ARTICLES IN THIS ISSUE

• Securing Your Greatest Economic Asset
• CME: Out with the Old and In with the New: The Next Accreditation System
Congratulations to Dr. Ruple Galani, 2019 DCMS President!

DCMS Leadership Academy
Building the next generation of physician leaders.

Topics include:
- Emotional Intelligence
- Strategic Planning
- Time Management
- Organizational Culture
- Management Styles
...and more!

DCMS members pay just $399 for the 3-day course

2019 Dates: Feb. 8, Mar. 8, Apr. 12

Space is limited
Call 904-355-6561 today!
Scenes from the Duval County Medical Society Annual Meeting and Inaugural Ball 2018
Securing Your Greatest Economic Asset

By Zachary Cohen, Financial Advisor

It’s disconcerting to think over one in four of today’s twenty-year olds will become disabled before they retire. Did you know that most physicians don’t have enough emergency funds to cover 35 months, which is the average duration of a long-term disability claim? Most people don’t appreciate the commitment and perseverance physicians demonstrate throughout their academic and working careers. Working endless hours for years and earning a minimal salary while stacking up student loan debt at close to 7% in medical school, makes everyone wonder, “was it even worth it?” Then you sit back and think about the income potential, a physician’s cumulative earnings over their career, it makes the sacrifice a little easier to swallow.

A disruption of cash flow as a result of a disability will lessen the likelihood of someone being able to justify the time, student loans and sacrifice they’ve made for the future. Disability income insurance is a protection plan every medical student, resident, fellow or physician should own to know their sacrifice was always worth it. It’s obvious this is something all professionals should have in place, but how easy is it to qualify for disability insurance and what’s the process? What other options are out there? Every sales person has a pitch and they all sound believable.

When you think about the causes for disability, usually accidents are not the culprit, but back injuries, cancer, heart diseases, and mental/nervous disorders, are the main reasons physicians lose their ability to earn a future income, with musculoskeletal disorders being the number one cause (disabilitycanhappen.org). The insurance companies know the risk to their bottom line, and are laser focused on the risk of covering your future income potential.

The cumulative benefit payout on a long-term disability policy is often around four to seven million. When you understand the risk to the insurance company, you can clearly see why the disability underwriting process can be stringent and intrusive and why disability plans can be so expensive. Although the price tag can be steep, this is the best option to protect someone’s future earnings ability. Unfortunately, physicians can’t rely on the social security disability program. In fact, for 2018, if you’re making over $1,500 per month, your payment would be reduced to zero (Dr. David A Morton III 2018).

What about your group disability offered through your employer? Many of us believe group disability is a sufficient option. Yes, it’s cheap and easy. However, group disability leaves a significant gap in coverage taking into account the taxability of benefits, caps on monthly benefits, limited definitions and portability issues. Most claims are not work related, and therefore not covered by worker’s compensation. Knowing your greatest economic asset in life is your ability to earn your future income potential, the only way to protect it is by owning the right individual disability policy for your specialty. An individual disability policy affords you the time necessary to recuperate before returning to work while replacing a greater percentage of income in the event you are unable to work due to an injury or illness.

I’m sure we would all like to avoid intrusive medical exams, bothersome insurance agents and the time-consuming underwriting process involved with obtaining an individual disability policy. There is a way! All employers should be aware of a program called Guaranteed Standard Issue or GSI. These programs avoid detailed medical underwriting, financial documentation and, more importantly, can protect those physicians with health issues from being limited or denied the ability to protect themselves adequately. The underlying product is an individual policy that’s individually owned and portable, meaning employees are in control of policy decisions and can take the policy with them if they leave their employer.

Given today’s competitive employment environment, employers are regularly looking for valuable benefits to attract and retain employees. What if there was a solution that could protect employees along with the future earnings trajectory of the business while providing potential tax benefits? By implementing a Guaranteed Standard Issue Plan, employers can also enjoy a year after year, annual tax deduction.

We understand there’s a real urgency to get the appropriate protection plan in place for your greatest economic asset, it’s important to be aware of all the options. Buyers beware of those insurance agents contracted to sell proprietary products for one institution. As an independent financial planning firm, we’d be honored to review your disability plan. We’ll provide a comparative analysis for the best available options depending on your state and medical specialty. There are various ways to structure a disability program, make sure you’re working with an advisor who can help you understand how these contracts work while providing you with the most suitable options available. St. Johns Asset Management is proud of our partnership with the DCMS. Through this partnership we are able to offer a permanent discount and streamlined underwriting, potentially avoiding the need for a medical exam for all members, including residents.

