MEDICAL BOARD OF CALIFORNIA

LICENSING COMMITTEE MEETING AGENDA

MEMBERS OF THE COMMITTEE
Janet Salomonson, M.D., Chair
Michael Bishop, M.D.
Silvia Diego, M.D.
Denise Pines
Gerrie Schipske, R.N.P., J.D.

Embassy Suites – Burlingame
Santa Cruz Room
150 Anza Blvd.
Burlingame, CA 94010
650-342-4600 (directions only)

Thursday, January 31, 2013
1:45 p.m. – 2:15 p.m.
(or until completion of business)

Action may be taken on any item listed on the agenda.

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources.

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE.
If a quorum of the Board is present, members of the Board who are not members of the Committee may attend only as observers.

1. Call to Order / Roll Call

2. Public Comment on Items Not on the Agenda
Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting. [Government Code Sections 11125, 11125.7(a)]

3. Approval of the Minutes from the October 25, 2012 Meeting

4. Update on Licensing Program Staffing – Mr. Worden

5. Update on the Business Process Reengineering Primary Recommendations – Mr. Worden
   A. Revision of Physician and Surgeon Application and Streamline Process
   B. Medical Board of California Web Site Related to Applications
   C. Revision of the Policy and Procedure Manual

6. Update on Status of Strategic Plan Components – Mr. Worden

7. Update on Physician Supervision Requirements for Allied Health Care Professions: Perfusionists and Anesthesia Technologist/Technician – Mr. Worden

8. Discussion and Consideration of the Accreditation Council for Graduate Medical Education – International (ACGME-I) and Royal College Canada International (RCCI) - Accredited Postgraduate Training Programs – Mr. Worden and Mr. Heppler

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board's licensing and regulatory functions.

9. Discussion and Consideration to Update Existing Statutes and/or Regulations for Board Recognition of Postgraduate Training due to ACGME / American Osetopathic Association AOA / AACOM Merger: Recommendation to Full Board – Mr. Worden and Mr. Heppler

10. Agenda Items for the April 25-26, 2013 Meeting in the Los Angeles Area

11. Adjournment

NOTICE: The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Tim Einer at (916) 263-2389 or email tim.einer@mbc.ca.gov or send a written request to Tim Einer at the Medical Board of California, 2005 Evergreen Street, Ste. 1200, Sacramento, CA 95815. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meeting Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the President may apportion available time among those who wish to speak.

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For additional information, call (916) 263-2389.

MEDICAL BOARD OF CALIFORNIA

LICENSING COMMITTEE MEETING

Sheraton San Diego Hotel and Marina Room
Fairbanks A & B
1380 Harbor Island Drive
San Diego, CA 92101

Thursday, October 25, 2012

MINUTES

Agenda Item 1 Call to Order / Roll Call

Dr. Salomonson called the Licensing Committee meeting to order on October 25, 2012, at 2:03 p.m. Mr. Worden called the roll. A quorum was present and notice had been sent to interested parties.

Members Present:
Janet Salomonson, M.D., Chair
Michael Bishop, M.D.
Silvia Diego, M.D.
Gerrie Schipske, R.N.P., J.D.

Other Members Present:
Dev GnaneDev, M.D.
Sharon Levine, M.D.
Denise Pines
Barbara Yaroslavsky

Staff Present:
Angela Chang, Investigator
Dianne Dobbs, Department of Consumer Affairs, Legal Counsel
Tim Einer, Administrative Assistant
Kurt Heppler, Staff Counsel
Kimberly Kirchmeyer, Deputy Director
Armando Melendez, Business Services Analyst
Regina Rao, Business Services Analyst
Letitia Robinson, Research Specialist
Kevin Schunke, Outreach Manager
Barbara Shakowski, Investigator
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief of Enforcement
Renee Threadgill, Chief of Enforcement
See Vang, Business Services Analyst
Linda Whitney, Executive Director
Curtis Worden, Chief of Licensing

Members of the Audience:
Teresa Anderson, California Academy of Physician Assistants
Hilma Balaian, Kaiser Permanente
Yvonne Choong, California Medical Association (CMA)
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)
Long Do, CMA
Jack French, Consumers Union CA Safe Patient Network
Doreathea Johnson, Department of Consumer Affairs, Legal Affairs
Lisa McGiffert, Consumers Union CA Safe Patient Network
Carole Moss, Consumers Union CA Safe Patient Network/Nile's Project
Ty Moss, Consumers Union CA Safe Patient Network/Nile's Project
Maryann O'Sullivan, Consumers Union CA Safe Patient Network
Carlos Ramirez, Senior Assistant Attorney General, Office of the Attorney General
Loren Reed, Department of Consumer Affairs, Public Affairs Office
Harrison Robbins, M.D.
Kathryn Scott, Lenscrafters
Carrie Sparrevohn, Midwifery Advisory Council
Charlene Zettel, Donate Life California

Agenda Item 2 Public Comments on Items Not on the Agenda
No public comment was offered.

Agenda Item 3 Approval of Minutes from the July 19, 2012 Meeting
Dr. Bishop made a motion to approve the minutes from the July 19, 2012 meeting; s/Diego; motion carried.

Agenda Item 4 Update on Licensing Staffing
Mr. Worden thanked staff for doing an excellent job in the past and current fiscal year, and provided an update on the Licensing Program staffing. There are three vacancies in the Licensing Program: one Office Technician (OT) position and two Managements Service Technician (MST) positions. Interviews have been held for the OT position and management is in the process of setting interviews for the two MST positions. Interviews have also been completed for Seasonal Clerk positions that will replace the Student Assistant positions. In addition, Licensing was able to retain some of the Retired Annuitant positions temporarily while management is in the process of hiring Permanent Intermittent employees to take their place.

Agenda Item 5 Updates on the Business Process Reengineering (BPR) Primary Recommendations
Mr. Worden provided an update on the BPR primary recommendations. Staff have completed the revision of the Physician's and Surgeon's application and the development of a new Fee Schedule. The application was posted to the Board's Web site the previous day. The new application is designed to be easier to read and follow. Staff plan to improve the Web site, including adding some pop-up fields for specific questions to help facilitate the application process. The application was also modified to accommodate the applicants who qualify under Senate Bill (SB) 122 that is going

into effect January 2013.

Dr. Salomonson asked Mr. Worden to remind the audience about the candidate pool that will be affected by SB 122.

Mr. Worden replied that SB 122 will allow candidates that have attended an unrecognized medical school or a disapproved medical school and have met certain other requirements to be eligible to apply for a California Physician's and Surgeon's license. Staff is going to start working on the Web site to accommodate the changes for the new Physician's and Surgeon's application and to include the SB 122 changes. Staff will then work on updating the Licensing Program's Policy and Procedures manual thereafter.

Agenda Item 6 Update on Strategic Plan Components

Mr. Worden stated there are several components that will not be implemented until the years 2013 and 2014. He provided an update on the following components that are currently being worked on within the Licensing Program:

Objective 1.1 requires the Licensing Program to examine the current Continuing Medical Education (CME) structure and its effectiveness. The current California requirements and opportunities for improvement were presented to the Board at the meeting in May 2012. Staff is continuing to work on this component, including preparing an article for the Board's newsletter that will inform physicians of the requirements, as well as provide information on available resources.

Objective 1.3 requires the Licensing Program to define what is necessary to promote safer entry into medical practice after extended absences, as well as conducting a review of current data that includes ongoing work with the Federation of State Medical Board (FSMB) to determine what is required prior to resuming clinical practice for physician re-entry. The FSMB is still looking at many of the issues. This task is ongoing and now part of the Board's Sunset Review.

Objective 1.4 requires the Licensing Committee, or a subcommittee, to examine FSMB maintenance of licensure and the American Board of Medical Specialties (ABMS) maintenance of certification initiatives, study what should be adopted in California, and determine how to collaborate with FSMB and ABMS. A meeting was held between the Board staff and FSMB at the beginning of October 2012. During the meeting, FSMB provided an overview of its pilot program. The dates of the objectives will need to be re-considered as it is dependent upon when FSMB has concluded and published the data from its maintenance of licensure pilot programs.

Objective 1.5 requires the Licensing Program to conduct a comprehensive review of the international medical schools. The Licensing Program has hired an additional analyst. The new analyst is working on going through the existing list and contacting medical schools to make sure that they are current and still meet the requirements. This review was just started and will continue.

Objective 2.1 requires the Licensing Program to develop a plan to conduct a complete review of all laws and regulations relating to licensing to identify if they are still relevant, if they need to be amended or eliminated, and to identify any requirements that are not necessary for the safety of practice, but may be

serving as barriers for qualified applicants. The review will also include updating requirements to coincide with current educational requirements. This task is part of the Board's Sunset Review.

Objective 2.8 requires the Licensing Program to clarify the Board's responsibility to regulate outpatient surgery centers and obtain resources to be effective. In 2012, staff was able to launch the outpatient surgery center database on the Board's Web site, which complied with the requirements outlined in the Business and Professions Code section 1248. Staff is currently reviewing laws outlining requirements, as well as other requirements for outpatient accreditation agencies.

Objective 2.9 requires the Licensing Program to examine the affiliated healing arts programs within the Board to determine if there is a need to move the programs to a more appropriate board or bureau. This task was completed and is a part of the Sunset Review report.

Objective 5.5 requires licensing applications to be reviewed within 45 days. The Board has been in compliance with this component for this quarter of the fiscal year. Staff have been reviewing applications within the 45 day goal; staff is currently reviewing applications within 30 days from receipt for both United States and International Medical School graduates.

Objective 5.6 requires the Licensing Program to establish means of better educating staff about the Board's activities, including encouraging them to attend meetings. Staff have been encouraged to attend Board meetings; however, staff can generally attend Board meetings only in Sacramento due to travel restrictions. Management provides updates to the staff when the meetings have been completed and informs them of new laws and regulation changes that will be adopted.

Agenda Item 7 Presentation on Physician Supervision Requirements for the Allied Health Care Professions

Mr. Worden provided a presentation on requirements for the Allied Health Care Professions for the Medical Board, as well as other boards that are health related.

Mr. Heppler confirmed with Mr. Worden that he reviewed the applicable statutes and regulations in preparation of the presentation.

Mr. Worden, upon request by Ms. Schipske, stated that for registered nurses written standardized procedures or protocols may be required for some functions, particularly when performing overlapping medical functions. Physical presence of a supervisor may or may not be required, dependent upon standardized procedure specifications.

Dr. Diego confirmed with Mr. Worden that medical assistants can be supervised by physician assistants if they work in certain locations (i.e. community or free clinic), otherwise physician assistants cannot supervise medical assistants.

Dr. Diego confirmed with Mr. Worden that an optometrist can dispense lenses based on their license. She then asked what the responsibilities are of an optometrist assistant. Mr. Worden stated they are similar to a medical assistant, and their scope is limited to specific requirements within the statute.

Dr. Diego asked if the associate social worker is supervised by a licensed clinical social worker, and what is the supervision and scope. Mr. Worden stated he was not sure, but could research the subject.

Ms. Schipske stated one of the reasons the Board Members asked for the information regarding supervision requirements for the allied health care professions is they grapple with the issue of required supervision for those who do procedures, such as Botox and other beauty related procedures. Questions often come up as to whether or not nurses or other midlevel professionals can do that type of work without the direct supervision of physicians. Ms. Schipske stated it comes down to standardized procedures and protocols as to whether or not a nurse can act independently or have a required physician on site. So it is important to look at all areas since beauty related procedures are a common practice.

Dr. Salomonson stated there were certain areas where those who could supervise had to be board certified. For example, in Behavioral Science it could not be any physician; it had to be a psychiatrist.

Dr. Salomonson asked Mr. Worden to explain the requirements for anesthesia providers.

Mr. Worden explained that anesthesiologists can practice in a dental office if they are approved to do so and pointed out that there are dentists who are approved for administering anesthesia. It cannot be just any dentist and would have to be one that is trained in administering anesthesia.

Ms. Schipske asked if something was mentioned regarding an anesthesiologist technician and profusionist since they are other professionals that do invasive work.

Mr. Worden replied that he did not provide any information on those professions, but would do so in the future.

Agenda Item 8 Update on Implementation of SB 122

Ms. Simoes and Mr. Worden provided an update on the implementation of SB 122. SB 122 (Chapter 789, Statutes of 2012) was signed into law by the Governor. Originally, this bill included language that would have only required five years of practice in another state or country in order to be eligible for licensure. It also would only have required one year of post graduate training and ABMS certification or two years of post graduate training. This language was taken to the Licensing Committee and to the Board at the July Board meeting. The Licensing Committee and the Board voted to support alternative language that uses the concepts in existing law, but added consumer protection elements. The language contained in SB 122 that was signed into law is the language supported by the Board.

