing	Clerical	Technical	
EXAMPLE	Johnston FMC	Tom Smith, MD	0/0 min	8-8 (M-F) 8-1 (S)	10,000	1:4	16	8	MS=2 OP=1	10	8	NA	NA
	FMC #1												
	FMC #2												
	FMC #3												
	FMC #4												
	FMC #5												

Additional Information:

- # of other learners in the FMC = specify the type and number of other learners in the FMC. Use the following categories: medical students=MS; other residents = OR; nurse practitioners = NP; other professionals=OP, e.g. dentists, podiatrists.
- Other Personnel in the FMC: specify _____

	FMC1	FMC2	FMC3	FMC4	FMC5	FMC6
2. ANSWER YES OR NO TO THE FOLLOWING:						
a) Does the entry to the FMC have signage that clearly identifies it as an FMC?						
b) Does the residency director have control of the education activities in the FMC?						
c) Does the residency director have control of the activities of the support personnel in the FMC?						

	FMC1	FMC2	FMC3	FMC4	FMC5	FMC6
d) Does the director of the FMC report to the Program Director?						
e) Does the appointment system assure maximum accessibility of the resident to his/her patients in the FMC.						
f) Is there a business office or business function area in the FMC?						
g) Is there a conference room large enough to accommodate the residents, faculty, etc., at this FMC?						
h) Do FMC patients have convenient access to imaging services?						
i) Do FMC patients have convenient access to a diagnostic laboratory?						
j) Do patients have access to a program physician after hours?						
k) Do family physician faculty see patients without residents in the FMC?						

Provide responses in the expandable boxes below. If multiple centers are used, specify if one answer applies to them all or identify each FMC and provide the information.

3. For any NO answers in question 2 on the previous chart, identify the point and provide an explanation or description.

4. Describe in detail any activities that take place in the FMC that are not FM residency related.

5. If other specialties are located on the same floor of the facility, explain and demonstrate on the floor plan how the FMC is a discrete unit that is separate from these areas.

6. If multiple Family Medicine Centers are used, describe the following:

a) How residents are assigned to the Centers and whether the assignments are for all three years of training. If not, provide specific details about levels of training involved.

b) The degree of contact among the residents from the multiple Centers

7. Provide the following information on the record system:

a) What kind of system is used? If an electronic medical record is not used currently, what are the program's plans for implementing one in the near future?

b) If an EMR system is not used, explain how patients' ambulatory records are maintained in the FMC and how easy and prompt accessibility to these records is ensured.

8. Do patients' records contain documentation of all facets of family care, including care provided in the FMC, hospital, home, via telephone and in other sites?
YES () NO ()

If NO, explain.

d) Do the residents have easy access to the FMC records 24 hours a day? ... YES () NO ()

If NO, explain.

9. If patient visits from a second FMC and/or other longitudinal clinics are used to meet the minimum patient visit requirements, (a) describe the clinic(s) being used and how continuity is ensured, and (b) identify who supervises residents at these sites.

10. Describe how faculty members provide role modeling for residents. For each FMC, provide the number of hours per week faculty spend seeing patients in the FMC without residents.

11. Copy as many of this sheet as necessary to supply the requested information for each FMC.

Name of Center:	
Address:	
Number of residents assigned by FM Year (e.g., 2-2-2):	
Name of Director of FMC:	

Attach (behind this page on a sheet no larger than 11" X 17") a legible drawing of the floor plan of the FMC. Where multiple centers are used, put the name and FMC # on each drawing. Label each room to indicate its function. Be sure that all required areas are clearly identified according to the key below. If any required areas are missing, identify the required area and explain. Read the page that is entitled FAMILY MEDICINE CENTER for guidelines on exclusivity. Demonstrate clearly on your diagram that the FMC is separated appropriately from other activities.

Do not submit a reduced copy of a blueprint.

Use the key provided below to identify the required areas on the FMC drawing. Use sufficiently large letters and numbers that are easily recognizable on the drawing.

- A = waiting room
- B = reception/appointment desk for FMC only
- C = business office
- D = records (if an EMR is not used)
- 1 = exam rooms (provide total number of rooms on the drawing)
- 2 = procedure room(s) (separate from exam rooms)
- 3 = office lab
- 4 = office library
- 5 = resident work area
- 6 = precepting room
- 7 = other (identify and explain)
- 8 = conference room*
- 9 = faculty offices*

*If not in the FMC, provide specific details regarding location and proximity to FMC

If any of these required components is not included in the FMC, provide an explanation below.