For eight years, Zach Cohen has specifically worked with doctors and healthcare executives in sculpting custom disability insurance plans. You can reach him at his Jacksonville office at 904-644-7803.


For eight years, Zach Cohen has specifically worked with doctors and healthcare executives in sculpting custom disability insurance plans. You can reach him at his Jacksonville office at 904-644-7803.

Out with the Old and In with the New: The Next Accreditation System

Background:
The Duval County Medical Society (DCMS) is proud to provide its members with free continuing medical education (CME) opportunities in subject areas mandated and suggested by the State of Florida Board of Medicine to obtain and retain medical licensure. The DCMS would like to thank the St. Vincent’s Healthcare Committee on CME for reviewing and accrediting this activity in compliance with the Accreditation Council on Continuing Medical Education (ACCME).

This issue of Northeast Florida Medicine includes an article, “Out with the Old and In with the New: The Next Accreditation System” authored by Leslie Caulder, BAS, C-TAGME, Jennifer Hamilton, BA, C-TAGME, Danielle Palmer, BAA, Denise West, MA, and Linda R. Edwards, MD, which has been approved for 1 AMA PRA Category 1 credit.™ For a full description of CME requirements for Florida physicians, please visit www.dcmsonline.org.

Faculty/Credentials:
Leslie Caulder, BAS, C-TAGME, Assistant Director, Education and Training Programs, Jennifer Hamilton, BA, C-TAGME, Residency & Fellowship Coordinator II, Danielle Palmer, BAA, GME Accreditation Administrator, and Denise West, MA, GME Accreditation Administrator, are with the Office of Educational Affairs, University of Florida College of Medicine-Jacksonville. Linda R. Edwards, MD, is the Senior Associate Dean and DIO at University of Florida College of Medicine-Jacksonville.

Objectives:
1. Identify the differences between the ACGME’s current Next Accreditation System (NAS) and the pre-NAS process
2. Understand the purpose of the Annual Program Evaluation and Self-Study
3. Be able to recognize the ACGME’s Milestones

Date of release: Jan. 1, 2019  Date Credit Expires: Jan. 1, 2021  Estimated Completion Time: 1 hour

How to Earn this CME Credit:
1) Read the “Out with the Old and In with the New: The Next Accreditation System” article.
2) Complete the posttest. Scan and email your test to Kristy Williford at kristy@dcmsonline.org.
3) You can also go to www.dcmsonline.org/NEFMCME to read the article and take the CME test online.
4) All non-members must submit payment for their CME before their test can be graded.

CME Credit Eligibility:
A minimum passing grade of 70% must be achieved. Only one re-take opportunity will be granted. If you take your test online, a certificate of credit/completion will be automatically downloaded to your DCMS member profile. If you submit your test by mail, a certificate of credit/completion will be emailed within four weeks of submission. If you have any questions, please contact Kristy Williford at 904-355-6561 or kristy@dcmsonline.org.

Faculty Disclosure:
Leslie Caulder, BAS, C-TAGME, Jennifer Hamilton, BA, C-TAGME, Danielle Palmer, BAA, Denise West, MA, and Linda R. Edwards, MD report no significant relations to disclose, financial or otherwise with any commercial supporter or product manufacturer associated with this activity.

Disclosure of Conflicts of Interest:
St. Vincent’s Healthcare (SVHC) requires speakers, faculty, CME Committee and other individuals who are in a position to control the content of this educational activity to disclose any real or apparent conflict of interest they may have as related to the content of this activity. All identified conflicts of interest are thoroughly evaluated by SVHC for fair balance, scientific objectivity of studies mentioned in the presentation and educational materials used as basis for content, and appropriateness of patient care recommendations.

Joint Sponsorship Accreditation Statement
This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of St. Vincent’s Healthcare and the Duval County Medical Society. St. Vincent’s Healthcare designates this educational activity for a maximum of 1 AMA PRA Category 1 credit.™ Physicians should only claim credit commensurate with the extent of their participation in the activity.
Abstract
Understanding and adhering to the Accreditation Council for Graduate Medical Education (ACGME) program requirements is essential for programs seeking initial accreditation or for those wishing to maintain accreditation. ACGME’s implementation of the Next Accreditation System (NAS) dramatically changed the way the organization accredits programs. This system has moved from a cyclical accreditation review process to a continuous accreditation model. The University of Florida College of Medicine-Jacksonville has implemented several processes, allowing institutional oversight of program accreditation to mirror the NAS process.