This bill allows individuals who have attended and/or graduated from an unrecognized or disapproved school to be eligible to apply for licensure in California if they have continuously practiced in another state for ten years, if they went to an unrecognized school, or twenty years of continuous practice if they went to a disapproved school. This bill also requires individuals to be certified by a specialty board of the ABMS, to have successfully completed a licensing exam required in existing law, to have successfully completed three years of post graduate training, and to not have any discipline on their license in another state or any adverse judgments or settlements relating to the practice of medicine. This bill allows the Board to adopt regulations to establish procedures for accepting transcripts, diplomas, and any other supporting information or records when the originals are not available due to circumstances outside the applicant's control. This

bill also allows the Board to adopt regulations authorizing the substitution of additional specialty board certification for years of practice of licensure for considering the certification for a physician and surgeon.

The Board supported this language because requiring ten or twenty years of continuing practice in another state, among other requirements, are substantial enough to ensure consumer protection. The Board's implementation plan for this bill is to include a summary in the Board's upcoming newsletter, to train Board staff on the new law and the new internal processes and procedures, and to update the Licensing application and instructions. The application is now on the Board's Web site and information regarding the new law will be posted to the Web site shortly. Once application issues are determined, staff will work on the need for regulations. The discussion regarding a need for regulations will most likely be brought to the Board at the April 2013 Board meeting. Staff will also send notifications to those applicants that the Licensing Program is aware of so that they may apply under this new law.

Mr. Worden stated that when the Board receives a new licensing application from an applicant, the front end staff will prepare the application file and assign the file to the analyst who is assigned to work the files based on the first letter of the last name. Once the analyst receives the file and determines the applicant has attended and/or graduated from an unrecognized or disapproved school, the application file will be transferred to an analyst who is assigned to analyze this type of application file. This analyst will prepare the file for the Application Review Committee (ARC). Only one staff member will work these particular applications so the need for additional regulations can be easily identified. It is going to be a controlled process that the international licensing mangers will oversee. Licensing staff will be trained on the new process shortly.

Agenda Item 9 Agenda Items for the January 31 – February 1, 2013 Meeting in the San Francisco Bay Area

- Ms. Schipske requested information regarding supervision of profusionists and anesthesiologist technicians.
- Mr. Worden requested a discussion regarding International Post Graduate Training.

Agenda Item 10 Adjournment

The meeting adjourned at 2:42 p.m.

The full meeting can be viewed at www.mbc.ca.gov/board/meetings/index.html.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: January 12, 2013

ATTENTION: Licensing Committee

SUBJECT: Healthcare Practitioner Supervision Requirements for Perfusionists, and Anesthesia Technologist and Technician

STAFF CONTACT: Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

No action is necessary. At the October 25, 2012, Licensing Committee meeting, the following information was requested as a follow-up to my presentation on allied health care supervision requirements.

PERFUSIONIST:

A Perfusionist is a trained allied health professional responsible for the heart-lung machines necessary for cardiovascular surgeries. This individual must be supervised by a licensed physician and surgeon in accordance with Section 2590 (a) of the Business and Professions Code. Since January 1, 1993, no person shall hold himself or herself out as a perfusionist, unless 1) he/she is a graduate of a training program reviewed by the Accreditation Committee on Perfusion Education and approved by the Commission on Accreditation of Allied Health Educations Programs or its successor, and 2) he/she has successfully completed the entire examination of the American Board of Cardiovascular Perfusion or its successor agency. The Medical Board of California, nor any other governmental agency, licenses or certifies these individuals.

ANESTHESIA TECHNICIAN/TECHNOLOGIST GENERAL INFORMATION:

An Anesthesia Technician's role is to support the work done by the professional anesthesia personnel (Anesthesiologist or Certified Registered Nurse Anesthetist). Anesthesia Technicians are responsible for managing the anesthesia equipment and for its proper maintenance.

Depending on individual expertise and training, the task of the Anesthesia Technician, Certified Anesthesia Technician (Cer.A.T.) and Certified Anesthesia Technologist (Cer.A.T.T.) may include equipment maintenance and servicing, such as: cleaning, sterilizing, assembling, calibrating and testing, troubleshooting, requisitioning and recording of inspections and maintenance. They may operate a variety of mechanical, pneumatic and electronic equipment used to monitor, evaluate and manage the patient undergoing anesthesia.

The official recognition for Anesthesia Technologists and Technicians is by the American Society of Anesthesia Technologists and Technicians (ASATT) through national certification.

This certification is currently not required by any states, but some employers require it either prior to or within two years of hire.

The Anesthesia Technician, Certified Anesthesia Technician and Certified Anesthesia Technologist is a lesser skilled and trained professional who assists the anesthesia care team in an operating setting. These individuals may be supervised by an Anesthesiologist or Certified Registered Nurse Anesthetist. These individuals are not licensed or certified by any governmental agency in California.

ANESTHESIA TECHNICIAN:

An Anesthesia Technician is an individual who has not meet the requirements to apply for the American Society of Anesthesia Technologists and Technicians national certification examination or has met the requirements but has opted to not pursue the credentials of becoming a Certified Anesthesia Technician.

CERTIFIED ANESTHESIA TECHNICIAN:

The Certified Anesthesia Technician (Cer.A.T.) is a technician who has successfully completed the examination requirements established by the American Society of Anesthesia Technologist and Technicians (ASATT). The Cer.A.T. is an allied healthcare professional who is an essential member of the anesthesia patient care team, as observed by the American Society of Anesthesiologists (ASA), the American Association of Nurse Anesthetists (AANA) and the Association of periOperative Registered Nurses (AORN). The Cer.A.T. performs duties under the supervision of the licensed anesthesia care providers.

CERTIFIED ANESTHESIA TECHNOLOGIST:

A Certified Anesthesia Technologist (Cer.A.T.T.) is a technician who has successfully completed both the Certified Anesthesia Technician and Technologist Examinations per the requirements established by the ASATT. The Cer.A.T.T. is distinguished from the Cer.A.T. by additional levels of training and experience.

ISSUES FOR CONSIDERATION:

None

RECOMMENDATION:

None

ATTACHMENTS:

1. Business and Professions Code Section 2590-2596

ATTACHMENT 1

BUSINESS AND PROFESSIONS CODE SECTION 2590-2596

2590. (a) For purposes of this section, "perfusion" means those functions necessary for the support, treatment, measurement, or supplementation of the cardiovascular system, circulatory system with or without the oxygenation circuit, or any combination of those activities, and to ensure the safe management of physiologic functions by monitoring the necessary parameters of those systems pursuant to an order and under the supervision of a licensed physician and surgeon.

(b) Perfusion services include, but are not limited to, all of the following:

(1) The use of extracorporeal circulation, cardiopulmonary support techniques, and other ancillary therapeutic and diagnostic technologies. "Extracorporeal circulation," as used in this section, means the diversion of a patient's blood through a heart-lung machine or a similar device that assumes the functions of the patient's heart, lungs, or both.

(2) Counterpulsation, ventricular assistance, autotransfusion, including blood conservation techniques, myocardial and organ preservation, extracorporeal life support, and isolated limb perfusion.

(3) The use of techniques involving blood management, advanced life support, and other related functions.

(c) Perfusion services also include, but only during the performance of functions described in subdivision (b), the following:

(1) The administration of pharmacological and therapeutic agents, blood products, or anesthetic agents through the extracorporeal circuit or through an intravenous line as ordered by a physician and surgeon.

(2) The performance and use of anticoagulation analysis, physiologic monitoring, blood gas and chemistry analysis, hematocrit analysis, hypothermia, hyperthermia, hemoconcentration, and hemodilution. Nothing in this paragraph shall exempt perfusionists from the requirements of Chapter 3 (commencing with Section 1200), including, but not limited to, quality assurance and equipment maintenance requirements.

(3) The observation of signs and symptoms related to perfusion services.

(4) Making a determination whether the signs and symptoms related to perfusion services exhibit abnormal characteristics.

(5) Implementation, based on observed abnormalities, of appropriate reporting, or perfusion protocols, or changes in treatment regimen, pursuant to an order by a physician and surgeon, or the initiation of emergency procedures. "Perfusion protocols" as used in this section means perfusion-related policies and protocols

developed or approved by a licensed health facility or a physician and surgeon through collaboration with administrators and health professionals, including perfusionists.

(d) Commencing January 1, 1993, no person shall hold himself or herself out as a perfusionist, unless at the time of doing so the person meets the educational and examination requirements specified in subdivisions (e) and (f).

(e) Except as provided in subdivision (f), persons holding themselves out as perfusionists shall be graduates of a training program described in Section 2592 and produce satisfactory evidence of successful completion of the entire examination of the American Board of Cardiovascular Perfusion, or its successor agency, or the equivalent thereof if an equivalent is determined to be necessary by the Division of Licensing of the Medical Board of California.

(f) Any person may be deemed to have completed the equivalent of the examination and education requirements if that person is currently certified by the American Board of Cardiovascular Perfusion, or if, as of January 1, 1993, the person has practiced as a perfusionist and has annually performed a minimum of 40 cases of cardiopulmonary bypass during cardiac surgery in a licensed health facility and has done so for at least five years since January 1, 1987. For the purposes of this subdivision, "licensed health facility" means a health facility licensed in any jurisdiction within the United States.

(g) In order to continue to use the title of "perfusionist," the person shall complete the continuing education requirements of, or maintain active certification by, the American Board of Cardiovascular Perfusion, or its successor agency, or the equivalent if an equivalent is determined to be necessary by the Division of Licensing of the Medical Board of California.

(h) Any person who violates this section is guilty of a misdemeanor.

2591. (a) After completion of an approved perfusion training program, as defined in Section 2592, and until notification of passage of the entire examination of the American Board of Cardiovascular Perfusion, or its successor agency, that person shall identify himself or herself only as a "graduate perfusionist."

(b) The use of the title "graduate perfusionist" is valid for no more than three years from the date of completion of an approved perfusion training program.

2592. (a) Except as otherwise provided in Section 2590, all persons calling themselves perfusionists shall be graduates of an approved perfusion training program.

(b) For purposes of this article, an "approved perfusion training program" means a training program in perfusion reviewed by the

Accreditation Committee on Perfusion Education and approved by the Commission on Accreditation of Allied Health Education Programs or its successor or the equivalent training program if an equivalent is determined to be necessary by the Division of Licensing of the Medical Board of California.

2593. (a) During the period of any clinical training provided by an approved perfusion training program, perfusion may be performed by a student enrolled in the approved perfusion training program when those services are part of his or her course of study.

(b) A person enrolled as a student in an approved perfusion training program shall be identified as a "student perfusionist" or as a "perfusion intern."

(c) During the period of any clinical training, a student perfusionist or perfusion intern shall be under the direct supervision of a perfusionist who has met all the requirements of this chapter. For purposes of this section, "direct supervision" means assigned to a perfusionist who is on duty and immediately available in the assigned patient care area.

2595. Nothing in this chapter shall limit, preclude, or otherwise interfere with the practices of other persons licensed or otherwise authorized to practice under this division in performing perfusion services consistent with the laws governing their respective scopes of practice. None of the activities described in subdivisions (b) and (c) of Section 2590, including, but not limited to, extracorporeal life support, shall be construed to be exclusively perfusion services, but may be performed by other licensed persons when consistent with their respective scopes of practice.

2596. It is the intent of the Legislature that authority be reserved to the Division of Licensing of the Medical Board of California to adopt examination, continuing education, and training standards for perfusionists, with appropriate consultation, in the event that existing standards of the American Board of Cardiovascular Perfusion or the Accreditation Committee on Perfusion Education of the Committee on Allied Health Education and Accreditation of the American Medical Association prove inadequate after an appropriate trial period of at least three years.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: January 19, 2013

ATTENTION: Licensing Committee

SUBJECT: ACGME / RCPSC Accreditation of Postgraduate Training Programs Review of Current Statutes, Regulations

STAFF CONTACT: Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

To advise the full Board of the this issue and to authorize Licensing staff to continue to monitor and research the progress of the Accreditation Council Graduate for Medical Education-International and the Royal College Canada International postgraduate training programs and how these programs may or may not prove to be acceptable to use for meeting licensure requirements in the U.S. in general and California specifically.

BACKGROUND:

The Accreditation Council Graduate for Medical Education (ACGME) is the accreditation agency that accredits physician and surgeon postgraduate training in the United States. The Royal College of Physicians and Surgeons of Canada (RCPSC) is the accreditation agency that accredits physician and surgeon postgraduate training in Canada. Applicants for licensure as a physician and surgeon in California, who have graduated from a U.S. or Canadian medical school that is accredited by the Liaison Committee on Medical Education (LCME), must satisfactorily complete a minimum of one year of ACGME or RCPSC postgraduate training. International medical school graduates must satisfactorily complete two years of ACGME or RCPSC accredited training to qualify for medical licensure in California.

