President’s Corner

Quinn Turner, MS

Entering my office this morning, I noticed a familiar small business card holder that has been on my desk for more than twenty years. On the back of the case are the names of the 1994–95 transitional year residents who were here at Iowa Methodist for their first year of residency training that academic year. Looking at the names, I wondered about these physicians today as they become or approach age 50. They live in Colorado, South Dakota and here in Iowa, practicing anesthesia and radiology. I have no doubt that they have experienced moments of great fulfillment in their careers. Concurrently, I’m sure that they’ve faced challenging times – as we all do. They may well be physician educators or even program directors. Unquestionably, they have improved and saved the lives of many people under their care. I remember these young physicians, fresh out of medical school, as they prepared for their first rotations here as residents. I recall as they left us, ambitious and ready for categorical training.

All who choose graduate medical education as a career can readily share similar memories. Regardless of our individual job titles or positions, all of us recognize the high expectations associated with the training of physicians. Whether you’re a DIO, program director, coordinator, or a colleague in another association or accrediting body, all of us contribute significantly to the successful preparation and training of residents, medical students and allied health professionals. We enable these talented individuals to gain the skills necessary to become confident, effective providers. These learners depend upon us for many things, and, through a combination of our own talents, we meet and exceed expectations. In the end, the success of our graduates is a testament to our collective efforts.

Within the ever-changing landscape of GME, AHME continues to provide unwavering support to all of us in this important field. In its 62nd year, our association utilizes multiple sources to support GME professionals. AHME leadership continuously seeks to provide a combination of education, advocacy and networking opportunities to its members. An ever-present goal is to engage members in the association – to encourage them to become active in the committees and councils, to volunteer as presenters or moderators at the Institute, the Academies or webinars; and to share thoughts and questions on the Message Board or through the AHME News.

At July’s meeting of the Academic Leadership and Program Development Committee in Chicago, where the content of the May 2018 AHME Institute in Phoenix was discussed, debated, and after thorough review, approved, I walked away extremely impressed. The level of engagement and commitment shown by the AHME Council Chairs, the Board and staff was exceptional. The Institute in Phoenix will provide attendees with a wide variety of pertinent plenary and break-out sessions along with many opportunities to network.

Speaking of AHME’s councils, the five groups have noted much progress in recent months. The newest entry, the Council of Osteopathic Educators (COE), has made great strides in its first year. Under the direction of Dr. Jonathan Rohrer, the Associate Dean
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With JeriSue Petrie’s leadership, the Council on Professional and Faculty Development (CPFD) was formed this year using the former Council on Continuing Medical Education (CCME) as its foundation. AHME Past President Dr. David Piper was key to positioning the CCME as a strong resource. The “repurposing” of this council to the CPFD will provide members with even greater resources going forward. The CPFD offered a June webinar on faculty development, and has created a special section on the AHME website to showcase educational materials used for faculty development purposes.

AHME Past President Carrie Eckart directs the Council of Institutional Leaders (COIL). One of COIL’s goals for the upcoming academic year is to expand its networking council that endeavors to connect newcomers with mentors to build relationships to ease the transition into a new administrative role. The Council of Transitional Year Program Directors (CTYPD), under the direction of Dr. Ashley Maranich, continues to provide TY program directors and coordinators with educational programming unique to that one-year program. CTYPD membership has grown over the past year. The TY track at the Institute features a special session each year with the ACGME TYRC.

On a personal note, I am very honored to serve as AHME’s president. This organization is key to the professional lives of many people, including my own. I am consistently impressed with the level of commitment and guidance exhibited by Dr. Kim Mohn and the AHME staff, as well as the many, many members who devote their time and talent to ensure that the association provides top-notch support to GME professionals both today and in the future. A coordinated succession plan within AHME is key to the association’s long-term success. The leadership provided by immediate past-president Dr. Marko Jachtorowycz was outstanding. President-elect Tia Drake will be exceptional in her guidance of AHME in 2018-19.

In closing, I ask that you take a moment to assess what’s important to you in your professional growth. Think about the physicians to whom you have provided guidance, support and knowledge so far in your career. As we enter another recruitment cycle, think of those you will impact in the future—regardless of your position. In the end, what we learn through the receipt of professional knowledge, networking and the sharing of best practices empowers us to guide these talented men and women to the best of our abilities as they prepare to become the providers of tomorrow. Know that AHME stands ready to support you in your important work both today and going forward.
The Impact of Immigration Developments on U.S. Residency Recruitment and Health Care: A Perspective from the Educational Commission for Foreign Medical Graduates (ECFMG)

William W. Pinsky, MD - President and Chief Executive Officer at the Educational Commission for Foreign Medical Graduates (ECFMG)

The Executive Orders (EOs) on immigration signed by President Trump in early 2017 created a challenging environment for the 2017-2018 residency recruitment season. With the recent opening of registration for the Main Residency Match for the 2018-2019 academic year, AHME News sat down with ECFMG President & CEO William W. Pinsky, MD, to get his perspective on the impact of recent immigration developments on U.S. graduate medical education (GME) and health care.

What have been the biggest challenges from your perspective?

I think the timing of the EOs and the fluid nature of the situation were significant challenges for both U.S. training programs and foreign national physicians applying to these programs. The first and second EOs hit in the weeks just before and after the Match’s Rank Order List deadline, respectively. This created a context of uncertainty and anxiety for many, at a time of high-stakes decision-making.

What effect do you think recent immigration developments had on the 2017 Match?

More foreign national physicians matched, and their match rate also increased, compared to the prior year. In fact, this year’s Match marked the sixth annual increase in the number of foreign national physicians matching to first-year residency positions. While these results are encouraging, we still need to know more about any impact on applicants from specific countries, including those countries identified in the EOs. Additionally, I heard from many Program Directors and DIOs with small to moderate sized programs who told me they needed to have a “safe” strategy for the Match, and therefore preferentially ranked individuals whom they believed would be able obtain a visa. These were not candidates who in prior years would have had a priority ranking. So, although the statistics are good, I believe individuals who would have matched in prior years were adversely affected.

More significant than the results of any one Match is the potential accumulated effect of fewer international physicians entering the U.S. health care system over a sustained period. If U.S. immigration
policy causes physicians and programs to make different choices—choices that reduce the number of international physicians entering U.S. GME—this could have a negative effect on health care in the United States.