Introduction
The Accreditation Council for Graduate Medical Education (ACGME), founded in 1981, brought much needed organizational structure and educational standards to graduate medical education (GME) programs in the United States. In 2017-2018, the ACGME had at least 8212 sponsoring institutions and 11,140 residency and fellowship programs, with 136,828 housestaff receiving specialty specific training in those programs. Through the use of specialty Review Committee(s) (RC), the Council started on a journey to standardize educational practices, foster public confidence, and document physician competence. Physicians who completed an ACGME-accredited residency or fellowship program would have achieved specialty specific competence. Over the years, the ACGME has launched several influential initiatives to foster and encourage physicians to broaden their learning beyond the textbook. According to Nasca et al in the article, The next GME accreditation system: rationale and benefits, “The aims of the Next Accreditation System (NAS) are threefold: to enhance the ability of the peer-review system to prepare physicians for practice in the 21st century, to accelerate the ACGME’s movement towards accreditation on the basis of educational outcomes and to reduce the burden associated with the current structure and process-based approach.” The purpose of this article is to review the changes in the accreditation process and share how the University of Florida College of Medicine-Jacksonville (UFCOM-J) and its accredited residencies and fellowships have moved from the standard accreditation model to the Next Accreditation System (NAS), which launched in July 2013.

The Accreditation Process
In the NAS, initial accreditation has remained remarkably similar to the pre-NAS process. First, the application is submitted to the ACGME. The review committee either does a paper review or schedules a pre-accreditation site visit. Following the paper review or Site Visit (SV), the RC makes the accreditation status decision and approved programs receive initial accreditation. However, the process in the NAS has changed the continued accreditation flow. At the conclusion of the initial accreditation period, the ACGME awards one of four accreditation statuses: Continued Accreditation, Accreditation with Warning, Probationary Accreditation, or Accreditation Withdrawn. Prior to the implementation of the NAS, the ACGME determined a program’s accreditation status based upon data provided to the RC through submission of the Program Information Form (PIF) and the associated SV. Programs began preparing nine months to a year before the anticipated SV date. The program submitted the PIF to the site visit or approximately ten to fifteen days before the scheduled visit. After the visit, the SV team submitted their report to the RC for consideration at their next meeting. During the
Review Committee meeting, members evaluated the materials and determined the accreditation status based on the information from the PIF and the Site Visit Report. Programs received notification of the committee’s accreditation decision eight to ten months after the SV PIF submission. Continued accreditation statuses were set for periods between two and five years. Programs on probation could expect to have another SV within 15 months. Review committees made accreditation decisions based on a snapshot in time, or a biopsy, of the program’s adherence to the RC standards (Figure 1). The NAS has dramatically changed this process by replacing cyclical reviews with annual reviews.

During the pre-NAS cyclical accreditation process, institutions were required to perform a programmatic Internal Review (IR) at the mid-point of the accreditation cycle. The institutional requirements did not specify how this internal review was to be conducted, only that it would occur. At UFCOM-J, the process included a panel review and interview session. The panel consisted of the Designated Institutional Official (DIO), who was also the Senior Associate Dean for Educational Affairs, the Associate Dean for Educational Affairs, two or more program directors and/or associate program directors, a hospital administrator, and a resident/fellow from another program. The program director was required to complete an internal review form addressing citations, attrition, board certification, in-service examinations, and program requirements. In addition, the program’s residents/fellows and faculty completed an anonymous survey assessing the program. The panel reviewed the completed PIF and survey results prior to a scheduled IR meeting. The meeting included separate group interviews with the faculty and trainees to discuss any issues identified on the survey and the program as a whole, as well as an interview with the program director and coordinator. An internal review report was provided to the Graduate Medical Education Committee for review and approval. The internal review report identified issues and assisted the program director with the development of solutions prior to the next ACGME Site Visit. Post-NAS, the ACGME no longer requires internal reviews. The UFCOM-J continues to conduct IRs of all programs in the initial accreditation phase to ensure that new programs remain in substantial compliance with the ACGME common and program specific requirements.

### Annual Program Evaluation (APE)

As a part of the new Common Program Requirements (CPRs) implemented through NAS, all programs are required to complete an Annual Program Evaluation (APE). The APE is a self-assessment that mirrors information requested annually by the ACGME through the Accreditation Data System (ADS). Even though the institution is no longer required to complete internal reviews, programs in continued accreditation status complete the annual review process using the institution’s Annual Program Evaluation Review (APER) form.