VI. FAMILY MEDICINE CENTER PATIENT POPULATION

Report figures for the most recent one year period and specify the inclusive dates for which the information is provided. July 1, 20____ to June 30, 20____. Be prepared to provide documentation of the figures reported below.

FMC #	# of residents assigned to FMC			# of weeks/year residents see pts in the FMC			Average # of hours in FMC/week			Average # of pt visits/year seen in FMC			Annual # of pt visits in FMC (faculty + residents)	# of pts hospitalized/year from FMC
	FM YR1	FM YR2	FM YR3	FM YR1	FM YR2	FM YR3	FM YR 1	FM YR2	FM YR3	FM YR1	FM YR2	FM YR3		
FMC 1														
FMC 2														
FMC 3														
FMC 4														
FMC 5														
FMC 6														

1. How does the program document that each resident provides continuity of care in the FMC?

2. Describe any scheduled interruptions in resident attendance in the FMC, e.g., during rural rotations. Include duration of each and specify the year of training involved. (Do not include personal interruptions for individuals such as, sick leave or maternity/paternity leave.)

3. Describe the system that is in place to audit FMC charts on a regular basis. If there is no system, explain.

3a. Indicate the 10 most frequently performed procedures, **for which a trained preceptor is available to instruct the residents**, at the FMC where your residents will train. Let 1 indicate the most frequently performed procedure. Then, select all procedures that residents must learn before they graduate by placing an "x" in the row with the procedure. Select at least 5 procedures.

Procedure	10 most frequently performed Procedures (1-10)	Procedures all residents must learn before graduation (Identify at least 5)
Androscopy		
Anoscopy only		

Procedure	10 most frequently performed Procedures (1-10)	Procedures all residents must learn before graduation (Identify at least 5)
Bladder Catheter		
Cardiovascular Stress test/Treadmill		
Cast Removed		
Cast/Splint Applied		
Cerumen Removal		
Cervical Cap Fitting		
Circumcision, Pediatric		
Colonoscopy		
Colposcopy		
Cryosurgery, Skin		
Cryosurgery Cervix		
Diaphragm Fitting		
EKG Interpretation		
Electrodesiccation of Lesion		
Endocervical Curettage		
Endometrial Biopsy		
Excisional Biopsy, Skin		
Flex Sig w/wo Bx		
FNA Breast Cyst		
Foreign Body Removal, Eye		
Foreign Body Removal, Skin		
Genital Wart Treatment		
I&D Abscess, Skin		
I&D Bartholin Cyst		
Incise External Hemorrhoid		
Ingrown Toenail Surgery/Excision		
Internal Hemorrhoid Banding		
IUD Insertion		
IUD Removal		
IV Start/IV Med given		
Joint Aspiration		
Joint Injection		
Laceration Complex		
Laceration Simple		
LEEP		
Nasopharyngoscopy		
Norplant Removal		
NST/CST Interpretation		
OB Ultrasound		
Osteopathic Manipulation		
Pap Smear		
Reduce Subluxed Radial Head		
Sebaceous Cyst Removal		

Procedure	10 most frequently performed Procedures (1-10)	Procedures all residents must learn before graduation (Identify at least 5)
Shave Biopsy, Skin		
Skin Punch Biopsy		
Skin Tag Removal		
Slit Lamp		
Spinal Tap		
Spirometry		
Subungal Hematoma Evacuation		
Suture Removal		
Tonometry		
Trigger Point Injection		
Tympanometry/Hearing Test		
Vasectomy		
Wet Mount		

3b. For each Family Medicine Center, record your patient visit data by gender for the previous academic year. Duplicate the following table as necessary.

Age of Patient	Family Medicine Clinic		
	# Females	# Males	# Total
Under 2			
2-9			
10-19			
20-29			
30-39			
40-49			
50-59			
60-69			
70 and over			

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International Updates

[Advanced Specialty Program Information Forms \(PIFs - updated 02.16.12\)](#)

[International Foundational Requirements \(updated 11.2.11\)](#)

[Advanced Specialty Program Requirements \(updated 10.10.11\)](#)

[Program Documents for Continued Accreditation \(updated 10.10.11\)](#)

[Glossary of Terms \(updated 07.21.11\)](#)

[Family Medicine Program Application Document \(updated 07.21.11\)](#)

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ACGME-I Institutional Application Site Visit Frequently Asked Questions (FAQs)

Who will conduct the site visit?

