Frequently Asked Questions: Family Medicine
(FAQs related to ACGME Program Requirements for Family Medicine effective July 1, 2023)
Review Committee for Family Medicine
ACGME

Question	Answer
Oversight	
Are there exceptions to the limit of one hour of travel time between the primary clinical site and participating sites? *[Program Requirement: I.B.5.]*	Exceptions may be considered depending upon the circumstances. Specifically, the Review Committee expects to see written verification from programs that they provide housing at the distant site, and/or that such experiences do not require excessive travel regularly (i.e., educational experience that requires greater than one hour of travel, but infrequent and with shift lengths that allow appropriate rests with the travel time considered).
What should the makeup of the Family Medicine Practice (FMP) advisory committee be, and if a program has more than one FMP and those FMPs are in proximity, can the advisory committee be shared? *[Program Requirement: I.D.1.h)]*	The FMP advisory committee must have community members and clinical leaders whose role is to assess and address the needs of the community cared for by the FMP. The intent of the requirement is to encourage a mixture of individuals using FMP services (patients, caregivers, family members), residents, faculty members, and care delivery leaders. Each FMP should have a unique advisory committee. For example, programs with three FMPs should have three separate advisory committees. Similarly, Federally Qualified Health Center (FQHC) boards with 51 percent community membership meet this requirement if the functions of assessing and addressing the needs of the FMP community are part of the work of the board, and only one FMP is supported by that board.
Personnel	
What is the difference between administrative time for the program director and devoted time for core faculty members? [*Program Requirements: II.A.2.a), II.B.4.e) – effective July 1, 2024]*	Starting July 1, 2024, administrative time for program directors is defined differently than it is for core faculty members. For program directors, this is time spent *only* doing administrative tasks and does not include precepting, resident supervision, scholarly activity, or their own direct patient care. For core faculty members, devoted time includes all time spent doing work for the residency outside of their own direct patient care. Therefore, devoted time for core faculty members includes administration, scholarly activity, and resident supervision, including precepting.
Who should serve as a role model for residents in inpatient adult care, maternity care, and other locations outside of the FMP? *[Program Requirements: II.B.1.c),*	All accredited family medicine programs must have a family medicine physician faculty member role modeling adult inpatient medicine. Programs providing maternity care competency training to the level of independent practice must have a family medicine physician role modeling this care. Core or non-core family medicine physician faculty members who satisfy program requirement II.B.4., including the corresponding Background and Intent, can serve in this role. There may be separate individuals for

<table>
<tr><th>Question</th><th>Answer</th></tr>
<tr><td>II.B.1.d).(1)-(3)]</td><td>each subcomponent of this requirement. For example, there may be a non-core family medicine physician faculty member role modeling inpatient care of adults and another role modeling maternity care.</td></tr>
<tr><td>What qualifications are acceptable for faculty members dedicated to the integration of behavioral health?

[Program Requirement: II.B.2.h.)]</td><td>A qualified family physician, psychiatrist, or other behavioral health professional would meet the requirement for such faculty expertise. “Qualified” implies a specific interest, education/training, and experience in behavioral health.</td></tr>
<tr><td>Can faculty members who are not family physicians be considered in calculating the core faculty-to-resident ratio requirement?

[Program Requirement: II.B.4.b)]</td><td>Faculty members who are not family physicians may be core faculty members, but only core faculty members who are family physicians meet this requirement. Non-family physician faculty members may be core faculty members, but they do not count toward the required number in II.B.4.b).</td></tr>
<tr><td>How should programs with a resident complement not equally divisible by four (or six for programs with fewer than 13 residents) meet the core family medicine physician faculty requirement that becomes effective July 1, 2024?