Have foreign national physicians who matched been able to enter the United States and begin their training?

Many foreign national physicians who enter U.S. GME do so in J-1 visa status. ECFMG is the sole J-1 visa sponsor of foreign national physicians in U.S. clinical training programs and sponsors more than 10,000 physicians annually for U.S. GME. As the J-1 visa sponsor, ECFMG is able to track the progress of J-1 physicians as they arrive at their training programs. ECFMG issued initial J-1 visa sponsorship for 2,766 physicians to begin training in June or July of this year. As of August 15, 97.8% of these physicians had successfully secured J-1 status and arrived at their U.S. training programs.

For the subset of these physicians from countries identified in the second EO, 87.7% are at their training programs in J-1 status, with most of the remaining physicians already in the United States waiting for a change in visa status from U.S. Citizenship and Immigration Services. Pakistan is not one of the countries identified in EOs, but we did note a higher J-1 visa denial rate for Pakistani physicians, compared to previous years. However, the majority of Pakistani physicians who initially were denied a J-1 visa reapplied and received the visa. I am pleased to report that as of mid-August, 95.3% of Pakistani physicians initially sponsored by ECFMG had reported to their training programs in J-1 status.

These results are very important because a primary goal of the J-1 visa program is to promote educational and cultural exchange. While some J-1 physicians remain in the United States after completion of their GME programs, others take their knowledge and training back to their home countries. The ability of foreign national physicians to train in the United States builds health workforce capacity in many other countries and provides physicians in much-needed medical specialties for the world’s patients.

How has ECFMG responded to this situation?

The first EO on January 27 touched off a period of intense activity at ECFMG. Our first task was to understand the EO and its implications for the physicians and medical educators that we serve. We consulted with immigration counsel and collaborated with other organizations to gather and share information. We then looked across ECFMG’s services to identify physicians who might be impacted—physicians traveling to the United States to take USMLE Step 2 CS, those participating in the 2017 Match, potential visa applicants, and those already in U.S. training programs. For each impacted physician, we assigned an ECFMG staff member to provide consistent information and support. I also communicated directly with physicians and U.S. training programs to provide available updates and guidance. Members of the media were keenly interested, and I had the opportunity to speak with more than a dozen journalists to share information on the role of international physicians in this country.

What challenges do you see for the future?

In the short term, we are heading into a second resident recruitment season with a great deal of uncertainty. The travel restrictions announced on September 24 may be the first in a series of new developments that will unfold during the recruitment process for 2018-2019. One challenge for programs will be to continue to select the best and the brightest, without regard to nationality, in order to continue to produce the best physicians possible.

For the longer term, I share the concern of many others that the United States will be perceived as an unwelcoming place for the talented international physicians that we need. As a group, international medical graduates tend to practice in primary care specialties and in underserved areas. Any disruption to the ability of international physicians to train and practice here will have a negative effect on patient care.

Are there any final thoughts you would like to share with our readers?

While the immigration landscape will continue to change over time, the fact that international physicians play a critical role in U.S. health care will not change any time soon. Another constant is the mission of the U.S. GME community to select and train outstanding physicians. Each year, thousands of foreign national physicians enter U.S. GME. ECFMG looks forward to continuing to serve and support all international physicians and their U.S. training programs in pursuit of our shared mission to promote quality health care for all.
An updated version of the CLER Pathways to Excellence: Expectations for an Optimal Clinical Learning Environment to Achieve Safe and High Quality Patient Care was released in May. This version includes a new focus area that recognizes the critical role of clinical learning environments in designing and implementing systems that monitor and support the well-being of residents, fellows, faculty members, and other members of the clinical care team.

Over the past year, a series of Issue Briefs were released to supplement the CLER National Report of Findings 2016. Each issue in the series features one of the focus areas of the CLER Program, supplementing the key challenges and opportunities highlighted in the National Report and enhancing the discussion as to their relevance and potential impact on graduate medical education and patient care. Recognizing that the clinical learning environment is a shared space, the briefs were introduced in collaboration with other organizations to message the importance of creating clinical learning environments that optimize learning while ensuring safe, high-quality patient care.

The Pursuing Excellence in Clinical Learning Environments initiative continues to promote transformative improvement through facilitated collaborative activities. The Pathway Innovators recently completed their first year of a 4-year journey to develop and test innovative models that enhance integrated education and clinical care. The eight sites have expanded their thinking and risen to the challenge of being pioneers of change. They will share their learning at the Accreditation Council for Graduate Medical Education Annual Education Conference in 2018.

A call for applications for a Patient Safety Collaborative kicked off the second phase of the Pursuing Excellence initiative this spring. A diversity of organizations and ideas were put forth by the community. The selected sites will begin their 18-month collaborative work together this fall.

The CLER Program completed second visits to Sponsoring Institutions with three or more core residency programs and is well underway to completing initial visits to the Sponsoring Institutions with one or two such programs. The CLER Program is in the process of synchronizing the timelines of these two components into one 24-month cycle.

**Physician Wellness and Burnout: ABMS Call for CME Activities**

ABMS invites CPD/CME providers to submit lifelong learning and self-assessment activities that:

- Support the development of high-functioning physicians
- Address physician wellness and burnout

Accredited educational activities will be reviewed by participating Member Boards of the American Board of Medical Specialties, for inclusion in the ABMS MOC Directory, which provides physicians with easy access to board-approved activities.

For details and submission instructions, please visit abms.org/wellness

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Single Graduate Medical Education Accreditation System Update

Lorenzo L. Pence, DO, FACOFP - Senior Vice President, Osteopathic Accreditation at the Accreditation Council for Graduate Medical Education (ACGME)

Background

The Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM) started the journey toward a single accreditation system for US graduate medical education (GME) in 2014 with the signing of a Memorandum of Understanding (MOU). Since the last AHME update (fall 2015), much progress has been made in this transition.

The terms of the MOU allow a five-year window for all AOA-approved institutions and programs to apply for and achieve ACGME accreditation, and the AOA agrees to cease accreditation of GME programs after June 30, 2020.

The procedure for AOA-approved programs applying for ACGME accreditation starts with institutional sponsorship. Each program needs an ACGME-accredited Sponsoring Institution in order to submit an application for accreditation. When an AOA institution (or program) submits an application for ACGME accreditation, it receives a status of Pre-Accreditation and will be reviewed at a future meeting of the ACGME’s Institutional Review Committee. Pre-Accreditation signifies that an application for ACGME accreditation was submitted; it does not mean or imply that a program has been accredited by the ACGME.