The ACGME-I utilizes a qualified person who has experience in institutional level Graduate Medical Education. The site visitor is often a person who is a Designated Institutional Official (DIO). The ACGME-I Review Committee selects the site visitor who will do the institutional site visit.

The role of the site visitor is to produce a written report that verifies and clarifies the information the institution submitted in the Application for International Institutional Accreditation (AIIP) and attachments. To collect the information for this report, the site visitor interviews the Designated Institutional Official, Program Directors, GMEC members, and an institution administrative representative.

What do I need to know about preparing the Institutional application documents?

An important aspect of preparing for a site visit is the preparation of the AIIP and attachments. A well-prepared AIIP describes the institution accurately, completely and truthfully. It should be comprehensive, specific and concise, and answer questions completely. An incomplete or inaccurate AIIP or attachments can be a contributing factor to the ACGME-I Review Committee specifying areas of non-compliance with the standards (known as citations) and a negative accreditation decision.

Before preparing the AIIP and attachments, you should review the institutional requirements. You should also allow sufficient time to gather the data needed for completing the documents. In completing the documents, remember that the site visitor and ACGME-I Review Committee members will not be familiar with the specifics of your institution. Also, you should not rely on the site visitor to relate to the ACGME-I Review Committee information that is relevant to compliance with the institutional accreditation standards. If something is relevant to the review, you should include it in the documents.

Contact Dr. William Rodak (wrodak@acgme-i.org) or Mr. James Cichon (jcichon@acgme-i.org) if you need help with any questions about the documents. If you have a technical problem with any aspect of the documents, contact your ADS Representative via e-mail to WebADS@acgme.org and include the name of your country in the subject line.

Whether you complete the documents yourself or delegate parts to others and then compile the full document, an independent third party should review the entire document for consistency, accuracy, and clarity.

How do we set up the schedule for the day of the site visit?

On the day of the visit, the site visitor will need to meet with the DIO, core accredited residency Program Directors, GMEC members, and a key institutional administrative representative such as the Chief Executive Officer.

ACGME-I staff will provide detailed instructions and work directly with you to finalize the site visit day's schedule. We will also indicate the institutional and program level staff roles and functions which require interviews and will work with you to identify specific staff members to participate in the interview sessions on the day of the site visit.

A typical agenda for an institutional site visit would be:

08:30—09:00	Meet/overview of day with DIO and Administrative Coordinator
09:00—10:30	Interview with DIO and detailed review of AIIA and attachments
10:30—11:30	Interview with all accredited core residency Program Directors
11:30—12:00	Interview with GMEC members
12:00—12:30	Lunch
12:30—13:00	Interview with CEO
13:00—13:30	Final meeting with DIO

Again, this is a typical agenda but the schedule for your site visit day may vary.

What logistical preparations should be made for the day of the site visit?

1. The site visitor is not familiar with your institution and will need directions to the facility. You should arrange for a place and time to meet the site visitor. Often this is the main lobby of your building where you can greet the site visitor and escort him or her to the room reserved for the site visit.
2. Please provide an emergency phone contact number (Designated Institutional Official, Institutional Administrator) to the site visitor. This is strictly precautionary in case the site visitor finds it necessary to contact the institution the day/evening before the site visit.
3. The site visit should take place in a single, well-lighted conference room with a table sufficiently large to allow the site visitor to do his/her work.
4. If lunch is scheduled during the site visit, please keep the menu simple.
5. The Designated Institutional Official needs to clear his/her schedule for the entire time of the site visit. We would ask the DIO turn off her/his cell phone/pager,

arrange for coverage, and respond only to very urgent matters during the course of the site visit.