[Program Requirement: II.B.4.b) – effective July 1, 2024]</td><td>The number of core family medicine physician faculty members is determined by program size and outlined in the table below.
<table>
<tr><th>Number of Residents</th><th>Required Core Faculty Members</th></tr>
<tr><td>0-6</td><td>1</td></tr>
<tr><td>7-12</td><td>2</td></tr>
<tr><td>13-15</td><td>3</td></tr>
<tr><td>16-19</td><td>4</td></tr>
<tr><td>20-23</td><td>5</td></tr>
<tr><td>24-27</td><td>6</td></tr>
<tr><td>28-31</td><td>7</td></tr>
<tr><td>32-35</td><td>8</td></tr>
<tr><td>36-39</td><td>9</td></tr>
<tr><td>40-43</td><td>10</td></tr>
<tr><td>44-47</td><td>11</td></tr>
<tr><td>48-51</td><td>12</td></tr>
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Question	Answer
Can faculty members who are not family physicians or who are not physicians be core faculty members? *[Program Requirements: II.B.4., II.B.4.c)-e) – effective July 1, 2024]*	Non-family physicians and non-physicians can be core faculty members if they meet the hours requirements as specified in requirements II.B.4., II.B.4.c) or d), and II.B.4.e). If the program director determines that a psychologist, pharmacist, non-family physician, or other health professional is a core faculty member, then that person should devote the percentage of time for teaching, administration, scholarly activity, and supervising resident patient care, as noted in II.B.4., II.B.4.c) or d), and II.B.4.e).
How much non-clinical dedicated time is required for core faculty members, and may a program distribute the faculty time in aggregate to meet the clinical and non-clinical educational needs of the residents while providing flexibility for programs/faculty members in their personal clinical time exclusive of residents? *[Program Requirements: II.B.4.c)-e) – effective July 1, 2024]*	The core faculty time requirements address the role and responsibilities of core faculty members, inclusive of both clinical and non-clinical activities, and the corresponding time to meet those responsibilities. The requirements do not address how this is accomplished, and do not mandate dedicated or protected time for these activities. Programs, in partnership with their Sponsoring Institutions, will determine how compliance with the requirements is achieved. Because these requirements are categorized as "detail," programs with a Continued Accreditation status will not be issued citations on them, and the Committee would be disinclined to cite programs on Initial Accreditation if they are working in partnership with their Sponsoring Institution to ensure substantial compliance is achieved.
Educational Program	
Will the Review Committee expect incoming PGY-2 and PGY-3 residents to provide care for a minimum of 1650 patient encounters in the FMP site? *[Program Requirement: IV.B.1.b).(1).(a).(ii)]*	The 1650 continuity visit requirement will be applied to 2023 graduates. For graduates of 2024 and beyond, the Committee will be considering FMP visit volume, hours, and continuity in its assessment of the learning environment of the FMP and expects programs to do the same. The number of visits a resident has in the FMP is one of the components used by the committee to assess the learning environment for this competency. Programs can use the previous 1650 visit requirement as one measure of competence in this domain, even though it no longer will be cited by the committee.
What are the Committee's expectations regarding educational experiences, and how should they be documented or verified? *[Program Requirements: IV.C.1.a-c)]*	An educational experience is defined as a planned learning activity that is an integrated component of the overall curriculum; is developed around a set of competencies with tailored learning objectives and with significant input from program faculty members; includes an experiential aspect to learning (if the number of patient encounters is not otherwise specified); is supervised; has evaluation (including reflection) and feedback mechanisms; and has sufficient length (if length is not otherwise specified) and content to ensure residents achieve the desired competencies. The documentation and verification of experiences should be done utilizing the same tools used to assess the residents' learning

Question	Answer
	experience in all other aspects of the curriculum (including evaluations, logging, schedules, competency assessment tools, etc.).
Do visits or hours in the FMP count toward program requirements other than those related to FMP continuity? *[Program Requirement: IV.C.3.c).(5)]*	A program may not double count hours or visits in the FMP to meet more than one requirement. Curriculum experiences (hours or visits) in the FMP can fulfill non-continuity requirements only if they are additional experiences separate from their continuity clinics. For example, programs may not count hours or visits caring for older adults in the FMP (IV.C.3.l)) if they are also part of the 1,000-hour FMP continuity experience (IV.C.3.c).(5).(b).(i)). This applies to other similar requirements such as ambulatory pediatrics (IV.C.3.f)) and gynecology (IV.C.3.h)).
Will a skilled nursing facility or skilled nursing unit satisfy the long-term care requirement? *[Program Requirement: IV.C.3.c).(5).(a)]*	The Review Committee recognizes that long-term care may include both temporary and ongoing long-term care. A skilled nursing facility or skilled nursing unit usually provides temporary long-term care, bridging inpatient care with dismissal to home management or movement to a nursing home setting. A skilled nursing facility may provide some portion, but not the majority of, a resident's experience in long-term care.
What types of care should be counted toward the 1,000-hour continuity requirement? *[Program Requirement: IV.C.3.c).(5).(b).(i)]*	The Review Committee expects this requirement will be met by the scheduled hours residents spend providing in-person or telemedicine care to patients in the resident's continuity clinic (FMP). It does not include time outside the FMP doing indirect patient care activities such as charting, inbox management, population health management, or patient encounters performed outside of the FMP. The Committee expects programs to track and report individual resident hours in the FMP.
How should patient-sided continuity be calculated? *[Program Requirement: IV.C.3.c).(5).(b).(ii)]*	Patient-sided continuity is the percentage of FMP visits that resident-paneled patients have with their resident primary care physician. The 30 percent and 40 percent continuity requirement will be calculated from the visits that occurred during the PGY-2 and PGY-3 years, respectively. Patient primary care physician assignment at the time of the visit should be used to determine continuity. Individual resident (not team) continuity will be assessed. For example: PGY-3 Resident A has a panel of 300 patients who have a total of 1,000 visits to the FMP during the PGY-3 year, and 600 of these visits are with Resident A. Resident A's PGY-3 patient-sided continuity is 600/1,000 x 100 = 60 percent. The Committee will ask programs to provide individual resident visit and panel data in the Accreditation Data System (ADS) and will aggregate data to assess the learning environment in this domain.
How should resident-sided continuity be calculated? *[Program Requirement:*	Resident-sided continuity is the percentage of visits residents have with patients on their panel. The 30 percent and 40 percent continuity requirement will be calculated from the visits that occurred during the PGY-2 and PGY-3 years, respectively. Patient primary care physician assignment at the time of the visit should be used to