Once an institution has Pre-Accreditation, its sponsored programs may submit applications. Programs that submit completed applications will be granted Pre-Accreditation status which, again, is not synonymous with Initial Accreditation. To achieve Initial Accreditation (and, ultimately, Continued Accreditation), a Sponsoring Institution or program must be found by its ACGME Review Committee to be in substantial compliance with the applicable Institutional and/or Program Requirements.

If an institution or program, after review, does not achieve Initial Accreditation, it will receive a status of Continued Pre-Accreditation. The Review Committee will send a Letter of Notification (LON) with the accreditation decision, accompanied by citations that identify areas of non-compliance with the applicable requirements.

Programs with Continued Pre-Accreditation status may reapply (programs that fall under the terms of the MOU would not need to pay additional fees) by submitting an updated application that includes responses to the citations from the prior review, as well as information about how they have been or are being corrected. If determined by the Review Committee to be necessary, another site visit may be scheduled. Using the results from the additional site visit and/or the updated application, the Review Committee will make another accreditation decision.

Programs cannot achieve Initial Accreditation until their Sponsoring Institution has achieved Initial Accreditation. If a Review Committee reviews a program with Pre-Accreditation or Continued Pre-Accreditation and determines it to be in substantial compliance with the Program Requirements, but the Sponsoring Institution has not achieved Initial Accreditation, the program will receive a status of Initial Accreditation Contingent. Such a program is not an accredited program until its Sponsoring Institution has achieved Initial Accreditation, at which point the program’s status will change from Initial Accreditation Contingent to Initial Accreditation. In the case of fellowships, the core residency program must be accredited before a fellowship application may be submitted.

Notable Transition Points

The transition to a single GME accreditation system is in its 26th month, and will be at its halfway point on January 1, 2018. Some of the notable points during the transition to-date include:

- AOA and AACOM became membership organizations of the ACGME
- Osteopathic physicians have been added to the ACGME Board of Directors (nominations from AOA and AACOM)
- The MOU directed the development of two new ACGME committees:
  1. Osteopathic Principles Committee (granting Osteopathic Recognition to ACGME-accredited programs)
  - First reviewed applications and granted Initial Recognition to 18 programs in November 2015
  2. Review Committee for Osteopathic Neuromusculoskeletal Medicine
  - A new ACGME specialty
  - First program application reviewed and Initial Accreditation conferred in June 2016
- Osteopathic physicians added to all ACGME Review Committees with corresponding AOA specialties
- First AOA institutions achieved Initial Accreditation in May 2015, with an effective date of July 1, 2015
- Review Committees for 24 specialties corresponding with the same AOA specialties will accept AOA board certification for an ACGME program director
- The ACGME Board of Directors directed all Review Committees to add AOA board pass rates to the specialty-/subspecialty-specific Program Requirements for those specialties/subspecialties that have corresponding AOA board certification exams. Currently 21 specialties have incorporated AOA board pass rates into their requirements, and other specialties are in the process of adding them.
- 105 institutions have applied for ACGME accreditation (Table 1)
  - 79 institutions have achieved Initial Accreditation
  - 1 institution has achieved Continued Accreditation
• 506 residency and fellowship programs have applied for ACGME accreditation (Table 1)
  - 225 residency programs and fellowships have achieved Initial Accreditation
• 111 programs have achieved Osteopathic Recognition (Table 2)
  - 11 programs pending review for Osteopathic Recognition
• ACGME, AOA, and ACOM entered into an agreement that provides protection for residents in AOA-approved training programs, which do not achieve ACGME accreditation prior to June 30, 2020, when the AOA will no longer accredit graduate medical education programs. The agreement will give the AOA restricted authority to extend the AOA accreditation date to allow any remaining resident in such programs to complete training in an accredited program.
• ACGME Pre-Conference for Osteopathic Programs and Institutions in conjunction with the ACGME Annual Educational Conference, 2018 will be the fourth year of this pre-conference.
• ACGME and AODME held the first Joint Pre-Conference for Osteopathic Programs and Institutions during the 2017 ACGME Annual Conference
• Osteopathic physicians have been hired as Field Representatives in both the Department of Field Activities (accreditation) and the Clinical Learning Environment Review Program (CLER)

AOA programs continue to apply for ACGME accreditation. Most specialty programs that are four to five years in length submitted applications by December 2016. The ACGME expects a similar bolus of applications from three-year programs by December 2017. As more institutions and programs apply for ACGME accreditation, Review Committees have added meetings to their calendars.

Challenges
Over the last 26 months, there have been challenges for institutions and programs in the transition to a single GME accreditation system. Some of these include:
• Becoming familiar with ACGME Institutional and Program Requirements and the review process
• Adjusting to a new application process
• Providing sufficient detail when writing an application
• Program Letters of Agreement (PLAs) lacking required elements
• Identifying and providing scholarly activity
• Limited or lack of physician mentoring in inpatient obstetrics and pediatrics (family medicine)

Even with some challenges, designated institutional officials (DIOs), program directors, and faculty members have gained experience, are addressing challenges, are making necessary adjustments, and are having more successes in achieving Initial Accreditation.

Osteopathic Recognition
Osteopathic Recognition is a designation conferred by the ACGME’s Osteopathic Principles Committee upon ACGME-accredited programs that demonstrate, through a formal application process, the commitment to teaching and assessing Osteopathic Principles and Practice (OPP) at the graduate medical education level. Prior to the MOU, there was no formal recognition of osteopathic medicine by the ACGME. Now, any ACGME-accredited specialty or subspecialty program may apply for and receive Osteopathic Recognition.

Programs must submit an application for Osteopathic Recognition. The application is completed entirely online in the ACGME’s Accreditation Data System (ADS). The application process does not require duplication of information already entered and maintained in ADS as related to accreditation, as a program’s existing information (including basic details about the program, faculty members, and residents/fellows) is pulled into the Osteopathic Recognition application directly through the system. Applications for Osteopathic Recognition do not require a site visit and are reviewed by the Osteopathic Principles Committee, which has delegated authority by the Board of Directors to oversee Osteopathic Recognition. If a submitted application demonstrates substantial compliance with the Osteopathic Recognition Requirements, the program will receive a status of Initial Recognition. Programs with a status of Pre-Accreditation can also apply for Osteopathic Recognition, and will be reviewed by the Osteopathic Principles Committee once they achieve Initial Accreditation. Applications for Osteopathic Recognition will be accepted indefinitely for existing and new programs, even after June 30, 2020. There are no ACGME fees associated with Osteopathic Recognition.