ACGME / ACGME-I:

For the past 30 years, ACGME only evaluated postgraduate training residency and/or fellowship programs in the U.S. The RCPSC previously only evaluated postgraduate training residency programs in Canada. ACGME has announced it will be evaluating postgraduate training in other countries, as ACGME-International (ACGME-I). The RCPSC has created a new division Royal College Canada International (RCCI) and is currently providing postgraduate training consultation services to other countries.

ACGME-I recently completed the first phase of a partnership with the Ministry of Health in Singapore to restructure the GME accreditation system in that country. Currently, there are 39 ACGME-I accredited residency programs in Singapore (Attachment 1). Meanwhile, the ACGME-I has signed contracts in Qatar and Abu Dhabi in the United Arab Emirates and is negotiating with officials in Oman. The ACGME-I standards are not identical to the U.S. standards, ACGME-I has incorporated the different delivery systems between U.S. and international countries.

As ACGME-I continues to expand and accredit postgraduate training programs in other countries with standards similar to the standards in the U.S. the net effect could be an influx of physicians and surgeons with this type of postgraduate training applying for licensure in the United States and more specifically California. Currently ACGME-I postgraduate training is not acceptable in California and/or other states at this time.

RCPSC / RCCI:

RCCI has recently provided services in the following countries and/or worked with organizations or medical schools/teaching hospitals, within these countries and/or organizations (Attachment 2):

Australia - Royal Australasian College of Physicians and the Royal Australasian College of Surgeons

Haiti - RCCI delivers simulation training to health professionals in Haiti to improve front-line care.

La Francophonie - At the 2011 annual Conference International Des Doyens De Faculte De Medecine D'Expression Francasie, RCCI presented the CanMEDs frame work and provided an overview of the RCPSC accreditation standards.

Chile - A RCCI team has recently (2011) been invited by the Pontifical Catholic University in Santiago, Chile to review up to eight residency training programs utilizing Canadian standards.

India - RCCI is exploring opportunities with medical organizations in India to help Indian authorities implement national standards for the evaluation and assessment of postgraduate medical trainees.

Oman - RCCI has signed an agreement with Oman Medical Specialties Board to develop a lasting educational partnership. RCCI reviewed a number of postgraduate training programs.

Saudi Arabia - RCCI has signed agreements with the Saudi Commission on Health Specialties and medical education organizations in Saudi Arabia to facilitate the transfer of Canadian expertise and standards in postgraduate medical education to Saudi Arabian educators. Saudi Arabia is looking to implement (with modifications that reflect local needs and realities) enhanced standards in medical education and residency training that draw upon Canadian standards, experience and advice.

China - RCCI is exchanging knowledge with a number of Chinese organizations involved in medical education and postgraduate medical training. They are exploring how RCCI might offer Canadian expertise and standards in postgraduate medical education.

RCCI runs conferences, short courses and workshops for international medical faculty on all aspects of the CanMEDS competencies and standards. This includes physician evaluation and

assessment, curriculum development, examiner and surveyor training, accreditation standards for residency programs and the training of clinician educators.

RCCI also provides conferences, short courses and workshops for practitioners that include online bio-ethics modules for physicians and simulation workshops that equip physicians and health care teams with training in difficult critical care situations. RCCI can deliver workshops using high-fidelity simulation platform or "virtual patient" technology- either onsite or remotely.

RCCI uses Canadian standards to perform operational reviews of international specialty residency programs, providing its partners with an assessment of their strengths and opportunities for improvement. In addition, RCCI offers consulting services covering postgraduate medical education standards, systems and tools as well as continuing professional development standards and programming. RCCI also provides advice on issues involving human resources and health system reform.

Based upon the information available, it appears RCCI may move into the accreditation of postgraduate training residency programs in other countries. The initial programs likely will be in the UK and Australia since the postgraduate training programs in those countries are similar to Canada's.

ISSUES FOR CONSIDERATION:

ACGME has created a new international division; ACGME-I using criteria for accreditation that is similar to the criteria that ACGME uses to accredit postgraduate training programs in the U.S. and is now accrediting postgraduate residency training programs in other countries.

RCPSC has created a new international division; RCCI. At this time it appears that the RCPSC/RCCI has not accredited any international postgraduate residency training programs. However, it is likely that the RCCI will be accrediting international postgraduate training programs based upon the CanMED requirements for RCPSC postgraduate training.

Based upon the information that is available as of the date of this document, ACGME-I has accredited postgraduate training programs in Singapore. RCCI to date has not accredited any international postgraduate training programs.

Upon reviewing the appropriate statutes with MBC legal counsel; Business and Professions Code (B&P) Sections 2065, 2066, and 2096 (Attachment 3), and B&P Sections 2102, and 2103 (Attachment 4), it has been determined that theses statutes do not need to be amended at this time. Upon review of the associated regulations- CCR Sections 1320 and 1321 (Attachment 5), it has been determined that CCR Section1321 currently does not include approval of ACGME-I and/or RCCI accredited postgraduate training for licensure in California.

ACGME-I has already accredited 39 postgraduate training programs in Singapore at three different hospitals that are Joint Commission accredited. These programs are part of the Singapore Health Services PTE LTD (Affiliated Medical Schools – Duke/National University of Singapore and National University of Singapore), the National University Health System

(Affiliated Medical School – National University of Singapore), and the National Healthcare Group (Governmental Agency Hospital). In addition, Duke University School of Medicine has a joint medical school in Singapore to teach medicine based upon the U.S. medical school system. The medical school is known as Duke/National University Singapore Graduate School of Medicine.

RCCI has already taken the first step of consulting and setting up new international postgraduate training programs to be equivalent to RCPSC accredited postgraduate training programs. It is safe to assume that RCCI accreditation for these new postgraduate training programs will be following in the near future.

At this time no state within the U.S. recognizes either ACGME-I or RCCI postgraduate training as meeting licensure requirements for licensure as a physician and surgeon. What staff does not know, is if these individual would be hired in the health care system in California if they have not been in a program on U.S. or Canadian soil, even if these international postgraduate training programs become recognized for licensure in the future, since postgraduate training is partly used to access if the individual can work within our institutions/system and under our rules/laws.

RECOMMENDATION:

The two California recognized postgraduate training accrediting entities have expanded their reach or jurisdiction and have begun to approve and/or setup postgraduate training programs which most likely result in accreditation at a later date, in countries other than the U.S. or Canada. As ACGME and RCPSC continue to expand where they provided accreditation for postgraduate training programs, the Board should continue to monitor international postgraduate training programs of both the ACGME and RCPSC.

ATTACHMENTS:

1. ACGME-I: Information and Accredited Postgraduate Residency Programs
2. RCCI: Information
3. Business and Professions Code Sections: 2065, 2066 and 2096
4. Business and Professions Code Sections: 2102 and 2103
5. California Code of Regulations Section 1321

ATTACHMENT 1

Welcome to ACGME-International

A website for the 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 ACGME-I is a voluntary peer-review process of evaluation performed by a non-governmental agency. The goals of the process are to evaluate, improve, and publicly recognize programs and sponsoring institutions in GME that are in substantial compliance with standards of educational quality established by 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 educated in an educational setting where these standards have been met.

International Updates

Ten Fellowships/Subspecialty Program Requirements for Internal Medicine now available. (updated 10.08.12)

Ten Fellowships/Subspecialty Program Application Documents for Internal Medicine now available. (updated 10.08.12)

Advanced Specialty Program Requirements for Urology now available. (updated 10.08.12)

Advanced Specialty Program Application Documents for Urology now available. (updated 10.08.12)

Advanced Specialty Program Information Forms (PIFs - updated 10.08.12)

Advanced Specialty Program Requirements (updated 10.08.12

Glossary of Terms (updated 07.21.11)

Frequently Asked Questions

ACGME International Mission

The Accreditation Council for Graduate Medical Education International LLC (ACGME-I) is a non-governmental organization that accredits graduate medical education (GME) programs outside of the United States. Its mission is to improve health care by assessing and advancing the quality of resident physicians' education through accreditation to benefit the public, protect the interests of residents, and improve the quality of teaching, learning, research, and professional practice.

International Updates

Ten Fellowships/Subspecialty Program Requirements for Internal Medicine now available. (updated 10.08.12)

Ten Fellowships/Subspecialty Program Application Documents for Internal Medicine now available. (updated 10.08.12)

Advanced Specialty Program Requirements for Urology now available. (updated 10.08.12)

Advanced Specialty Program Application Documents for Urology now available. (updated 10.08.12)

Advanced Specialty Program Information Forms (PIFs - updated 10.08.12)

Advanced Specialty Program Requirements (updated 10.08.12

Glossary of Terms (updated 07.21.11)

Frequently Asked Questions

ACGME International

ACGME International LLC (ACGME-I) - Public

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Sponsor Search

GO

Code	Name	DIO Lastname	Number of Accredited Programs
770022	Singapore Health Services Pte Ltd	Lim	13
770030	National University Health System	Ooi	14
770039	National Healthcare Group	Chew	12

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ACGME International

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770022 - SINGAPORE HEALTH SERVICES PTE LTD
8007700001 - *Singapore*

Original Accreditation Date: July 01, 2010
Accreditation Status: Continued Accreditation
Accreditation Effective Date: October 20, 2012

Cycle Length: 3.0
Last Site Visit Date: November 22, 2010
Date of Next Site Visit (Approximate): October 01, 2015

Residents Rotate Through This Institution: No

CEO INFORMATION

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Designated Institutional Official
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Sponsor Summary

31 Third Hospital Avenue
#03-03 Bowyer Block C
Singapore 168753

http://www.singhealthresidency.com.sg

Joint Commission Approved? Yes
Ownership or Control Type: *No Information Currently Present*
Type of Institution: General/Teaching Hospital
DIO Address: Singapore Health Services Pte Ltd

2 Jalan Bukit Merah
Block 1, Level 1
Singapore 169647

Affiliated Medical Schools: [82502] Duke-Nat Univ of Singapore, Singapore
[82501] Nat Univ of Singapore, Singapore

Sponsored Programs

Code	Specialty	PD Last Name	Total Residents Filled
0407700004	Anesthesiology	Poopalalingam	35
1107700004	Emergency medicine	Leong	15
1207700003	Family medicine	Ho	32
1407700004	Internal medicine	Ghee Chee	101
2207700003	Obstetrics and gynecology	Chern	27
2407700004	Ophthalmology	Yeo	12
2607700004	Orthopaedic surgery	Singh	8
2807700004	Otolaryngology	Tan	7
3007700004	Pathology	Lai	7
3207700003	Pediatrics	Shahdadpuri	43
4207700004	Radiology-diagnostic	Lim	21
4407700005	Surgery	Cheow	26
9997700004	Transitional year	Lim	42

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770030 - NATIONAL UNIVERSITY HEALTH SYSTEM
8007700002 - *Singapore*

Original Accreditation Date: July 01, 2010
Accreditation Status: Continued Accreditation
Accreditation Effective Date: October 20, 2012

Cycle Length: 3.0
Last Site Visit Date: November 22, 2010
Date of Next Site Visit (Approximate): October 01, 2015

Residents Rotate Through This Institution: No

CEO INFORMATION

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Sponsor Summary

1E, Kent Ridge Road
Singapore 119228

http://www.nuhs.edu.sg

Joint Commission Approved? Yes
Ownership or Control Type: *No Information Currently Present*
Type of Institution: General/Teaching Hospital
DIO Address: 1E, Kent Ridge Road
Singapore 119228

Affiliated Medical Schools: [82501] Nat Univ of Singapore, Singapore

Sponsored Programs

Code	Specialty	PD Last Name	Total Residents Filled
0407700003	Anesthesiology	Goy	19
1107700003	Emergency medicine	Peng	15
1207700004	Family medicine	Tan	11
1407700003	Internal medicine	See Meng	81
2207700002	Obstetrics and gynecology	Tan	6
2407700003	Ophthalmology	Tan	6
2607700003	Orthopaedic surgery	Thambiah	6
2807700003	Otolaryngology	Ngo	6
3007700003	Pathology	Lee	4
3207700002	Pediatrics	Aw	27
3807700001	Preventive medicine	Lee	15
4207700003	Radiology-diagnostic	Teo	8
4407700004	Surgery	Iyer	10
9997700003	Transitional year	Huggan	26

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770039 - NATIONAL HEALTHCARE GROUP
8007700003 - *Singapore*

Original Accreditation Date: July 01, 2010
Accreditation Status: Continued Accreditation
Accreditation Effective Date: October 20, 2012

Cycle Length: 4.0
Last Site Visit Date: November 22, 2010
Date of Next Site Visit (Approximate): October 01, 2016

Residents Rotate Through This Institution: No

CEO INFORMATION

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Sponsor Summary

NHG Residency
Ren Ci Hospital, Level 15, 71 Irrawaddy Road
Singapore 329562

http://www.nhgresidencyprogram.com.sg

Joint Commission Approved? Yes
Ownership or Control Type: Governmental Agency
Type of Institution: Other
DIO Address: NHG Residency

Ren Ci Hospital, Level 15, 71 Irrawaddy Road
Singapore 329562

Sponsored Programs

Code	Specialty	PD Last Name	Total Residents Filled
0407700001	Anesthesiology	Kan	16
1107700001	Emergency medicine	Heng	11
1207700002	Family medicine	Tan	26
1407700002	Internal medicine	Koh	80
2407700002	Ophthalmology	Lee	8
2607700002	Orthopaedic surgery	Sathappan	8
2807700002	Otolaryngology	Chong	8
3007700001	Pathology	Chuah	4
4007700001	Psychiatry	Chiam	32
4207700002	Radiology-diagnostic	Wong	11
4407700003	Surgery	Vijayan	20
9997700001	Transitional year	Goh	28

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ATTACHMENT 2

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- Royal College Canada International (RCCI)
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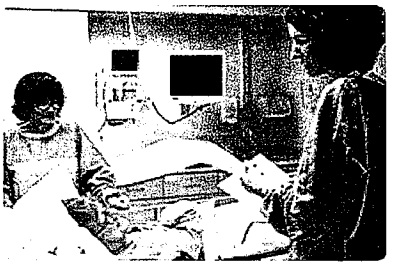
Strengthening specialty medicine to meet society's needs



The Royal College sets the highest standards for specialty medical education in Canada. At the same time, we support lifelong learning for specialist physicians and promote sound health policy. In carrying out our broad mandate, the following are among our core tasks.