Question	Answer
IV.C.3.c).(5).(b).(iii)]	determine continuity. Individual resident (not team) continuity will be assessed. For example: PGY-3 Resident B had 1,000 visits in the FMP during the PGY-3 year and 500 of them were with patients on Resident B's panel. Resident B's PGY-3 resident-sided continuity is 500/1,000 x 100 = 50 percent. The Committee will ask programs to provide individual resident visit and panel data in ADS and will aggregate data to assess the learning environment in this domain.
What is considered an "active patient" on a resident's panel. *[Program Requirements: IV.C.3.c).(5).(b).(iv).-(vi)]*	The Committee has not specified parameters of empanelment, such as "active patient." Active patients are traditionally defined as those patients who have been seen in the FMP within a specific time. Only patients with FMP visits within this time are included in the clinician's panel. The conventional look-back period ranges from 18-36 months (24 months is common). The program will determine the appropriate time by balancing the comprehensiveness and accuracy of population management with resident training and patient care.
What empanelment and continuity data should programs measure and report in ADS? *[Program Requirements: IV.C.3.c).(5).(b).(iv).– (vi)]*	Programs will report individual resident visit and panel data for active patients in ADS starting in 2024. This data will include individual resident PGY-1, -2, and -3 yearly panel size (total, under 18 years, over 65 years), total panel visits, panel visits with resident primary care physician, total resident visits, and residents' visits with patients on their panel. The Committee will review individual resident and aggregate data to assess the learning environment in this domain. The ACGME will indicate when panel data should be reported in ADS for each program.
What are the suggested targets for resident panel size? *[Program Requirement: IV.C.3.c).(5).(b).(vi)]*	The Committee has not specified resident panel size. The appropriate panel size may be determined by quantifying supply and demand, utilizing measures of resident clinic access, the amount of time the resident is in clinic, the interplay between patient- and resident-sided continuity, and the exposure necessary for resident competence in the FMP. The correct panel size will be the number that best fits these measures. Minimum and maximum panel sizes may be defined in future requirements.
Can time spent caring for children in the urgent care setting be used to meet the required 50 hospital or emergency setting visits? *[Program Requirements: IV.C.3.c).(2))]*	The expectation is that residents have a minimum number of encounters with acutely ill children to prepare them for independent practice. The Committee does not consider an urgent care setting in and of itself as satisfying the spirit of the requirement. However, the program does have some flexibility to determine what constitutes an acutely ill pediatric patient, as well as the specific urgent care setting (as these might vary considerably based on region, severity of patients seen, etc.).
How should programs demonstrate compliance with the requirement for 50 emergency department encounters with children? *[Program Requirement: IV.C.3.g)]*	The Committee does not prescribe the method to track the experiences, allowing programs flexibility. The expectation is that residents meet the minimum number of encounters with acutely ill children in a fashion which prepares them for independent practice.

Question	Answer
What is the implication of using "and" versus "or" regarding hours/months of certain patient exposures/experiences? *[Program Requirements: IV.C.3.i)-k)]*	The nature of these requirements is to allow for flexibility in designing curricular experiences without time restrictions, while ensuring adequate experience for each resident. If a requirement uses “and,” the program must document *both* hours *and* patient numbers; if a requirement uses “or,” the program can use either measurement.
How should programs design and implement elective experiences? [Program Requirement: IV.C.3.u)].	Elective experiences should be driven by individualized learning plans, address future practice goals, and require resident-specific pre-planning of each elective. The assessment tools can include resident self-assessment and reflection on needs met with the planned elective rotation. Standard assessment tools can also be used, such as those found in the Milestones Resources. Programs may create a list of electives that meet the learning goals and competencies of the curriculum. The Committee has not set criteria for the number of experiences created by programs or the residents. Programs may utilize elective time to address learning gaps for residents not meeting competency goals, areas of concentration, or tracks. For programs that do not utilize traditional block scheduling, 600 hours is considered the equivalent of six months. Programs are encouraged to use their Program Evaluation Committee to build, evaluate, and improve the elective experience.
The Learning and Working Environment	
What are the expectations of the Committee with respect to faculty members precepting residents via telemedicine? *Program Requirement: VI.A.2, VI.A.2.b).(1).(b)*	It is the responsibility of the program and Sponsoring Institution to ensure that in situations where a faculty member is precepting via telemedicine (while the resident has a face-to-face encounter with the patient), there is either direct or indirect supervision available to the resident as needed, as compliance with the supervision requirements still applies.
Who should be included on the interprofessional teams? *[Program Requirement: VI.E.2.]*	Examples of professional personnel who may be part of the interprofessional teams include nurses, medical assistants, advanced practice providers, pharmacists, social workers, psychologists, dentists, occupational and physical therapists, and care coordinators.
Other	