Programs with Osteopathic Recognition must formally designate residents receiving osteopathic-focused education. They may choose to designate all or a portion of their residents/fellows, based on interest and the ability to meet established matriculation requirements. The Osteopathic Recognition Requirements will only apply to those designated residents.

Programs with Osteopathic Recognition may appoint any candidate to an osteopathic-focused position, as long as he or she is eligible to enter the ACGME-accredited program. This includes allopathic medical school graduates who traditionally were unable to receive osteopathic postgraduate training. Candidates may be required to satisfy additional pre-requisite requirements, based on prior education in OPP; pre-requisite criteria may differ by program.

Osteopathic Recognition is an opportunity to:
• Perpetuate education that emphasizes the practice of osteopathic medicine across the spectrum of GME
• Expand education in OPP beyond its traditional reach
• Provide opportunity for all medical school graduates (osteopathic and allopathic) to learn and/or enhance their education in OPP

The majority of programs that have achieved Osteopathic Recognition have been in primary care specialties, but other specialties and subspecialties have also achieved Osteopathic Recognition (Table 2). ACGME programs that have applied for and achieved Initial Osteopathic Recognition fall into three categories:
• AOA-approved programs that have successfully achieved ACGME accreditation
• Dually-accredited programs (programs with prior accreditation by both the ACGME and the AOA)
• ACGME-accredited programs that historically have not provided formal osteopathic education (including military programs)

The Osteopathic Principles Committee is excited about program successes and is especially enthusiastic about programs that achieved Osteopathic Recognition but never offered education in OPP in the past. The number of programs seeking Osteopathic Recognition from each of these categories continues to grow, and the ACGME is optimistic that this trend will continue well into the future.

Conclusion

The transition to a single accreditation system for US GME is approaching the halfway point. In the beginning, program applications came in at a slower rate than was expected. This was in part due to institutional and program administrators and staff members needing time to become familiar and knowledgeable about the ACGME process. As they have acclimated to the application process and continued to reach out to ACGME Executive Directors, applications have continued to increase. Over the last several months, dozens of institutions and hundreds of programs have not only applied for ACGME accreditation and/or Osteopathic Recognition, but have been successful in achieving Initial Accreditation and/or Initial Recognition.

The timeline for AOA programs to transition to ACGME accreditation under the terms of the MOU ends June 30, 2020. The MOU was a starting point for Osteopathic Recognition, but it is not the end. The future of osteopathic medicine remains strong with opportunities to expand education in OPP to residents and fellows in all ACGME-accredited programs that seek Osteopathic Recognition.

References:
3. ACGME Website, http://www.acgme.org/
Table 1*
**Specialty and Subspecialty Applications**

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<th>ACCREDITATION STATUS</th>
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*September 18, 2017, Total Specialty and Subspecialty Applications

Table 2*
**Osteopathic Recognition**

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*September 18, 2017, Total Specialty and Subspecialty Applications for Osteopathic Recognition*
Fall 2018: The Accelerating Change in Medical Education Initiative

Victoria Stagg Elliott, MA – Technical Writer at the American Medical Association
Mellie Villahermosa Pouwels, MA– Director of Medical Education Collaboration at the American Medical Association
Richard E. Hawkins, MD – Vice President of Medical Education Outcomes at the American Medical Association

The American Medical Association (AMA) launched the Accelerating Change in Medical Education initiative in 2013 with 11 $1 million five-year grants funding transformative projects at medical schools. The selected schools, including several AHME members, formed the Accelerating Change in Medical Education Consortium, which facilitates and supports the development and spread of innovative ideas between and among institutions. The AMA awarded another 21 medical schools $75,000 three-year grants in 2016. These schools joined the consortium, and now the 32 members are involved in projects to transform medical education in several important areas. Although each school project is unique, this innovative work falls into several thematic categories. This article highlights the work of AHME-affiliated schools in the following categories:

- Teaching new content in health systems science
- Working with health care delivery systems in novel ways
- Making technology work for learning
- Developing flexible, competency-based pathways
- Improving population-based care through workforce solutions

In regard to teaching new content, the consortium is focusing on health systems science as the third pillar of medical education, to be taught in integration with the basic and clinical sciences. In late 2016, the AMA consortium published the Health Systems Science textbook which was authored by consortium members and distributed by Elsevier. This textbook is the first comprehensive health systems science resource designed for health professional students and other learners across the continuum of education and practice. It includes chapters on value in health care, patient safety, leadership, population health, socio-ecological determinants of health, quality improvement, teamwork, clinical informatics, health care economics, and health care policy.

Indiana University School of Medicine (IUSM), which is one of the consortium members also affiliated with AHME, created a teaching electronic medical record system (tEMR) that is a clone of an actual clinical EMR and utilizes de-identified and misidentified real data on more than 10,000 patients. This tEMR allows medical students to write orders and notes, view data on patients, and access just-in-time information. It provides a realistic and safe environment to learn about health systems science and to practice clinical decision making skills. Students work within a virtual health system and use the tEMR to identify errors and patient safety issues, initiate quality improvement, measure the success of these efforts, and gain comfort in their own approaches to practice. In April 2017, IUSM’s tEMR was launched as the Regenstrief EHR Clinical Learning Platform and made more widely available to other medical schools as well as institutions educating other health care professionals.

To develop flexible, competency-based pathways while working with a health care delivery system in a novel way, Ohio University Heritage College of Osteopathic Medicine, another consortium member also affiliated with AHME, has launched a new curriculum, Value-Based Care, which is an innovative, competency-based program integrating primary care delivery and undergraduate medical education. Concurrently with academic classes, students are embedded within a patient-centered medical home operated within the Cleveland Clinic in order to promote a seamless continuum between

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**EASILY POST & MANAGE CLINICAL ROTATIONS**

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undergraduate medical education, graduate medical education, and clinical practice.