Again, the institutional requirements do not specify how to accomplish the annual review. To accomplish this requirement, the UFCOM-J established a Committee for Annual Program Evaluation and Review (CAPER), a subcommittee of the Graduate Medical Education Committee (GMEC), charged with reviewing each program’s self-assessment/APE for compliance with ACGME program standards. Table 1 lists the key focus areas for CAPER participants. The program director and coordinator complete a UFCOM-J standardized Annual Program Evaluation and Review
(APER) form and provide supporting data, which is then reviewed/evaluated by faculty and residents during their Program Evaluation Committee (PEC) meeting. During the PEC meeting, the program develops action items and timelines for improvements in the following areas, as applicable: 1) self-identified areas of weakness; 2) citations or areas of concern in the ACGME’s most recent Accreditation Letter; and, 3) items marked as non-compliant or needs improvement during the previous year’s APE review.

A primary and secondary reviewer analyze the submission, comparing the program’s data with the RC’s requirements. The reviewers share their analysis at the CAPER meeting, where the committee mutually decides the recommended final statuses: continued annual review, follow-up review/progress report, or special review. The committee chair provides the GMEC with an executive summary of each program and recommended status for the GMEC’s final approval. The CAPER’s detailed review provides timely identification of areas of concern or potential non-compliance.

The CAPER provides the DIO with data across all programs, allowing the institution to examine trends and to identify areas of improvement needed on the program and/or institutional level. The trends sheet (“dashboard”) provides a visualization tool of each focus area to create action items for possible implementation during the next academic year. The Office of Educational Affairs (OEA) identifies trends through data analysis of the focus areas. The trends sheet in Table 2 lists the programs across the top and key areas from the APER form on the left side.

Self-Study and Programmatic Site Visit

To bolster this new era of program introspection, the ACGME also implemented the Self-Study (SS). The programs self-assessment through the APE provides the foundation for the Self-Study. According to the ACGME, “The Self-Study is an objective, comprehensive evaluation of the residency or fellowship program, with the aim of improving it. Underlying the Self-Study is a longitudinal evaluation of the program and its learning environment, facilitated through sequential annual program evaluations that focus on the required components, with an emphasis on program strengths and ‘self-identified’ areas for improvement.”

The Self-Study is an eight-step process: 1) Assemble the Self-Study group, 2) Engage program leaders and constituents in a discussion of program aims, 3) Aggregate and analyze data from the program’s APE and the Self-Study to create a longitudinal assessment of program strengths and areas for improvement, 4) Examine the program’s environment for opportunities and threats, 5) Obtain stakeholder input on strengths, areas for improvement, opportunities, and threats to prioritize actions, 6) Interpret the data and aggregate the self-study findings, 7) Discuss and validate the findings with stakeholders, 8) Develop a Self-Study document for use in further program improvement as the

<table>
<thead>
<tr>
<th>Table 1: CAPER Key Focus Areas:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Annual Program Evaluation/Program Evaluation Committee (PEC)</td>
</tr>
<tr>
<td>- Faculty List</td>
</tr>
<tr>
<td>- Survey Results- Assess results, identify areas of concern, develop a plan to improve</td>
</tr>
<tr>
<td>- Citations</td>
</tr>
<tr>
<td>- Board Certification</td>
</tr>
<tr>
<td>- In-training Exam</td>
</tr>
<tr>
<td>- Scholarly Activity</td>
</tr>
<tr>
<td>- Clinical Measures- Based on data from chosen key clinical indicators</td>
</tr>
<tr>
<td>- Patient Safety</td>
</tr>
<tr>
<td>- Quality Improvement and Work in Inter-professional Teams</td>
</tr>
<tr>
<td>- Supervision</td>
</tr>
<tr>
<td>- Professionalism [includes code of conduct violations (warnings and disciplinary actions)]</td>
</tr>
<tr>
<td>- Faculty Development (Individual faculty participation in faculty development activities in education)</td>
</tr>
<tr>
<td>- Didactic Curricula</td>
</tr>
<tr>
<td>- Milestones- Assess trends in aggregated resident/fellow performance on milestones to affect curricular change</td>
</tr>
<tr>
<td>- Rotation Review- Identify changes and improvements that need to be made to the curriculum (adding or removing rotations or sites and making improvements to specific rotations)</td>
</tr>
<tr>
<td>- Case Logs</td>
</tr>
<tr>
<td>- Goals and Objectives</td>
</tr>
<tr>
<td>- Clinical Competency Committee (CCC)</td>
</tr>
<tr>
<td>- Learning and Working Environment</td>
</tr>
<tr>
<td>- Well-Being</td>
</tr>
<tr>
<td>- Evaluations</td>
</tr>
<tr>
<td>- Transitions of Care</td>
</tr>
</tbody>
</table>