6. The Program Directors interview:
 - a. All accredited core residency program directors participate in the interview
 - b. Program directors scheduled for the interview need to turn off their cell phones/pagers and arrange for coverage for the duration of the session.
 - c. The site visitor's discussion will include program directors' perceptions of institutional resources and support, their views of how they relate to the institution as program directors, and their perceptions of the institution's strengths and areas for improvement
7. The Graduate Medical Education Committee (GMEC) members interview:
 - a. The site visitor needs to meet with 4-6 members of the GMEC. The Chairperson of the GMEC should be included in the interview group.
 - b. GMEC members scheduled for the interview need to turn off their cell phones/pagers and arrange for coverage for the duration of the session.
 - c. The site visitor's discussion will include the GMEC members' perceptions of the strengths and areas of improvement for the GMEC
8. The CEO interview:
 - a. The site visit needs to interview an organizational executive level person such as the CEO
 - b. The site visitor's discussion will include the CEO's perceptions of the executive and governance level support and involvement in GME in the institution.

What happens on the day of the site visit?

On the day of the site visit, be flexible and understand that schedules may be changed or be delayed to accommodate the information collection needs of the site visitor. The site visitor's role is to verify and clarify the information you provided in the AIIA and attachments and to note any institutional accreditation standards whose compliance was not confirmed. The ACGME-I Review Committee makes the final evaluation and accreditation decision for the institution.

At the end of the visit the site visitor cannot give you detailed feedback since she or he is not the final decision-maker. Accreditation decisions are the purview of the ACGME-I Review Committee. The site visitor may be able to offer general observations regarding the institution strengths and opportunities for improvement, but these are solely based on the site visitor's own institutional experience.

Can I make changes to the application documents after submission to ADS?

The AIIA and attachments sent to the ACGME-I must be in final form when the DIO submits them to ADS. Minor discrepancies can be clarified with the site visitor on the day of the visit.

If errors are discovered on the day of the site visit, it is acceptable to make minor changes to selected pages, provided that it can be done before the site visitor departs. Do not ask the site visitor to wait while you make extensive changes. Once pages have been changed, a copy of the revised pages should be given to the site visitor with the changes highlighted.

What happens after the site visit?

After the site visit, the site visitor submits a written report to ACGME-I staff who review the document for completeness. The Review Committee's review of your institution is based on your AIIA and attachments, the site visitor's report, and other information relevant to your institution. During the institutional accreditation review, the site visitor provides a summary of his/her findings to the Review Committee with a recommendation for accreditation status. He or she may also respond to questions from the Review Committee. On completion of the site visitor's report, the site visitor leaves the meeting. The ACGME-I Review Committee then deliberates and makes the final accreditation decision.

After the ACGME-I Review Committee makes the accreditation decision, the DIO will be notified via e-mail of the accreditation status. This occurs within 5 business days of the end of the meeting. The detailed accreditation decision including citations as applicable will be posted on ADS between 30 and 60 days after the ACGME-I Review Committee meeting. The DIO will be notified of the posting.

ACGME-I Program Application Site Visit Frequently Asked Questions (FAQs)

Who will conduct the site visit?

The ACGME-I utilizes a physician who is of the same specialty as the program for which he or she conducts the site visit. The ACGME-I Review Committee selects the physician site visitor who will do a given site visit.

The role of the site visitor is to produce a written report that verifies and clarifies the information the program submitted in the Application for International Program Accreditation (AIPA) and its attachments including the Advanced Specialty Program Information Form (AS-PIF). To collect the information for this report, the site visitor interviews the program director, core faculty members, department chair/division chief, and the designated institutional official (DIO) and/or other administrative representatives. For Transitional Year programs, the site visit also includes interviews with representatives from other departments with which the program interacts.

What do I need to know about preparing the program application documents?

An important aspect of preparing for a site visit is the preparation of the AIPA and attachments including the AS-PIF. Well prepared documents describe the residency program accurately, completely and truthfully. They should be comprehensive, specific and concise, and answer questions completely. Incomplete or inaccurate documents can be a contributing factor to the ACGME-I Review Committee specifying areas of non-compliance with the standards (known as citations) and a negative accreditation decision.

Before preparing the AIPA and attachments including the AS-PIF, you should review the foundational and your advanced specialty program requirements as well as the institutional requirements. You should also allow sufficient time to gather the data needed for completing the documents. In completing the documents, remember that the site visitor and ACGME-I Review Committee members will not be familiar with the specifics of your program. Also, you should not rely on the site visitor to relate to the ACGME-I Review Committee information that is relevant to compliance with the accreditation standards. If something is relevant to the review, you should include it in the documents.