The competency-based system integral to this project continually assesses a student’s readiness for practice. Students have to achieve academic and clinical milestones that are not fixed within a specific timeframe. This milestone approach is incorporated into both medical school and residency. Advancement is based solely on attainment of competencies determined by multiple objective assessments, not by number of years in the program.

Also based in Cleveland, the innovative project at Case Western Reserve University School of Medicine teaches new content in health systems science while working with multiple health care delivery systems. Medical students become “navigators” and part of interprofessional teams at one of two high-performing patient-centered medical homes serving veterans and newly-arrived refugee families in the area. Patient navigators become critical members of the health care team leading to increased health system knowledge and positive impact on the team and patient care. Navigators also work with the electronic health record systems at their sites and receive targeted trainings around EHR navigation and the use of registries in population health management.

Also an AHME affiliate, the University of Texas Rio Grande Valley School of Medicine is making technology work for learning by working with the local health care delivery system. Tablet computers have been incorporated into a curriculum that aims to develop and implement educational models that nurture excellent communicators who use technology to support, rather than impede, the exchange of information and empathetic interactions with patients, families, and care teams. Students use the tablets in multiple settings, for numerous preventive health, health maintenance and health care delivery purposes. Specifically, the students gain direct experiential interaction and learning within colonias, impoverished rural settlements in unincorporated areas along the US-Mexico border, and use these tablets to gather information through ethnographic-style field notes. These include oral histories, demographics, and other facts related to the health status and care needs of patients and family members. Once compiled, students interpret and reflect upon their experiences.

As a consortium member, Morehouse School of Medicine has expanded their efforts in improving population-based care through workforce solutions. Approximately 75% of Morehouse’s students are from groups underrepresented in medicine. The attrition rate is below 2% and the pass rates on USMLE Step 1 exceed national pass rates. This medical school’s efforts to further increase physician diversity are reflected in its recent doubling of class size and its increased efforts to utilize community-based training sites. The importance of both its historical and innovative pipelines is even more evident with its increased class size. Morehouse continues to develop enhanced collegiate pipeline efforts with local colleges, expand pipeline mentoring support through alumni, support an undergraduate health sciences academy with other historically black institutions in the region, and engage current students in longitudinal peer mentoring of pipeline students. In order to maintain its low attrition rate, Morehouse has created a curriculum that allows for strong faculty-student interactions with longitudinal supervision by a limited number of faculty members. The preclinical curriculum is structured to incrementally build concepts and skills. Students are assessed by regular examinations, simulation activities, and feedback with early support for deficits.

The work of these schools and other members of the consortium has begun to spread to non-member institutions through dozens of peer-reviewed published papers and presentations at local, regional, and national medical education meetings including at the AHME Institute. To learn more about any project highlighted in this article, please contact Mellie Villahermosa Pouwels via email at Mellie.Pouwels@ama-assn.org.

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10% OFF for AHME members!
Transforming CME: Update from the ACCME

Graham T. McMahon, MD, MMSc
President and CEO, Accreditation Council for Continuing Medical Education (ACCME®)

ACCME is on a mission to transform Continuing Medical Education (CME) through innovation, evolution, and alignment. To facilitate this transformation, we’re working to simplify the accreditation requirements and process, encourage and reward best practices in education, and increase the value of CME for all of our stakeholders.

The most visible change, you might say, is our new look, which was designed to convey the lifelong journey of learning and the forward trajectory of the CME community. You can see it on our website, www.accme.org. You can also find new marks for CME providers to use to communicate their accreditation status and the value of their work.

But the transformation doesn’t stop there; we’ve focused our efforts on renewing CME on a deeper level, too. From collaborating with organizations including the American Medical Association (AMA) and certifying boards, to reaching out to hospital and health system leaders about the importance of leveraging CME to improve patient care, we are striving to better meet the needs of education providers, clinicians, and teams where they live, work, and learn.

There are more than 1,800 accredited CME providers – and most of those, more than 1,000 – are hospitals and healthcare delivery systems. Hospital CME programs include more than five million interactions with clinician learners each year. This means that accredited CME is a tremendous resource offering institutions the power and capacity to address many of the challenges we face in our changing healthcare environment. At ACCME, we want to do everything we can to support you – our community of educators – so that you can continue to create “educational homes” that tackle health challenges while nurturing the professional development – and passion – of your learners.

AMA/ACCME Alignment and Simplification

In response to feedback from clinicians and educators, the AMA and the ACCME collaborated to simplify and align our expectations for accredited CME activities certified for AMA PRA Category 1 Credit™. Reflective of the AMA and ACCME’s shared values, the simplification is designed to encourage innovation and flexibility in accredited CME while continuing to ensure that activities meet education standards and are independent of commercial influence.

These changes do not represent any new rules for accredited providers. In fact, they mean fewer rules. As part of the alignment, the AMA has simplified and reduced its learning format requirements to provide more flexibility for CME providers. To further encourage innovation in educational design and delivery, CME providers may design and deliver an activity that uses blended or new approaches to driving meaningful learning and change. More information is available on the ACCME website.

CME that Counts for MOC

The ACCME has collaborated with certifying boards to facilitate the integration of CME and Maintenance of Certification (MOC), enabling CME providers to use one unified system to register CME activities that count for MOC. CME providers can now use the ACCME database to register activities and participant data for the American Board of Anesthesiology (ABA) Maintenance of Certification in Anesthesiology Program (MOCA®); American Board of Internal Medicine (ABIM) Medical Knowledge MOC points and ABIM Practice Assessment MOC points; and American Board of Pediatrics (ABP) Lifelong Learning and Self-Assessment for MOC Part 2. When activities are registered, they display in CME Finder, an online search tool, helping physicians to find accredited CME activities that count for MOC.

ACCME/ACGME Coordination

The ACCME has collaborated with certifying boards to facilitate the integration of CME and Maintenance of Certification (MOC), enabling CME providers to use one unified system to register CME activities that count for MOC. CME providers can now use the ACCME database to register activities and participant data for the American Board of Anesthesiology (ABA) Maintenance of Certification in Anesthesiology Program (MOCA®); American Board of Internal Medicine (ABIM) Medical Knowledge MOC points and ABIM Practice Assessment MOC points; and American Board of Pediatrics (ABP) Lifelong Learning and Self-Assessment for MOC Part 2. When activities are registered, they display in CME Finder, an online search tool, helping physicians to find accredited CME activities that count for MOC.
CMS Includes Accredited CME as an Improvement Activity in the Quality Payment Program Proposal

The Centers for Medicare & Medicaid Services (CMS) included accredited CME as an improvement activity in the proposed changes for the Quality Payment Program. The proposed rule would make changes in 2018, the second year of the Quality Payment Program, as required by the Medicare Access and Chip Reauthorization Act of 2015 (MACRA).