Accreditation

We accredit the residency programs at 17 universities across Canada and also accredit the learning activities that physicians pursue in their continuing professional development programs.

Credentials

We verify that a physician has met all the requirements necessary for Royal College certification. To become eligible for the next stage of assessment — examination — physicians must meet an array of credentialing requirements set by the Credentials Committee and a designated specialty committee of the Royal College.

Examination

With significant assistance from our volunteer Fellows, we produce the national certification exams, which we also administer. Read more about the examination process.

Maintenance of Certification

We have developed and continue to deliver the Maintenance of Certification (MOC) Program, a continuing professional development program, to meet the lifelong learning needs of Fellows. Individuals who are not Fellows may also participate in the MOC Program. Read more about continuing professional development.

CanMEDS

We developed the CanMEDS Physician Competency Framework with the goal of improving patient care. CanMEDS, an educational framework, guides all of the Royal College's core activities.

Awards and Grants

The Royal College distributes more than $1 million a year in awards, grants, fellowships and visiting professorship programs. Funds are provided by member donations, through a portion of membership dues, through the Royal College's Education Fund and from private endowments.

Policy initiatives

We work to analyze complex and abundant information about health care and health system issues with the goal of enabling a better health system for all Canadians. Read more about our policy and advocacy roles.

Research and innovation

We continually enhance our role in scholarship, in particular our research in medical education and health policy. As an example, our Centre for Learning in Practice (CLIP) conducts theoretical and applied research into how education affects physician practise.

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About Us

Our vision

The best health for all.
The best care for all.

Our mission

To improve the health and care of Canadians by leading in medical education, professional standards, physician competence and continuous enhancement of the health system.

Read our new strategic plan »

Five things that distinguish us as the Royal College

We set the highest standards

The Royal College is the national professional association that oversees the medical education of specialists in Canada. We accredit the university programs that train resident physicians for their specialty practices, and we write and administer the demanding examinations that residents must pass to become certified as specialists.

We promote lifelong learning

We protect the health of Canadians by helping physicians build skills, knowledge and expertise in their specialties. Our Maintenance of Certification Program supports specialist physicians along their paths of lifelong learning and professional development and ensures their continued competence in a constantly evolving medical environment.

We are influential in the medical community

We share our expertise and maintain close working relations with Canada's 17 university medical schools, national professional associations, national specialty societies, voluntary health organizations and government agencies. Our voice is respected and influential in critical discussions on issues that affect medical education, medical research and the delivery of high-quality health care to Canadians.

We advance scholarship and research

We contribute to scholarship on medical education, educational standards and health policy. In collaboration with leading researchers and partners in specialty medicine, we work to establish more effective ways to assess physician competence and find innovative solutions to health system issues that are important to Canadians.

We have an international presence

We support global standards in health care, training values and professional development by sharing our educational activities and tools with sister colleges in other countries. We establish relations with global partners and assist them to build their capacity to provide specialty medical education and create their own sustainable health systems. Read more about our international activities.

Learn more about what we do »

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From simple beginnings to health system leadership

In June 1929, a special Act of Parliament established The Royal College of Physicians and Surgeons of Canada to oversee postgraduate medical education. At first, the Royal College offered just two specialty qualifications: Fellowship in general medicine and Fellowship in general surgery. Now, the Royal College recognizes 67 disciplines, granting Fellowships in 29 specialties, 35 subspecialties and three special programs.

Prime Minister John Diefenbaker opens the Stanley Avenue building in 1961, the home of the Royal College prior to its move in 1992 to its present location at 774 Echo Drive in Ottawa, Ont.

One high standard for certification

From the 1940s to the 1970s, the Royal College conducted examinations at two levels in most specialties: Fellowship, the higher qualification, or Certification, a lesser designation. In 1972, the Royal College abolished this dual standard and began to offer a single certification, ensuring only the highest standards for specialty medical education.

Meanwhile, in 1968, the Royal College established the McLaughlin Examination and Research Centre at the University of Alberta and Laval University to research and develop modern techniques for evaluating specialist physicians. In 1987, the Royal College merged the centre's two components into a bilingual McLaughlin Centre based in Ottawa.

Taking on a broader role

In recent years, the Royal College has expanded its activities and voice, becoming increasingly active in research, public policy and international affairs.

CanMEDS framework and lifelong learning

In 1996, the Royal College adopted CanMEDS, a medical education framework it developed in-house that emphasizes the essential competencies of a physician. CanMEDS was a major achievement: all 17 medical schools in Canada use it and it is also respected and used around the world. In 2000, the Royal College introduced the Maintenance of Certification Program, a lifelong learning program for specialist physicians that helps ensure the highest standards in all specialties.

Health policy and advocacy

Since the mid-1980s, the Royal College has become increasingly active in issues that are important to Canadians. Aboriginal health, injury prevention, patient safety and health human resources are just a few public policy areas to which the Royal College has leant its voice.

International involvement

In 2009, Royal College Canada International was established, which serves as the Royal College's mechanism for facilitating international initiatives. Expanding activities in the international arena include the Royal College's collaborative relationships with sister colleges in other countries.

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CanMEDS

CanMEDS: better standards, better physicians, better care

In the early 1990s The Royal College developed an innovative, competency-based framework that describes the core knowledge, skills and abilities of specialist physicians. Known as the *CanMEDS Physician Competency Framework*, it was formally adopted by the Royal College in 1996.

CanMEDS is an educational framework identifying and describing seven roles that lead to optimal health and health care outcomes: medical expert (central role), communicator, collaborator, manager, health advocate, scholar and professional.

The overarching goal of CanMEDS is to improve patient care. The model has been adapted around the world in the health profession and other professions.

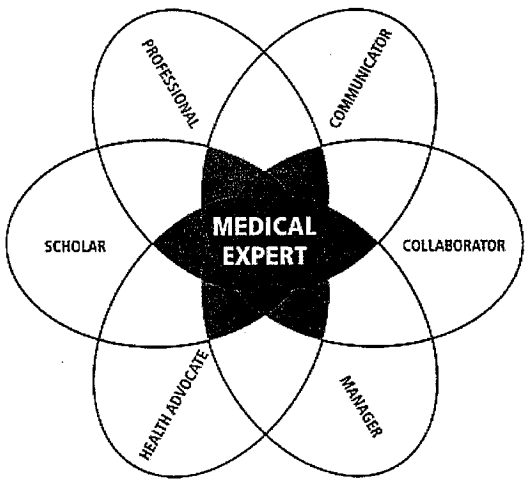
CanMEDS guides our core activities

The CanMEDS Roles have been integrated into the Royal College's **accreditation standards**, **objectives of training**, **final in-training evaluations**, **exam blueprints** and Maintenance of Certification Program. The Royal College is developing new products and services to help with the teaching and assessment of the CanMEDS Framework across the continuum of medical education and practice.

We encourage you to explore these resources to learn more about CanMEDS.

- Clinician Educator Program
- Core CanMEDS 2005 Framework
- Other CanMEDS resources
- CanMEDS online store
- CanMEDS workshops
- CanMEDS What Works/Best Practices

CanMEDS Diagram



ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA | CANMEDS

In 2001, the Royal College developed a diagram that illustrates the seven CanMEDS Roles and their interconnections. Officially trademarked, the CanMEDS diagram and associated materials can be reproduced only with permission from the Royal College. To obtain permission, please contact canmeds@royalcollege.ca.

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Royal College Canada International (RCCI)

RCCI

A Sample of Our Work

Royal College International Web Form

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The Royal College is expanding its international activities

More than ever before, the Royal College, through Royal College Canada International (RCCI), is involved in international, volunteer-driven medical education projects. Fellows are encouraged to get involved.

Our international services

Education

RCCI runs conferences, short courses and workshops for international medical faculty on all aspects of the CanMEDS competencies and standards. This includes physician evaluation and assessment, curriculum development, examiner and surveyor training, accreditation standards for residency programs and the training of clinician educators. Find more information about our CanMEDs products and services.

We also provide conferences, short courses and workshops for practitioners that include online bio-ethics modules for physicians and simulation workshops that equip physicians and health care teams with training in difficult critical care situations. We can deliver workshops using our high-fidelity simulation platform or our "virtual patient" technology — either onsite or from remotely. Learn more about our simulation workshops.

Residency program consultations

We use Canadian standards to perform operational reviews of international specialty residency programs, providing our partners with an assessment of their strengths and opportunities for improvement.

Advisory and consulting services

We offer consulting services covering postgraduate medical education standards, systems and tools as well as continuing professional development standards and programming. We can also provide advice on issues involving health human resources and health system reform.

Learn more

For information on how the Royal College can help your organization, please contact us at international@royalcollege.ca.

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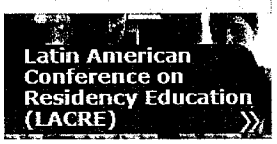

Sharing expertise across borders and cultures

Canada is a global leader in medical education. Integral to our system are the high standards that the Royal College maintains for residency training.

The Royal College engages in collaborative and often altruistic international activities as a good global citizen. We contribute to international conferences, host delegations and offer assistance when organizations from abroad approach us in an effort to improve their systems of residency medical education.

Formalizing our approach

To respond to an increasing number of international requests, the Royal College has formed a new division: Royal College Canada International (RCCI). RCCI offers the Royal College's services to international organizations on a cost -recovery basis.

Benefits from international activities include:

- professional development opportunities for Fellows who volunteer for interesting international projects
- feedback from partners about our standards, which helps keep the Royal College at the forefront of medical education and continuing professional development
- supplemental revenues to support domestic programs and other altruistic pursuits of the Royal College

Get involved

We invite Fellows and other professionals to join our International Academy. Please register your interest in participating in Royal College international activities by completing our web form. This new web profile tool will enable

- easier matching of your current skills and interests with available opportunities,
- improved communication of relevant Royal College international news and updates,
- more efficient means of sharing up-to-date information on expertise with our international partners, and
- formal recognition of your contributions to international outreach through an annual letter of recognition.

Go to Royal College International Academy web form »

International Academy - Frequently Asked Questions

Learn about our services

Read about the array of services the Royal College offers to its international partners.

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Royal College Canada International (RCCI)

RCCI

A Sample of Our Work

Royal College International Web Form

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A sample of our work abroad

International conferences

The Royal College hosts the annual International Conference on Residency Education (ICRE). In September 2011, the conference takes place Quebec City in September.

The Royal College hosts the annual International Medical Educators Leaders Forum (IMELF). In September 2011 the forum will take place in Quebec City.

The Royal College delivers the Saudi Arabian Conference on Medical Education in collaboration with the King Saud bin Abdulaziz University for Health Sciences. The February 2012 conference takes place in Riyadh, Saudi Arabia.

Australia

The Royal College is engaged in a tri-partite alliance with the Royal Australasian College of Physicians and the Royal Australasian College of Surgeons. This partnership focuses on research and development in areas of shared interest in medical education.

