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.

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(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.

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(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 Progtam 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:
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> 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

About the AOA
AOA Membership
Leadership & Policy
Related Organizations
AOA Store

Accreditation
Predoctoral Accreditation
Postdoctoral Training Approval
OPTI Approval
Healthcare Facilities Accreditation Program
CME Sponsor Accreditation

Advocacy
National Osteopathic Advocacy Center
AOA Legislative Priorities
Federal Initiatives
Regulatory Issues
Write to Congress
DO Day on Capitol Hill
State Government Affairs
For Policymakers
AOA Health Policy Forum

Education
Students
Interns and Residents
AOA Post Match
Mentoring Program
Postdoctoral Training
OPTI Clearinghouse
OGME Development Initiative

Events
Osteopathic Medical Education Leadership Conference
CME Sponsors Conference
AOA Midyear Meeting
DO Day on Capitol Hill
National Osteopathic Medicine Week
AOA ROME Conferences

AOA > Inside the AOA > **Timeline: AOA Response to ACGME Changes**

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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1090 Vermont Ave. NW, Suite 500
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ATTACHMENT 6

HFAP
Healthcare Facilities Accreditation Program

Overview

Customer Login

Password

- How to apply?
- Forgot your username or password?
- Need to create a profile?

About HFAP

- Overview
- Staff
- FAQs
- Opportunities

What Would You Like to Do?

- Authorization Manager
- Change in Ownership Form
- Manage HFAP Applications
- Manual Updates
- Manual Viewer
- Order Manual
- Quality Measure Reports
- Standards Interpretation Questions
- Update Contact Information

Quality and Patient Safety

- Complaint Information
- Patient Safety
- Quality

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

HFAP
Healthcare Facilities Accreditation Program

Frequently Asked Questions

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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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