The proposed rule, if adopted, will provide more flexibility and freedom for educators to engage with clinicians in a learner-centered, quality improvement process. The inclusion of accredited CME reflects recommendations from the CME community. CME stakeholders, including the ACCME, suggested that CMS leverage the existing CME framework to simplify clinicians’ ability to meet the Quality Payment Program requirements and facilitate their participation. As the next steps, the ACCME anticipates collaborating with the CME community and CMS to identify a simple, nimble mechanism for reporting clinician engagement that will relieve the burden on clinicians.

Patient Engagement in CME

We believe that patients, families, caregivers, and public representatives can increase the relevance, meaning, and impact of CME when they participate as members of the education team. Patients, for example, often become experts in their condition, closely observe clinicians and the practice environment, and experience the intimacy of clinical encounters. Through sharing their experiences, they can provide essential feedback and can guide educators and clinicians in meeting their needs and priorities. That’s why we included Criterion 24, which recognizes providers that incorporate patients and/or public representatives as planners and faculty in planning and delivery of CME, in the Menu of Criteria for Accreditation with Commendation.

To help CME providers integrate patients and public representatives into CME, we’ve created a patient engagement in CME webpage with links to FAQs, examples, a tip sheet, CEO’s message, and video featuring the perspective of patients, advocates, physicians, and educators.

New Resources: Commendation Criteria and COI Flowchart

We’re pleased to share the following new resources, available on the ACCME website:

- **Criteria for Accreditation with Commendation Resources:** To support your implementation of the Menu of Criteria for Accreditation with Commendation, we’ve created resources for each of the five categories of the criteria. These resources include tutorials, video overviews, compliance examples, and FAQ.

- **Flowchart for the Identification and Resolution of Personal COI:** ACCME requirements are designed to ensure that accredited CME provides a safe place for learning, independent of commercial influence and conflicts of interest. To support compliance with the ACCME Standards for Commercial SupportSM: Standards to Ensure the Independence of CME Activities, we’ve created a flowchart tool that can be used as a simple, step-by-step guide to identify relevant financial relationships and resolve conflicts of interest in CME activities.

Leverage the Power of Education

In a recent invited commentary in *Academic Medicine,* “The Leadership Case for Investing in Continuing Professional Development,” I highlight principles and action steps for aligning leadership and educational strategy and urge institutional leaders to embrace the continuing professional development of their human capital as an organizational responsibility and opportunity — and to view engagement in education as an investment in people.

The commentary might prove a useful resource for you to start a conversation with your leadership about how CME can serve as a strategic partner to advance institutional goals. The more that we, as a community, invest in education, the more successful we will be, as we work together to achieve our shared goal of optimizing care for the patients we all serve.

For regular updates on ACCME, please visit our website (www.accme.org), or follow us on Twitter (https://twitter.com/AccreditedCME), Facebook (https://www.facebook.com/AccreditedCME), and LinkedIn (https://www.linkedin.com/company/AccreditedCME). For questions, email info@accme.org.

SAVE THE DATE

ACCME 2018 MEETING

Thank you to those of you who participated in our inaugural ACCME Meeting in April. More than 400 participants from across the CME and healthcare communities met to explore how evolution, innovation, and alignment in education advances health professional practice and patient care. Interested in joining us next year? We’ve already started making plans – save the date for April 16-19, 2018 and keep your eye out for more information at www.accme2018.org.
Best Practices from Our Members

AHME News likes to feature articles that highlight members’ best practices. We invite you to submit your institution’s best practices in any area of medical education to Jeff Levine, Editor, at jeff.levine@ahsys.org.

The following three articles are summaries of the first-place award-winning posters that were presented at the 2017 AHME Institute.

“TOOLS FOR WELLNESS” – COMMUNITY-WIDE PHYSICIAN WELL-BEING RESIDENT WORKSHOP

First Place Poster Committee Co-Winner at the 2017 AHME Institute

Bethany J Figg, MBA, MLIS - CMU Medical Education Partners Graduate Medical Education Department; Marge Thompson, MSA - Covenant Healthcare, Patient Safety and Quality Department; Mary Jo Wagner, MD - CMU Medical Education Partners Graduate Medical Education Department

Following our spring CLER site visit and the ACGME Symposium on Physician Well-Being, the GME Department partnered with our region’s two hospitals and healthcare professionals including patient safety and quality officers, risk managers, and spiritual advisors in our community to develop the resident workshop. The purpose of this event was to:

- Utilize educational intervention to promote resident physical and mental health.
- Demonstrate community-wide resources.
- Highlight the impact of physician well-being on professionalism and patient safety.

Interactive, hands-on short sessions were utilized and proved very popular. The residents indicated they would remember these lessons well:

- Each resident was provided with four oddly shaped decorative stones, and given instructions to write their top four current priorities or stressors on each stone (i.e. family, sleep, patient care). Next, they were instructed to try and balance all four stones. After failing to stack them vertically, they were encouraged to connect the stones horizontally. This demonstrated the ability to maintain balance by tackling each task singularly.
- Our Employee Assistance Program (EAP) spoke on resident self-care in the areas of coping mechanisms for stress, depression, and marriage counseling.
- A massage therapist from the rehabilitation department taught the residents stretches, proper stance for prolonged standing, and the utilization of a tennis ball in a long tube sock to self-massage muscle knots and pressure points in the back.
- A unique Inter-Faith Wellness Panel was assembled, including panelists with various professions, faiths, and cultural backgrounds to represent the diversity of the residents in our GME Programs. Each panelist described their background, how their belief system influenced their sense of well-being, and their practices to help them find and maintain peace and resilience.
- Several on-line resources were introduced and practiced including “Three Good Things” and “One Moment Meditation”.
- A packet of resources including contact information, services offered, and coupons to promote wellness and health were issued to each resident. Online access to all resources were posted on the residents’ intranet.
- At the beginning of the workshop, two patient safety events involving residents were presented. Closing the workshop was an interactive discussion identifying the contributing factors of fatigue and burnout on these events. Safety Behaviors such as Peer Checking and Coaching, Clarifying Questions, Checklists and S.T.A.R. (Stop, Think, Act, Review) were reinforced.