Haiti

The Royal College delivers simulation training — the Acute Critical Events Simulation course — to health professionals in Haiti as part of an international altruistic partnership to improve front-line care.

La Francophonie

The Royal College participates in the annual Conférence Internationale Des Doyens De Faculté De Médecine D'Expression Française (CIDMEF). At the 2011 conference, the Royal College presented the CanMEDS framework and provided an overview of the Royal College's accreditation standards and system.

Chile

A team from the Royal College has been invited by the Pontifical Catholic University in Santiago, Chile to review up to eight residency training programs using Canadian standards. These reviews will be completed on a cost-recovery basis by the end of 2011.

India

The Royal College is exploring opportunities with medical organizations in India about how we might help Indian authorities implement national standards for the evaluation and assessment of postgraduate medical trainees.

Oman

The Royal College has signed an agreement with the Oman Medical Specialties Board to develop a lasting educational partnership. The Royal College has sent teams of expert reviewers to Oman to review a number of postgraduate training programs on a cost-recovery basis. Discussions continue on opportunities for building on this partnership.

Saudi Arabia

The Royal College is discussing with educational authorities and a number of medical education institutions in Saudi Arabia about how Canadian standards — such as the CanMEDS competencies — could be adopted within the Saudi Arabian medical education system.

The Royal College has signed agreements with the Saudi Commission on Health Specialties and medical education organizations in Saudi Arabia to facilitate the transfer of Canadian expertise and standards in postgraduate medical education to Saudi Arabian educators. Saudi Arabia is looking to implement (with modifications that reflect local needs and realities) enhanced standards in medical education and residency training that draw upon Canadian standards, experience and advice.

Discussions continue with Saudi Arabian officials and organizations about how we can broaden and deepen the partnership between Canada and Saudi Arabia in the areas of medical education and postgraduate training.

China

The Royal College is exchanging knowledge with a number of Chinese organizations involved in medical education and postgraduate medical training. We are exploring how we might offer them Canadian expertise and standards in postgraduate medical education, as well as the Royal College's simulation training expertise.

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ATTACHMENT 3

2065. Unless otherwise provided by law, no postgraduate trainee, intern, resident, postdoctoral fellow, or instructor may engage in the practice of medicine, or receive compensation therefor, or offer to engage in the practice of medicine unless he or she holds a valid, unrevoked, and unsuspended physician's and surgeon's certificate issued by the board. However, a graduate of an approved medical school, who is registered with the board and who is enrolled in a postgraduate training program approved by the board, may engage in the practice of medicine whenever and wherever required as a part of the program under the following conditions:

(a) A graduate enrolled in an approved first-year postgraduate training program may so engage in the practice of medicine for a period not to exceed one year whenever and wherever required as a part of the training program, and may receive compensation for that practice.

(b) A graduate who has completed the first year of postgraduate training may, in an approved residency or fellowship, engage in the practice of medicine whenever and wherever required as part of that residency or fellowship, and may receive compensation for that practice. The resident or fellow shall qualify for, take, and pass the next succeeding written examination for licensure, or shall qualify for and receive a physician's and surgeon's certificate by one of the other methods specified in this chapter. If the resident or fellow fails to receive a license to practice medicine under this chapter within one year from the commencement of the residency or fellowship or if the board denies his or her application for licensure, all privileges and exemptions under this section shall automatically cease.

2066. (a) Nothing in this chapter shall be construed to prohibit a foreign medical graduate from engaging in the practice of medicine whenever and wherever required as a part of a clinical service program under the following conditions:

(1) The clinical service is in a postgraduate training program approved by the Division of Licensing.

(2) The graduate is registered with the division for the clinical service.

(b) A graduate may engage in the practice of medicine under this section until the receipt of his or her physician and surgeon's certificate. If the graduate fails to pass the examination and receive a certificate by the completion of the graduate's third year of postgraduate training or if the division denies his or her application for licensure, all privileges and exemptions under this section shall automatically cease.

(c) Nothing in this section shall preclude a foreign medical graduate from engaging in the practice of medicine under any other exemption contained in this chapter.

2096. (a) In addition to other requirements of this chapter, before a physician's and surgeon's license may be issued, each applicant, including an applicant applying pursuant to Article 5 (commencing with Section 2100), except as provided in subdivision (b), shall show by evidence satisfactory to the board that he or she has satisfactorily completed at least one year of postgraduate training.

(b) An applicant applying pursuant to Section 2102 shall show by evidence satisfactory to the board that he or she has satisfactorily completed at least two years of postgraduate training.

(c) The postgraduate training required by this section shall include at least four months of general medicine and shall be obtained in a postgraduate training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada (RCPSC).

(d) The amendments made to this section at the 1987 portion of the 1987-88 session of the Legislature shall not apply to applicants who completed their one year of postgraduate training on or before July 1, 1990.

ATTACHMENT 4

2102. An applicant whose professional instruction was acquired in a country other than the United States or Canada shall provide evidence satisfactory to the board of compliance with the following requirements to be issued a physician's and surgeon's certificate:

(a) Completion in a medical school or schools of a resident course of professional instruction equivalent to that required by Section 2089 and issuance to the applicant of a document acceptable to the board that shows final and successful completion of the course. However, nothing in this section shall be construed to require the board to evaluate for equivalency any coursework obtained at a medical school disapproved by the board pursuant to this section.

(b) Certification by the Educational Commission for Foreign Medical Graduates, or its equivalent, as determined by the board. This subdivision shall apply to all applicants who are subject to this section and who have not taken and passed the written examination specified in subdivision (d) prior to June 1, 1986.

(c) Satisfactory completion of the postgraduate training required under subdivision (b) of Section 2096. An applicant shall be required to have substantially completed the professional instruction required in subdivision (a) and shall be required to make application to the board and have passed steps 1 and 2 of the written examination relating to biomedical and clinical sciences prior to commencing any postgraduate training in this state. In its discretion, the board may authorize an applicant who is deficient in any education or clinical instruction required by Sections 2089 and 2089.5 to make up any deficiencies as a part of his or her postgraduate training program, but that remedial training shall be in addition to the postgraduate training required for licensure.

(d) Passage of the written examination as provided under Article 9 (commencing with Section 2170). An applicant shall be required to meet the requirements specified in subdivision (b) prior to being admitted to the written examination required by this subdivision.

(e) Nothing in this section prohibits the board from disapproving a foreign medical school or from denying an application if, in the opinion of the board, the professional instruction provided by the medical school or the instruction received by the applicant is not equivalent to that required in Article 4 (commencing with Section 2080).

2103. An applicant who is a citizen of the United States shall be eligible for a physician's and surgeon's certificate if he or she has completed the following requirements:

(a) Submitted official evidence satisfactory to the board of completion of a resident course or professional instruction equivalent to that required in Section 2089 in a medical school located outside the United States or Canada. However, nothing in this section shall be construed to require the board to evaluate for equivalency any coursework obtained at a medical school disapproved by the board pursuant to Article 4 (commencing with Section 2080).

(b) Submitted official evidence satisfactory to the board of completion of all formal requirements of the medical school for graduation, except the applicant shall not be required to have completed an internship or social service or be admitted or licensed to practice medicine in the country in which the professional instruction was completed.

(c) Attained a score satisfactory to an approved medical school on a qualifying examination acceptable to the board.

(d) Successfully completed one academic year of supervised clinical training in a program approved by the board pursuant to Section 2104. The board shall also recognize as compliance with this subdivision the successful completion of a one-year supervised clinical medical internship operated by a medical school pursuant to Chapter 85 of the Statutes of 1972 and as amended by Chapter 888 of the Statutes of 1973 as the equivalent of the year of supervised clinical training required by this section.

(1) Training received in the academic year of supervised clinical training approved pursuant to Section 2104 shall be considered as part of the total academic curriculum for purposes of meeting the requirements of Sections 2089 and 2089.5.

(2) An applicant who has passed the basic science and English language examinations required for certification by the Educational Commission for Foreign Medical Graduates may present evidence of those passing scores along with a certificate of completion of one academic year of supervised clinical training in a program approved by the board pursuant to Section 2104 in satisfaction of the formal certification requirements of subdivision (b) of Section **2102**.

(e) Satisfactorily completed the postgraduate training required under Section 2096.

(f) Passed the written examination required for certification as a physician and surgeon under this chapter.

ATTACHMENT 5

16 CCR § 1321

Cal. Admin. Code tit. 16, § 1321

Barclays Official California Code of Regulations Currentness
Title 16. Professional and Vocational Regulations
Division 13. Medical Board of California [FNA1]
Chapter 1. Division of Licensing
Article 6. Postgraduate Training (Refs & Annos)
[FNa1] For disposition of former Sections 1370-1375.45, see Table of Parallel Reference, Chapter 13.2, Title 16, California Code of Regulations.

§ 1321. Approved Postgraduate Training.

(a) Postgraduate training programs meeting the standards of the Accreditation Council on Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada shall be approved for the postgraduate training specified in Sections 2065, 2066, 2096, 2102, and 2103 of the code.

(b) A current list of such programs shall be maintained on file in the Sacramento office of the division.

(c) An applicant shall have been formally admitted to any postgraduate training program which is completed in order to qualify for licensure as a physician and surgeon. As used in this section, "formally admitted" means the applicant has met the program's requirements for admission to the programs.

(d) An applicant shall have completed one continuous year of approved postgraduate training in a single program in order to qualify for licensure as a physician and surgeon. The one year may be interrupted in cases due to illness or hardship. With respect to an applicant who qualifies for licensure by completing at least two years of approved postgraduate training, the second year shall be one continuous year in a single program, which may be the same or a different program than the first year. The second year may be interrupted in cases due to illness or hardship.

Note: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2005, 2037, 2065, 2066, 2096, 2102 and 2103, Business and Professions Code.

HISTORY

1. Amendment of subsection (a) filed 8-15-78; effective thirtieth day thereafter (Register 78, No. 33).

2. Amendment of subsection (a) filed 8-5-81; effective thirtieth day thereafter (Register 81, No. 32).

3. Repealer of subsection (c) filed 2-16-84; effective thirtieth day thereafter (Register 84, No. 7).

4. Amendment of subsections (a) and (b), and new subsections (c) and (d) filed 5-10-89; operative 6-9-89 (Register 89, No. 19).

5. Amendment of subsections (a), (b) and (c) filed 3-9-94; operative 4-8-94 (Register 94, No. 10).

6. Amendment of subsections (a) and (d) and amendment of Note filed 1-19-2000; operative 2-18-2000 (Register 2000, No. 3).

7. Change without regulatory effect amending subsection (a) filed 1-31-2005 pursuant to section 100, title 1, California Code of Regulations (Register 2005, No. 5).

16 CCR § 1321, 16 CA ADC § 1321

This database is current through 9/28/12 Register 2012, No. 39

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: January 11, 2013

ATTENTION: Licensing Committee

SUBJECT: ACGME / AOA Accreditation of Postgraduate Training Programs Review of Current Statutes, Regulations

STAFF CONTACT: Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

To advise the full Board of the need to amend Business and Professions Code Section 2089.5 in order to be able to recognize Accreditation Council Graduate for Medical Education accredited postgraduate training in hospitals that are accredited by the American Osteopathic Association-Healthcare Facilities Accreditation Program and to reflect the name change of the Joint Commission on Hospital Accreditation to the Joint Commission, and recommend the language change be part of the Sunset Review.

BACKGROUND:

The Accreditation Council Graduate for Medical Education (ACGME) is the agency that accredits physician and surgeon postgraduate training in the United States for allopathic medical school students, for required clinical clerkship training, and graduates for the required minimum postgraduate training. ACGME accredited postgraduate training programs were previously only provided in hospitals accredited by the Joint Commission on Hospital Accreditation, now known as Joint Commission (JC). Recently, ACGME has accredited ACGME postgraduate training programs in hospitals that are accredited by the American Osteopathic Association-Healthcare Facilities Accreditation Program (AOA-HFAP). Currently ACGME accepts approximately 1,000 osteopathic medical school graduates into ACGME accredited postgraduate programs each year. Some Osteopathic Medical Licensing authorities, including the Osteopathic Medical Board of California, accept both AOA and ACGME accredited postgraduate training for licensure purposes for osteopathic medical school graduates.

The American Osteopathic Association (AOA) is the accreditation agency that accredits physician and surgeon postgraduate training in the United States for osteopathic medical school graduates. AOA postgraduate training is currently provided in hospitals that are accredited by the AOA-HFAP and/or the JC.

California Business and Professions Code (B&P) Section 2089.5 states that clinical clerkship training must be completed at hospitals that have ACGME accredited postgraduate training programs and the hospital must be accredited by the Joint Commission on Hospital Accreditation.