Question	Answer
What is the timetable for review of an application for a new program?	The review process for a new program application takes approximately 12 months from the time the application is received by the ACGME until the Review Committee evaluates the application. Programs should consult the National Resident Matching Program (NRMP) and Electronic Residency Application Service (ERAS) for their deadlines. Upon receipt of the application by the ACGME, an accreditation application site visit will be scheduled. Once the Site Visit Report is submitted by the Accreditation Field Representative, the file will be prepared for consideration by the Review Committee at its next available meeting. Residents should not be appointed prior to accreditation of the program.
Can an accredited program move from one hospital to another?	The Review Committee executive director should be informed of such plans and will advise the program regarding the steps that must be followed. A program is accredited as it was constituted at the time of its last review. It may not be "moved" without Review Committee approval. If a Sponsoring Institution wants to relocate a residency program from one hospital to another, a site visit may be required. If the primary clinical site wants to retain the program, the issue should be resolved locally between the hospital and its Sponsoring Institution. The welfare of the residents currently in the program must be considered.
How can a program's Sponsoring Institution changed?	In order to change the sponsor of a core program, a letter signed by the designated institutional officials (DIOs) of both the relinquishing Sponsoring Institution and the accepting Sponsoring Institution should be submitted (two separate letters may be submitted). The existing sponsor should agree explicitly to the change in sponsorship. The proposed sponsor should agree to assume the responsibilities of a Sponsoring Institution that are outlined in the ACGME Institutional Requirements. The letter should contain a statement on the impact the change will have upon the structure and curriculum of the residency. If the change is approved, the program name and listing will be changed in ADS as appropriate. Questions should be addressed to the Review Committee executive director and the executive director of the Institutional Review Committee. Contact information can be found on the ACGME website.

Question	Answer
What is the process for merging two programs?	Contact the Review Committee executive director to discuss the type of merger and how to describe it for the Review Committee's consideration. When two programs combine to form a new entity, documentation describing the proposed combined program is required. The executive director will advise whether a site visit will be required prior to Committee review of the proposal. A request for voluntary withdrawal of accreditation and the date of closure must be submitted using ADS by each of the currently accredited programs. The newly constituted program will be issued a new ACGME 10-digit program number.
Where and how should non-family medicine faculty members be listed in the ADS Annual Update?	After all of the family medicine faculty members in a program have been entered, identify the individuals responsible for teaching family medicine residents in the following areas: (listed in this order) human behavior/mental health; adult medicine; critical care; obstetric care; gynecologic care; surgery; orthopaedic surgery; sports medicine; emergency medicine; neonates, infants, children, and adolescents; older patients; and skin. Provide the American Board of Medical Specialties (ABMS)/American Osteopathic Association (AOA) certification information for all faculty members.
How should a family medicine faculty member who also teaches geriatric medicine or another subspecialty be listed in the ADS Annual Update?	The ADS Annual Update should contain the individual's primary specialty information (American Board of Family Medicine (ABFM) or American Osteopathic Board of Family Physicians (AOBFP) certification date) along with information on the most recent date of subspecialty certification.
How will the requirements that are effective July 1, 2023 be applied to 2023-2026 resident graduates?	The Program Requirements for Family Medicine in effect prior to July 2023 will be applied to 2023 graduates. For the interim revisions, effective for the 2024 and 2025 graduates, the Committee will assess the program's learning environment utilizing the new requirements with the understanding that programs will need leniency during this transition. For those programs on Initial Accreditation, with current citations, or on Probation, previous citations will be assessed utilizing the new requirements.
How should programs determine changes to a resident's curriculum or extension of their education and training when applying family leave policies (e.g., ABFM, institutional, health system)?	The decision of whether a resident does or does not extend education and training and which, if any, curricular adjustments are needed will be made by the program director with Clinical Competency Committee advice based on resident competence for advancement, autonomous practice at graduation, and individual resident learning needs. Refer to the ACGME Institutional Requirements , as well as the ABFM website, for details regarding leave and board eligibility.