Contact Dr. William Rodak (wrodak@acgme-i.org) or Mr. James Cichon (jcichon@acgme-i.org) if you need help with any questions about the documents. If you have a technical problem with any aspect of the documents, contact your ADS

ACGME-I Program Application Site Visit FAQs

Representative via e-mail to WebADS@acgme.org and include the name of your country in the subject line.

Whether you complete the documents yourself or delegate parts to others and then compile the full documents, an independent third party should review the entire document for consistency, accuracy, and clarity before it is submitted to your DIO for final review, approval, and submission.

How do we set up the schedule for the day of the site visit?

On the day of the visit, the site visitor will need to meet with the program director, faculty members, Department Chair/ Divisional Chief, and the DIO or another administrative representative.

ACGME-I staff will provide detailed instructions and work directly with you and/or your DIO to finalize the site visit day's schedule. We will also indicate program staff roles and functions which require interviews and will work with you to identify specific staff members to participate in the interview sessions on the day of the site visit.

A sample agenda for a program application site visit would be:

08:30 – 09:00	Meet/overview of day with PD and Coordinator
09:00 – 10:30	Interview with PD and detailed review of AIPA and attachments including the AS-PIF
10:30—11:30	Interview with core faculty members
11:30 – 12:00	Interview with Department Chair/Division Chief
12:00 – 12:30	Interview with DIO
12:30 – 13:00	Lunch
13:00 – 13:30	Final meeting with PD

Again, this is a typical agenda but the schedule for your site visit day may vary.

What logistical preparations should be made for the day of the site visit?

1. The site visitor is not familiar with your institution and will need directions to the facility. You should arrange for a place and time to meet the site visitor. Often this is the main lobby of your building where you can greet the site visitor and escort him or her to the room reserved for the site visit.
2. Please provide an emergency phone contact number (Program Director, Program Coordinator) to the site visitor. This is strictly precautionary in case the site visitor finds it necessary to contact the program the day/evening before the site visit.

3. The site visit (with exception of tours of on-call rooms or other facilities as required) should take place in a single, well-lighted conference room with a table sufficiently large to allow the site visitor to do his/her work.
4. If lunch is scheduled during the site visit, please keep the menu simple.
5. The Program Director needs to clear his/her schedule for the entire time of the site visit. We ask that the Program Director turn off her or his cell phone/pager, arrange for coverage, and respond only to very urgent matters during the course of the site visit.
6. The faculty interview
 - a. The site visitor's discussion will include faculty members' perceptions of the program, institutional support, their role(s) in the program, and their perceptions of the program's strengths and areas for improvement.
 - b. Faculty members scheduled for the faculty interview need to turn off their cell phones/pagers and arrange for coverage for the duration of the session.
 - c. The faculty interview group should be no more than 10 people including the Associate Program Director(s) and other core faculty members.
7. The Chair/Chief interview
 - a. The site visitor will meet your Department Chair or Division Chief
 - b. The site visitor's discussion will include departmental or divisional support and resources for the program, and organizational structures which affect the program.
8. The DIO interview
 - a. The site visitor will meet with your DIO
 - b. The site visitor's discussion will include the institutional support and oversight of the program, the DIO's perceptions of the program, and the DIO's review and approval of the AIAP and attachments including the AS-PIF.

What happens on the day of the site visit?

On the day of the site visit, be flexible and understand that schedules may be changed or be delayed to accommodate the information collection needs of the site visitor. The site visitor's role is to verify and clarify the information you provided in the application documents and to note any accreditation standards whose compliance was not confirmed. The ACGME-I Review Committee makes the final evaluation and accreditation decision for the program.

At the end of the site visit, the site visitor cannot give you detailed feedback since she or he is not the final decision-maker. The final accreditation decision is the purview of the ACGME-I Review Committee. The site visitor may be able to offer general observations regarding the program strengths and opportunities for improvement, but these are solely

based on the site visitor's specialty specific experience.

Can I make changes to the documents after our DIO has reviewed, approved, and submitted them to ADS?

The documents sent to the ACGME-I must be in final form; the DIO's signature confirms this. No changes can be made after it has been sent and before the day of the site visit. Minor discrepancies can be clarified with the site visitor on the day of the site visit.

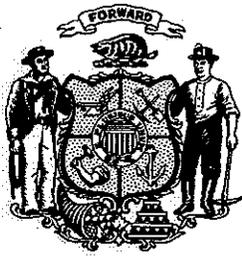
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What happens after the site visit?