Upon staff's analysis of the information that is currently available regarding the ACGME and AOA postgraduate training programs. Staff has determined there would not be a loss in consumer protection.

ISSUES FOR CONSIDERATION:

Currently B&P Section 2089.5 only recognizes ACGME accredited programs that are in hospitals that are accredited by the Joint Commission on Hospital Accreditation for allopathic medical school student clinical clerkship training.

ACGME and AOA have reached an agreement that ACGME will accredit all postgraduate training that was previously accredited by AOA. The majority of AOA accredited postgraduate training is currently provided in hospitals that are accredited by the AOA-HFAP. However, there are some hospitals that are currently accredited by both the JC and AOA-HFAP.

The Joint Commission on Hospital Accreditation is now known as the Joint Commission.

B&P Section 2089.5 needs to be amended to reflect the changes in ACGME / AOA accredited postgraduate training accreditation and the approved hospital accreditation agencies for hospitals with ACGME accredited programs.

RECOMMENDATION:

Amend B&P Section 2089.5 in the Board's Sunset Review to reflect the needed changes to ensure that B&P Section 2089.5 meets the current needs of the Board.

ATTACHMENTS:

1. Business and Professions Code Section 2089.5
2. Business and Professions Code Section 2089.5 with Recommended Amendments
3. AOA Correspondence Dated November 22, 2011
4. AOA Correspondence to ACGME, Dated November 23, 2011
5. AOA Web Site Printout – Timeline: AOA Response to ACGME Changes, Dated October 24, 2012
6. AOA-HFAP Web Site Printouts: Overview and Frequently Asked Questions

ATTACHMENT 1

California Business and Professions Code Section: 2089.5

2089.5. (a) Clinical instruction in the subjects listed in subdivision (b) of Section 2089 shall meet the requirements of this section and shall be considered adequate if the requirements of subdivision (a) of Section 2089 and the requirements of this section are satisfied.

(b) Instruction in the clinical courses shall total a minimum of 72 weeks in length.

(c) Instruction in the core clinical courses of surgery, medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry shall total a minimum of 40 weeks in length with a minimum of eight weeks instruction in surgery, eight weeks in medicine, six weeks in pediatrics, six weeks in obstetrics and gynecology, a minimum of four weeks in family medicine, and four weeks in psychiatry.

(d) Of the instruction required by subdivision (b), including all of the instruction required by subdivision (c), 54 weeks shall be performed in a hospital that sponsors the instruction and shall meet one of the following:

(1) Is a formal part of the medical school or school of osteopathic medicine.

(2) Has a residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada (RCPSC), in family practice or in the clinical area of the instruction for which credit is being sought.

(3) Is formally affiliated with an approved medical school or school of osteopathic medicine located in the United States or Canada. If the affiliation is limited in nature, credit shall be given only in the subject areas covered by the affiliation agreement.

(4) Is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada.

(e) If the institution, specified in subdivision (d), is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada, it shall meet the following:

(1) The formal affiliation shall be documented by a written contract detailing the relationship between the medical school, or a school of osteopathic medicine, and hospital and the responsibilities of each.

(2) The school and hospital shall provide to the board a description of the clinical program. The description shall be in sufficient detail to enable the board to determine whether or not the program provides students an adequate medical education. The board shall approve the program if it determines that the program provides an adequate medical education. If the board does not approve the program, it shall provide its reasons for disapproval to the school and hospital in writing specifying its findings about each aspect of the program that it considers to be deficient and the changes required to obtain approval.

(3) The hospital, if located in the United States, shall be accredited by the Joint Commission on Accreditation of Hospitals, and if located in another country, shall be accredited in accordance with the law of that country.

(4) The clinical instruction shall be supervised by a full-time director of medical education, and the head of the department for each core clinical course shall hold a full-time faculty appointment of the medical school or school of osteopathic medicine and shall be board certified or eligible, or have an equivalent credential in that specialty area appropriate to the country in which the hospital is located.

(5) The clinical instruction shall be conducted pursuant to a written program of instruction provided by the school.

(6) The school shall supervise the implementation of the program on a regular basis, documenting the level and extent of its supervision.

(7) The hospital-based faculty shall evaluate each student on a regular basis and shall document the completion of each aspect of the program for each student.

(8) The hospital shall ensure a minimum daily census adequate to meet the instructional needs of the number of students enrolled in each course area of clinical instruction, but not less than 15 patients in each course area of clinical instruction.

(9) The board, in reviewing the application of a foreign medical graduate, may require the applicant to submit a description of the clinical program, if the board has not previously approved the program, and may require the applicant to submit documentation to demonstrate that the applicant's clinical training met the requirements of this subdivision.

(10) The medical school or school of osteopathic medicine shall bear the reasonable cost of any site inspection by the board or its agents necessary to determine whether the clinical program offered is in compliance with this subdivision.

ATTACHMENT 2

Proposed Language Amendments Identification:
New Language - Underlined
Deleted Language - ~~Strikethrough~~

California Business and Professions Code Section: 2089.5

2089.5. (a) Clinical instruction in the subjects listed in subdivision (b) of Section 2089 shall meet the requirements of this section and shall be considered adequate if the requirements of subdivision (a) of Section 2089 and the requirements of this section are satisfied.

(b) Instruction in the clinical courses shall total a minimum of 72 weeks in length.

(c) Instruction in the core clinical courses of surgery, medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry shall total a minimum of 40 weeks in length with a minimum of eight weeks instruction in surgery, eight weeks in medicine, six weeks in pediatrics, six weeks in obstetrics and gynecology, a minimum of four weeks in family medicine, and four weeks in psychiatry.

(d) Of the instruction required by subdivision (b), including all of the instruction required by subdivision (c), 54 weeks shall be performed in a hospital that sponsors the instruction and shall meet one of the following:

(1) Is a formal part of the medical school or school of osteopathic medicine.

(2) Has a residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada (RCPSC), in family practice or in the clinical area of the instruction for which credit is being sought.

(3) Is formally affiliated with an approved medical school or school of osteopathic medicine located in the United States or Canada. If the affiliation is limited in nature, credit shall be given only in the subject areas covered by the affiliation agreement.

(4) Is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada.

(e) If the institution, specified in subdivision (d), is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada, it shall meet the following:

(1) The formal affiliation shall be documented by a written contract detailing the relationship between the medical school, or a school of osteopathic medicine, and hospital and the responsibilities of each.

(2) The school and hospital shall provide to the board a description of the clinical program. The description shall be in sufficient detail to enable the board to determine whether or not the program provides students an adequate medical education. The board shall approve the program if it determines that the program provides an adequate medical education. If the board does not approve the program, it shall provide its reasons for disapproval to the school and hospital in writing specifying its findings about each aspect of the program that it considers to be deficient and the changes required to obtain approval.

(3) The hospital, if located in the United States, shall be accredited by the Joint Commission ~~on Accreditation of Hospitals~~ or the American Osteopathic Association - Healthcare Facilities Accreditation Program, and if located in another country, shall be accredited in accordance with the law of that country.

(4) The clinical instruction shall be supervised by a full-time director of medical education, and the head of the department for each core clinical course shall hold a full-time faculty appointment of the medical school or school of osteopathic medicine and shall be board certified or eligible, or have an equivalent credential in that specialty area appropriate to the country in which the hospital is located.

(5) The clinical instruction shall be conducted pursuant to a written program of instruction provided by the school.

(6) The school shall supervise the implementation of the program on a regular basis, documenting the level and extent of its supervision.

(7) The hospital-based faculty shall evaluate each student on a regular basis and shall document the completion of each aspect of the program for each student.

(8) The hospital shall ensure a minimum daily census adequate to meet the instructional needs of the number of students enrolled in each course area of clinical instruction, but not less than 15 patients in each course area of clinical instruction.

(9) The board, in reviewing the application of a foreign medical graduate, may require the applicant to submit a description of the clinical program, if the board has not previously approved the program, and may require the applicant to submit documentation to demonstrate that the applicant's clinical training met the requirements of this subdivision.

(10) The medical school or school of osteopathic medicine shall bear the reasonable cost of any site inspection by the board or its agents necessary to determine whether the clinical program offered is in compliance with this subdivision.

ATTACHMENT 3

AMERICAN OSTEOPATHIC ASSOCIATION

142 East Ontario Street, Chicago, IL 60611-2864 · 312 202 8000 | 800 621 1773

November 22, 2011

Timothy C. Flynn, MD, FACS
Chair
ACCGME Board of Directors
515 N. State Street
Chicago, IL 60654

Thomas J. Nasca, MD, MACP
Chief Executive Officer
ACGME
515 N. State Street
Chicago, IL 60654

Dear Dr. Flynn and Dr. Nasca:

Thank you for the opportunity to provide comments regarding the proposed changes to the ACGME Common Program Requirements with respect to Prerequisite Clinical Education at the residency and fellowship levels. As discussed in greater detail below, the American Osteopathic Association (AOA) believes that the proposal will deprive the public of well trained physicians because it will severely constrain the ability of osteopathic physicians to transfer into ACGME approved residency training and result in an inefficient, if not wasteful, use of limited taxpayer resources available for graduate medical education.

1. Proposed Common Program Requirements

The proposed Common Program Requirements will require that any prerequisite clinical training required by residency or fellowship training programs take place in an ACGME-approved setting. That rule will impact osteopathic physicians who may choose to complete one or more years of training in an osteopathic (AOA-approved) program before matriculating in an ACGME-approved program. Under the proposed Common Program Requirements, osteopathic physicians in AOA approved residency programs would be unnecessarily forced to repeat postgraduate training in an ACGME-approved setting before continuing with the ACGME training. Due to CMS policies and limits on funding for graduate medical education, the proposed Requirements may deny some physicians access to positions because repeating and then completing residency training may exceed the maximum five years of 100% funding. Similarly, the proposed requirements may also foreclose training options for osteopathic physicians who want to practice in states that require DOs to complete an osteopathic internship year in order to qualify for licensure (Florida, Michigan, Oklahoma and Pennsylvania).

This represents a dramatic shift in ACGME policy. For more than 40 years, osteopathic physicians have been welcomed into ACGME-training programs at the residency and fellowship levels. Physicians who have completed AOA training have advanced successfully through ACGME training. Whereas ACGME's proposed Common Program Requirements will effectively halt recognition of prior osteopathic residency training, AOA-approved training is recognized by all state

licensing boards as satisfying requirements for postdoctoral education, by the CMS for funding of GME, by all branches of the military medical corps, the Veterans Administration, and the US Public Health Service, to name just a few. Similarly, osteopathic physicians who complete AOA residency training are eligible for membership and fellowship in professional organizations like the American Academy of Family Physicians, American College of Physicians, American Academy of Neurology, American Academy of Psychiatry, American College of Surgeons, and many others. Hospitals and medical centers throughout the United States have completed comprehensive reviews of the AOA residency training standards and recognized them as equivalent for purposes of credentials and privileges. Recognizing the quality of osteopathic residency training, many hospitals and hospital systems include both AOA and ACGME training programs (e.g., Henry Ford Health System, Geisinger, Cleveland Clinic, University of Wisconsin, Advocate/Lutheran General) within their GME programming.

2. Adverse Impact on Physicians and Programs

The current system that allows osteopathic physicians to transfer between AOA and ACGME residency training has worked well for the residents, for the programs, and for CMS and the taxpayers who fund residency training. For residents, the current system provides a fair opportunity to select between training programs that include osteopathic principles and practice as a core competency (i.e., AOA) and those that do not (i.e., ACGME). Those who intend to practice in Florida, Michigan, Oklahoma or Florida can satisfy the requirements of those states for one year of osteopathic postdoctoral training while still having the option to train in ACGME-approved programs after completing a year of AOA approved training. Similarly, physicians interested in a specialty with prerequisite clinical training or a fellowship also are given broader options and can transfer seamlessly between ACGME and AOA training. The current system is also a benefit for the training programs and directors of medical education, who are empowered to select among the broad range of qualified DO and MD applicants. Finally, the system works well for taxpayers and CMS because they are only required to provide funding once for the clinical training prerequisites and do not have to pay the cost for physicians to repeat training.

Approving the Common Program Requirements would reverse these opportunities. Osteopathic physicians could still transfer into ACGME training, but would be forced to repeat one or more years of training to do so. Osteopathic physicians well prepared to enter fellowships would be denied the opportunity to advance their careers. Programs would not be given the option to select residents who they might otherwise prefer. In an era of GME cost consciousness, this proposal may raise the cost of training physicians.