The Resident post-workshop survey indicated that during the following month, 79% would practice meditation, 79% will utilize massage, 73% would focus on personal beliefs/spiritual guidance, and 97% would use humor to reduce stress while promoting well-being. Many institutions are focusing on identifying depression and physician burnout, but our workshop took a proactive approach providing resources to help the residents decrease stress, and help them build resilience against depression and burnout.

EVALUATION OF RESIDENT REPORTED CONFIDENCE PERFORMING ENTRUSTABLE PROFESSIONAL ACTIVITIES

First Place Poster Committee Co-Winner at the 2017 AHME Institute

Steve Craig, MD and Hayden Smith, PhD, MPH - UnityPoint Health – Des Moines

The use of Entrustable Professional Activities (EPAs) in medical education was initially recommended by Olle ten Cate in 2005. EPAs are tasks and responsibilities that medical trainees are permitted to perform unsupervised once they have demonstrated sufficient competence. These activities are independently executable, observable, and measurable in process and outcome, and are therefore suitable for entrustment-based decisions.

In May 2014, the Association of American Medical Colleges (AAMC) published a document titled Core Entrustable Professional Activities for Entering Residents. The document extended the concept of EPAs to undergraduate medical education and outlined 13 professional activities that all graduating medical students should be able to perform when entering residency training.

To date, there have been no published studies examining the EPAs as a tool to help determine readiness for postgraduate training. Our poster summarized a one-year study conducted to examine entering resident self-reported confidence performing the 13 EPAs and how these confidence levels change during the first year of training. The study was conducted by the seven ACGME-accredited residency
programs affiliated with the Des Moines Area Medical Education Consortium during the 2015-2016 academic year. These programs included general surgery, internal medicine, pediatrics, two family medicine and two transitional year residency programs. There was a total of 46 first-year residents entering the programs in July 2015. Electronic surveys were administered at the beginning of residency training (baseline) and after 3, 6, and 12 months of training to all eligible residents.

Residents reported a high level of confidence performing four EPAs at baseline. These include performing a history and physical, documenting a clinical encounter, providing an oral presentation, and collaborating in an inter-professional team. Conversely, more than two-thirds of residents reported a lack of confidence performing four EPAs at baseline. These included entering and discussing orders and prescriptions, giving/receiving patient handovers, performing general procedures, and identifying system failures and contributing to safety/improvement. A significant positive trend in confidence from baseline to 12 months was seen in almost all EPAs. However, more than 10% of residents reported not being confident performing two EPAs after twelve months of training. The two EPAs were for performing general procedures and identifying system failures and contributing to safety/improvement.

With increased attention during postgraduate medical training on patient safety, these study findings raise concerns about what activities entering residents can be safely entrusted to perform. The results suggest that medical schools need to more closely examine the preparation of graduating students in these EPA areas. Residency programs at a minimum should not allow entering residents to perform these activities unsupervised until competence has been demonstrated. Entering residents should receive close supervision in the 13 EPA areas until faculty have observed and documented each entering resident’s competence in completing these varied clinical activities.

**RETHINKING RESIDENT RECRUITMENT: A NOVEL REGIONAL RECRUITMENT ROADSHOW**

**First Place Poster Viewer’s Choice Winner at the 2017 AHME Institute**

**Caroline C. Diez, BA, C-TAGME and Vinod Nambudiri, MD, MBA – Grand Strand Medical Center**

Residency recruitment is a costly, complex enterprise with a large applicant burden of both direct costs (often several thousands of dollars) and indirect costs (such as time away from educational experiences). While alternatives to standard on-site interviews have been trialed, they have yet to become a widely-accepted standard in the residency recruitment process. For applicants attempting to secure a Transitional Year (TY) residency spot, the challenges are compounded, as applicants must simultaneously interview for two residency positions. The problem is particularly challenging for candidates in our region, given the paucity of TY residency spots; in a three-state radius (Georgia, North Carolina, and South Carolina) there are 14 medical schools and only 50 ACGME-accredited TY residency positions. Our institution, Grand Strand Medical Center, hosts a 12-position TY residency program, accounting for 24% of the regional and 50% of state-wide spots.

We sought to alleviate the burden placed on TY applicants in the Southeast through implementation of a novel recruitment strategy. Additionally, we sought to provide applicants with an experience on-par with on-campus interviews by drawing upon the strengths offered during the in-person interview. We incorporated program leadership and representatives into each site visit. We began by using geographic filters to focus on applicants with ties to our three-state region. We then identified four regional cities that are home to academic medical centers (Augusta, Greenville/ Spartanburg, Columbia and Charleston). Candidates were selected for days based on geographic proximity. The interview days were divided into two sessions to minimize candidate time away from campus. These sessions were held close to each academic medical center. Two additional on-campus interview days with associated “open houses” at our institution were offered for applicants who were unable to attend the regional interviews, or for those participants who wanted to additionally visit our institution in person.

Overall, feedback was universally positive. The biggest strengths noted were the streamlined interview process and how it saved time and money. One weakness reported by candidates was only meeting one resident and one faculty member during the interview day. We interviewed 55 candidates across the four “Roadshow” dates. 90% of those candidates traveled less than 30 minutes for the interview. Of the 59 candidates interviewed regionally, 17 elected to attend our institution “open house” days. We interviewed an additional 32 candidates in Myrtle Beach. Our program matched in our top 50 ranked candidates. Within that top 50, 29 candidates attended our regional interview days, while the remaining 21 were interviewed on-campus. Out of the 12 matched residents, 10 were matched from our original catchment area, with two residents coming from our “Roadshow.”

We believe that this approach is a strategy that other residency programs can emulate for successful regionally-targeted, candidate-centered recruitment. This approach reduces the applicant burden while providing in-person interactions with key program leadership and current residents.
Details on AHME’s educational sessions are posted at [www.ahme.org](http://www.ahme.org) when registrations open. Notification is made via email so be sure to keep an eye on your inbox for upcoming events.

**EDUCATIONAL OPPORTUNITIES**

**AHME Academy**
The AHME Academy is a one-day primer for new residency program administrators to gain an overview of their duties and for experienced administrators to learn some fresh approaches to their responsibilities. Its format allows for great networking and opportunities to learn the latest and greatest happenings in medical education. They typically occur two times per year and are often hosted by a member hospital in easily accessible locations.