After the visit, the site visitor submits a written report to ACGME-I staff who review the document for completeness. The ACGME-I Review Committee's review of your program is based on your AIPA and attachments including the AS-PIF, the site visitor's report, and any other information relevant to your program

During the program accreditation review, the site visitor provides a summary of his/her findings to the Review Committee with a recommendation for accreditation status. He or she may also respond to questions from the Review Committee. On completion of the site visitor's report, the site visitor leaves the meeting. The ACGME-I Review Committee then deliberates and makes the final accreditation decision.

After the ACGME-I Review Committee makes the accreditation decision, the program director and the DIO will be notified via e-mail of the accreditation status. This occurs within 5 business days of the end of the meeting. The detailed accreditation decision including citations as applicable will be posted on ADS between 30 and 60 days after the ACGME-I Review Committee meeting. The program director and DIO will be notified of the posting.



SCOTT WALKER
OFFICE OF THE GOVERNOR
STATE OF WISCONSIN

P.O. Box 7863
MADISON, WI 53707

July 2, 2012

Dr. Timothy Westlake
1403 Bristlecone Drive
Hartland, WI 53029

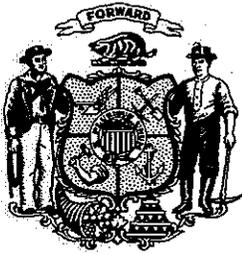
Dear Dr. Westlake:

I am pleased to appoint you to the Medical Examining Board, effective July 02, 2012. Your experience, knowledge, and dedication will be a true asset to my administration and a great benefit to the people of Wisconsin.

I look forward to working with you to find innovative ways of delivering services and implementing positive change for the citizens of our state.

Sincerely,

Scott Walker
Governor



SCOTT WALKER
OFFICE OF THE GOVERNOR
STATE OF WISCONSIN

P.O. Box 7863
MADISON, WI 53707

GOVERNOR'S APPOINTMENT

NAME: Timothy Westlake

MAILING ADDRESS: 1403 Bristlecone Drive
Hartland, WI 53029

E-MAIL ADDRESS: timothy.westlake@gmail.com

RESIDES IN: Hartland, WI

TELEPHONE: (c) 414-418-5007

OCCUPATION: Physician: Lake Country Emergency
Physicians

APPOINTED TO: Medical Examining Board
Doctor-Medicine 7

TERM: A term to expire July 1, 2016

SUCCEEDS: Dr. Sujatha Kailas

SENATE CONFIRMATION: Required

DATE OF APPOINTMENT: July 2, 2012

DATE OF NOMINATION: July 2, 2012

SCOTT WALKER
OFFICE OF THE GOVERNOR
STATE OF WISCONSIN

P.O. Box 7863
MADISON, WI 53707

July 2, 2012

Dr. Mary Jo Capodice
526 St. Clair Avenue
Sheboygan, WI 53081

Dear Dr. Capodice:

I am pleased to appoint you to the Medical Examining Board, effective July 2, 2012. Your experience, knowledge, and dedication will be a true asset to my administration and a great benefit to the people of Wisconsin.

I look forward to working with you to find innovative ways of delivering services and implementing positive change for the citizens of our state.

Sincerely,

A handwritten signature in black ink, appearing to be 'S. Walker', with a stylized flourish at the end.

Scott Walker
Governor



SCOTT WALKER
OFFICE OF THE GOVERNOR
STATE OF WISCONSIN

P.O. Box 7863
MADISON, WI 53707

GOVERNOR'S APPOINTMENT

NAME: Mary Jo Capodice

MAILING ADDRESS: 526 St. Clair Avenue
Sheboygan, WI 53081

E-MAIL ADDRESS: mary.jo.capodice@aurora.org

RESIDES IN: Sheboygan, WI

TELEPHONE: (c) 920-698-0153
(h) 920-457-0318

OCCUPATION: Corporate Medical Director-Aurora
Occupational Health

APPOINTED TO: Medical Examining Board
Doctor-Osteopathy

TERM: A term to expire July 1, 2014

SUCCEEDS: Dr. Raymond P. Mager

SENATE CONFIRMATION: Required

DATE OF APPOINTMENT: July 2, 2012

DATE OF NOMINATION: July 2, 2012