3. The Rationales for the Change are Not Persuasive

The osteopathic medical profession, through the AOA, has been in periodic communication with the ACGME regarding issues of common concern, such as limitations on duty hours. We were not advised of the discussions that led to the proposed Common Program Requirements or the concerns that prompted the suggested change. The only formal information we have is the explanation in the Impact Statement. Hence, we provide a response to the issues identified in the public record. Should ACGME have other concerns, we would be pleased to provide a supplemental response or meet to discuss them.

The Impact Statement suggests two rationales for the rule, neither of which is persuasive. The first advantage proposed is for public safety. It is asserted that residents and fellows who have not completed training in an ACGME program have "unknown" levels of training. While medicine is increasingly a data driven process, ACGME offers no data to support the suggestion that public safety is jeopardized. The AOA is not aware of any studies that suggest physicians who completed AOA training before continuing into ACGME residencies or fellowships are unprepared or perform differently than similarly situated residents from ACGME programs. The evidence indicates otherwise. The fact is that osteopathic physicians have been moving from AOA approved programs into ACGME residencies and fellowships for more than 40 years. The quality of AOA-trained physicians is well known and sought after by many ACGME programs and directors of medical education.

To the extent there are questions in the Resident Review Committees (RRCs) about the quality of the AOA's postdoctoral training, we note that the AOA's accreditation standards and the process for reviewing and approving programs and trainees are readily available for review. In the past, AOA and ACGME representatives studied each others' processes and ACGME representatives have attended meetings of the AOA's Program and Trainee Review Council and Council on Osteopathic Postdoctoral Training. The ACGME could also inquire of the many hospitals and health care systems that have both accredited ACGME and AOA training programs. It seems logical and cost effective that the ACGME would work with the AOA in advancing postdoctoral accreditation, similar to ACGME's work with the Canadian system.

The second rationale in the Impact Statement is for improving the quality of resident education. The impact statement reasons that non-ACGME programs are deficient because "they lack accreditation oversight by" ACGME/RCPSC and are not "monitored or evaluated according to ACGME/RCPSC standards" and, consequently, ACGME and RCPSC are unable to "confirm for the public the quality of education received by students who train in programs they do not accredit."

The reasoning here appears to be that the quality of resident education will improve because of the ACGME's expertise in accrediting graduate medical education. While the AOA has great respect for the ACGME and its processes, the AOA also stands behind the quality of our processes. The quality of AOA accreditation of graduate medical education has been considered and found appropriate by governmental authorities (Department of Veterans Affairs, military medical corps, state licensing boards) and non-governmental authorities (hospitals and health systems offering GME, hospitals and healthcare systems evaluating physicians for credentialing and privileging, private payors, etc.). If ACGME is not comfortable with the decisions reached by others, the AOA's standards and processes are open and transparent.

Conclusion

The Proposed Common Program Requirements will disrupt a system of graduate medical education that has worked well for trainers, training programs and the public we serve for more than 40 years. The AOA offers a program of quality graduate medical education. With more than 40 years of experience with residents and fellows transferring into ACGME programs after one or more years of AOA clinical training, the ACGME has knowledge that allowing DOs to transfer into these training programs does not threaten public safety. To the extent additional information is needed about the AOA's accreditation process, it can consult with AOA or the hospitals and health care systems where ACGME and AOA training take place. With scarce public resources available for

support of graduate medical education, the public should not be forced to pay the expense of having qualified physicians repeat a year of training.

In addition, it's important for you to note that all osteopathic physicians entering AOA or ACGME-training have completed four years of osteopathic medical school in the U.S. The AOA does not accept any foreign medical graduates into its postdoctoral training programs without completing its osteopathic medical school curriculum.

The AOA requests that you withdraw the proposed requirements or at the very least amend them to include AOA-accredited residency programs. We believe the proposals as currently written present a lose-lose situation for our health care system. If the proposed policies cannot be withdrawn, we recommend they be modified as follows:

III.A.2. Prerequisite clinical education for entry into ACGME-accredited residency programs must be accomplished in ACGME-accredited residency programs, AOA-ACCREDITED RESIDENCY TRAINING PROGRAMS, or Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited residency programs located in Canada.

III.A.3. Prerequisite clinical education for entry into ACGME-accredited fellowship programs must meet the following qualifications:

III.A.3.a) for fellowship programs that require completion of a residency program, the completion of an ACGME-accredited residency program, AN AOA-ACCREDITED RESIDENCY TRAINING PROGRAM, or an RCPSC-accredited residency program located in Canada.

III.A.3.a) for fellowship programs that require completion of some clinical education, clinical education that is accomplished in ACGME-accredited residency programs, AOA-ACCREDITED RESIDENCY TRAINING PROGRAMS, or RCPSC-accredited residency programs located in Canada.

Thank you for your consideration of these comments. We look forward to discussing this issue with you in more detail.

Sincerely yours,

Martin S. Levine, DO
AOA President

John B. Crosby, JD
AOA Executive Director

ATTACHMENT 4

AMERICAN OSTEOPATHIC ASSOCIATION

142 East Ontario Street, Chicago, IL 60611-2864 312 202 8000 | 800 621 1773

November 23, 2011

Timothy Flynn, MD, FACS
Chair, ACGME Board of Directors
Accreditation Council for Graduate Medical Education
515 N. State Street
Chicago, IL 60610

Dear Dr. Flynn:

The undersigned osteopathic associations thank you for the opportunity to provide comments on the following proposed changes to the Common Program Requirements for entry into ACGME residency and fellowship training:

III.A.2. Prerequisite clinical education for entry into ACGME-accredited residency programs must be accomplished in ACGME-accredited residency programs or Royal College of Physicians and Surgeons of Canada (RSPSC)-accredited residency programs located in Canada.

III.A.3. Prerequisite clinical education for entry into ACGME-accredited fellowship programs shall meet the following qualifications:

III.A.3.a) for fellowship programs that require completion of a residency program, the completion of an ACGME-accredited residency program or an RCPSC-accredited residency program located in Canada.

III.A.3.a) for fellowship programs that require completion of some clinical education, clinical education that is accomplished in ACGME-accredited residency programs or RCPSC-accredited residency programs located in Canada.

The allopathic and osteopathic medical professions have a long history of interaction at the GME level. For more than 40 years, osteopathic graduates have been welcomed into MD training programs. For years, DO residents have received acceptance of their PGY-1 AOA-approved training toward the fulfillment of ACGME training requirements in family medicine, physical

medicine and rehabilitation, radiology, and anesthesiology. Many of our graduates who enter ACGME-accredited programs are attracted to the breadth and geographic diversity that ACGME programs offer.

Osteopathic training is equivalent to allopathic training, with DOs possessing additional skills in osteopathic manipulative medicine and knowledge of osteopathic principles and practices. The osteopathic core competencies in postdoctoral training are the following:

1. Osteopathic Philosophy and Osteopathic Manipulative Medicine
2. Medical Knowledge
3. Patient Care
4. Interpersonal and Communication Skills
5. Professionalism
6. Practice-Based Learning and Improvement
7. Systems-Based Practice

These core competencies, similar to the ACGME core competencies, are the foundation for osteopathic postdoctoral training.

The proposed Common Program Requirements place barriers on the resident selection process without credible research evidence to support the restriction. While hundreds of osteopathic physicians have transferred to ACGME programs after their initial years of training and others have advanced to fellowship training from AOA base residency programs, we are not aware of any evidence of inadequate training within osteopathic medical programs. In fact, evidence suggests otherwise. ACGME program directors continue to seek out residents and fellows from AOA-approved training programs.

The proposed policies are an anathema to the established recognition of osteopathic medicine by other entities. While the proposed policies halt recognition of osteopathic residency training, AOA-approved training is recognized by state licensing boards as satisfying requirements for postdoctoral education, by the CMS for funding GME, and by all branches of the military medical corps, the Veterans Administration, and the U.S. Public Health Service. Similarly, osteopathic physicians who complete AOA training are eligible for membership and fellowship in professional organizations like the American Academy of Family Physicians and the American College of Surgeons, to name a few. Hospitals and medical centers throughout the United States have completed comprehensive reviews of the AOA residency training requirements and recognize them as equivalent for purposes of credentials and privileges. Recognizing the quality of osteopathic residency training, many hospitals and hospital systems include both AOA- and ACGME-accredited training programs.

The proposed policies do not increase the quality of care and, in fact, have the potential to reduce quality. Program directors well know the attributes, knowledge, and skills of successful residents in their programs. By restricting who a program director may select, the quality of patient care may be harmed. Again, there is no evidence that osteopathic medical residents have inadequate training.

The proposed policies may increase the cost of GME. The resources to support GME are scarce and unlikely to increase. Most of the current GME funding is provided by taxpayers through CMS. The AOA believes that limited public resources for GME should be deployed efficiently for the public benefit. Forcing physicians who have already completed one or more years of AOA-

approved osteopathic residency training to repeat a first year of training is not an appropriate use of resources, when the same funds could be used to pay for another physician's graduate training.

Despite the proposed implementation date, the proposed requirements are already affecting students, residents, faculty members, and program directors. We are hearing reports that ACGME program directors are declining meetings with potential and current DO student and resident applicants. These circumstances have the potential to significantly disrupt DO students'/residents' planned career pathways.

We are interested in cooperating with the ACGME to produce a better GME system. The osteopathic system has its own initiatives to improve quality. For more than a decade, the AOA has hosted the Web-based Clinical Assessment Program to evaluate the care provided in family practice and internal medicine residency programs. The AOA has instituted requirements for uniform residency standards and a triennial review of those standards. The Osteopathic Postdoctoral Training Institutions (OPTIs) provide a mechanism to provide osteopathic manipulative training and research resources. The AOA certifying boards undergo a triennial evaluation to ensure their examinations meet and exceed rigorous uniform psychometric standards. The osteopathic community embraces quality and has credible accreditation and certification processes to support our quality efforts.

In addition, it is important for you to note that all osteopathic physicians entering AOA or ACGME training completed four years of osteopathic medical school in the U.S. The AOA does not accept any foreign medical graduates into its postdoctoral training programs without completing its osteopathic medical school curriculum.

It is imperative that the ACGME's proposed Common Program Requirements on entry into ACGME accredited training programs be withdrawn in order to ensure the continued efficient training of our nation's physician workforce. If the proposed policy cannot be withdrawn, we recommend it be modified as follows:

> III.A.2. Prerequisite clinical education for entry into ACGME-accredited residency programs must be accomplished in ACGME-accredited residency programs, **AOA-ACCREDITED RESIDENCY TRAINING PROGRAMS**, or Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited residency programs located in Canada.
>
> III.A.3. Prerequisite clinical education for entry into ACGME-accredited fellowship programs shall meet the following qualifications:
>
> III.A.3.a) for fellowship programs that require completion of a residency program, the completion of an ACGME-accredited residency program, **AN AOA-ACCREDITED RESIDENCY PROGRAM,** or an RCPSC-accredited residency program located in Canada.
>
> III.A.3.a) for fellowship programs that require completion of some clinical education, clinical education that is accomplished in ACGME-accredited residency programs, **AOA-ACCREDITED RESIDENCY PROGRAMS,** or RCPSC-accredited residency programs located in Canada.

We look forward to discussing this issue with you in more detail.

Signed:

The American Osteopathic Association
The American Academy of Osteopathy
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Osteopathic Neurologists and Psychiatrists
American College of Osteopathic Obstetricians and Gynecologists
American College of Osteopathic Pediatricians
American Osteopathic Academy of Addiction Medicine
American Osteopathic Academy of Orthopedics
American Osteopathic Academy of Sports Medicine
American Osteopathic Association of Medical Informatics
American Osteopathic Association of Prolotherapy Integrative Pain Management
American Osteopathic College of Anesthesiology
American Osteopathic College of Dermatology
American Osteopathic College of Occupational and Preventive Medicine
American Osteopathic Colleges of Ophthalmology & Otolaryngology Head & Neck Surgery
American Osteopathic College of Pathologists
American Osteopathic College of Physical Medicine & Rehabilitation
American Osteopathic College of Proctology
American Osteopathic College of Radiology
American Osteopathic Society of Rheumatology
Association of Osteopathic Directors and Medical Educators

CC: Thomas J. Nasca, MD, ACGME Chief Executive Officer
Martin S. Levine, DO, AOA President
Ray E. Stowers, DO, AOA President-elect

ATTACHMENT 5

AMERICAN OSTEOPATHIC ASSOCIATION

Timeline: AOA Response to ACGME Changes

Updated Oct. 24, 2012

Timeline of requests by the AOA to address the ACGME's proposed common program requirements:

NEW **Oct 24, 2012** – The AOA has entered into an agreement with ACGME and AACOM to pursue a single, unified accreditation system for graduate medical education programs in the United States beginning in July 2015. Read more about the agreement.