**AHME Webinars**
AHME conducts six webinars per year on topics relevant to the field of medical education. Hosted by a specific Council each time, the webinars are one hour in length and feature experts from around the country. And you don’t have to leave your desk to participate!

**Upcoming Webinar Schedule!**
AHME Members can register for the full series of webinars at a 25% discount. Members still have the option of registering for individual webinars at the regular rate of $100/per session.

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<th>Schedule</th>
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Package Price: $450.00 (includes 6 sessions shown in the schedule above)

Contact the AHME office at 724-864-7321 or info@ahme.org for more information or to receive the Webinar Package Registration Form. AHME members can also purchase the package on the Events page of the AHME website (www.ahme.org).

**REMEMBER AHME MEMBERS:**
Information about AHME happenings are communicated to the membership via Constant Contact, an email marketing provider. When you opt out of those mailings, you no longer receive information from AHME staff or leadership – including announcements about upcoming webinars and other educational opportunities. Don’t miss out! Stay connected by keeping your contact information current with AHME staff.
Pointe Hilton Tapatio Cliffs Resort – Phoenix, Arizona May 16–18, 2018

The Association for Hospital Medical Education is putting together an outstanding program for its 2018 AHME Institute! Sessions will include GME, CME and UME topics that are current, relevant, and important to medical education professionals. The presenters will feature some new faces as well as popular, seasoned conference speakers. All will be providing critical medical education updates.

Slated for May 16-18 in Phoenix, the 2018 AHME Institute will be one you won’t want to miss. Every room at the Pointe Hilton Tapatio Cliffs Resort is a suite with access to all that makes Phoenix so special, including desert charm and modern amenities. Add to that the classic meeting space, and you’ve got it all.

The Institute provides a large number and wide variety of educational sessions that will give you information and tools you can take back to your office and use right away. Below is the list of plenary session titles, as well as those being presented by organizations that contributed articles to this newsletter edition. Keep in mind that there are many other possible sessions you can attend! You’ll want to send multiple people from your office to maximize the learning.

The 2nd CLER National Report of Findings: A Preview
ACGME Update and Town Hall
Navigating the Self-Study and the 10-year Accreditation Site Visit: The “What, Why, and How” to Prepare Your Program
National Academy of Medicine GME Outcomes and Metrics Workshop: Genesis, Findings, and Implications for Medical Educators
Bridging the Generation Gap in Medical Education: Understanding the Millennial Learner
The Role of International Medical Graduates in the US Healthcare System: Past, Present, and Future
IMGs in US GME: ECFMG Update on the Educational and Immigration Requirements, Policies, and Best Practices
ACCME Updates
AMA’s Accelerating Change in Medical Education Initiative Update

The Institute is your one-stop opportunity to hear from the most influential people in key medical education organizations. Representatives will be on hand to present the most up-to-date topics from their organizations. AHME members and other experts in the medical education continuum fields will be well represented in the speaker roster as well.

Some of the other features of the 2018 AHME Institute include:
- Extensive programming with multiple breakout sessions
- Other experts in the field of medical education to provide you with the most up-to-date, nuts-and-bolts, take-and-use-today information
- Networking opportunities through meals and fun events
- An on-site poster session to present what you and your peers in other institutions are doing to improve and advance your programs
- Exhibitors with practical products and services to help you do your job
- Sessions expressly for Program Administrator & Coordinator learning
- Specific programming for Transitional Year professionals
- Dedicated sessions focused on topics specific to professional and faculty development
- Sessions geared to the work of your Institutional Leadership
- Information relevant to the Osteopathic educators community

At the Pointe Hilton Tapatio Cliffs Resort, you will find a lovely retreat nestled in the desert mountain landscape. And the educational program will be just as great: presenters from across the country who are bringing their expertise on a slate of topics designed to help you be better informed and better able to do your job.

The full 2018 AHME Institute brochure and other information will be available on the AHME website (www.ahme.org) in early November.
Welcome to the AHME MESSAGE BOARD CORNER.

In this section we highlight recent active Message Board threads which may be of special interest to you.

These threads are linked in the pdf version of the newsletter on the AHME website so you can go directly to the conversation and read the current content. If you are a member of the Message Board you can join in the conversation. Remember the AHME Message Board is open to all medical education professionals; not just AHME members.

Feel free to register yourself or send this link to others who may be interested:

AHME Message Board Registration Site

Or if you prefer, contact Quinn Turner, the Message Board Administrator at quinn.turner@unitypoint.org and he will get you activated.

Here are several recent threads:
- CCC Report Format
- Program Administrator Wellness Study
- ADS Update/Transitional Year Resident
- Medical Student Rotators - Handbook

AHME News Feedback

Please give us feedback on the AHME News content and coverage by sending an email to sandi@ahme.org. If you have ideas and suggestions for topics or questions you would like to see covered in the News, let us know. Counterpoint opinions on content and issues are always welcome and appreciated.

THE MESSAGE BOARD

has the following topic areas for medical education professionals to post questions and seek information from others:

- Undergraduate Medical Education
- Graduate Medical Education
- CME, CPD, and Faculty Development
- Miscellaneous Topics
- Program Administrator Forum
- Transitional Year Program Forum

If you haven’t done so already, please sign up and start sharing with the medical education community.
Guide to Medical Education in the Teaching Hospital

FIFTH EDITION

- 8.5x11; 650 pages; paperback
- Published in November 2016
- Chapters from AAMC, ABMS, ACCME, ACGME, ECFMG, FSMB
- Available through Amazon and Barnes & Noble
- For more information, www.AHME.org
President’s Corner
The Impact of Immigration Developments on U.S. Residency Recruitment and Health Care: A Perspective from the Educational Commission for Foreign Medical Graduates (ECFMG)
CLER Update
Single Graduate Medical Education Accreditation System Update
Fall 2018: The Accelerating Change in Medical Education Initiative

Transforming CME: Update from the ACCME
Best Practices from Our Members
“Tools for Wellness”– Community-Wide Physician Well-Being Resident Workshop
Evaluation of Resident Reported Confidence Performing Entrustable Professional Activities
Rethinking Resident Recruitment: A Novel Regional Recruitment Roadshow