Sept. 28, 2012 – AOA Trustee Boyd R. Buser, DO, along with representatives from other osteopathic groups, testified at a public hearing of the ACGME Committee on Requirements on the future of graduate medical education accreditation, including the possibility of a common accreditation system that accredits allopathic and osteopathic GME programs and preserves osteopathic access to current ACGME programs. The committee is reviewing hundreds of written comments and will make its final recommendations to the ACGME board. We will advise the osteopathic family about the board's decision as soon as we know the outcome.

Sept. 6, 2012 – The AOA-ACGME Joint Task Force met once again in continuing discussions to seek the withdrawal or amendment of proposed Common Program Requirements. These meetings have been mutually respectful and we are hopeful that we can preserve DOs' access to ACGME programs when the ACGME Board meets to decide the issue on Sept. 28-29. AOA Trustee Boyd R. Buser, DO, will testify at the ACGME Board meeting.

July 9, 2012 – AOA Trustee Boyd R. Buser, DO, and John B. Bulger, DO, chair of the AOA Program and Trainee Review Council, led the AOA delegation at a Joint Task Force meeting with ACGME leadership at AOA headquarters in Chicago today as we continue to seek amendment or withdrawal of the proposed Common Program Requirements. Our Joint Task Force agreed to develop, and hopes to eventually form consensus, on potential scenarios of interaction between our two GME accreditation organizations that would preserve DOs' access to ACGME programs.

May 25, 2012 – AOA leadership met with ACGME leadership at ACGME headquarters to continue our advocacy to withdraw or amend the proposed Common Program Requirements. A robust discussion focused on various scenarios of interaction between the two GME accreditation organizations. Both sides agreed that the meeting was productive and agreed to continue the discussion in early July. To allow the discussions between the AOA and ACGME to progress, the ACGME decided to delay its scheduled June vote on the proposed Common Program Requirements until September.

May 8, 2012 – A follow-up meeting between AOA and ACGME leadership has been tentatively scheduled for May 25. Additional updates will be available after the meeting.

March 27, 2012 – The AOA continued its advocacy to withdraw or amend the ACGME's proposed Common Program Requirements by hosting ACGME leadership for a meeting at AOA headquarters. Officials from each organization discussed the ACGME's Next Accreditation System (NAS) and how osteopathic and allopathic accreditation systems might better relate to

More Information

Learn more about the agreement with ACGME, read statements of support and frequently asked questions.

each other.

Jan. 23, 2012 – The AOA and AACOM leadership met with ACGME leadership to discuss the proposed Common Program Requirements changes. ACGME leadership stated that they will follow their process of having comments submitted in November go to the Council of Review Chairs for consideration in February. That Council's recommendations go forward to the Committee on Requirements in June. The Requirements Committee's recommendations go to the ACGME Board of Directors in June or September. The AOA is working with the ACGME to make the proposed Common Program Requirements more palatable. We also urged the ACGME to send a letter to their program directors stating that the proposed requirements are just that – proposed. We hope this will reduce the number of withdrawn interviews.

The ACGME indicated that they would respond to student and resident concerns. Students and residents who have questions regarding the proposed Common Program Requirements should contact **Marsha Miller, Associate Vice President of Resident Services**, at (312) 755-5041 or mmiller@acgme.org. If you have a complaint about a withdrawn interview, you may also contact Marsha Miller or fill out a complaint form available on the ACGME website.

Note that there is no uniformity in ACGME standards regarding DO graduates. Some specialties allow it; others have an established policy against it. Just because a specialty says "no" does not necessarily mean they have violated their policies, but it is always good for you to check.

Please use these mechanisms to answer your questions or file complaints. ACGME leadership encourages their use. We continue to vigorously oppose the Common Program Requirement and are working with ACGME leadership to that effect.

Dec. 21, 2011 – AOA Executive Director John B. Crosby, JD, spoke with Thomas Nasca, MD, ACGME CEO, and came to an agreement to hold a meeting of the AOA-AACOM-ACGME leaderships to discuss the proposed policies. The leadership meeting is scheduled for the fourth week in January.

Nov. 23, 2011 – Comments formally submitted to ACGME from AOA and osteopathic specialty colleges.

View Comments Submitted by the AOA

View Comments Submitted by Specialty Colleges

Nov. 14, 2011 – The Daily Report informs all members about the proposed Common Program Requirements and the AOA's actions to date.

Nov. 11, 2011 – The AOA sent e-alert messages to students, ACGME-trained DOs, OPTIs, state affiliates, and specialty colleges apprising them of the situation and asking them to contact MD program directors to support rescinding the proposed policies. Several specialty colleges are submitting comments directly through the ACGME comment process.

Nov. 10, 2011 – 21 osteopathic organizations sent a joint letter to Dr. Flynn, ACGME Board Chair, requesting withdrawal of the common program requirements and arrangement of meetings to work through the issues. No reply as of yet.

Nov. 10, 2011 – AOA Executive Director John Crosby, JD, and Stephen C. Shannon, DO, MPH, AACOM CEO and President, sent a letter to Timothy Flynn, MD, Chair of the ACGME Board of Directors, requesting withdrawal of the common program requirements and arrangements of meetings to work through the issues. No reply as of yet.

Oct. 10, 2011 – President Levine wrote to Dr. Nasca requesting a meeting to discuss faculty credentialing and the proposed common program requirements. Dr. Nasca responded by encouraging the submission of public comments and declined the request for a meeting.

Sept. 8, 2011 – AOA President Martin S. Levine, DO, wrote a letter to the

ACGME Preventive Medicine Residency Review Committee requesting reconsideration of Section III, A, 1, that requires at least 12 months of clinical education in an ACGME residency program prior to appointment in the preventive medicine program. The letter asks the Preventive Medicine Residency Review Committee to accept 12 months of training in an AOA-approved postdoctoral training program as meeting the requirements of the new policy. No response was received.

July 28, 2011 – COPT Chair Michael I Opipari, DO, sent a letter to Thomas Nasca, MD, CEO of the ACGME, requesting cessation of the unusual application of the ACGME faculty credentialing policy in Radiology, General Surgery, and Psychiatry. No response was received

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ATTACHMENT 6

HFAP
Healthcare Facilities Accreditation Program

Overview

Healthcare Facilities Accreditation Program (HFAP) is **authorized by the Centers for Medicare and Medicaid Services** (CMS) to survey **all** hospitals for compliance with the Medicare Conditions of Participation and Coverage.

Originally created in 1945 to conduct an objective review of services provided by osteopathic hospitals, **HFAP has maintained its deeming authority continuously since the inception of CMS in 1965** and meets or exceeds the standards required by CMS/Medicare to provide accreditation to **all** hospitals, ambulatory care/surgical facilities, mental health facilities, physical rehabilitation facilities, clinical laboratories and critical access hospitals. HFAP also provides certification reviews for Primary Stroke Centers.

HFAP's surveying process and standards benefit from **oversight by a wide range of medical professionals**, including both allopathic and osteopathic disciplines.

The HFAP Difference

HFAP is user friendly

- Our standards manual is clear and easy to read, and our **accreditation requirements are clearly tied to the corresponding Medicare Conditions of Participation**.
- Successful accreditation is based on the facility's ability to correct deficiencies **so there is no downside to discovery of issues** during the survey process.

HFAP is educationally focused

- Our **surveyors are experienced health care professionals** who understand the many complexities of a health care facility and **help make the survey process more realistic and educational**.
- If a deficiency is identified, **our surveyors** are able to draw from their experience and **offer practical solutions, usually on the spot**.

HFAP is cost effective

- The **fee for HFAP accreditation is straightforward** and because our standards are so clearly written, **additional consultations and workshops are available, but not required**.
- HFAP accreditation also is **recognized by the federal government, state departments of public health, insurance carriers and managed care organizations**.

Learn more about accreditation by HFAP

- **Accreditation by HFAP**
- **Testimonials**
- **Frequently Asked Questions**
- **Apply Online**
- **Contact HFAP**

Healthcare Facilities Accreditation Program
142 E. Ontario Street Chicago, IL 60611 Phone: (312) 202-8258 Copyright 2013. All rights reserved.

Frequently Asked Questions

What is HFAP?
What types of facilities does HFAP accredit?
Who recognizes HFAP?
What is the basis for HFAP accreditation standards?
How are the HFAP standards developed?
What are the major steps in the HFAP accreditation process?
How long does it take to be accredited by HFAP?
Can we switch our facility's accreditation to HFAP without interruption in our Medicare reimbursement?
How do I apply for accreditation and/or certification?
How do I apply for reaccreditation and/or recertification?

What is HFAP?

Healthcare Facilities Accreditation Program (HFAP) is one of only four national voluntary accreditation organizations authorized by the Centers for Medicare and Medicaid Services (CMS) to survey acute care hospitals, critical access hospitals, and ambulatory surgical centers for compliance with the Medicare Conditions of Participation and Conditions for Coverage.

Originally created in 1945 to conduct an objective review of services provided by osteopathic hospitals, HFAP has become a recognized and sought after accreditor for all hospitals. HFAP has maintained its deeming authority continuously since the inception of CMS in 1965 and meets or exceeds the standards required by CMS.

What types of facilities does HFAP accredit?

The HFAP accredits and crosswalks to CMS standards (as applicable) for the following programs:

- Hospitals and their clinical laboratories
- Ambulatory care/surgical facilities
- Mental health facilities
- Substance abuse facilities
- Physical rehabilitation facilities
- Clinical laboratories
- Critical access hospitals

The HFAP provides certification in the following disease management programs/Centers of Excellence:

- Primary Stroke Center Certification

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Who recognizes HFAP?

In addition to its deeming authority from the Centers for Medicare and Medicaid Services (CMS), HFAP also is recognized by:

- National Committee for Quality Assurance (NCQA)
- Accreditation Council for Graduate Medical Education (ACGME)
- State Departments of Public Health
- Managed care organizations
- Insurance companies

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What is the basis for HFAP survey standards?

- Medicare Conditions of Participation
- National Fire Protection Association (NFPA) Life Safety Code
- Institute for Healthcare Improvement
- Agency for Healthcare Research & Quality (AHRQ)
- National Quality Forum
- Non-Medicare quality standards that include input from our accredited organizations

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How are the HFAP accreditation standards developed?

The basis of the HFAP standards is the Medicare Conditions of Participation (CoPs) for the type of facility being

accredited. The standards are cross-walked to the CoPs. This cross-walk approach means anyone reading the HFAP standards manual can see clearly how each standard ties directly to the Medicare requirements.

HFAP standards are composed primarily of the Medicare requirements plus standards proven to elevate quality and patient safety. Approximately 80% of the HFAP standards are cross-walked to the Medicare CoPs.

Compliance with HFAP requirements assures compliance with Medicare standards.

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What are the steps in the HFAP accreditation process?

While the actual steps may vary depending on your situation, they include:

- Application
- Survey
- Deficiency report
- Plan of corrections/Corrective action response
- Accreditation action

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How long does it take to become accredited by HFAP?

From application to accreditation, the process can take from three to six months to complete. The four basic factors that impact how long the accreditation process actually will take are:

- The size and complexity of the facility
- Whether it is a new facility or one reapplying for accreditation
- The scheduling of the survey
- How quickly the facility corrects the deficiencies identified in the survey

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Can we switch our facility's accreditation to HFAP without interruption in our Medicare reimbursement?

Yes. If you are considering switching your accreditation to HFAP **our staff will work with you to ensure there is no interruption in accreditation or reimbursement.**

Ideally, we would like to begin the application process at least six months prior to the expiration date of your current accreditation. If your current accreditation is due to expire soon here is how the process works to keep your facility in compliance:

- Notify your current accreditation organization in writing as soon as your facility's management has made its decision.
- Work out a plan with your current accreditation organization for an orderly transition.
- If your facility and accreditation organization cannot agree on a plan and the accreditation organization immediately withdraws its accreditation, your facility's Medicare provider agreement is not affected.
- The current accreditation organization must notify the CMS Central Office and applicable Regional Office that it has withdrawn its accreditation and the effective date.
- If your facility's termination by the current accreditation organization is concurrent with a new recommendation for accreditation, with deemed status by HFAP, then it may remain under HFAP rather than transfer to the State Survey Agency jurisdiction.
- If your facility's termination by the current accreditation organization is NOT concurrent with a new recommendation for accreditation, with deemed status by HFAP, your facility is placed under State Survey Agency jurisdiction until the CMS central office and appropriate regional offices receive and approve a new recommendation for accreditation, with deemed status by HFAP.
- When your facility's accreditation and deemed status is reestablished it is placed under HFAP for ongoing monitoring and oversight.

Whether concurrent transition or non concurrent transition(from your present accreditation organization to the State Survey Agency and then to HFAP), there is no interruption in the Medicare provider agreement and no break in Medicare reimbursement.

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